SOME LEGAL ASPECTS OF HUMAN ORGAN TRANSPLANTATION IN CANADA

J.-G. CASTEL*

Toronto

Introduction

On March 16th, 1968, Philip Blaiberg, the then world lone heart transplant survivor left the Groote Schuur Hospital in Cape Town, South Africa. He was accompanied to the entrance of the hospital by Dr. Christiaan Barnard, who headed the transplant team that gave the fifty-three year old dentist the heart of Clive Haupt, a twenty-four year old coloured man who died of brain damage after collapsing on a beach.¹

For centuries man had been searching for a way to transplant body organs or parts from a healthy animal or individual into another animal or person whose organs or parts had been destroyed or damaged by disease or injury.

¹The operation on Dr. Blaiberg was the third of its kind. The first heart transplant operation took place in South Africa, on December 3rd, 1967 and involved Mr. L. Washkansky. The patient survived eighteen days. On December 6th, 1967, Dr. Kantrowicz of New York performed a similar operation on a baby. The operation was unsuccessful. Since that time almost thirty heart transplant operations have been performed in several countries of the world with varying degrees of success.

At a meeting of the Council for International Organizations of Medical Sciences, held in Geneva in June 1968, which was devoted to heart transplants and attended by twenty-four of the world's most prominent heart surgeons, it was said that “heart transplants at the moment are a form of palliative (temporarily or superficially relieving) of an exceptional character, the results of which are not yet determined”.

*J.-G. Castel, S.J.D., of Osgoode Hall Law School, York University, Toronto.
It is only since World War Two that attempts to transplant skin, bone, corneas, kidneys and more recently hearts, have proven successful. Actually, surgical questions concerning transplantation were solved around 1950, and the internal medicine problems around 1956. Compatibility questions, however, are just beginning to be sorted out in the major medical centres of the world.

Today, as the successful Cape Town operation indicates, the technical difficulties involved in transplants have to some extent been overcome and considerable progress has been made towards solving the immunological problems.

The first organ transplantation was performed in Boston in 1954, when a healthy kidney from one identical twin was successfully transplanted into the other twin who was dying of kidney failure. Since that time, more than two thousand kidney transplants have been given to patients around the world with a large number of recipients surviving with functioning kidneys for up to three years.

The recent dramatic developments in heart transplantation in South Africa, in the United States of America, France, England and Canada indicate that other vital organs also may be successfully transplanted. Attempts have already been made to transplant the liver which involves a more difficult operation because its functions are more complex than those performed by the heart, which, after all, is principally a pump and consists of tissues from a germinal source. Some day, it may be possible to transplant someone’s reproductive organs, or brain.2

Human organ transplantation poses difficult technical, ethical, moral and legal problems which concern not only practising doctors but also lawyers, moralists, sociologists and the community at large. The Nuremberg trial has clearly demonstrated the dangers involved when experiments are performed on healthy human subjects. “Science has made us Gods before we are even worthy of being men.”3

On the question of transplants, the law has not greatly cooperated with the medical profession. It has not kept pace with scientific advancement in this field of medicine. Court decisions are rare and of little assistance, as common law and statute law contain a great number of obsolete rules especially with respect to dead bodies, the prime source of transplants. Even recent legis-

---


3 J. Rostand, Pensées d’un biologiste (1939).
Human transplants bring many moral and ethical problems to mind. For instance, is it right for the hope of patients for survival to be based on the expectation of death of others? Is it ethical for a surgical team to await the death of one patient to save another? Is it right to remove an organ from a healthy live donor when the recipient's prolongation of life after treatment is limited to one, two or three years? Will the transplant do any good? More generally, is the right to experiment a fundamental freedom for the physician? What are its limitations? How should the recipients be selected when there is a shortage of donors and equipment? On what basis should such a choice be made? For instance, should an infant of tender years or an unskilled individual's life be prolonged? Who is qualified and has the right to adjudicate the value of someone else's years? To what extent is a surgeon in a position to choose between the risk incurred by the donor of the transplant and the value of the life of the recipient?

However, see Burger, Reflections on Law and Experimental Medicine (1968), 15 U.C.L.A. L. Rev. 436: "The complaint of some is that our standards of ethics and rules of law do not keep pace with scientific developments and the potentials of experimental medicine, and thus do not give experimental programs a free rein. This is probably correct. Law and ethical standards are not subjects of research and discovery; they are the fruits of slow evolutionary processes. The law does not search out as do science and medicine; it reacts to social needs and demands. Law is not an end in itself—it is a tool, a means. Tools are not ordinarily made to hammer out solutions to hypothetical problems but for real problems, which means that the problem must arise, exist, and be recognized before the law reacts to provide a solution. Here is where science and law differ. We cannot, therefore, compare rates of development in such dissimilar areas as science and medicine with law and ethics."

In the case of a transplant from a live donor, the problem of selection is unlikely to arise as the recipient must find his own donor. With respect to transplants from cadavers, the choice is usually determined by medical criteria and the recipient's availability at the time of the donor's death. When there are several available and compatible recipients, it would seem that the selection of one of them should not be made by ad hoc comparative judgments of social worth.


At a recent meeting of heart surgeons convened in Geneva by the Council for International Organizations of Medical Sciences, it was unanimously decided that the choice of a heart donor must be guided by the following considerations:

"1. His heart must be in perfect condition at the time of removal."
To attempt to solve these moral and ethical problems uniformly is almost impossible as the answers would depend primarily upon a person's religious views, his attitude to the sanctity of the human body and his respect for the individual.  

I. Medical Aspects of Transplantation.

It is difficult to appreciate the ethical, moral and legal aspects of human organ transplantation without some knowledge of its technical aspects as, historically, significant advances in medicine have resulted in many dogmatic declarations by men not fully acquainted with the technical aspects involved. For instance in 1796, when Jenner first attempted smallpox vaccination, the great philosopher I. Kant stated that such an experiment had lowered mankind to the level of animals. Animality, he said is being inoculated to man.

Every time that the loss or failure of a vital organ of a patient endangers his life and such loss or failure cannot be compensated for either by some other organ assuming an additional load as in the case of kidneys, or by a mechanical appliance or an artificial organ, modern medicine has recourse to homotransplants. However, the major limitations of this new technique is the shortage of supply. Of course, eventually, the best way to overcome this shortage of supply is to solve the immunological barrier to heterotransplantation or to make available artificial organs that are permanently built into a patient.

1. General.

Transplants are generally divided into the following categories:

2. An immunological examination of the compatibility of donor and receiver must precede the transplant.
3. The examination of the donor must reveal a state of complete and irreversible abolishment of the brain's functions.  

4a Note that at the time of writing (April 1968), in England, a Committee of medical, legal and religious leaders appointed by the Minister of Health to study the ethical, legal and moral issues involved in transplant operations had not yet made its report.

5 In general, see Woodruff, M.F.A., The Transplantation of Tissues and Organs (1960); Starzl, T.E., Marchiora, T.L. et al., Transplantation (1964); Murray, J.E., Gleason, R., Bartholomay, A., Transplantation (1965).

6 No one knows precisely how many people die each year who might be saved by kidney transplants. In the United States of America estimates range all the way from 6,000 to 20,000. No more than 450 patients receive kidney transplants annually.

7 A new serum made of antilymphocyte globulins and injected into the recipient reduces the chances of transplant rejection. Lymphocytes (small white corpuscles) belonging to the intended recipient are injected into an animal (horse or ewe). As a result, the animal produces an anti-serum from which the globulins are extracted.
autotransplants, isotransplants, homotransplants and heterotransplants.

A. Autotransplants are pieces of tissue (or possibly organs) transplanted from one part of the patient's body to another. Autotransplantation can be used only where the patient is able to withstand the loss of tissue from one part of his body to be grafted to another.

B. Isotransplants are pieces of tissue or organs transplanted from one identical twin to another.

Unless technical problems develop, autotransplants and isotransplants are almost always successful as the rejection reaction is non-existent. In the case of identical twins the donor and the recipient are histocompatible.

C. Homotransplants are pieces of tissue or organs from one person to be transplanted to another (or in animal experiments, transplants from one animal to another of the same species). Ordinarily such transplants may survive for a few days or weeks before they are destroyed as a result of an immunological reaction of the body which regards the transplanted tissues or organs as foreign. However, when the tissue transplanted is avascular (or structural) as for instance in the case of the cornea or blood vessels, the transplant will generally be successful. Otherwise, in order to be successful, the recipient's reaction to the transplant must be abolished or weakened by some immunosuppressive therapeutic procedure.

D. Heterotransplants are transplants from an animal to man or from an animal of one species to a recipient of another species. So far such transplants have not been successful as they are quickly rejected by the recipient's body.

Homotransplants are usually classified in the following categories:

i) Pieces of tissue or organs given voluntarily by living donors. For obvious reasons, such donations are limited by the nature of the tissue or organ. It is not possible to give one's liver or heart and survive whereas this is not so in the case of a kidney. In general, kidney transplants from live donors do not present a danger to them if they are in good health, as a person can live as well with one kidney as with two. The risk for the donor is 0.12% and

---

^8 It was reported in March 1968 that University of Miami investigators may be on the right track in search of a way to transplant animal kidneys into people. Graft rejection is closely connected with a mysterious substance called complement.
is estimated by insurance companies to be identical to a ten mile car trip per work day. However, there always is an operative risk that the healthy donor might suffer some injury.

ii) Pieces of tissue or organs removed in the course of ordinary surgical operations. In practice, it is very rare that such material can be used by another patient.

iii) Pieces of tissue or organs removed from dead bodies. In this case, obviously, there is no risk to the donor. Dead bodies are the only source of transplants for organs such as the heart or liver. The success of the transplantation depends upon the type of tissue or organ involved and the speed with which it is removed after the death of the donor. Some organs must be removed before they have been irreparably damaged by lack of blood circulation. It is also possible that the deceased's organs are diseased and thus unsuitable for transplantation.

Skin, bones, blood vessels and corneas, can be removed or transplanted many hours after death and have a low incidence of rejection reaction. On the other hand, kidneys and the liver deteriorate rapidly and must be transplanted soon after cessation of circulation in order to survive and function.

If the kidneys can be removed and perfused in less than one hour after cessation of circulation in the donor, the chances for survival are good.9

The heart may survive at least two hours without changes due to a complete lack of blood circulation.

2. Death.

Medically, it is very important to define the moment of death so that removal of tissue or organs, when legally permissible, can take place as soon as possible. In other words, what is the earliest time at which a transplant may be removed?

Advances in resuscitation and techniques for bypassing the heart and reducing the body's oxygen require a revision of present ideas on the diagnosis of death. In some instances a patient's respiration and heartbeat may be maintained by artificial means

9 Kidneys begin to deteriorate immediately after circulation has stopped and will not “keep” more than about four hours. Recently Dr. F. O. Belzer of the University of California disclosed that he has devised a kidney preserver which he hopes will keep kidneys in good condition for as long as three days thus giving the surgeons time to do the necessary tissue matching and to select the recipient who is most likely to accept the donor's kidney without rejection. Dr. Belzer is planning to modify the machine so that it can preserve hearts (Time Magazine, March 22nd, 1968, Canada Edition, p. 53).
for a long period of time. A heartbeat can also be restored by external or internal massage, by the use of an electrical pacemaker, or by electric defibrillation.

It is possible for a person in a state of artificial survival to "die" while some of his organs continue to be irrigated by machines for some time afterwards. Conversely, a person is not necessarily dead because his heart has ceased to beat.

The question that arises is whether a vital organ can be removed from a person who still has a heartbeat and a circulation and who according to ordinary standards is alive although he is a "living cadaver" because irreversible destruction of brain matter with no possibility of regaining consciousness has taken place.

The traditional tests of death may be stated in this way: "the apparent extinction of life, as manifested by the absence of heartbeat and respiration". Approaches of this kind were formulated at a time before certain body functions could be artificially prolonged. They served well the society they were designed to control. Now the context has changed. The need for review of traditional tests of death has been given additional emphasis by the development of sophisticated homotransplantation techniques.

Two basic questions seem to be involved in the case of a patient whose "life" is artificially maintained by mechanical devices, as for instance a respirator or an electric pace-maker, although he has had irreversible destruction of brain matter and is not salvageable. The patient has no hope of ever regaining consciousness and if the respirator or pace-maker is stopped, his heart and circulation will also stop within a few minutes. As mentioned earlier the first question is whether it is legally and ethically possible to remove a vital organ while the heart is still beating or before the respirator is turned off. There is an additional issue as to whether and at what stage, without incurring the danger of a possible charge of homicide, a physician may turn off the respirator and wait for the heartbeat to stop so that the patient is dead according to the conventional definition of death and it is permissible to remove the organ in question.

Discontinuation of extraordinary measures to keep a patient alive may perhaps be morally justifiable but under the classical definition of death an irreversibly unconscious person whose life depends on a machine is still alive and until "death" occurs it is forbidden to interfere with his body.

The conclusion that a person is dead,—who has been kept

---

alive by artificial means—should be based on proof of the existence of irreversible lesions inconsistent with survival, especially the destructive and irreversible character of changes in the central nervous system considered as a whole.  

In the case of a person in a vegetative state, it has been said by experts in the field that it is possible to establish death by the use of an electroencephalograph and a variety of other physiological measurements other than the absence of a heartbeat and cessation of respiration.

When the chances of recovery of consciousness have been totally eliminated, brain death has occurred, although everyone agrees that lack of function of the mind alone is insufficient evidence of death. The physician must be sure that the brain is so damaged that consciousness cannot be regained.

Some physiologists accept one minute of electroencephalograph silence as uncontroversial proof of death, others three or five minutes.

This test is not sufficient, as there should be no error in the diagnosis of death, especially in transplantation operations, as the donor must be protected against a surgeon exercising too much haste in removing vital organs in circumstances where medical resuscitation is still possible. The prospective donor's fundamental right to live must be respected. Also, the surgeon is entitled to be guided by rules that will protect his freedom and foster progress in the science of transplantation.

To sum up, the classical signs of death must be re-examined by the medical and legal professions and brought up to date for purposes of transplantation.

Death, however, does not lend itself to a purely legal definition. It is essentially a technical professional medical problem. The law must allow physicians to decide the moment of death on the basis of medical evidence. What is needed is a medical definition of death that would have legal force. In other words, medicine and the law must agree to define death upon well-established medical principles. In this respect the physiologist must play a leading role.

11 In most countries the present medical tests of death are: the absence of heartbeat and respiration, dilated pupils (mydriasis) and the total lack of reflexes.
13 In France for instance, until recently, the Code Napoléon (art. 77) stated that the officer of civil status had to ascertain the death of a person. Since March 28th, 1960, this ascertainment is made by a physician.
Although death is primarily a medical question, the law should nevertheless devise certain procedures designed to protect the patient's life against the danger of a hasty diagnosis. For instance, the death certificate of a patient kept "alive" by artificial means should be issued only after consultation with at least three physicians. If a transplant is envisaged, the team performing the operation should not be involved in the ascertainment of the death of the donor. It should only proceed after a decision has been reached as to death and the machines have been turned off by the attending physician upon the advice of two other physicians including at least one or two specialists. The members of the transplant team naturally interested in saving their patient should not be placed

four hours must elapse between the time of death and the interment or an autopsy. (Note that in the case of autopsies, a law of February 7th, 1924 required death to be established by the absence of heartbeat and respiration.) This delay makes it difficult to perform transplant operations. On October 20th, 1947, however, a government decree declared that, in a restricted number of hospitals "si le médecin-chef de service juge qu'un intérêt scientifique ou thérapeutique le commande, l'autopsie et les prélèvements pourront, même en l'absence d'autorisation de la famille, être pratiqués sans délai". (See also government directive of January 27th, 1955.) Two of the hospital's physicians must ascertain the death of the donor by application of traditional tests. These tests which were to be found in government directives (e.g. February 3rd, 1948, September 19th, 1958. An early diagnosis of death could be established, independently of, or in addition to, direct examination, by several exploratory methods) have now been changed. On April 27th, 1968 an official definition of death was adopted by the Council of Ministers upon recommendation of the French Academy of Medicine. The absence of heartbeat, blood circulation and of respiration are no longer to be considered as signs of death. The clinical signs of death are now the total absence of cerebral activity evidenced by several flat electroencephalograms as well as a complete lack of reflexes for a sufficient period of time.

Note that on December 15th, 1967, Mr. Gerbault had introduced a bill (No. 621) in the French National Assembly which purported to define clinical death and to allow the removal of organs for transplanting purposes.

In England a group appointed by the British Medical Association to define the point of death is still searching for an answer (April 1968).

A conference called by the Minister of Health which met on March 6th concluded that "no attempt should be made to lay down a legal definition of death or rules which doctors should observe" Hansard, House of Commons, March 25th, 1968, col. 217. However, the Minister's conference recommended that to allay public disquiet vital organs should not be removed from a donor "until spontaneous vital functions had ceased".

It has been suggested that a patient's "death" whose "life" is artificially maintained by mechanical devices should be established by proof of irreversible damage incompatible with life, e.g. the irreparable character of the alterations of the central nervous system taken as a whole. This proof would be based on a systematic analysis of the circumstances in which the lesions took place; on the total absence of all reflexes; on the presence of complete bilateral mydriasis, a flat encephalogram and the artificial nature of blood circulation and respiration the spontaneous activities of which are null or incapable of maintaining vital functions without mechanical devices; and, possibly on the existence of large lesions of the central nervous system directly observable as in the case of open head injuries.
in a position of conflict of interest. Conversely, the medical team working to save the donor's life should not be the same as the one looking after the intended recipient of the transplant.

From a moral and ethical point of view, a very important question is—assuming that all hope is abandoned for saving the patient—when can supportive therapy be withdrawn? Is it right in such a case to maintain the circulation and the respiration by artificial means for the sole purpose of saving this patient's vital organs which if transplanted into another person might save the latter's life? If the physician were to wait until death occurred in the conventional sense, the possibility of a successful transplantation would decrease considerably.

It must be noted that in 1957, Pope Pius XII when asked in which circumstances a doctor should stop artificial respiration to a patient who is virtually dead, replied that any mechanical devices designed to prolong life involved extraordinary treatment. A physician is only obligated to give ordinary treatment to a patient. If the physician, after consulting the patient's family, believes that there is no hope of prolonging life without the equipment, he is morally entitled to stop the respirator. Death is caused by the disease or injury not by stopping the machine. The Pope indicated that Roman Catholic theology was not concerned with the definition of death.\(^\text{14}\)

From a psychological point of view, it is doubtful whether the public at large would accept the idea of removal of vital organs from "living" persons prior to what is now commonly accepted as death.

Perhaps, from the point of view of an individual's right to life, because of the special interest of transplanters and possible abuses, it might be better not to extend the definition of death but rather restrict it.

II. Legal Problems.

We are concerned here with homotransplants although it is quite possible that in the near future heterotransplants will also be successful.

What are the legal problems involved in human organ transplantation?\(^\text{15}\) In general, they are related to live donors, cadavers.

---


Some Legal Aspects of Human Organ Transplantation

recipients, attending physicians and next of kin. For instance, in what circumstances may a volunteer donor be considered free from undue influence? Is it legal to "mutilate" a healthy donor for the advantage of another person? Should the donation of organs or parts of the body be limited to those that could not produce a permanent deficiency in the donor? Should the donor be allowed to consent to a serious operation upon himself for the benefit of another, especially when, as a result of the removal of the donated organ, his health might be seriously endangered with only the prospect of a moderate prolongation of the receiver's life? Should the State intervene in such cases? What type of special protection should be given to minors, people of low intelligence or prisoners in regard to donations of organs or tissues?

Should death be defined and, in this connexion, for how long should "life" be maintained in a donor with irrevocable damage to the brain? When does death occur if such a "life" is artificially maintained?¹⁶

Should payment or indemnification be received by the donor for his organs? More generally, should human organs or tissues be available for sale?

If it is legal to sell organs, must the amount of money paid to the donor be included in his income tax or is it a capital gain? Is the sale subject to sales tax? If the organ is given by the donor to the recipient, should a gift tax be paid? Finally, should the value of usable organs from cadavers be included in the decedent's estate?

What are the standards to be applied to the recipient's consent to a transplant?

Is it suicide if the intended recipient of a transplant refuses to be operated upon?

Should parents or guardians have the right to refuse treatment to their children?

Should a surgeon be allowed to take an organ out of a cadaver without the deceased family's permission in order to save a life? What can or cannot be removed from a cadaver and who can give

¹⁶ See preceding section.
legal permission? Are testamentary bequests binding on the heirs or next of kin?

Which provincial law applies in determining who controls the body of a deceased person?

What type of regulations are necessary to control the interprovincial shipment of organs?

Should penalties be provided for wrongful removal of organs from a live donor or from a cadaver?

Has a dead body "human” rights to be protected?

What would be the liability of a surgeon who lost a patient, the recipient, owing to his ignorance of the very latest developments in regard to compatibility or some other aspect of transplantation?

Some of these questions will be examined in this article, having in mind existing legal rules in Canada. As many of these questions have not yet been considered by the courts or the legislatures, an attempt will be made to suggest some possible answers and the areas where legislative action should take place.

In the field of transplantation, the practical possibilities are limitless. Scientific progress is so rapid that it is not easy for the law to keep up with it. New techniques require new regulations. The legal solutions must be constantly reappraised to reflect medical improvements as they affect present-day life. The various Human Tissue Acts adopted by the Provinces of Canada are, in some respects, already obsolete and need to be revised. In view of the tremendous future of organ transplantation and the public interest it has aroused, the legislator, once appraised of the problems involved, must step in and, in consultation with the medical profession, adopt rules that will protect the individual against possible abuses but at the same time remove some of the legal constraints that might limit further medical progress. Laws dealing with scientific matters should be periodically revised. There is hardly any reason why the body of a deceased person could not be made available to any designated hospital automatically upon death to provide organs for someone else, unless the hospital authorities have reason to believe that the deceased in his lifetime had forbidden this to be done.

1. Problems Relating to the Live Donor, the Recipient, the Hospital and the Members of the Team Performing the Operation.

A. General.

A surgeon owes to his patient a duty in tort as well as in con-
tract. He is civilly liable in damages if he performs an operation in a negligent and unskilful manner. In some of these cases, he may also be charged with criminal negligence. If he operates without the express consent of the patient, except in cases of emergency, when obviously, the operation is necessary to save life, he is civilly liable for assault (if the patient is conscious at the time) and battery.

From a philosophical point of view, it is objectively difficult to accept the view that a transplantation operation or any other necessary operation is a lawful infliction of harm. As far as the recipient is concerned, it certainly is a beneficial act. Naturally before an operation, the hospital and the members of the transplantation team will want to be certain that they are protected from possible legal action by the donor or the recipient.

B. Professional Skill and Knowledge.

Would the members of the transplantation team be civilly liable if they lost the recipient of the transplant as a result of their ignor-


In general see Prosser, Handbook of the Law of Torts (3rd ed., 1964), pp. 33 et seq., 102 et seq., 164 et seq.; Gray, Law and the Practice of Medicine (1953); Wasmuth, Law for the Physician (1966); Fleming, the Law of Torts (3rd ed., 1965), pp. 115-116; Haines, Gibson, Courts and Doctors (1952), 30 Can. Bar Rev. 483, 498. For the civil law position see Crépeau, La responsabilité civile du médecin et de l'établissement hospitalier (1956); La responsabilité médicale et hospitalière dans la jurisprudence québécoise récente (1960), 20 R. du B. 433; La responsabilité civile médicale et hospitalière (1968); Meredith, Malpractice Liability of Doctors and Hospitals (1956); Savatier, Problèmes juridiques de la greffe humaine, Cahiers Laënnec (1956), No. 1, pp. 21-27. In a recent case, Sirianni v. Anna (1967), 285 N.Y.S. 2d 709, it was held that a cause of action did not exist in favor of a donor of a human organ against a defendant who removed a vital organ from the donee in a negligent manner. The court was of the opinion that the conduct of the donor in surrendering one of her kidneys to preserve the life of her son was a clearly defined, independent, intervening act with full knowledge of the consequences. There was no room for the “rescue doctrine to apply”. (See Eckert v. Long Island Railroad Co. (1871), 43 N.Y. 502; Wagner v. International Railway Co. (1921), 232 N.Y. 176, 133 N.E. 437, 19 A.L.R. 1.) The plaintiff had alleged that her health had been impaired by the loss of one of her kidneys which she had voluntarily donated to her son who was dying of a kidney ailment. She sought damages against the defendants on the theory that their negligent conduct in removing the kidneys from her son was available to her in order to maintain the action.

ance of the latest developments in the field of transplantation?

The answer to this question is the same for any kind of new treatment. The members of the team would not incur liability if they made diligent use of all the information which could reasonably be available to them.21

In general, each case must depend upon its own circumstances. A surgeon is not an actual insurer, he does not undertake that he will cure.22 He only owes a duty to the patient to use the diligence, care, knowledge, skill and caution in performing the operation of an average technician of the special class to which he belongs.23 If he holds himself out as a specialist in transplantation techniques and the patient accepts treatment with that understanding, he must possess a higher degree of skill with respect to transplantation than the ordinary surgeon.24 The standard of care is modified accordingly.

The size and character of the community in which a surgeon practises, and the facilities available there are some of the factors that will be taken into account by the courts in applying the general professional standard. Thus, recently, in the United States of America, it has been held in Brune v. Belinkoff that "the proper standard is whether the physician, if a general practitioner, has exercised the degree of care and skill of the average qualified practitioner, taking into account the advances in the profession. In applying this standard it is permissible to consider the medical

---

21 For a case involving a type of operation that was in its infancy in Ontario at the time and a very distinct and notable advance in the practice of medicine see Aynsley et al. v. Toronto General Hospital et al., [1968] 1 O.R. 425, (1968), 66 D.L.R. (2d) 575 (H.C.), at pp. 586-587.
resources available to the physician as one circumstance in determining the skill and care required. Under this standard some allowance is thus made for the type of community in which the physician carries on his practice. . . . One holding himself out as a specialist should be held to the standard of care and skill of the average member of the profession practising the specialty, taking into account the advances of the profession. And as in the case of the general practitioner, it is permissible to consider the medical resources available to him”. The courts will not condemn an honest exercise of judgment even though other practitioners may disagree with that judgment. If a surgeon followed a method of operation that is an established practice although not approved by all surgeons, he will not be liable in damages.

In Wilson v. Swanson, a case which involved an error of judgment on the part of a surgeon, the Supreme Court of Canada laid down a threefold test: “(1) The surgeon undertakes that he possesses the skill, knowledge and judgment of the average. (2) In judging that average, regard must be had to the special group to which he belongs. From a general practitioner at a rural point, a different standard is exacted than from a specialist at an urban point. (3) If the decision was the result of exercising that average standard, there is no liability for an error in judgment.”

Rand J. said: “In the presence of such a delicate balance of

---

25 (1968), 235 N.E. 2d 793, at p. 798. The Supreme Judicial Court of Massachusetts overruled Small v. Howard (1880), 128 Mass. 131 which had first enunciated the so-called “community” or “locality” rule that the defendant is bound “to possess that skill only which physicians and surgeons of ordinary ability and skill, practising in similar localities, with opportunities for no larger experience, ordinarily possess; and he [is] not bound to possess that high degree of art and skill possessed by eminent surgeons practising in large cities, and making a specialty of the practice of surgery”. Small v. Howard has been followed and applied by a long line of cases some of which are quite recent. The “community” or “locality” rule has been modified in several American jurisdictions and criticized in legal periodicals (McCoid, The Care Required of Medical Practitioners (1959), 12 Vanderbilt L. Rev. 549, at p. 569 et seq.). Some courts have extended the geographical area that constitutes the community; others have emphasized such factors as accessibility to medical facilities and experience; still others have adopted a standard of reasonable care which allows the locality to be taken into account as one of the circumstances, but not as an absolute limit upon the skill required. In cases involving specialists the courts of several American states have completely abandoned the “locality” rule. For a survey see Brune v. Belinkoff, ibid. In Canada cf. Zirkler v. Robertson (1897), 30 N.S.R. 61 (S.C.); Challand v. Bell, supra, footnote 22.

26 Challand v. Bell, ibid.
29 As summarized by Riley J. in Challand v. Bell, supra, footnote 22, at p. 154.
30 Supra, footnote 28, at pp. 119-120 (D.L.R.).
factors, the surgeon is placed in a situation of extreme difficulty; whatever is done runs many hazards from causes which may only be guessed at; what standard does the law require of him in meeting it? What the surgeon by his ordinary engagement undertakes with the patient is that he possesses the skill, knowledge and judgment of the generality or average of the special group or class of technicians to which he belongs and will faithfully exercise them. In a given situation some may differ from others in that exercise, depending on the significance they attribute to the factors in the light of their own experience. The dynamics of the human body of each individual are themselves individual and there are lines of doubt and uncertainty at which a clear course of action may be precluded.

There is here only the question of judgment; what of that? The test can be no more than this: was the decision the result of the exercise of the surgical intelligence professed? or was what was done such that, disregarding it may be the exceptional case or individual, in all the circumstances, at least the preponderant opinion of the group would have been against it? If a substantial opinion confirms it, there is no breach or failure. . . .

An error in judgment has long been distinguished from an act of unskilfulness or carelessness or due to lack of knowledge. Although universally accepted procedures must be observed, they furnish little or no assistance in resolving such a predicament as faced the surgeon here. In such a situation a decision must be made without delay based on limited known and unknown factors; and the honest and intelligent exercise of judgment has long been recognized as satisfying the professional obligation."

In the United States of America, it is pointed out by Professor Prosser31 that by undertaking to render medical services a physician or surgeon holds himself out as having standard professional skill and knowledge. "He must have the skill and learning commonly possessed by members of the profession in good standing, and he will be liable if harm results because he does not have them. . . . Sometimes this is called the skill of the 'average' member of the profession; but this is clearly misleading, since only those in good professional standing are to be considered, and of these it is not the middle but the minimum common skill which is to be looked to."

This distinguished author is of the opinion that the standard is "one of 'good medical practice' which is to say what is customary and usual in the profession".33

32 Ibid., p. 165.
33 Ibid., pp. 167-168.
C. Consent.

(i) Adults

The doctor-patient relationship is contractual and arises out of an express or implied agreement. When such a contract exists, does consent to the doctor-patient relationship—which includes acceptance of treatment in general—necessarily imply consent to surgical treatment? The answer will depend upon the circumstances.

When is the patient's express consent to an operation needed? What is the nature and scope of such consent? What weight will be given to it when it has been obtained? In other words, what are the standards to be applied to the donor's and recipient's consent to a transplantation operation? Is the surgeon obliged to educate the patient about the operation before a valid consent may be given? What rules should be followed in the case of minors, prisoners and mentally deficient people? Should minors close to maturity be allowed to express their opinion? What if the parent or guardian refuses to give his consent?

In Bonner v. Moran the United States Court of Appeals for the District of Columbia, was of the opinion that a surgical operation is a technical battery regardless of its result, and excusable only when there is express or implied consent by the patient. The rule is well established that "... before a physician or surgeon may perform an operation upon a patient, he must obtain the
consent either of the patient, if competent to give it, or of someone legally authorized to give it for him, unless immediate operation is necessary to save the patient's life or health, although under exceptional circumstances the consent may be regarded as having been impliedly given".

One of the leading cases in the United States of America is Schloendorff v. Society of New York Hospital where Mr. Justice Cardozo stated: "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." It is difficult to imagine a situation where the doctrine of emergency could be invoked without the patient's consent.

In Canada see Mulloy v. Hop Sang, supra, footnote 20; Beausoleil v. La Communauté des Soeurs de la Charité, supra, footnote 35; Dufresne v. X, [1961] Que. S.C. 119. Cf. Lafrenière v. Hôpital Maisonneuve et autres, [1963] Que. S.C. 467 (express consent to a special anaesthetic not necessary); in Marshall v. Curry, supra, footnote 20, Chisholm C.J. said at pp. 274-275 (D.L.R.): "1) that in the ordinary case where there is opportunity to obtain the consent of the patient it must be had. A person's body must be held inviolate and immune from invasion by the surgeon's knife, if an operation is not consented to; 2) that such consent by the patient may be express or implied. If an operation is forbidden by the patient, consent is not to be implied: and 'it must be constantly remembered that in this connection silence does not give consent, nor is compliance to be taken as consent'."

Where an emergency arises which could not be anticipated it is not useful to strain the law by establishing consent by fictions. "It is better to rule that it is the surgeon's duty to act in order to save the life or preserve the health of the patient; and that in the honest execution of that duty he should not be exposed to legal liability." In Murray v. McMurchy, [1949] 2 D.L.R. 442, 1 W.W.R. 989 (B.C.), the possibility of future hazard did not absolve the surgeon from obtaining consent. Prosser, op. cit., footnote 19, p. 105 points out that the consent is to the surgeon's conduct. If the surgeon goes beyond the consent given he is liable "unless the situation is one of unforeseen emergency, critical in its nature, which will justify the surgeon in proceeding on the assumption that the patient would consent if he were conscious and understood the situation".

38 Annotation (1932), 76 A.L.R. 562. Also Bang v. Charles T. Miller Hospital (1958), 251 Minn. 427, 88 N.W. 2d 186. In a case of emergency, when the patient is unconscious, the surgeon should act according to his own best judgment and consent on the part of the injured person would be implied: Mohr v. Williams (1905), 104 N.W. 12, at p. 15, 95 Minn. 261, at p. 269. If a surgeon is confronted with an emergency which endangers the life or health of the patient he "may lawfully, and it is his duty to perform such operation as good surgery demands, without such consent": Pratt v. Davis (1906), 224 Ill. 300, at p. 310, 79 N.E. 562, at p. 565. See also Jackovich v. Yocum (1931), 212 Iowa 914, 237 N.W. 444, 76 A.L.R. 551. In O'Brien v. Cunard SS Co. Ltd. (1891), 154 Mass. 272, 28 N.E. 266, it was held that where one on ship-board voluntarily submits to vaccination by the ship's physician in order to obtain the proper certificate to pass quarantine, she cannot maintain an action against the ship-owner for assault by the physician for performing such vaccination. Statutes in many provinces place a duty on parents to have their children vaccinated against small pox; see for instance in Quebec, Public Health Act, R.S.Q., 1964, c. 1961, ss. 124, 125, 132.

In Canada see Mulloy v. Hop Sang, supra, footnote 20; Beausoleil v. La Communauté des Soeurs de la Charité, supra, footnote 35; Dufresne v. X, [1961] Que. S.C. 119. Cf. Lafrenière v. Hôpital Maisonneuve et autres, [1963] Que. S.C. 467 (express consent to a special anaesthetic not necessary); in Marshall v. Curry, supra, footnote 20, Chisholm C.J. said at pp. 274-275 (D.L.R.): "1) that in the ordinary case where there is opportunity to obtain the consent of the patient it must be had. A person's body must be held inviolate and immune from invasion by the surgeon's knife, if an operation is not consented to; 2) that such consent by the patient may be express or implied. If an operation is forbidden by the patient, consent is not to be implied: and 'it must be constantly remembered that in this connection silence does not give consent, nor is compliance to be taken as consent'."

Where an emergency arises which could not be anticipated it is not useful to strain the law by establishing consent by fictions. "It is better to rule that it is the surgeon's duty to act in order to save the life or preserve the health of the patient; and that in the honest execution of that duty he should not be exposed to legal liability." In Murray v. McMurchy, [1949] 2 D.L.R. 442, 1 W.W.R. 989 (B.C.), the possibility of future hazard did not absolve the surgeon from obtaining consent. Prosser, op. cit., footnote 19, p. 105 points out that the consent is to the surgeon's conduct. If the surgeon goes beyond the consent given he is liable "unless the situation is one of unforeseen emergency, critical in its nature, which will justify the surgeon in proceeding on the assumption that the patient would consent if he were conscious and understood the situation".

38 Annotation (1932), 76 A.L.R. 562. Also Bang v. Charles T. Miller Hospital (1958), 251 Minn. 427, 88 N.W. 2d 186. In a case of emergency, when the patient is unconscious, the surgeon should act according to his own best judgment and consent on the part of the injured person would be implied: Mohr v. Williams (1905), 104 N.W. 12, at p. 15, 95 Minn. 261, at p. 269. If a surgeon is confronted with an emergency which endangers the life or health of the patient he "may lawfully, and it is his duty to perform such operation as good surgery demands, without such consent": Pratt v. Davis (1906), 224 Ill. 300, at p. 310, 79 N.E. 562, at p. 565. See also Jackovich v. Yocum (1931), 212 Iowa 914, 237 N.W. 444, 76 A.L.R. 551. In O'Brien v. Cunard SS Co. Ltd. (1891), 154 Mass. 272, 28 N.E. 266, it was held that where one on ship-board voluntarily submits to vaccination by the ship's physician in order to obtain the proper certificate to pass quarantine, she cannot maintain an action against the ship-owner for assault by the physician for performing such vaccination. Statutes in many provinces place a duty on parents to have their children vaccinated against small pox; see for instance in Quebec, Public Health Act, R.S.Q., 1964, c. 1961, ss. 124, 125, 132.

In Canada see Mulloy v. Hop Sang, supra, footnote 20; Beausoleil v. La Communauté des Soeurs de la Charité, supra, footnote 35; Dufresne v. X, [1961] Que. S.C. 119. Cf. Lafrenière v. Hôpital Maisonneuve et autres, [1963] Que. S.C. 467 (express consent to a special anaesthetic not necessary); in Marshall v. Curry, supra, footnote 20, Chisholm C.J. said at pp. 274-275 (D.L.R.): "1) that in the ordinary case where there is opportunity to obtain the consent of the patient it must be had. A person's body must be held inviolate and immune from invasion by the surgeon's knife, if an operation is not consented to; 2) that such consent by the patient may be express or implied. If an operation is forbidden by the patient, consent is not to be implied: and 'it must be constantly remembered that in this connection silence does not give consent, nor is compliance to be taken as consent'."

Where an emergency arises which could not be anticipated it is not useful to strain the law by establishing consent by fictions. "It is better to rule that it is the surgeon's duty to act in order to save the life or preserve the health of the patient; and that in the honest execution of that duty he should not be exposed to legal liability." In Murray v. McMurchy, [1949] 2 D.L.R. 442, 1 W.W.R. 989 (B.C.), the possibility of future hazard did not absolve the surgeon from obtaining consent. Prosser, op. cit., footnote 19, p. 105 points out that the consent is to the surgeon's conduct. If the surgeon goes beyond the consent given he is liable "unless the situation is one of unforeseen emergency, critical in its nature, which will justify the surgeon in proceeding on the assumption that the patient would consent if he were conscious and understood the situation".

39 (1914), 211 N.Y. 125, 105 N.E. 92.

40 Ibid., at pp. 129 (N.Y.), 93 (N.E.).
be applied to a live donor of a transplant. On the other hand, in the case of the recipient of a transplant from a dead donor, there may be occasions where the surgeon could be faced with an emergency situation, as for instance where an unconscious recipient's curve of life is declining fast and the dead victim of an accident becomes available for a transplantation operation which must take place immediately. It all depends upon the circumstances.

Failure to disclose the risks known to the surgeon invalidates the consent. Thus, even though the donor or the recipient has signed a written consent, it might not exonerate the surgeon from civil liability if it is possible to prove that he withheld facts that were necessary to form the basis of an intelligent consent to the

---

41 As to unauthorized extension of surgery see Meredith, op. cit., footnote 18, p. 144 et seq. Unless he has received the patient's authority for that purpose, a surgeon is not, as a general rule, justified in extending the surgery or treatment beyond the scope of the consent merely because in his opinion it is in the patient's interest to do so. Unauthorized extension is justified in cases of emergency only when strict adherence to the terms of the consent would endanger the life or health of the patient: Murray v. McMurchy, supra, footnote 38. However, after the patient has consented to the general nature of the treatment, it is not necessary for the doctor to obtain his consent to every technical procedure necessary to cure him. See Male v. Hopmans, [1966] 1 O.R. 647, (1965), 54 D.L.R. (2d) 592, aff'd, [1967] 2 O.R. 457 (C.A.).


"When the case involves no substantial misunderstanding of the nature and character of the touching, but plaintiff claims he was not fully or correctly informed as to collateral hazards attendant upon the procedure, the judicial approach is quite different from that found in battery cases. Here defendant-physician's obligation and plaintiff-patient's corresponding right is less certain in nature, more flexible in character and subject to considerable variation. While it is often stated as a general proposition that the patient has the right to be advised of collateral hazards and the physician has the duty so to advise him most cases have recognized...that this obligation is not rigid and cannot be prescribed with specificity. It is only a part of the broad obligation of the physician to use reasonable care, but as any sophisticated person knows, the elasticity in that concept is more than negligible." See Plante, op. cit., footnote 36 at p. 653.

In the battery cases, the factual issue is as follows: "Did the physician, by the words he spoke, or by his incomplete statement, or by his failure to explain written words, leave the patient with a substantial misunderstanding as to the general nature and character of the touching which the patient was to undergo? . . . When we turn to medical negligence cases . . . the question is not whether defendant conveyed a clear impression of the nature and character of the intended touching. It is assumed that he did so. The question is whether defendant violated his obligation to the patient to describe, collateral consequences that might ensue as a result of the intended and permitted touching, or from some other source such as the healing process." Ibid., pp. 657-658.
transplant. The surgeon must not minimize the known dangers of the operation in order to induce his patient's consent. However, in discussing the element of risk involved in the transplantation, the surgeon has such discretion that is consistent with the full disclosure of facts necessary to an informed consent. In other words, the patient must have knowledge of what he consents to. As stated in Bowers v. Talmage: "Unless a person who gives consent to an operation knows its dangers and the degree of danger, a 'consent' does not represent a choice and is ineffectual."

It would seem that in the case of a transplantation operation, the type of risk involved and the novelty of the operation should have a bearing on the completeness of the disclosure required. In order for the consent to be knowing and voluntary, the donor and the recipient are certainly entitled to full disclosure of all possible serious collateral hazards. For instance recent medical research seems to indicate that the powerful drugs used to prevent the body from rejecting an organ transplant may leave the recipient vulnerable to cancer because his defences have been immobilized.

Of course, the surgeon's duty does not mean that he must apprise the patient of each infinitesimal or speculative element

---

43 For a case involving the testing of a new anaesthetic see Halushka v. University of Saskatchewan (1965), 53 D.L.R. (2d) 436 (Sask. C.A.). The court said: "In ordinary medical practice the consent given by a patient to a physician or surgeon to be effective must be an 'informed' consent freely given. It is the duty of the physician to give a fair and reasonable explanation of the proposed treatment including the probable effect and any special or unusual risks. . . . There can be no exceptions to the ordinary requirements of disclosure in the case of research as there may be in ordinary practice. The researcher does not have to balance the probable effect of lack of treatment against the risks involved in the treatment itself. The example of risks being properly hidden from a patient when it is important that he should not worry can have no application in the field of research. The subject of medical experimentation is entitled to a full and frank disclosure of all the facts, probabilities and opinions which a reasonable man might be expected to consider before giving his consent." Noted Mackenzie (1966), 1 Ottawa L. Rev. 236. See also Kenny v. Lockwood, [1932] 1 D.L.R. 507, [1932] O.R. 141 (C.A.) and Nuremberg Principles, infra, footnote 74.

44 Salgo v. Leland Stanford Jr Univ. Board of Trustees, supra, footnote 42, at p. 181 (P.).

45 (1964), 159 So. 2d 888, at p. 889 (Fla).

46 In Male v. Hopmans, supra, footnote 41, it was held that in view of the plaintiff's serious condition, the defendant was justified in using a drug according to good medical practice and it was unnecessary to obtain consent for every technical procedure to effect a cure. Cf. Smith v. Auckland Hospital Board. [1965] N.Z.L.R. 191 (C.A.).

Note that the most common cause of death among heart transplant patients has been the overall state of their health before the operation. Almost anyone sick enough to qualify for a heart transplant may already be too sick to survive. As a result, standards for deciding who should receive transplants are changing. See Time Magazine, May 24th, 1968, Canada Edition, p. 47.
making up such risks as it would often be psychologically harmful to frighten him with too remote possibilities.\textsuperscript{47}

Professor Prosser\textsuperscript{48} maintains that in the light of the possible highly undesirable effects upon a number of patients of disclosure of some medical or surgical risks, it would be better to treat disclosure as a question of negligence involving professional standards of conduct only.

A transplant operation is a new type of operation of a very serious nature especially for the live donor and he should be given adequate explanations to decide whether he would rather forego surgery than submit to it. There is always the danger involved that an overly enthusiastic transplant team may not disclose all that is relevant to the operation to be performed in order to prevent the patient from withdrawing.

Obviously, an unconscious person who has not given prior consent should never be a donor. In the case of an unconscious recipient, the consent should be sought of the next of kin unless it is an emergency.

Of course, where there is an active misrepresentation on the part of the surgeon, the consent given is invalid.\textsuperscript{49}

Actually, it could be argued that a live donor should not be able to consent to a serious operation upon himself for the benefit of another especially when as a result of the removal of the donated organ, his health may be seriously endangered with only the prospect of a moderate prolongation of the receiver's life. Some day the donor could be in desperate need of the missing organ.\textsuperscript{50}

\textsuperscript{47} In general see McCoid, The Care Required of Medical Practitioners (1959), 12 Vand. L. Rev. 549, at pp. 586-597.


\textsuperscript{49} Woods v. Brumlop, supra, footnote 42, at p. 525 (P.). See also Paulsen v. Gundersen (1935), 218 Wis. 578, 260 N.W. 448.

\textsuperscript{50} Even if such consent is given by the donor, it may not protect the surgeon performing the transplant operation from possible criminal responsibility arising from non-compliance with s. 45 of the Canadian Criminal Code, supra, footnote 19, which states that "Every one 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". (Italics mine).

This section should be read in connexion with s. 191 which provides that

(1) Every one is criminally negligent who
(a) in doing anything, or
(b) in omitting to do anything that is his duty to do, shows wanton or reckless disregard for the lives or safety of other persons.
Stricter standards should be applied to the donor's consent than to the recipient's consent. For instance, in the case of a live donor, it may be advisable to assess his physical and psychiatric health as a condition precedent to his giving an organ. This examination could be made by a board consisting of an independent physician, the surgeon who will carry out the transplantation operation and a representative of the hospital where the operation will be performed or of the Department of Health.

Another solution would be to require the donor's consent to be given to a judge or magistrate of his domicile or residence or of the district where the hospital where the transplantation will be carried out is located. The judge or magistrate or the medical board would make sure that the volunteer donor is free from undue influence. This is particularly important in the case of prisoners. Actually, it is better to refuse transplants from persons under restraint. Where there is evidence that strong pressures are exercised on the donor, he should not be allowed to give consent.

Finally, it is essential that the consent of the donor or the recipient be revocable at any time.

From a practical point of view, although consent to surgery does not have to be in writing to be valid, it is preferable to have the patient sign a written document to that effect in the presence of witnesses after careful explanation of the risks involved in the operation by the head of the transplantation team.

(2) For the purpose of this section 'duty' means a duty imposed by law.

As far as the donor is concerned, the surgical operation performed upon him, for instance, the removal of a healthy kidney, is certainly not for his benefit, and may be considered unreasonable within the terms of s. 45(b).

On the other hand s. 187 of the Criminal Code which provides that "Every one who undertakes to administer surgical or medical treatment to another person or to do any other lawful act that may endanger the life of another person is, except in cases of necessity, under a legal duty to have and to use reasonable knowledge, skill and care in so doing" does not require the surgical treatment to be for the benefit of the patient. See also ss 191-193 and R. v. Giardine (1939), 71 C.C.C. 295 (Ont.).

As to forms of consent to operations see Meredith, op. cit., footnote 18, pp. 147-150.

The following forms are used by the Toronto General Hospital:

**TORONTO GENERAL HOSPITAL**

**CONSENT TO KIDNEY TRANSPLANT**

**PUBLIC PATIENT DONOR**

Name of patient .................................................. Case No. ........................
Age ........................................ Sex ....................... Marital status ......................

1. I authorize such surgeons, anaesthetists and assistants as may be on the staff of the Toronto General Hospital or as may be selected or approved by a member of its medical staff to operate and/or assist in operating on me for the purpose of removing one of my kidneys and placing such kidney in the body of
2. Dr. ............................................................. has explained to me, and I understand, the nature of and the risks involved in such an operation, including the risk that the kidney so removed may not function when transplanted and the risk that my remaining kidney may be, or subsequently become injured or diseased.

3. If any condition is discovered at the time of the operation that was not previously apparent and that in the judgment of the operating surgeon calls for surgical procedures in addition to or in substitution for those initially contemplated, I authorize him to take whatever measures he may consider necessary.

4. The name and address of my spouse, parent, child, nearest relative or nearest friend, is ........................................................................................................................................................................

................................................................. Date ................................................................. Signature of patient

Witness ............................................................................................................................. Address

PRIVATE PATIENT DONOR

1. I authorize the surgeon whom I have engaged, or who has been engaged on my behalf together with other surgeons, anaesthetists and assistants of his own selection as he may require, to operate and/or assist in operating on me for the purpose of removing one of my kidneys and placing such kidney in the body of ..................................................

[Clauses 2, 3 and 4 are the same as in the case of a public patient donor.]

TORONTO GENERAL HOSPITAL
CONSENT TO KIDNEY TRANSPLANT
PUBLIC PATIENT RECIPIENT

Name of patient .............................................. Case No. ..........................
Age ........................................... Sex ........................................... Marital status ...........................................

1. I authorize such surgeons, anaesthetists and assistants as may be on the staff of the Toronto General Hospital or as may be selected or approved by a member of its medical staff to operate and/or assist in operating on me for the purpose of placing in my body a kidney removed from ............................................

2. Dr. ............................................................. has explained to me, and I understand, the nature of and the risks involved in such an operation, including the risk that the kidney so removed may not function when transplanted to my body.

3. If any condition is discovered at the time of the operation that was not previously apparent and that in the judgment of the operating surgeon calls for surgical procedures in addition to or in substitution for those initially contemplated, I authorize him to take whatever measures he may consider necessary.

4. The name and address of my spouse, parent, child, nearest relative or nearest friend, is ........................................................................................................................................

................................................................. Date ................................................................. Signature of Patient or person authorized to act on patient's behalf.

Witness ............................................................................................................................. Address

PRIVATE PATIENT RECIPIENT

1. I authorize the surgeon whom I have engaged, together with such other surgeons, anaesthetists and assistants of his own selection as he may require, to operate and/or assist in operating on me for the purpose of placing in my body a kidney removed from ............................................

[Clauses 2, 3 and 4 are the same as in the case of a public patient.]
What would be the position of a surgeon, if an adult, the intended receiver of the transplant, after having accepted the doctor-patient relationship, refused to submit to the operation? What should the surgeon do? If he goes ahead with the operation without the consent, he may, as noted before, subject himself to civil liability. If he does not operate, the patient may die and he may be guilty of criminal negligence.\(^{53}\) In other words, should the patient be allowed to take his life into his hands or is the surgeon justified in going ahead with the transplantation in such circumstances? Should he seek prior court authorization? Should welfare agencies have this adult patient made a ward of the state especially if he has important social obligations to the community? More generally, has the patient the "right to die" and if he dies as a result

Wasmuth and Stewart, \textit{op. cit.}, footnote 15, at p. 470, suggest the following adult live donor consent form:

\begin{verbatim}
Permission to Remove Kidney for Transplantation
(Adult Live Donor Form)

Doctor ....................................................... has explained to me that the life
of .......................................................... is endangered due to irreversible
kidney disease. It has also been explained to me that a kidney can be
transplanted from one person to another by surgical operation. The
immediate risks to me of the operation for removal of my kidney, as well
as the possible future permanent injury to my health suffered as a direct
result of the removal of my kidney have been fully explained to me. I am
also aware of the possibility that such kidney transplant might not be
successful.

In an effort to benefit ................................................., I nevertheless
wish and do request, authorize and direct Doctor ........................................
to remove one of my kidneys by means of surgical operation in order that
this kidney may be transplanted into ..........................................................

Date ........................................ Signature of donor

This is to certify that the above form was read and signed by the donor in
my presence. Further, it is my opinion that ..................................................
understands fully the contemplated procedure, its risks, and possible consequences.

Date ........................................ Witness

Note that in Quebec "It is forbidden for any administrator of a hospital,
his employees or any physician to require any patient or his representatives
to renounce the responsibility resulting from his hospitalization, medical
examinations, treatments or surgical operations. If such renunciation is
given, it is null", Hospitals Act, R.S.Q., 1964, c. 164, s. 19.

Waivers of liability are deemed to be against the public policy of
Quebec: Crépeau, \textit{La responsabilité médicale et hospitalière dans la jurisprudence québécoise récente, op. cit.}, footnote 18, at p. 449 and Mayrand,
\textit{Cf., Meredith, op. cit., ibid., p. 150.}

At common law "ordinarily it is not against public policy for one to
exempt the other from responsibility for what would ordinarily be a breach
of duty", Fleming, \textit{op. cit.}, footnote 18, p. 257; Prosser, \textit{op. cit.}, footnote
18, p. 450 \textit{et seq.}
\end{verbatim}

\(^{53}\) See s. 191(1) of the Canadian Criminal Code, \textit{supra}, footnote 19.
of his refusal to submit to the operation, is it suicide? The intended recipient should have the right to die as long as he weighed the consequences of the operation against the dangers of accepting it. As an American court said in the case of a blood transfusion, the patient must refuse on a calculated decision.

"It is the individual who is the subject of a medical decision who has the final say and this must necessarily be so in a system of government which gives the greatest possible protection to the individual in the furtherance of his own desires."

Yet should an individual have the right to die particularly when his death may endanger the public health or welfare of the community?

(ii) Minors

As in the case of adults, consent, express or implied, is needed for operations on minors, since at common law all minors are incapable of giving a valid consent. Such consent must be given by the parent or guardian who has control as to what surgery will be done on his children.

In determining whether a surgeon may operate on a child without the consent of his parent or guardian, the basic considera-

---

44 Did the surgeon "aid" the patient to commit suicide. See Criminal Code, ibid., s. 212(b). For an interesting case involving a refusal to receive blood transfusions see Application of the President and Directors of Georgetown College (1964), 331 F. 2d 1000, at p. 1008. The court considered the argument that if attempted suicide is lawful or not made unlawful, "an individual's liberty to control himself extends even to the liberty to end his life". See also Note, The Right to Die (1966), 18 U. of Fla L. Rev. 591 and Comment, The Right to Die (1964), 9 Utah L. Rev. 161. In Canada see Masny v. Carter-Halls Aldinger Co., (1929) 3 W.W.R. 741, 24 Sask. L. R. 216 which involved an adult who refused to be operated upon. Also Meredith, op. cit., footnote 18, p. 153 et seq. Note that statutory laws provide for compulsory treatment in special circumstances as for instance when a person suffering from communicable venereal disease neglects or refuses to be treated. See in Ontario the Venereal Diseases Protection Act, R.S.O., 1960, c. 415, ss 2, 4, 10.


46 Erickson v. Dilgard, ibid., at p. 706; Sharpe and Hargest, Lifesaving Treatment for Unwilling Patients (1968), 36 Fordham L. Rev. 695.

47 Bonner v. Moran, supra, footnote 20. Nathan, Medical Negligence (1957), p. 171 et seq.; Zoski v. Gaines (1939), 271 Mich. 1, 260 N.W. 99. In Quebec "the father's consent should always be obtained, failing which and assuming that to delay the operation would be inadvisable, the mother's consent is sufficient. If neither parent is living, the consent should be given by the minor's tutor or curator as the case may be", Meredith op. cit., footnote 18, p. 140 and Children's Memorial Hospital v. Davidson (1936), 74 Que. S.C. 268 (father's liability for hospital services).
tion is whether the proposed operation is for the benefit of the child and is done for the purpose of saving his life or limb.\textsuperscript{58}

Some American courts seem to feel that a surgeon may be justified to accept the consent of a minor close to maturity who is able to understand the nature of the operation which is for his benefit and is of small importance.\textsuperscript{59} However, if there is no emergency, it is preferable to obtain the parent’s or guardian’s consent in addition to that of the minor of mature understanding.

When the operation is for the benefit of another, the consent of both the parent or guardian and minor should not be dispensed with under any circumstances. Actually, from a public policy point of view, it is advisable to prohibit any operation that is not beneficial to the child. Another approach would be to obtain the court’s authorization.

This is what took place for the first time in Massachusetts in 1957 when several requests were made for the transplantation of a kidney in identical twins who were under twenty-one years of age. In order to be fully protected against possible criminal and civil liability, the hospital trustees and surgical staff of the Peter Bent Brigham Hospital in Boston sought a declaratory judgment as to whether they should be allowed to perform such a transplantation. In \textit{Masden v. Harrison}\textsuperscript{60} and in two other cases,\textsuperscript{61} the court authorized the hospital and surgeons to proceed with the operations.

In each of the three cases, the court relied upon the testimony of the parents, the fact that the donor and recipient had given their consent after being fully informed of the nature of the operation and its possible consequences, and psychiatric evidence that grave emotional disturbance could affect the health and physical well being of the donor if the operation could not take place and the

\textsuperscript{58}Bonner v. Moran, \textit{ibid.} The emergency doctrine applies to minors and adults alike. Note that the consent of parents has been dispensed with when they could not be reached quickly. \textit{Luka v. Lowrie} (1912), 171 Mich. 222, 136 N.W. 1106; see also \textit{Jackovach v. Yocum, supra}, footnote 38.

\textsuperscript{59}Bakker v. Welsh (1906), 144 Mich. 632, 108 N.W. 94 (17 years) to be compared to Zoski v. Gaines, \textit{supra}, footnote 57; Bishop v. Shurly (1926), 211 N.W. 75 (19 years); Lacey v. Laird (1956), 166 Ohio, St. 12, 139 N.E. 2d, 25 (18 years); (1957), 10 Vand. L. Rev. 619; (1957), 9 West Res. L. Rev. 101; however see \textit{In re Hudson} (1942), 126 P. 2d 765 (15 years).


\textsuperscript{62}For an analysis of the opinions see Curran, \textit{A Problem of Consent: Kidney Transplantation in Minors} (1959), 34 N.Y.U.L. Rev. 891.
recipient died as a result of the refusal. Thus, the operation was deemed to be for the benefit of the donor as well as the recipient. Actually, the benefit was more the prevention of a possible detriment to the donor. These operations involved twins and it is questionable whether this argument could be invoked when the donor and the recipient are not related.

It must be noted that in these cases, the court pointed out that it is important for the hospital and the surgeon to obtain not only the consent of the parents but also that of each of the twins after their being fully informed of the nature of the operation and of its possible consequences and it is clear that each understands the situation. Of course, the minors involved were at least fourteen years old. Would their consent have been required if they had been younger or incapable of understanding the operation and its consequences?

Assuming that medically it is feasible and advisable to transplant organs from very small children, it would seem wrong for a court to allow the operation on the donor even if parental consent has been obtained. The courts or the parents should not be allowed to deprive a child of one of his vital organs without his consent or his intelligent comprehension. Whether a minor donor close to maturity should be able to give his consent if he is intelligent enough to understand the nature and consequences of his act is a difficult question to answer. As in the case of adult donors some control is needed to make sure that the minor’s consent is the result of his own decision free from pressure and coercion. In the case of a recipient minor the situation is different.

Although it is difficult to determine the precise age under which a child should have no capacity to assent to an operation, it would seem that below sixteen, a child is too young to give a valid consent under any circumstances. Public policy demands legal protection of the personal rights as well as property rights.

\[63\] In *Bonner v. Moran*, supra, footnote 20, a case involving a fifteen year old donor, the Court of Appeals was of the opinion that the trial judge had erred in charging that if the jury believed that the boy himself was capable of appreciating and did appreciate the nature and consequences of the operation and actually consented or by his conduct impliedly consented, the verdict must be for the surgeon. The court rejected s. 59(1) of the American Law Institute, Restatement of the Law of Torts, supra, footnote 34, which takes the view that if the minor is capable of appreciating the consequences of the invasion and gives an informed consent, there is no liability even though the parent or guardian has not consented. See also s. 892.

\[64\] In the case of a donor of a transplant who is a minor, the issue does not appear to be one of property law. Thus it is not necessary to obtain
of individuals who are incapable of intelligent decision by reason of their youth.

the judicial approval which is often required when dealing with the property rights of a minor.

Wasmuth and Stewart, op. cit., footnote 15, at pp. 469-470, indicate that the Peter Bent Brigham Hospital of Boston, Massachusetts uses the following live donor permit to transplant kidneys from minors.

.................................................... HOSPITAL

Request for Kidney Transplant Operation
in Release of All Claims

Whereas ....................................................... born on ................................and residing on ............................................ has a serious kidney ailment and is in danger of losing ............ life unless an operation is performed on ............; and whereas certain doctors connected with the ............................................................... Hospital are willing to perform this operation upon the said ....................................................... in the hope of saving the life of the said ....................................................... and whereas the doctors who propose to perform said operations and the Hospital and its staff of doctors and medical associates wish to be absolved from any and all liability, damages, law suits and causes of action as a result of the operation, now therefore in consideration of the operation to be performed and any further operations which may in the opinion of those doctors be necessary therewith, we, ............................................................... and .............................................., the intended recipient of the operation and the intended donor fully realizing that the operation may be unsuccessful and may result in either losing their life or in future physical incapacity, illness or illnesses directly or indirectly caused by said operation, we nevertheless both jointly and severally on behalf of ourselves, our heirs, administrators, executors, and assigns do hereby request that said operation be performed upon ............................................................... and hereby RELEASE AND FOREVER DISCHARGE the ..................................................................... Hospital, its director, and all persons on its medical or surgical staff who are in any way directly or indirectly connected with said operations or any other future operations resulting from them, for our post-operative care while in the ..................................................................... Hospital, from all damages or causes of action, either at law or in equity, which we may have or acquire or which may accrue to us, our heirs, administrators, executors or assigns as a result of these operations or medical care arising therefrom. We intend this to be a complete RELEASE AND DISCHARGE of all persons as well as any corporate entity having anything to do with the operations and we intend hereby to RELEASE AND FOREVER DISCHARGE said persons from all liability whatsoever. It is clearly understood by all parties to this instrument that no representations have been made to any of us regarding the success of the operations, and we fully understand that said operations are somewhat in the nature of an experiment and are being performed in the hope of saving the life of the said ....................................................... . We have read all the statements contained herein and we fully realize that we are signing a complete release and bar to any further claims which we may have resulting from these operations.

.................................................... DONOR .................................................... RECIPIENT*

.................................................... PARENT .................................................... PARENT

.................................................... WITNESS

.................................................... DATE

*Should recipient be a minor, the signature of both parents must be obtained.
When the parent or guardian refuses to give his consent to the transplant (or if they cannot be reached), it may be possible to ask the court to overcome such refusal if it is felt that the life of the minor recipient is at stake. It is difficult to imagine a case where the court would permit the operation upon the donor as this operation is not intended to save his life. Many jurisdictions have statutes that authorize juvenile courts or an agency such as the Children's Aid Society to take temporary custody of the child as a "neglected child" or as a child "in need of protection" for the period of the treatment and to order necessary surgical care if the parent or guardian refuses to provide it for such minor child. In other jurisdictions it is possible for the courts, under statutory authority, to declare the minor a dependent child, and deprive the parents of custody. A guardian is appointed by the court with authority to consent to the operation.

As the United States Supreme Court said in *Prince v. Massachusetts*: "Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves."

In Ontario for instance, section 19(1)(b)(x) of the Child Welfare Act defines a child in need of protection as *inter alia* "a child [under sixteen years of age] where the person in whose charge he is, neglects or refuses to provide or secure proper medical, surgical or other remedial care or treatment necessary for his health or well-being, or refuses to permit such care or treatment to be supplied to the child when it is recommended by a duly qualified medical practitioner . . .".

Cases will usually be heard by the judge of a juvenile and family court having jurisdiction in the place where the child was taken into protective care. Where he finds the child to be in need

---

65 The Criminal Code, *supra*, footnote 19, punishes parents who neglect their children: s. 186(a) states that everyone is under a legal duty as a parent, foster parent, guardian or head of a family to provide necessaries of life for a child under the age of sixteen years; see also s. 189 (abandoning a child). Failure to give medical care has been held to be neglect. For instance, *New York Social Welfare Law*, as am. to May 16th, 1966, ss 396-398 (McKinney's Consolidated Laws of New York Annotated). See also *In re Vasko* (1933), 263 N.Y. Supp. 552; *In re Rotkowitz* (1941), 175 Misc. 948, 25 N.Y. 2d 624


69 S.O., 1965, c. 14, as am.
of protection he may make an order "that the child be made a ward of and committed to the care and custody of the [Children's Aid Society] having jurisdiction in the area in which the child was taken into the protective care of the society for such period, not exceeding twelve months, as in the circumstances of the case he considers advisable". During such period the Children's Aid Society has and assumes all the rights and responsibilities of a legal guardian of such ward for the purpose of his care, custody and control. These provisions do not apply to children over sixteen years of age. Does this mean that between the ages of sixteen and twenty-one the parent's or guardian's refusal cannot be overcome or that the minor recipient's consent is sufficient? In some jurisdictions such a minor may be made a ward of court.

(iii) Married Women

In the common law provinces, a married woman does not require her husband's consent to an operation. However, in operations that will or may result in sterility, abortion or miscarriage it is desirable to obtain the husband's consent.

In the Province of Quebec it is customary to ask the husband's authorization for an operation on his wife although this does not seem to be necessary since according to article 177 of the Civil Code "a married woman has full legal capacity as to her civil rights subject only to such restrictions as arise from her matrimonial status". Of course, if the spouses are separate as to property, no problem arises. When there is community of property between the consorts, I still think that the authorization of the husband may be dispensed with as here we are concerned with one of the wife's basic civil rights. However, if one considers the transplant as a gift, it could be argued that article 763 which states that "A wife common as to property must have her husband's consent to make or accept a gift inter vivos", is applicable.

(iv) Persons of Unsound Mind

When the donor or the recipient of a transplant is of unsound mind, authorization for the operation should be obtained from the person in whose custody or care the patient has been committed. Morally or ethically it would be wrong to allow a mentally deficient person to be a donor.

(v) Conclusions

From the point of view of public policy seen with the eyes of the donor, it seems that the opportunity of saving a life by rescu-
ing someone from drowning is in many respects comparable to the situation of a healthy donor giving one of his organs to save the recipient's life with just the difference that the donor has more time to make up his mind. On the other hand, the surgeon is faced with a delicate problem since he is bound by the Hippocratic oath to look after the health of his patient and thus cannot deliberately deprive a healthy donor of one of his organs.  

Except perhaps in extraordinary circumstances, as in the case of identical twins, it is considered almost impossible to support the view that parents should be allowed to consent to the removal of organs from their minor children. Actually, legislation should be passed to prohibit children under a certain age from acting as donors. Eighteen years of age appears to be a good limit since in many States or Provinces it is the age when persons may contract marriage without their parents' consent, can vote, or join the military forces.

More generally, a donor should never be allowed to give an unpaired vital organ such as the liver or the heart. In the case of the kidneys it is not easy to come to a definite conclusion. Again, the surgeon should refuse to perform the operation when the benefit to the recipient is problematic and the operation is more in the nature of a new experiment than for curative purposes. Here the law has to rely on the conscience of the surgeon. What is really needed at present is some legal machinery designed to ensure that consent has been freely given.

As to the rescue doctrine, see Fleming, op. cit., footnote 18, p. 165 et seq., and Siranni v. Anna, supra, footnote 18. In France transplants from a living donor are not allowed. Operations are not permitted except when they are for the benefit of the patient; see Ethics in Medical Progress (1966), p. 154.

The Hippocratic oath provides "the regimen I adopt shall be for the benefit of my patients according to my ability and judgment, and not for their hurt or for any wrong", History of Medicine (1966), 15 Encyclopedia Britannica 94 B.

On August 19th, 1947, a war crimes tribunal at Nuremberg, in a judgment against defendants who were accused of crimes involving experiments on human subjects, laid down ten standards to which physicians must conform when performing such experiments. For instance:

"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 constraint 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
D. Sale of Organs or Tissues by Live Donors.

Should human organs or tissue be available for sale? For instance, should the donor receive payment or indemnification for a transplant? In Quebec, according to article 1486 of the Civil Code, "Everything may be sold which is not excluded from being

and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment.

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, unprocurable by other methods or means of study, and not random and unnecessary in nature.

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."

See also the recommendations prepared by the World Medical Association in 1964:

"II.—Clinical Research Combined with Professional Care

1. In the treatment of the sick person the doctor must be able 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.

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."

an object of commerce by its nature or destination or by special provision of law".

Article 1059 also specifies that "those things only which are objects of commerce can become the object of an obligation". Furthermore, by virtue of article 1052, "the object of an obligation must be something possible and not forbidden by law or good morals". More generally, article 13 declares that "no one can by private agreement, validly contravene the laws of public order and good morals". Is a piece of tissue or an organ "an object of commerce", would its sale be "forbidden by law or good morals" in Quebec?

There is to my knowledge no statute in Quebec that forbids someone to sell his body or parts thereof. However, it is stated by Mr. Faribault that one cannot sell part of one's body for surgical purposes, but can during his life dispose of his dead body as "a future thing". This statement seems to be based on the civil law of France. In that country it is generally considered contrary to good morals to dispose of one's life, health or body without a proper motivation. However, in many countries including France it is ethically and legally acceptable to sell blood. Of course, should the sale of an organ be legal, nice problems of warranty could occur if, for instance, the kidney transplant caused some harm to the recipient. The French law stipulates, that human blood cannot be considered as a merchandise. From a public policy point of view it would seem that in order to prevent a traffic in organs or tissue, any remuneration for the donor should be prohibited. It would be advisable, however, to provide some special

---

78 See also articles 984, 989, 990 of the Civil Code which deal with the requirement that a contract must have a lawful cause or consideration.


82 Ibid. See also Savatier, De sanguine jus, Dalloz Chronique, XXIV, 1954, p. 141.

83 As to contracts illegal at common law on grounds of public policy see Cheshire and Fifoot, The Law of Contract (6th ed., 1964), p. 296 et seq. I was unable to find any case involving the sale of organs or parts of the body in common law jurisdictions.
insurance for the donor, should he become incapacitated as a result of the removal of the transplant or should he die. Such insurance could cover his medical expenses as well as support for himself and his family.

2. Problems Arising Out of the Use of Organs From Cadavers.

Cadavers are by far the most important source of transplants, since very few organs or tissue may be given by a live donor without endangering his health or his life.

As noted in Part I, organs such as kidneys and the liver must be removed from the cadaver donor as soon after death as possible if irreversible damage to the organ is to be avoided. This emphasizes the importance of an immediately available consent.

A very vexing problem confronting the hospital and the members of the transplantation team is that of determining who may give consent to remove the organs from a person who has just died or whose death is imminent. In the absence of statutory authority for a living authorized person to grant permission to remove such organs immediately after death, must permission be obtained from the executor or administrator, or from the next of kin? Also, in the absence of statutory authority, may a living person dispose of his body or part of his body after his death by will? Is there a property right in a cadaver?81 Even in States or Provinces where there is such statutory authority, is the bequest binding on the testator's executor, spouse or close relative? Would it be appropriate to obtain the consent of the member of the family who will have control of the cadaver after the death of the donor at the same time as that of the donor himself? Does consent to perform an autopsy imply consent to the removal of tissue or organs? More generally, should the present Human Tissue Acts and Anatomy Acts in force in several Canadian Provinces be replaced by a law that would simply state that a cadaver is available for therapeutic or scientific use if the deceased did not express a contrary wish? Such a statute would take care of situations where it is not possible to locate the spouse, executor or next of kin. Under present rules, the only problem then remaining would be the determination of the exact moment of death which as noted previously is essentially a medical problem.82

82 See supra, p. 350. In England, for instance, there is a private member's Bill (No. 101, March 13th, 1968) to which the House of Commons is shortly to give a second reading. It deals with renal transplants only and
A. Common Law Rules.

In England as well as in other common law countries, it has always been the law that the bodies of persons dying within the jurisdiction should be decently buried. However, the persons on whom the duty of disposal falls and the precise nature and scope of this duty have never been authoritatively determined.

Most of the cases are concerned with the liability to pay funeral expenses or with the liability for nuisance that arises from an unburied body. These cases seem to indicate that the obligation to bury the body of a deceased person lies on the executor or administrator, on the husband of a deceased wife and possibly on the wife of a deceased husband; on the parent of a deceased child and possibly on the child of a deceased parent; on the occupier of the premises on which the body is found or on the appropriate local authority where no suitable arrangements are being made otherwise.

From the point of view of transplantation where time is of the essence, it is essential to quickly determine who is in a position to authorize the removal of tissue and organs from a dead body. Thus, the transplant team is not concerned with the question of who should discharge the duty to bury or the question of liability for the payment of the funeral expenses. What is of primary importance is the problem of who, if anyone, is entitled to possession of the body of the deceased. The basic principle of the common law in this regard is that there can be no property in the dead body of a human being. This rule is of ancient origin. In England, from and after the time of the Norman Conquest and until the nineteenth century, the right of possession and disposition of a dead body was solely the subject of ecclesiastical cognizance. The Church took the body to itself. Common law courts were powerless respecting the body of a deceased person. The person having charge of a body cannot be considered the owner of it; he holds it only as a trust for the benefit of those who may from family

states in s. 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.” (June 1968).

83 Williams v. Williams (1882), 20 Ch.D. 659, at p. 663. Foster v. Dodd (1867), L.R. 3 Q.B. 67, per Byles J., at p. 77: “A dead body by law belongs to no one, and is, therefore, under the protection of the public.”

relationship or friendship have an interest in it. At common law, an heir has no property right in the body of his ancestor.

Conversely, a person cannot by will or otherwise dispose of his body after death and any directions he may have given are not binding upon his personal representatives or survivors. However, when the common law courts began to take jurisdiction over religious offences, they created a right of possession for the purpose of burial. They held that although there is no property right in a cadaver the person who has the duty to dispose of the body

See also Kuzenski, Property in Dead Bodies (1924), 9 Marq. L. Rev. 17.

Coke, Third Institute (Ed. 1817), Ch. 97, p. 203; 4 Blackstone, Commentaries on the Laws of England (1765), 236: for a criticism of the rule see Jackson, op. cit., footnote 84, p. 127 et seq. He points out that in the United States of America, at common law, the courts have refused to treat a dead body as property in a material or commercial sense. A dead body is not part of the assets of the estate, it may not be subject of a gift mortis causa. On the other hand the courts have recognized a right to possession as a quasi property right in the nature of a trust (ibid., pp. 133-134). This interest in the dead body vests in the relatives or in the next of kin and can be protected by an action at law.


For a Quebec case which analyses the civil law with respect to property in dead bodies see Phillips v. Montreal General Hospital (1908), 33 Que. S.C. 483, 4 E.L.R. 477. Davidson J. points out that there is marked sterility of discussion or even reference with respect to this subject in the French books. However, under the civil law a person may during his life dispose of his remains in whole or in part, so long as the disposition does not offend against public policy or police regulations. Thus, he may will his body to a school of anatomy. In the absence of personal directions, the remains are the property of the family just as the body of an animal (at pp. 488-489, S.C.). Also Ducharme v. Notre Dame Hospital (1933), 71 Que. S.C. 377; Dierkens, op. cit., footnote 15, p. 133 et seq., and Cass. 3, 7, 1899, Pas. 1899, t. 318 (Belgium). Also cf. p. 158:

Le droit sur le cadavre n'est pas un droit de propriété, mais un droit extrapatrimonial qui trouve son principe dans les liens du sang et de l'affection. Il ne revient pas à ceux qui succèdent in bona, mais à ceux qui succèdent in personam defuncti, aux continueurs de la personne, et ce non jure successionis, sed jure sanguinis. Il leur appartient, même s'ils sont exclus de la succession. Il s'agit d'une prérogative de la parenté.

In Miner v. C.P.R. (1910), 15 W.L.R. 161 varied in part 18 W.L.R. 476, 3 Alta L.R. 408 (C.A.) Beck J., after referring to the English rule that there can be no property in a corpse, quoted the following passage from Pettigrew v. Pettigrew (1904), 207 Pa 313, 64 L.R.A. 179: "But, inasmuch as there is a legally recognized right of custody, control, and disposition, the essential attribute of ownership, I apprehend that it would be more accurate to say that the law recognizes property in a corpse, but property subject to a trust, and limited in its rights to such exercise as shall be in conformity with the duty out of which the rights arise" and said: "I adopt this opinion and would express it thus: the law recognizes property in a corpse, a property, of course, which is subject, on the one hand, to the obligations, e.g., of proper care and prima facie of decent burial appropriate to its condition and the condition of the individual in his lifetime . . . and to the restraints upon its voluntary or involuntary
has the right to possess it until it is buried or otherwise disposed of. In general, in the absence of testamentary disposition providing otherwise, the right to the possession of a dead body for the purposes of preservation and burial belongs to the surviving spouse, children and next of kin. Where the deceased person has made a will naming one or more executors this right to possession would appear to be vested in the executor or executors.

At common law, permission for the removal of organs or tissues from the body of the deceased must be granted by the person or persons who are lawfully in possession of the body for the purpose of burial. Since, as noted earlier, organs must be removed immediately after death, it is often impossible to locate these persons in time in order to obtain their authorization. Should removal take place without such authorization, the members of the transplantation team would be civilly and criminally responsible.

An action for damages will lie at common law for the negligent handling of a cadaver or interference with its possession on the basis of the mental distress without circumstances of aggravation suffered by the spouse or the next of kin as a result of the wrongful act. No actual pecuniary damages need be alleged or proved.

disposal and use provided by law (e.g., the existence of conditions authorizing its use for anatomical purpose) or arising out of the fact that the thing in question is a corpse (e.g., no lien can attach: R. v. Fox and Ors (1841), 2 Q.B. 246, 114 E.R. 95, 13 Mews 354, a public exhibition contrary to public decency is not permissible...); and, on the other hand, the nature and extent of the right or obligation of the person for the time being claiming property (e.g., an executor, a husband, wife, next of kin, medical institute, etc.). See also R. v. Sharpe (1857), 26 L.J.M.C. 47, at p. 48, per Erle J. Also Hume, Dead Bodies (1956-58), 2 Sydney L. Rev. 109. In the United States of America the old English doctrine that the executor has the right to the custody and possession of the dead until after burial does not obtain. See Wasmuth and Stewart, op. cit., footnote 15, p. 451.

Halsbury, op. cit., ibid. For most practical purposes the right to possession is equivalent to ownership, see for instance art. 2268 of the Quebec Civil Code.


Hunter v. Hunter (1930), 65 O.L.R. 586. The executor of a deceased person was held to have the right to the possession of his body for the purpose of burial. The widow's claim to possession was denied by the court. In general see Jackson, op. cit., footnote 84, esp. pp. 41-55, 124-183.


For a case involving an unauthorized post mortem examination see Davidson v. Garrett (1899), 30 O.R. 653, 19 C.L.T. 279, 5 C.C.C. 200 (Ont. C.A.) and Phillips v. Montreal General Hospital, supra, footnote 88; cf. Miner v. C.P.R., supra, footnote 88. In general see Jackson, op. cit., footnote 84, pp. 124-183, esp. p. 142 et seq. which contains an excellent analysis of civil actions respecting cadavers.
Thus, an unauthorized autopsy is an unlawful trespass on personal rights and is capable of causing such a sense of outrage and of mental suffering as to constitute the proper elements of compensatory damages.93 Finally, according to section 167 of the Criminal Code, “every one who (a) neglects, without lawful excuse, to perform any duty that is imposed upon him by law or that he undertakes with reference to the burial of a dead human body or human remains or (b) improperly or indecently interferes with or offers any indignity to a dead body or human remains, whether buried or not is guilty of an indictable offence and is liable to imprisonment for five years”.94

In Canada, statutory offences have also been created by such Acts as the Anatomy Act,95 in relation to the removal of dead bodies for the purpose and the practice thereon of anatomy.

---

93 Prosser op. cit., ibid.
94 See R. v. Newcomb (1898), 2 C.C.C. 255 (N.S.). At common law any person who without lawful authority disposes of a dead body for dissecting purposes and for gain and profit is indictable: R. v. Gilles (1818), Russel and Ryan 366n also R. v. Lynn (1788), 2 Term Reports (Dunford and East) 733. See also Hume, op. cit., footnote 88, at p. 127: “At common law certain offences are recognised in relation to dead bodies, the principal ones being:

(a) The person on whom the duty of burial falls is guilty of a misdemeanour if, having the means, he fails to dispose of the body. R. v. Vann (1851), 2 Den. 325.

(b) It is a misdemeanour to prevent the burial of a body by refusal to deliver it to the executor or person lawfully entitled to possession of it or to bury it otherwise than in accordance with the directions of such person or to detain it as security for a debt owed by the deceased: Williams v. Williams (1882), 20 Ch.D. 659; R. v. Fox & Ors (1841), 2 Q.B. 246.

(c) It is a misdemeanour to dispose of the body so as to prevent the holding of an inquest which the coroner is entitled to hold R. v. Stephenson & Anor (1884), 13 Q.B.D. 331; R. v. Price (1884), 12 Q.B.D. 247; R. v. Davis (1942), 42 S.R. (N.S.W.) 263.

(d) It is a misdemeanour to disinter a body without lawful authority; R. v. Lynn (1788), 2 Term Reports 733, 100 E.R. 391; Foster v. Dodd (1867), L.R. 3 Q.B. 67, per Byles J., at p. 77; or for an undertaker to sell for the purpose of dissection or otherwise a body entrusted to him for the purpose of burial; R. v. Feist (1858), Dears. & B. 590, 169 E.R. 1132, 27 L.J. (N.S.) 164; R. v. Sharpe (1858), Dears. & B. 160, 169 E.R. 959; R. v. Cundick (1822), Dow. & Ry. N.P. 13.

It is no defence to such a charge that there was no want of decency or propriety or that the disinterment was for a pious or laudable motive. R. v. Sharpe, supra.

(e) It is a misdemeanour to expose a body on or near a public highway where it may be seen by passers-by in such a way as to shock public decency. R. v. Clark (1883), 15 Cox C.C. 171.

(f) It is no offence to burn a body provided

(i) the cremation is effected decently;

(ii) there is no nuisance;

(iii) there is no attempt to conceal the commission or impede the prosecution of any offence or to prevent the holding of any inquest. R. v. Stephenson & Anor (1884), 13 Q.B.D. 331; R. v. Price (1884), 12 Q.B.D. 247.

95 In Ontario see R.S.O., 1960, c. 14, s. 14, as am. by 1964, c. 2.
Even in the absence of specific legislation authorizing testamentary disposition of the donor’s body, it is difficult to understand why, in Canada today, a person may direct that his body be cremated and may not direct that it be used for therapeutic purposes or for the purpose of medical education or research **notwithstanding that the testator’s spouse or close relative object.**

---

96 See also Barish, *op. cit.*, footnote 81. Note that in 1965 the Falconer Foundation of New York recommended the printing of a card which contains the following authorization:

This will certify that I, ........................................................, do hereby express my will and desire that after my demise my body shall be used for the furtherance of medical science by the nearest medical school. My next of kin and any other persons legally responsible for the disposal of my body are individually and severally requested to respect and carry out my final wishes that my body be delivered to said institution into the custody of the Dean. In the absence of any specific instructions for the disposal of the remains after use for scientific purposes is completed the Dean is authorized to use his own discretion.

Given under my hand and seal
this .............. day of ................
in the year of our Lord
Nineteen Sixty-

Signature: ............................................................
Witness .....................................................
Witness .....................................................

The purpose of this card is to alert anyone at the scene of an accident to the desires of the deceased so that bodies intended for medical science would not be inadvertently embalmed, thereby denying the wishes of the deceased.

Wasmuth and Stewart suggest the following authorization for the removal of organs from cadavers, *op. cit.*, footnote 15, p. 471, to be signed by the *next of kin* of the deceased:

**Authorization to Remove Kidneys for Transplantation**

I hereby authorize and direct the surgeons on the staff of ........................................... Hospital to remove, by an abdominal incision, the kidneys from the body of ........................................................, deceased. It is my wish that these kidneys, if suitable, be used for purposes of transplantation, in order to attempt to preserve life, health, and well-being.

Signature

Relationship to deceased

Address

Witnesses

The Hospital for Sick Children of Toronto uses the following form:

**CONSENT TO REMOVAL OF PARTS OF A BODY**

**FOR THERAPEUTIC OR OTHER PURPOSES**

I, the undersigned, do hereby give my consent to the removal of ................ from the body of .......................... for therapeutic or other purposes.

Parent or
Legal Guardian

Address

Witness

Date


In England, the Anatomy Act, 1832, deals with two distinct sets of circumstances: First, the granting of permission for an anatomical examination by the person lawfully in possession of the body after death and second, with the case where a direction is given by a testator for such examination. "An executor, or other party having lawful possession of a dead body, and not being an undertaker or other party entrusted for the purpose only of interment, may permit the body to be anatomically examined, unless to the knowledge of that executor or other party, the deceased stated in writing during his life, or verbally in the presence of two or more witnesses during the illness of which he died, that he did not wish his body to undergo examination or unless the surviving husband or wife or any known relative of the deceased, requires interment without examination."

Section 8 of the Act also states that: "If the deceased at any time during his life in writing or verbally in the presence of two witnesses during the illness whereof he died shall direct an anatomical examination to be made or nominates a person authorised by the Act to carry out such examination and such direction or nomination comes to the knowledge of the person having lawful possession of the body that person shall direct in the one case or request and permit in the other an anatomical examination unless the surviving husband or wife or nearest known relative or any one or more of such person's nearest known relatives being of kin in the same degree require interment without such examination." Consent to have the body anatomically examined does not seem to imply consent to the removal of tissue or organs for transplantation purposes.

The Anatomy Acts in force in the Provinces of Canada vary in their contents. One of the most comprehensive Acts is that of Manitoba. Section 5 of the Act provides that:

---

97 2 & 3 Will. 4, c. 75, as am. by 1871, c. 16, 1887, c. 52, 1961, c. 54.
99 See s. 13. After anatomical dissection the Act requires that such body shall be decently interred. Retention of any part of it would be contrary to the Act since the body cannot be claimed to have been buried if a part of it is wilfully retained. This narrow interpretation has been rejected by Poi son, The Disposal of the Dead (1953), p. 29.
5. (1) The body of any person which remains unclaimed by a preferred claimant, for a period of forty-eight hours after the death of that person shall, at the expiration of that period, be under the control of the inspector [of Anatomy] or of the sub-inspector of the division or section within which death occurred.

(2) Any person who is a preferred claimant in respect of the body of a dead person may at any time claim the body from the inspector or a sub-inspector or an authorized person; and, on such a claim being made, the inspector or sub-inspector or the authorized person shall forthwith deliver the body to the preferred claimant.

Furthermore:

6. (1) Subject to this Act, any person who is a preferred claimant or other relative or bona fide friend of the deceased, and no other person, shall be entitled to claim the body of a dead person at any time after it has come into the possession or under the control of the inspector or a sub-inspector.

(2) Subject to section 5, the inspector or sub-inspector may accept or postpone such a claim.

(3) If the authorized person or a claimant is dissatisfied with the order or ruling of the inspector or sub-inspector, he may within two days from the date of the order or ruling, and after giving to the inspector or sub-inspector notice of his intention so to do, apply to a police magistrate for an order directing delivery of the body to him; and the police magistrate, if he is satisfied that the claim is justified, may, in his discretion, direct that the body be delivered to the applicant, subject to such conditions as the police magistrate may impose.

(4) Any person entitled to claim a body may present to the inspector or sub-inspector a duly signed and witnessed waiver or renunciation of his claim; and the body shall thereafter be deemed to be unclaimed.

(5) A person claiming a body may make the claim personally or through his duly authorized agent.

(6) A person who claims and receives a body under this section is responsible for the proper interment thereof and shall pay, or cause to be paid, the cost of that interment.

In 1959, subsections 4A, B, and C were added to section 6 to cover specific bequests of bodies for the purposes of anatomical or other scientific instruction or requirements.101

101 Ibid.
Notwithstanding anything in section 5, any person may, before his death, consent in writing over his signature, and in a form satisfactory to the inspector, to the use of his body after death for the purposes mentioned in subsection (1) of section 7 and to control thereof by the inspector for those purposes.

If, before or after the death of a person to whom subsection (4A) applies, the consent is approved and countersigned by a person entitled to claim the body of the deceased and presented to the inspector or a sub-inspector, the consent has the same effect as a waiver presented under subsection (4).

The death of the person entitled to claim the body after he has approved and countersigned the consent but before the death of the person in respect of whose body the consent is given, does not invalidate the consent or the approval and countersignature thereof.

According to section 7:

7. (1) Where the body of a dead person that is under the control of the inspector or a sub-inspector remains unclaimed for a period of twenty-four hours after coming under that control, the inspector or sub-inspector shall, if so required, deliver the body to the university for the purposes of anatomical or other scientific instruction or requirements.

(2) Where such a body is not required by the university, the inspector or sub-inspector shall dispose of it
(a) by delivery thereof to another institution or to a duly qualified medical practitioner, or registered dentist in accordance with, and as may be prescribed by, the regulations; or
(b) in such other manner as may be prescribed in the regulations.

8. (1) No person shall perform an autopsy or post mortem upon a body to which subsection (1) of section 5 refers, unless authorized in writing to do so by the coroner.

(2) Members of the staff and medical students and dental students of the university, with the approval of the physician or pathologist performing a medico-legal autopsy, may obtain therefrom such material in the recent state as they require for anatomical or other scientific instruction or requirements.

(3) Nothing in this Act abridges or curtails the powers or authority of the coroner.

The Act prohibits the sale or purchase of, or traffic in the bodies of dead persons. When a person dies in a hospital or other institution notice of the death must be given to a preferred claimant. Also according to section 17:

17. (1) Where a body
(a) is that of a person who dies, or is found dead, in a hospital or other institution, or

102 Ibid., s. 15.
103 Ibid., s. 16.
(b) is under the charge or control of an undertaker, coroner, physician, or other person, if
(c) the body is not claimed immediately by a preferred claimant, or
(d) the superintendent or other head of the hospital or institution, or the person in charge or control of the body as aforesaid, is of the opinion that the body will not be so claimed,
the superintendent or other head, or the person in such charge or control, shall immediately give notice of the death to the inspector, [of Anatomy]. . . .

On receipt of the notice the inspector will give notice of the death of the person to the university which has twenty-four hours to decide whether or not the body is required for purposes of anatomical or other scientific instruction or requirements.

In Ontario, the Anatomy Act provides that:

3. (1) A body,
   (a) of a person that is found publicly exposed or sent to a morgue upon which a coroner after having viewed it deems an inquest unnecessary; or
   (b) of a person who immediately before death was supported in and by a public institution,
   shall be placed immediately under the control of the local inspector of anatomy.

(2) Unless the body is claimed by,
   (a) a relative or bona fide friend; or
   (b) a county councillor, in the case of the body of a person who immediately before death was supported in and by a county home for the aged,
within twenty-four hours after being found or sent to a public morgue or within twenty-four hours after the death where the death took place in a public institution, the body shall be delivered by the local inspector to a person qualified to receive unclaimed bodies under section 5.

5. The persons qualified to receive unclaimed bodies under this Act are the teachers of anatomy or surgery in a school, and, if there is a school in the locality where there is a body to be delivered to persons so qualified, such school has the first claim to the body.

104 Supra, footnote 95.
105 See also ss 9 (duty of coroners) and 12 (duty of superintendent of public institutions).

In the provinces that have adopted Human Tissue Acts the bodies of donors that are not required for use by the hospital for transplantation purposes shall be made available to the local inspector of anatomy.

C. Post Mortem Examinations.

A post mortem examination of the body of a deceased person for the purpose of determining the cause of death may only be performed in certain circumstances.

(i) Official Post Mortem Examinations

In the various provinces of Canada there are statutory provisions whereby the coroner in some instances may order a post mortem examination of a dead person. For example, section 7 of the Ontario Coroner's Act provides that:

7. (1) Every person who has reason to believe that a deceased person died,
(a) as a result of,
   (i) violence,
   (ii) misadventure,
   (iii) negligence,
   (iv) misconduct, or
   (v) malpractice;
(b) by unfair means;
(c) during pregnancy or following pregnancy in circumstances that might reasonably be attributable thereto;
(d) suddenly and unexpectedly;
(e) from disease or sickness for which he was not treated by a legally qualified medical practitioner;
(f) from any cause other than disease; or
(g) under such circumstances as may require investigation,
    shall immediately notify a coroner of the facts and circumstances relating to the death.

Where there is reason to believe that a person died in any circumstances mentioned in section 7, the body of the deceased

---

107 Analyzed, infra, see for instance Ontario Act, S.O., 1962-63, c. 59, as am. by S.O., 1967, c. 38, s. 2(2). N.B.: S.N.B., 1964, c. 4, s. 2(2); N.S.: S.N.S., 1964, c. 5, s. 2(2); Alta: S.A., 1967, c. 37, s. 4; Nfld: S. Nfld, 1966-67, No. 78, s. 5.
108 A person who in writing at any time or orally in the presence of at least two witnesses during his last illness has requested that his body or a specified part or parts thereof be used after his death for therapeutic purposes or the purposes of medical educational research, Ontario Act, ibid., s. 1.
110 In Quebec see Coroners' Act, R.S.O., 1964, c. 29, s. 20 and Civil Code, art. 69. As to notices given by the person in charge of a mental hospital, prison, etc., see ss 21, 22.
“shall not be embalmed or cremated and no chemical shall be applied to it externally or internally and no alteration of any kind shall be made to it until the coroner so directs”.

Also, according to section 6(3) of the Ontario Human Tissue Act, an authority shall not be given to use the body of a deceased person, or to remove parts thereof for therapeutic purposes or for the purpose of medical education or research if the person empowered to give the authority has reason to believe that an inquest may be required to be held on the body of the deceased.

Where the coroner is informed that the dead body of a person is lying within his jurisdiction and that there is reason to believe that the person died in any of the circumstances mentioned in section 7, or that that person died while in the custody of an officer of a reformatory, industrial farm, jail or lockup or while a ward of a training school or resident or an in-patient in a hospital, institution or home as defined in the Act, he shall issue his warrant to take possession of the body and shall view the body and make such further investigation as is required to enable him to determine whether or not an inquest is necessary.

Where the coroner determines that an inquest is unnecessary, he will issue his warrant to bury the body or his consent to its use or to the use of parts of the body for therapeutic purposes or for the purpose of medical education or research or for anatomical examination.

---

111 Ibid., s. 8.
112 Supra, footnote 107.
113 See also Model Act, Human Tissue, s. 2(2)(c), 1965 Proceedings of the Conference of Commissioners of Uniformity of Legislation in Canada (herein after cited as Proceedings), p. 104.
114 S. 22, supra, footnote 109. Quebec Act, s. 21, supra, footnote 110.
115 Ibid., s. 21.
116 Ibid., s. 10. See also s. 21: “The coroner shall investigate the circumstances of the death and, if as a result of the investigation he is of the opinion that an inquest ought to be held, he shall issue his warrant and hold an inquest upon the body.” S. 22: “The coroner shall issue his warrant and hold an inquest upon the body.”
117 Ibid., s. 12(1).
118 Model Act, supra, footnote 113, s. 2(2)(c). Note that: “13. Where the coroner determines that an inquest is necessary, he shall issue his warrant for an inquest, and shall forthwith transmit to the Crown Attorney and the supervising coroner a signed statement setting forth briefly the result of the investigation and the grounds upon which he determined that an inquest should be held.”
119 See Quebec Coroners’ Act, supra, footnote 110, ss 49, 52. In Ontario the Anatomy Act, supra, footnote 95, also states: “9. Every coroner, whether he does or does not hold an inquest on a body found publicly exposed, to which his attention has been called, and which is not claimed in accordance with section 3, shall give notice to the local inspector or, if there is none, he shall cause the body to be interred at the expense of the municipality in which it was found.”
The coroner may order a post mortem examination as a supplemental means to determine whether the person died in any of the circumstances mentioned in section 7.

Section 23 states:

23. (1) A coroner may at any time during an investigation or inquest issue his warrant for a post mortem examination on the body, an analysis of the blood, urine, or the contents of the stomach and intestines, or such other examination or analysis as the circumstances warrant.

(2) Where a coroner has determined that an inquest is unnecessary, he shall not thereafter issue his warrant for a post mortem examination or analysis without the consent in writing of the Attorney-General, the Crown attorney or the supervising coroner.

The post mortem examination is within the discretion of the coroner. Such examination must be made as soon after the death of the deceased as is reasonably practicable. If a person dies in a hospital the post mortem examination of the body of this person will usually take place in that hospital. Although the person making a post mortem must provide so far as possible for the preservation of material which in his opinion bears upon the cause of death, he cannot remove organs or tissue for the purpose of transplantation without the consent of the person entitled to possession of the body.

Official post mortem examinations are carried out without the consent of the surviving spouse or the next of kin. If the coroner authorizes a post mortem wrongfully he may be held liable for damages. In Davidson v. Garrett however, it has been held that a

Also Study of Anatomy Act, R.S.Q., 1964, c. 250. S. 6 states: "Every coroner, whether he does or does not hold an inquest on any body found publicly exposed, shall also immediately notify the inspector or sub-inspector of the finding thereof."

In Quebec, see ss 17 and 30, supra, footnote 110.

Note that in Quebec s. 4 of the Study of Anatomy Act, supra, footnote 106, provides that:

"... When it is important that the cause of death should be clearly and satisfactorily determined, the superintendent of any institution to which this act applies may, in the case of the death of a patient supported by such institution, order an autopsy on the body; provided that nothing in this clause shall receive an interpretation inconsistent with the provisions of this act."

A post mortem may also be carried out under the provisions of hospital charters in the case of death of a non-paying patient, see Meredith, op. cit., footnote 18, p. 160 and Ducharme v. Notre Dame Hospital, supra, footnote 88.

Supra, footnote 92. See also Religieuses Hospitalières de l'Hôtel Dieu de Montréal v. Brouillette, [1943] Que. K.B. 441 (C.A.) which involved an official post mortem in a case where the widow had refused her consent to an unofficial post mortem on her husband's body.
medical practitioner holding a post mortem examination which is irregular, is not liable in trespass for his actions if they would have been lawful had the coroner proceeded regularly. Actually, for the advancement of medical science it would be advisable to pass legislation allowing doctors in a restricted list of hospitals to perform a post mortem immediately after death without the consent of any of the relatives whenever scientific or therapeutic interest warrants it.

(ii) Unofficial Post Mortem Examinations

The person who has the right to bury possesses the right to allow a post mortem examination. In other words, a proper consent is a prerequisite to an unofficial post mortem.

In the absence of special statutory provisions and of specific testamentary dispositions to that effect, the consent of the surviving spouse, if there is one, should be obtained unless the deceased was legally separated at the time of death. The surviving spouse has full authority over the body as against the next of kin. When the deceased left a will, it is advisable to obtain the consent of the executor as well as that of the surviving spouse. When there is no surviving spouse or if the parties were legally separated the consent should be given by the next of kin. Finally, in the case of a minor or a mentally deficient person, depending upon the circumstances, the parent, tutor, guardian or curator should give the consent.

123 See, infra, Human Tissue Acts.
124 See, for instance Aetna Life Ins. Co. v. Lindsay (1934), 69 F. 2d 627, at p. 630.
125 In England the Human Tissue Act, 1961, c. 54, provides in s. 2(2) that no post mortem examination which is not directed or requested by the coroner or other competent legal authority shall be carried out without the authority of the person in lawful possession of the body.
126 Wasmuth and Stewart suggest that consent to a post mortem examination may be obtained in any of the following ways, op. cit., footnote 15, p. 459:

1) by written authorization signed by the deceased during his lifetime.
2) by written consent of any party whom the deceased during his lifetime designated by written instrument to take charge of his body for burial.
3) by consent of the decedent's surviving spouse.
4) When the surviving spouse is incompetent, unavailable, or does not claim the body for burial, or when there is no spouse, by consent of any adult, child, parent, brother, or sister of the decedent. The consent of any one of such persons shall be sufficient provided that such autopsy shall not be performed under a consent given by one of such persons if, before such autopsy is performed, any of said others shall object in writing to the physician or the surgeon by whom the autopsy is to be performed.
5) When none of the above-named persons is available to claim the body, then the consent of any other relative or friend who assumes custody of the body for burial. Such ante mortem consent or post mortem consent for an autopsy probably is effective evidence in the absence of statute.
In the absence of statutory authority, it would appear that a document signed by the deceased to be carried in his wallet and incorporated in his will which contains the following language: "I consent to a post mortem examination of my dead body, including the privilege of using any of its parts for the benefit of mankind" is not binding on the person lawfully in possession of the body.

Usually permission to perform a post mortem examination does not include permission for the removal of tissue or organs. Thus, unless the persons whose consent is necessary specifically authorize the removal and retention of such tissue or organs as the hospital's physicians may consider advisable, there is no possibility of using this material for transplantation.

In the case of unauthorized post mortem examinations the plaintiff is entitled to recover moral as well as material damages. The basis of recovery is found in the personal right of the deceased's spouse or next of kin to bury the body. The right to the possession of the body for the purpose of burial is a right to the possession of the body intact.

In order to insure the possible removal of organs or tissue in a post mortem examination, it would be advisable for the consent form to contain a special provision to that effect.

---

127 See, supra, Common Law.

128 Note that there may be a contractual right of post mortem examination of a body by representatives of an insurance company in order that they may ascertain the cause of death in cases where it is important in determining the company's liability, Jackson, op. cit., footnote 84, p. 174; and Aetna Life Ins. Co. v. Lindsay, supra, footnote 124.

129 See Phillips v. Montreal General Hospital, supra, footnote 88; Edmonds v. Armstrong Funeral Home Ltd., supra, footnote 90; cf. Ducharme v. Notre Dame Hospital, supra, footnote 88; Davidson v. Garrett, supra, footnote 92.

130 Wasmuth and Stewart, op. cit., footnote 15, p. 471 reproduce an autopsy permit used by the Cleveland Clinic Foundation. This permit is as follows:

CLEVELAND CLINIC HOSPITAL

Cleveland, Ohio ..................................................

I do hereby grant permission to the authorities of The Cleveland Clinic Foundation of Cleveland to perform an autopsy on the body of ..................

................................................................. , a deceased patient, with the object of ascertaining the direct and indirect causes of death, including such examination of thorax and abdomen, brain, spinal cord, peripheral nerves, bones and marrow, neck, and organs of special senses, as may be necessary for this purpose, and to remove and retain such parts of the body as may be deemed necessary for study subsequent to the autopsy.*

................................................................. Witness to signature

................................................................. Signed
D. Disposal of a Dead Body and Parts Thereof in Accordance with the Cornea Transplant Acts and Human Tissue Acts.\textsuperscript{131}

In 1959 the Conference of Commissioners on Uniformity of

<table>
<thead>
<tr>
<th>Relationship to patient</th>
<th>Address</th>
<th>Approved</th>
<th>Hospital Superintendent</th>
</tr>
</thead>
</table>

*When permission for examination is limited, draw a line through each part for which permission for examination is not given.

In Toronto the Hospital for Sick Children uses the following consent to post mortem:

THE HOSPITAL FOR SICK CHILDREN

CONSENT TO POST MORTEM

I, the undersigned, do hereby give my consent to a Post mortem examination being held on the body of ............................................................

I understand that I am to make arrangements for burial when the examination has been completed.

PARENT OR LEGAL GUARDIAN

ADDRESS ............................................................

I also give consent for removal of the eyes, which will be placed in the Canadian Eye Bank and used for the restoration of sight in another person.

PARENT OR LEGAL GUARDIAN ............................................................

WITNESS ................................................................

DATE .................................................... 19 ............

TIME SIGNED (Use 24-hour Clock) ....................

The Toronto General Hospital uses a substantially similar form:

TORONTO GENERAL HOSPITAL

The undersigned, as ....................................................................................

(Capacity or Relationship)

of the late ....................................................................................,.......................

(name of deceased)

date of death)

hereby consents to and authorizes a post mortem examination on the body of the deceased, including the removal, use and disposal of any organs and tissues in the discretion of the Hospital, subject to the following:

*SPECIAL INSTRUCTIONS AND/OR RESERVATIONS, IF ANY

Dated the day of 19

WITNESS: ................................................................

(address) ................................................................

*IF EYES ARE TO BE REMOVED TO OBTAIN CORNEAL GRAFTS THIS SHOULD BE STATED AS A SPECIAL INSTRUCTION.

The forms used by the Toronto Western Hospital and the New Mount Sinai Hospital do not contain any reference to the removal of the eyes.

\textsuperscript{131} For a study of the legislation of some American States that permit an individual to dispose of his body after death by will see Wasmuth and Stewart, \textit{op. cit.}, \textit{ibid.}, p. 448 et seq.

About thirty-eight American States have in recent years adopted general gift statutes dealing with transplantation. In addition four States have statutes providing for the gift of eyes only. Most of these statutes differ in their enumeration of permissible donees; as to acceptable purposes of gifts, the minimum age of the donor, the method of execution of the instruments of gift, etc. In other words, the statutory picture is very confused, and a Uniform Act is needed to correct this situation. See, \textit{infra}, footnote 169.
Legislation in Canada approved a Model Cornea Transplant Act which is in substance of the same effect as the English Corneal Grafting Act, 1952. This Act provides that if any person either in writing at any time or orally in the presence of at least two witnesses during his last illness, has requested that his eyes be used after his death for the purpose of improving or restoring the sight of a living person, the administrative head of the hospital, or the person acting in that capacity if the donor dies in a hospital or if death takes place elsewhere, his spouse, or if none, any of his children of full age or, if none, either of his parents, or if none, any of his brothers or sisters or, if none, the person lawfully in possession of the body of the deceased person may authorize the removal of the eyes from the body of the deceased person by a duly qualified medical practitioner and their use for that purpose.

Where the prospective donor has not made a request that his eyes be used after his death for therapeutic purposes, his spouse, or if none, any of his children of full age, or if none, either of his parents, or if none, any of his brothers or sisters or, if none, the person lawfully in possession of the body of the deceased person may authorize the removal of the eyes for such purposes.

An authority given in accordance with the foregoing provisions is sufficient warrant for the removal of the eyes from the body for the purposes specified. The authority shall not be given if the person empowered to give it has reason to believe that the person who made the request subsequently withdrew it.

Finally, authority for the removal of the eyes shall not be given if the party empowered to give such authority has reason to believe that an inquest may be required to be held on the body of the deceased.

The Act does not make unlawful any dealing with the body of the deceased that would be lawful if it had not been passed.

This Uniform Model Act was adopted by eight of the nine common law Provinces and by the two Territories. New Brunswick did not adopt the Act as, in 1957, her legislature had passed a Corneal Grafting Act based on the United Kingdom Act of 1952.
In 1963 Ontario replaced its Cornea Transplant Act with a Human Tissue Act. This is what had happened in England in 1961 when the Corneal Grafting Act was also replaced by the Human Tissue Act.


Firstly, The Ontario Act applies to any part or parts of the body or the whole body and secondly, it deals with uses “for therapeutic purposes or for the purposes of medical education or research in accordance with the request of the donor.”

The Act does not change the common law rule that the deceased’s wishes are not legally binding upon his representatives or survivors since in cases where the deceased had made a request in the prescribed manner that his body or a specified part or parts thereof be used after his death for the purposes mentioned above, a specified person may not authorize the use of the body or the removal of the part or parts of the body and their use in accordance with the request.

Where the donor dies in a hospital, its administrative head or the person acting in that capacity may not give such authorization if he knows that any of the close relatives objects to the use of the body or parts thereof. However, if the donor’s whole body is not required by the hospital, the administrative head of the hospital shall immediately notify the local inspector of anatomy who shall then take control of the body. In such a case it would seem that the surviving relatives cannot object to the disposal of the body as the word “shall” is used instead of “may”.

It has been suggested that a possible interpretation of section 2(2) is that it is subject to section 2(1). The head of the hospital only has to notify the inspector of anatomy if he has authorized the use of the body and he has no use for it; if he has not authorized the use, he does not have to notify the inspector of anatomy.

There is no equivalent provision in the English Act, and under the Nova Scotia Act the inspector of anatomy “may” and not “shall” take control of the body.
Actually, why should it make any difference whether or not the donor dies in or out of a hospital? It could be argued that when the donor dies in a hospital the authorization should be given not only by the head of the hospital but also alternatively by the person who could have given it if the donor had died outside the hospital.\(^{150}\)

If authorization is deemed necessary at all, I would think that in all cases the same persons should be entitled to give their authorization. The reason why, in the case of a donor dying in a hospital, the statute gives authority to the administrative head and not to the relatives is probably a medical one.

In the case of transplants it is necessary to remove them as soon as the donor dies. Time is of the essence. By giving authority to the head of the hospital, the law wants to make sure that no time will be wasted and that the transplantation operation will be successful. On the other hand, if the hospital authorities have to start looking for the relatives and, assuming that they can find them within a reasonable period of time, obtain their authorization when they are likely to be grieving, it is improbable that any transplantation operation could be successfully performed.

When the donor dies in a place other than a hospital the person who according to section 3, may give permission for the body or any of the parts thereof to be used in accordance with the wishes of the deceased, is “his spouse or, if none, any of his children of full age or, if none, either of his parents or, if none, any of his brothers or sisters or, if none, the person lawfully in possession of his body”.

Under this section it is possible for one relative to give the authorization against the wishes of all the others. In order to avoid the possibility of family feuds it would be better if the Act had made the wishes of the deceased donor as binding as a will disposing of his assets, subject only to considerations of need and suitability. Effectiveness of the request should not depend on the authorization of another person.

Nor would it seem to be advisable to replace the present rule by one that would enable any relative to veto the use of the body or parts thereof as in practice such a rule could easily defeat the purpose of the Act.

An authority shall not be given under section 2 or 3 if the person empowered to give the authority has reason to believe that the person who made the request subsequently withdrew it.

\(^{150}\) Ibid., p. 66
In sections 4, 4(a) and 6(2) and (3) the Act deals with what may be done where the deceased has made no request and there is no evidence that he would have objected. Whether the donor dies in or outside a hospital "his spouse or, if none, any of his children of full age, or, if none, either of his parents or, if none, any of his brothers or sisters or, if none, the person lawfully in possession of the body\textsuperscript{151} of the deceased person may authorize the removal of any specified part or parts from the body of the deceased person by a duly qualified medical practitioner and their use for therapeutic purposes or for the purpose of medical education or research\textsuperscript{152}. The Act does not authorize the use of the whole body.\textsuperscript{153} There is no logical or ethical reason why a distinction should be made between the removal of part or parts of the body and the use of the whole body.

As in the case where a specific request was made by the donor, it is possible for one person to give an authorization despite the objections of all other relatives.\textsuperscript{154} Perhaps in such a case, any close relative or any member of a class of relatives should have the power to veto the use of the body or of the removal of part or parts thereof.

Finally, it should be noted that in 1967 the Ontario Legislature added section 4a to the Act to cover the case of a patient "who has not made a request to be a donor [and] is in the opinion of a duly qualified medical practitioner, incapable of making such a request and his death is imminent and inevitable".\textsuperscript{155}

Provided there is no evidence that the deceased would have objected,\textsuperscript{156} his relatives taken in the same order, as in the preceding section "may authorize the removal after death of any specified part or parts from the body of the person by a duly qualified medical practitioner and their use for therapeutic purposes or for the purposes of medical education and research".

Again, one must assume that this amendment is primarily concerned with the unconscious victim of an accident whose life may be artificially maintained by mechanical devices. In order to insure

\textsuperscript{151} A difficulty arises in determining who is in fact a person lawfully in possession of the body within the meaning of the Act, see s. 1(b), ibid. It could be argued that the class of persons who are in lawful possession of the body is at least as wide as the class of persons who are under an obligation to bury it.

\textsuperscript{152} S. 4 (italics mine), ibid.

\textsuperscript{153} See also New Brunswick and United Kingdom Acts, supra, footnotes 107 and 113. Cf. Nova Scotia Act which includes the whole body, supra, footnote 107.

\textsuperscript{154} Cf. United Kingdom Act, s. 1(2). ibid.

\textsuperscript{155} Supra, footnote 107.

\textsuperscript{156} S. 6(2), ibid.
the maximum success for the transplantation operation the Act allows the necessary authorization to be obtained before actual death. This is a very progressive step and should be extremely beneficial to recipients of transplants. This may also explain why the section applies only to any specified part or parts of the body and not to the whole body.

At the 1963 meeting of the Conference of Commissioners on Uniformity of Legislation in Canada, the Alberta Commissioners were asked to make a study of the subject of the Human Tissue Act and to submit a report at the next meeting of the Conference with a draft Act if they considered it advisable. At the 1964 meeting of the Conference, the Alberta Commissioners submitted a report as a result of which the subject was referred back to them for a further report and a draft Act embodying the following principles:  

1. When a deceased person has made a request for the use of his body or parts of his body for therapeutic purposes for medical education or research, if the deceased is apparently under the age of 21 he cannot give a binding bequest of his whole body—only the parts thereof, but in all other cases the request is binding, subject only to considerations of need and suitability.

2. Where a deceased has not made such a request, the draft Act should provide for the giving of authority with respect to the whole body as well as parts by a close relative in a manner similar to that contained in section 4 of the present Ontario Act with the exception that an authorization for the use of the whole body is subject to a veto by any one of the same class of relative.

In 1965 the Alberta Commissioners presented their report and their draft Model Act incorporating these principles. The Model Act was referred back to them with a request that they prepare a re-draft in accordance with the changes agreed upon at the annual meeting. Copies of the revised draft were then distributed to the Commissioners in their respective jurisdictions. As disapprovals by two or more jurisdictions were not received by the Secretary of the Conference by November 1965, the Act was formally adopted by the Conference and recommended for enactment.  

At the end of 1967 the Act had been adopted by Alberta, the North West Territories and Newfoundland.

---

As will be noted the final version does not retain all of the principles mentioned above.

The Model Act provides that:

1. (1) A person eighteen years of age or over may,
   (a) in writing at any time; or
   (b) orally in the presence of at least two witnesses during his last illness,

direct that his body or any specified part or parts thereof be used after his death for therapeutic purposes or for purposes of medical education or for purposes of medical research.

(2) Upon the death of the person, the direction is binding and is full authority for the use of the body or for the removal and use of the specified part or parts thereof for the purposes specified in the direction, except that a person,
   (a) shall not act upon a direction if he has reason to believe that the person who gave the direction subsequently withdrew it; and
   (b) shall not, except with the consent of a coroner, act upon a direction if he has reason to believe that an inquest may be required to be held upon the body.

(3) A direction given by a person under eighteen years of age is valid for the purposes of this section if the person who acted upon it had no reason to believe that the person who gave the direction was under eighteen years of age at the time he gave it.

This is an excellent provision since it enables minors close to maturity to direct that their bodies be used for therapeutic purposes or for the purpose of medical education or research. The final draft did not embody the principles that a minor "cannot give a binding bequest of his whole body". Persons over eighteen years of age are given the same right as adults. Under that age they cannot make a binding bequest at all. But more important is the fact that such direction is binding on the executor and close relatives. The direction does not depend upon a further authorization following the death of the donor. Thus, the wishes of the deceased cannot be defeated.

The difficulty for a hospital is to find out whether the deceased gave a direction, or whether he had withdrawn it. It would be advisable for every person to carry a card stipulating that he has given such a direction, or every voluntary donor could carry a card containing the following information: name, address, age, blood group (certified by a reputable laboratory), histocompatibility, and the words voluntary donor followed by his signature and that of two witnesses. This would solve the difficulties involved in obtaining prior consent or in locating such a consent.

166 Cf. Ontario Act, supra, footnote 107, ss 2 and 3.
According to section 2:

2. (1) Where a person other than a person who has made a direction under section 1 dies,
   (a) his spouse; or
   (b) if none, any one of his children twenty-one years of age or over; or
   (c) if none, either of his parents; or
   (d) if none, any one of his brothers or sisters twenty-one years of age or over; or
   (e) if none, the person lawfully in possession of the body, may direct that the body or any specified part or parts thereof may be used for therapeutic purposes or for purposes of medical education or for purposes of medical research.

   (2) The direction is full authority for the use of the body or for the removal and the use of the specified part or parts thereof for the purposes specified in the direction, except that a person,
   (a) shall not act upon the direction if he has actual knowledge that another member of the same class of persons as the person who gave the direction objects thereto; and
   (b) shall not act upon the direction if he has reason to believe that the deceased person would, if living, have objected thereto; and
   (c) shall not, except with the consent of a coroner, act upon a direction if he has reason to believe that an inquest may be required to be held upon the body.

   (3) In this section, "person lawfully in possession of the body" does not include
   (a) a coroner in possession of a body for the purpose of investigation; or
   (b) an embalmer or funeral director in possession of a body for the purpose of its burial, cremation or other disposition.

The Act wisely removes the possibility of family strife since it is not possible for one member of a class of relatives to give the authorization against the wishes of all the others.

It must also be noted that the Model Act does not distinguish between the use of parts and the use of the whole body except for limited purposes, nor does it distinguish between the case where the deceased died in a hospital and that where he died outside the hospital except where there is no request for the donor's body. Thus, section 3 provides that:

3. Where a direction has been given under section 1 or 2 for the use of a deceased person's body for the purposes of medical research or for purposes of medical education and at the time of the death there is no request for the use of the body for either of those purposes, (a) if the body is lying in a hospital the administrative head of the hospital; or

167 See s. 3.
(b) if the body is lying elsewhere than in the hospital, the person lawfully in possession of the body shall notify an inspector of anatomy who shall thereupon take control of the body and deliver it to a person qualified to receive unclaimed bodies under The Anatomy Act for the purposes of that Act.\textsuperscript{168}

Finally, the Act states that it does not make unlawful any dealing with the body of a deceased person or any part thereof that would be lawful if the Act had not been passed.

\textit{Conclusion}

The Model Act adopted by the Conference of Commissioners on Uniformity of Legislation in Canada\textsuperscript{169} and now in force in some

\textsuperscript{168} This section is to be omitted if the enacting Province has no medical school. In other Provinces it may be necessary to vary the section to conform to the local anatomy legislation.

\textsuperscript{169} In the United States of America the National Conference of Commissioners on Uniform State Laws has just prepared a second tentative draft of a Uniform Anatomical Gift Act which will be presented for discussion at its seventy-seventh meeting to be held in Philadelphia on July 22nd, 1968. Unless unforeseen difficulties arise, the draft as revised in light of discussions and suggestions received prior to and during the annual meeting, will be presented before the end of the meeting to the Conference for promulgation as a Uniform Act and for submission to the American Bar Association and other appropriate professional organizations for approval. On promulgation by the Conference the Act will be available for legislative adoption.

The Uniform Act is limited to \textit{ante mortem} gifts. It does not attempt to cover \textit{inter vivos} gifts, \textit{post mortem} autopsies or the delivery of unclaimed bodies to medical schools.

In the Prefatory Note and Comments to the Second Tentative Draft (1968), it is stated that the Act covers the following principal points (at pp. 11-12):

\textit{(1) Who may make an anatomical gift to take effect after death.} The gift may be made by the donor in his lifetime, assuming that he possesses proper legal capacity; also, if not made ante-mortem, it may be made by the surviving relatives in a stated order of priority; also certain other persons are authorized. [S. 2].

\textit{(2) To whom may a gift be made, and for what purposes.} The gift may run to a specific donee, or to any licensed hospital, teaching institution, or physician; and it may be made for teaching, research, therapy or transplant. [S. 3].

\textit{(3) How the gift is executed.} The gift may be executed by a document in writing, or, as in some states, by will; the document must be signed and witnessed by two persons; provisions are made for a card, like an American Express Card, to be carried on the donor's person to evidence the gift. [S. 4].

\textit{(4) Delivery of the document.} Delivery is not necessary to validity; but the will or other document or an attested copy thereof may, if desired by the donor, be delivered to expedite the appropriate procedures without delay immediately after death, or it may be filed in a local registry office if one exists in the area. [S. 5].

\textit{(5) Provisions for revocation.} Provisions are made for revocation during the life time of the donor, thus taking account of possible change of the donor's desires. [S. 6].

\textit{(6) Effect at and after death.} The time of death is determined by the
parts of Canada constitutes a great step forward as it recognizes the binding effect of a direction by a deceased person that his body or any specified part or parts thereof be used after his death for transplantation purposes.

In the absence of such direction the Act allows the spouse, children or next of kin to donate any of the decedent’s organs unless there is reason to believe that he would if living have objected to the gift. This is not altogether satisfactory as in practice express consent is very rare. In most cases the surgeon will have to make reasonable inquiries of the spouse and the next of kin before he can remove an organ. Since time is of the essence, often the opportunity to perform a transplant operation will be lost.

For this reason Lord Kilbrandon has proposed the following type of legislation to replace the Act presently in existence in the United Kingdom:

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.

This is certainly a step forward. However, the part of this proposal which deals with disfigurement could be omitted as it may donor’s attending physician. The gift is binding upon relatives. It is effective in any state. The donee may accept or reject the gift. If he accepts he may proceed to remove parts given to him, and, if only parts are given, after they are taken the body must be released to the relatives for burial. Possible civil or criminal liability of the surgeon who uses the body or removes the parts is precluded if he acts in good faith reliance upon the evidence of the gift without notice of revocation. [S. 7].”

It must be emphasized that the draft Model Act does not deal with the time of death, it merely provides that “The time of death shall be determined by the physician who attends the donor at his death, or, if none, the physician who certifies the death (s. 7(b)).” Furthermore the deceased donor’s physician must not be a participant in the procedures for removing the part or in transplanting it (ibid.). The Act does not cover the question of payment for gifts of body parts nor does it attempt to prescribe who shall get the organs if there is a shortage of supply.

Ethics in Medical Progress (1966), p. 212 et seq. See also supra, footnote 82.

To some extent Lord Kilbrandon’s proposal changes the condition precedent of consent to a condition subsequent of objection. See also the proposal made by Sanders and Dukeminier, op. cit., footnote 4, at pp. 412-413, the surgeon “ought to be told ‘you can remove cadaver organs to save the life of a living person unless the next of kin objects’. . . . the burden would be on the person who did not want the organs removed to enter his objection. . . . We need precisely to reverse what presently is the rule and what is the exception. The legal rule should favor removal of cadaver organs and preservation of life; the exception should permit objection and decay”. Personally, I am not in favour of allowing the spouse or the next of kin to object to the transplant. In fairness to the authors it must be said that they have some doubt about the wisdom of
constitute a psychological barrier for prospective donors by reminding them of possible disfigurement. It could also open the door to pointless litigation.

A major deficiency of the Model Act is that it does not refer to donations of organs or tissue by live donors.

As pointed out by Lord Kilbrandon legislation should be passed along these lines: "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." And he added:

(I would not include prisoners as being of full age and capacity, since they are under restraint.) This is needed to get over the law as it probably stands at the moment. The law at the moment considers that the procedure which the surgeon adopts is so severe that it is incapable of being consented to by the person being operated on unless that operation is for the person's own benefit. If that is not the law at the moment many people think it is, and we still need something like my suggestion for the purpose of declaring what the law is.

This rough draft leaves right out of consideration the mechanics of explanation to the person upon whom the operation is going to be done. This point is extremely important and will need very careful elucidation. It will probably be necessary for some professional official panel to be set up to say which procedures are justifiable, having regard giving the next of kin the right to object, but have included the principle in their proposal so as to obviate any constitutional problem regarding freedom of religion.

It has also been suggested by Professor Daube in Transplantation: Acceptability of Procedures and the Required Legal Sanctions in Ethics in Medical Progress (1966), p. 188, at pp. 192-193 that: "One could now aim at legislation which would make available a corpse for therapeutic or scientific use, if the deceased expressed a wish, not revoked, in this direction or, in the absence of such a disposition, if he did not express a contrary wish, if he did not belong to a group normally opposed to such availability, and if his next of kin does not immediately express a contrary wish. So long as there were no reasons for assuming the existence of any of these impediments, the use of the corpse would be permissible. Note that I place a scientific, experimental object on the same level as a distinctly therapeutic one—this by contrast, you will find, with transplantation from a living donor.

I think such legislation could be achieved, and it would give the medical profession all it wants. The question was put to me: suppose there are no other impediments but the next of kin is not known or not immediately available, yet instant use of, say the deceased's kidneys is essential? In this case, my law would concede their use. Every general regulation, alas, is a compromise, and the next of kin's protection cannot be absolute." Note that the Model Act, supra, footnote 113, substantially embodies this proposal. In general see Grad, Legislative Responses to the New Biology: Limits and Possibilities (1968), 15 U.C.L.A. L. Rev. 480, esp. at pp. 496-501.

to the risk which is going to be run. This is to cut out wild experimental surgery, which I don’t think the public would permit.

It is absolutely essential to make sure that the donor’s consent is free from any pressure. Also, in the case of a live donor, the organ donated should be taken for therapeutical purposes only and not for the purposes of medical education, research or experimentation.  

With respect to minors (as live donors), it is my belief that they should not be authorized to donate organs until they are close to maturity. Nor should the parents be allowed to consent to the removal of healthy organs from their children before they are dead.

Finally, some system of registration of potential cadaver donors should be organized on a national basis.

Today, there have been enough experimental transplants from one animal to another to enable surgeons to know most of the technical aspects involved. Similarly, the immunological techniques are fairly well understood. The question of the moment of death of the donor can be solved by adequate tests. It should not be merely a legal matter. The fear of modifying the personality of the receiver by the transplantation operation is unfounded. As Dr. Blaiberg can testify, a person’s mind, spirit, personality, thought, sensibility, and his vision of the world is not affected. The heart performs a purely mechanical function. There is less likelihood of changing the personality of a patient as a result of a heart transplantation than by applying certain techniques of psychoanalysis or neuro-surgery to mentally disturbed people.

Of course, accidents are possible. There could be a temporary stoppage of the heart. There is also the difficulty of finding a suitable donor. It is not as easy to find a heart as it is to find a kidney nor is it easy to maintain the recipient alive until the right heart is found. The main problem is to decide whether or not to operate. Such a decision should be made by a group of specialists and not by one person alone.

Basically, the difficulties are more technical and ethical than legal. The objectives of any modern legislation in the field of homotransplantation should be to prevent possible abuses with respect to the consent of live donors and at the same time facilitate the work of the transplantation team by devising rules that will enable the surgeons to operate as soon as a donor, dead or alive, becomes available.

174 For my proposals in the case of live donors see supra, p. 374.
Clearly, the predominant motivation of serious medical research and experimentation should not be the enhancement of national or personal prestige. However, from a moral point of view the difficult choice is to weigh the advancement of knowledge for the benefit of all mankind against the health and welfare of the individual donor and recipient.