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THE HUMAN TISSUE ACT 1964 AND THE NEED FOR REFORM

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ABSTRACT

The object of this paper is to analysis the law relating to cadaveric organ transplantation in New Zealand. The discussion involves a consideration of the common law and s 3 of the Human Tissue Act 1964. The paper concludes that s 3 is need of reform in order that the supply of organs might be increased.

WORD LENGTH

The text of this paper (excluding contents page, footnotes, bibliography and annexures) comprises 13,418 words.

CONTENTS

I INTRODUCTION

The prospect of transplanting body parts is recorded in the book of Genesis:[1]

> So the Lord God caused a deep sleep to fall upon the man, and while he slept took one of his ribs and closed up its place with flesh; and the rib which the Lord God had taken from the man he made into a woman...

However it wasn't until the twentieth century that organ transplantation became medically feasible. During the first world war, the transfusion of blood became common place. In the late 1920's skin grafts began and by the 1940's corneal transplants had become routine. In the 1950's[2] the transplantation of non-regenerating organs began. The transplantation of kidneys was largely routine by December 1967 when Doctor Christian Barnaad performed the first heart transplant. The next major development for transplantation surgery was the development of cyclosporin (an immunosuppressant) in 1983. The drug greatly extended the life expectancy of transplant patients because it was able to forestall the transplant patient's rejection of the new organ, without damaging the patient's immune system. The drug has shortened hospital stays and made organ transplants an option for high risk patients. As transplantation has moved from being experimental to routine, the once unanswered technical questions have now been replaced by those of an ethical and legal nature. The success of

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[1] *The Holy Bible* (Revised Standard Version, Eyre and Spottiswoode Limited, London, 1952) Genesis 2:21,22

[2] In 1951 Doctor David Hume performed the first non-regenerative vital organ (kidney) transplant in Boston. Doctor Hume used a cadaver donor; the transplantation was unsuccessful insofar as the recipient died. For a brief history of transplantation see David Lamb *Organ Transplants and Ethics (Routledge, London, 1990)* pp 7-23

transplantation surgery has led to a worldwide shortage of organs. In March 1996 there were 200 patients on the New Zealand kidney transplant waiting list. Approximately 80-100 can expect to receive a transplant in the next 12 months. Of the kidneys transplanted 75% come from cadavers, the balance are removed from live donors.[3]

The purpose of this paper is to discuss the law governing organ transplantations from cadavers in New Zealand. The discussion involves consideration of the common law and s 3 of the Human Tissue Act 1964 (the Act) which provides for the removal of organs from cadavers. With this in mind, the paper is divided into the following principal parts:

(a) The Common law,
(b) An analysis of s 3 of the Act,
(c) Non-compliance with s 3,
(d) The policy of s 3,
(e) Reform of s 3,
(f) Other reform options

It will be concluded that the language of s 3 of the Act is unclear. Where the lack of clarity cannot be attributed to poor drafting it can be explained with reference to the confused policy reasons for the section and the fact that developments in medical technology have overtaken its usefulness. The lack of clarity when coupled with the legislative intent to afford generous rights to relatives to object to transplantation has the effect of reducing the available number of organs for donation.

After a survey of different policy approaches to cadaveric organ retrieval

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[3]This information was provided by the National Kidney Foundation of New Zealand, PO Box 11141, Manners Street, Wellington. The Ministry of Health fixes the figure at 85% rather than 75%, see The Ministry of Health Tertiary Services Review Committee *Renal Replacement Services Issues Paper No. 3* (Ministry of Health, Wellington, May 1995) 13

it is concluded that the only practical and workable solution to the problems with s 3 is to change from the current system (that emphasises the relatives' rights to the body) to a system that favours the retrieval of organs for the benefit of a sick patient.

II THE COMMON LAW

Given the relatively recent development of transplant surgery it is, perhaps, not surprising that the common law provides little assistance in the area of cadaveric transplants. Essentially, this is because the common law does not recognise proprietorial rights in a corpse. In *R v Price*[4], Stephen J noted the facts in *R v Lynn*[5] (the disinterring and removal of a body) and said: "[T]he act done would have been a peculiarly indecent theft if it had not been for the technical reason that a dead body is not the subject of property."[6]

Pahl[7] notes the doubtful origins of the "no property in a corpse" rule as being founded on a wrong analysis of *Haynes* case[8]. The analysis incorrectly interprets a passage of the judgment that says a corpse cannot own property, to mean that a corpse was not, itself, property. It follows that if a corpse cannot, ordinarily,[9] be the subject of ownership a person cannot, by Will, determine what is to be done to his or her

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[4](1884) 12 QBD 247

[5](1788) 2 TR 733 & 100 ER 395

[6]Above n 4, 252. See also *Williams v Williams* (1882) 20 Ch D 659

[7]Susan Pahl "Whose Body is it Anyway?" [1992] NZLJ 427, 428

[8](1614) 12 Co Rep 113 and above n 5, 428

[9]This is not the case where the corpse acquires attributes sufficient to justify its preservation on scientific or other grounds: *Doodeward v Spence* (1908) 6 C.L.R 406

body after death. Although the common law was not prepared to recognise a property right in a cadaver it did establish a right to custody and possession of the corpse. This can be traced to the eighteenth century when the Courts recognised the public interest in the prompt burial of corpses. Principles were developed that obliged various classes of people in possession of the corpse to bury it. As Pahl notes:[10]

> There developed a right or duty to bury the deceased governed by a pecking order with the executors of the deceased at the top of the order followed by the wife and other relatives of the deceased, in turn followed by the householder in whose house the deceased died or where is or her body lay.

There is no authority to suggest that the right to possession of a cadaver, for burial purposes, can be extended to authorise the removal of tissue for transplantation purposes.[11]

In summary, the common law was concerned (due to public interest considerations) with imposing duties on others to bury a corpse rather than creating rights and powers over and in a corpse. The undeveloped state of the common law and the rapid development of new uses for once worthless body parts has led to the enactment of statutes regulating post-mortem examinations, anatomical examinations and the transplantation of organs.

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[10]Above n 7, 429. See also Gerald Dworkin "The Law Relating to Organ Transplantation in England" (1970) 3 MLR 353

[11]Australian Law Reform Commission *Human Tissue Transplant Report - No 7* (Australian Government Publishing Service, Canberra, 1977) 26

III SECTION 3 (1) OF THE ACT

On 9 September 1964 the Human Tissue Bill was read for the second time. The Honourable Mable B Howard remarked:[12]

> I wish he [the Honourable D N Mackay - Minister of Health] had found a different name for the Bill, it is awfully gruesome. Surely he could have found a slightly better name than this. However, I suppose a rose by any other name smells just as sweet... .

Despite the disagreement over the name, the Bill was read unopposed. Section 3 of the Act closely follows the Human Tissue Act 1961 (UK) (the UK Act). Section 3(1) of the Act states:[13]

> **Removal of human tissue for therapeutic purposes, etc.** - (1) If any person, either in writing at any time or orally in the presence of 2 or more witnesses during his last illness, has expressed a request that his body or any specified part of his body be used after his death for therapeutic purposes or for purposes of medical education or research, the person lawfully in possession of his body after his death may, unless he has reason to believe that the request was subsequently withdrawn, authorise the removal from the body of any part, or as the case may be, the specified part, for use in accordance with the request.
>
> 1(A) Where a record of a request in writing to which subsection (1) of this section applies is held on a health computer system, the person lawfully in possession of the body of the person who made the request may, in reliance on the record, unless that person has reason to believe that the request was subsequently withdrawn, authorise the removal from the body of any part or (as the case may be) the specified part for use in accordance with that request.

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[12](1964) 339 NZPD 2013 and 2014

[13]Sections 4 and 4A regulate post-mortem examinations and ss 5-9 (inclusive) provide for the conduct of anatomical examinations

In summary, it is necessary to show that the deceased requested in writing to donate tissue, or requested, in the presence of two witnesses, during the deceased's last illness, to donate tissue.

A The Written Request

The section is silent on whether the request must be signed and in the hand of the donor. It is unlikely that a court, given the purpose of s 3 (1), would insist on a handwritten request when pre-printed cards are available from the National Kidney Foundation of New Zealand. Similarly, a court would not insist on a signature if it was clear that the handwriting was that of the donor.

At the time of the issue of a full driver's licence, the applicant has an opportunity of becoming a donor, if this occurs the word "donor" will be typed on the licence. This licence may be the only physical indication of a deceased's wish to donate a body part. If the donor's request to donate has not been entered on the correct computer the licence will be the only record on which the person in possession might rely. It is, however, doubtful that it would constitute a written request; it appears to be more a notice to check the computer under the control of the Director-General of Health, than an instruction in itself. Additionally, if the licence is not found on the donor, there may be doubt as to whether or not the licence is in fact that of the deceased.

Section 3 (1A) allows the person in possession to rely on a record of the request held on a computer under the control of the Director-General of Health. Potential donor details are entered into the Master Patient Index (which is a computer system under the control of the Director-General) and the Land Transport Safety Authority computer[14] which is not under

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[14]This information was supplied by the National Kidney Foundation of New Zealand. Section 45 of the Transport (Vehicle and Driver Registration and Licencing) Act 1986, establishes a register of drivers licences and set outs the information that the register

the control of the Director-General. It is unlikely that the person in possession (who, for practical purposes, is often a doctor or nurse employed by a hospital) would have access to this computer.

Paragraph 4.2(b) of A Code of Practice for Transplantation of the Cadaveric Organs[15] (the Code) does not contemplate access to the Land Transport Safety Authority computer, it states:

> If the National Master Patient Index indicates that the potential donor has requested that specified organs be used for transplantation, or that any part of the body be used for the treatment of others, hospital staff may communicate with the hospital or organisation where the signed request is retained, to ensure that the computer record is correct.

The existence of two unrelated computer systems remains.[16] It is now necessary to consider who has the authority to sign a written request, which is, of course, the source document of any computer record.

B The Power to Donate

1 *Competency*

To be valid the written request will need to be made by a competent person[17]. The Act does not require a minimum age to be obtained

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is to contain. Section 45 does not provide for the entering of donor details into the register. By storing donor information it appears that the Land Transport Safety Authority is acting ultra vires section 45

[15]The Department of Health Working Party *A Code of Practice for Transplantation of Cadaveric Organs* (Department of Health, Wellington, 1987) 2

[16]See text at n 96

[17]I Kennedy and A Grubb *Medical Law Text with Materials* (2 ed, Butterworths, London, 1994) 1148

before the request can be made. Lanham[18] (commenting on the identical wording of s 1(1) of the UK Act) suggests that if a child is old enough to understand the nature of the request then it will be valid. If the child is not old enough then the s 3(1) procedure will not be applicable and the request will have to be made pursuant to s 3(2).[19] Should a young child's understanding of the request ever be queried, the House of Lord's decision in *Gillick v West Norfolk and Wisbech Area Health Authority*[20] may provide some guidance. While accepting that *Gillick* concerned the issue of whether or not a girl under 16 years of age could consent to contraceptive treatment without the express consent of her parents, it appears to be applicable to a child's understanding of the nature of request to donate organs. Fraser LJ agreed with the trial Judge and said that a doctor would be justified in providing contraceptive treatment if, though under 16 years of age, the girl understood his advice.[21] Mason and McCall Smith described this as the "mature minor" principle.[22] Paragraph 4.4 of the Code provides some practical guidance when it states that the agreement of the family or whanau should be obtained before a child's request for removal of organs is carried out.

2 *The extent of the power*

The National Kidney Foundation of New Zealand's form for the donation of organs[23] does not require the donor to date the form at the time of

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[18]David Lanham "Transplants and the Human Tissue Act 1961" (1971) 11 Med Sci Law 16, 17

[19]See text at n 29

[20][1985] 3 All ER 402

[21]Above n 20, 413

[22]Mason and McCall Smith *Law and Medical Ethics* (4 ed, Butterworths, London, 1994) 95

[23]See Appendix 1

signing. It will be necessary to rely on other evidence to determine the child's age when the request was signed.

The Foundation's request form also fails to set out the same options available under s 3(1). The section allows for the donation of the body (or part of) for therapeutic purposes, "[O]r for purposes of medical education or research... ." The request form specifies the options of: kidneys, eyes, heart, lungs, liver and bone transplantation. A wider option is also provided, it states, "Any part of my body be used for the treatment of others."[24] It is doubtful that this option is wide enough to encompass the medical education and research purposes envisaged in the section. The wording also does not allow for the donation of the whole body for therapeutic purposes, medical education or research which is another option available under s 3(1).[25]

The request form appears to reflect the confused wording of s 3(1). The section allows a donor to request his or her body (or part of) to be used for therapeutic purposes, medical education or research. However, the same section states that the person in possession of the body can only allow the removal of part of the body for the use requested.[26] Unfortunately, this anomaly was repeated when the 1989 amendment to the Act inserted s 3(1A). The relevant part of s 3(1) states:[27]

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[24]See Appendix 1

[25]It is accepted that Appendix 1 is entitled, "Form For Donation Of Organs For Therapeutic Purposes" and that it is printed by the National Kidney Foundation of New Zealand, whose principle aim is to increase the supply of organs

[26]See above n 17, 1151. Kennedy and Grubb record the same anomaly in s1(1) of the Human Tissue Act 1961 (UK)

[27]The author's emphasis

> If any person, ... has expressed a request that *his body or any specified part of his body* be used after his death for therapeutic purposes or purposes of medical education or research, the person lawfully in possession of his body after his death may, ..., authorise the removal from the body *of any part or, as the case may be, the specified part* for use in accordance with the request.

The section appears to prevent the authorisation of the entire body being used for therapeutic purposes, medical education and/or research. The anomaly remains unexplained.

If a written request does not exist the donor can request, in the presence of two witnesses during his or her last illness, that his or her body be used for therapeutic purposes. Kennedy and Grubb note that it is unlikely that the expression "last illness" will pose any interpretation problems, as hindsight (after the death of the donor) will assist in identifying the last illness.

C Lawfully in Possession

The common law right to possession of a body for burial purposes is acknowledged in s 2(2)(a) and (b) of the Act. The subsection states that, subject to any person's rights under any rule of law to possession of any body, the person for the time being in charge of a licenced hospital (under the Hospitals Act 1957 and the Mental Health (Compulsory Assessment & Treatment) Act 1992) within which a body is lying shall be the person lawfully in possession of the body.[28] The section is a convenient deeming provision that allows hospital staff to act on a donor's request. It prevents any delay in waiting for the deceased's spouse (a person who is entitled to possession) to authorise the donor's request.

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[28]Section 2 (2)(c) of the Act deems the Superintendent of a penal institution to be the person in lawful possession of an inmate's body

Section 3 (6) of the Act specifically excludes an undertaker who is in lawful possession of the body, as a person who may authorise the removal of tissue under s 3.

Section 3 (1) allows a person to specifically request that his or her body be used for donation purposes. Section 3(2) deals with the situation where the potential donor has not specifically consented to the removal of tissue.

IV SECTION 3(2)

Section 3(2) states:

> Without limiting subsection (1) of this section, it is hereby declared that the person lawfully in possession of the body of a deceased person may authorise the removal of any part of the body for use for the said purposes if, having made such reasonable enquiry as may be practicable, he has no reason to believe -
>
> (a) That the deceased person has expressed an objection to his or her body being so dealt with after death, and had not withdrawn it; or
>
> (b) That the surviving spouse or any surviving relative of the deceased person objects to the body being so dealt with.

D The Power to Donate

The subsection allows the person in possession to authorise the removal of tissue where that person has no reason to believe that the potential donor, or relative, opposes the removal. The inconsistent wording[29] within s 3(1) and s 3(1A) is continued in subsection (2). The s 3(2) person in possession is only allowed to authorise the removal of tissue,

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[29]See text at n 27

not it seems, release the body (or a part of it) for medical education or research. Section 3(2) also contains the requirement that the person be in lawful possession of the body; the meaning of this expression has already been discussed.[30] The words not common to s 3(1) will now be considered.

E Such Reasonable Enquiry as May Be Practicable

The Act does not define "reasonable" or "practicable". Skegg[31] suggests that a reasonable enquiry will have regard to the resources available to the person in possession. Secondly, the utility of the enquiry; the person in possession would not be expected to enquire of every available person known to the deceased when the chance of those persons revealing relevant information is slight. Thirdly, whether or not the subject of the enquiry is of an age or level of competence that would make an enquiry unreasonable. It would not be reasonable for enquiries to be made of a young child or a recently bereaved spouse. The interpretation of "practicable" has produced two approaches. Skegg argues[32] that the person in possession should, in determining how practicable an enquiry will be, be able to consider the optimum time within which a body part must be removed and transplanted. Skegg is of the view that s 1(2) of the UK Act (the wording of which is identical to s 3(2) of the Act) represents a compromise between the principle purpose of the Act (to provide body parts) with the relative's right to object to the donation. He argues that the right to object is not absolute because it is tempered by the subsection's requirement that the objection only be ascertained after a reasonable enquiry. He concludes

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[30]See text at n 10, n 11 and n 28

[31]Peter Skegg "Human Tissue Act 1961" (1976) 16 Med Sci Law 197. Skegg's discussion of reasonableness appears to be a development of Lanham's views at above n 18, 197

[32]Above n 31, 197

that, "[T]here is no warrant for excluding from consideration the time within which a part must be removed if it is to be of use for the intended and approved purpose".[33]

Dworkin takes a different view. He considers that the practicability of the enquiry, "[M]ust relate to the steps taken to trace the relatives not to the practicability of using the body, since the basis of the provision is to allow the relative to object if he so wishes."[34] Kennedy and Grubb prefer Dworkin's approach.[35] The Code also appears to support Dworkin's views. Paragraphs 4.3(a) to 4.3(e) deal broadly with reasonableness and practicability. Paragraph 4.3(d) endorses the view expressed in the United Kingdom Departmental Guidance Circular that:

> [I]n most instances it will be sufficient to discuss the matter with any one relative who has been in close contact with the deceased, asking him his own views, the views of the deceased and also if he has any reason to believe that any other relative would be likely to object.

The same paragraph goes on to discuss the concepts of unreasonableness and impracticability in the context of not being able to locate relatives, having to speak with relatives who are young children, and/or relatives who are seriously ill. There is no reference to practicability being linked to the need to remove a part as quickly as possible.

F The Objection

The section does not specify what form the objection should take. However the scheme of the Act is such that whenever writing is required

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[33]Above n 31, 197

[34]See Dworkin above n 10, 367

[35]Above n 17, 1155

it is specifically set out.[36] It is most likely that the objection will not need to be in writing.

G The Surviving Spouse or any Surviving Relative

The meaning of "surviving spouse" is clear. In comparison, the word "relative" is without definition and capable of many meanings. Section 2 of the Adoption Act 1955 restrictively defines the word relative to mean, "[I]n relation to any child, a grandparent, brother, sister, uncle or aunt, whether of the full blood, of the half blood, or by affinity." The omission of parents, step-parents, great-aunts and uncles and de facto partners reduces the value of the Adoption Act definition. The Code does not directly assist with the meaning of relative however, paragraph 4.4[37] states that it will be undesirable to remove a child's organs without the agreement of the "family" and/or "whanau". These words have a potentially wide definition which, when coupled with the statutory words, "[A]ny surviving relative" may suggest that a wide interpretation will be favoured.

H Objects

Skegg prefers[38] a broad interpretation of the word "objects", so that it includes potential objectors who could object if they knew of the proposal to remove an organ. Accordingly, he proposes that "objects" be extended to "would object". The Code, at paragraph 4.3(d) envisages the possibility of a potential objection when it states that a reasonable and practicable enquiry would involve asking a close relative of the deceased, "[I]f he has any reason to believe that any other relative

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[36]See above n 17, 1155

[37]See text at n 21

[38]Above n 31, 197

would be likely to object."[39]

The uncertain meaning of words and expressions within ss 3 (1) and 3 (2) has already been discussed. The uncertainty continues in s 3(4).

V SECTION 3(4)

Section 3(4) states:

> No such removal shall be effected except by a medical practitioner, who must have satisfied himself by personal examination of the body that life is extinct.

I Life is Extinct

The perhaps euphemistic expression "life is extinct" refers to death, which is not defined by the Act, or any other New Zealand statute. Traditionally, death has been defined as the irreversible cessation of heart beat and respiration. However, the advent of artificial respiratory and circulatory machines has meant that a person will remain "alive" long after the destruction of the brain stem. If the traditional definition of death is applied to this situation, the person would be defined as being alive, despite the fact that the destruction of the brain stem[40] makes it impossible for that person to ever independently maintain a heartbeat or to breathe. The traditional definition of death must be seen as obsolete and unworkable.

The need to define death is particularly important because of the very

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[39]The author's emphasis

[40]That part of the brain that is responsible for the basic functions of life, eg breathing and heartbeat. The brain stem, of all the parts of the brain, is least affected by the lack of blood. Invariably the death of the brain stem occurs after the death of the cerebral hemispheres and those other areas of the brain responsible for the higher functions of life

nature of cadaveric transplantation. The successful donation of organs such as the heart, kidney and liver is inextricably linked to the time the organ is deprived of circulatory blood. The very best dead donors are those who lie in an intensive care unit artificially ventilated. They will have often suffered brain stem death as a consequence of a haemorrage or a violent accident which largely unaffects the quality of the organs; artificial ventilation then ensures that the organs are nourished by oxygenated blood.

Paragraph 8 of the Code recognises the concept of brain stem death. It allows medical practitioners to diagnose death after the satisfactory conclusion of the clinical tests set out in the Code. Paragraph 9.4 of the Code says that after death, it is ethical to maintain, for a reasonable time, the artificial ventilation and respiration of corpses for the purpose of the removal of organs.

In Scotland and England there has been judicial acceptance of the concept of brain stem death. In *R v Malcherek*[41] and *R v Steele*[42] both victims died as a consequence of violent attacks. However, they did not die immediately, it was diagnosed that their brain stems were dead and, on this basis, they were disconnected from their ventilators. It was alleged that the disconnection was the cause of their deaths and not the earlier violent acts. Lane CJ did not accept the argument and said:[43]

> Where a medical practitioner adopting methods which are generally accepted comes bona fide and conscientiously to the conclusion that the patient is for practical purposes dead, and that such vital functions

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[41][1981] 2 All ER 422 (CA)

[42][1981] 2 All ER 422 (CA)

[43]Above n 41, 429

> as exist (for example, circulation) are being maintained solely by mechanical means, and therefore discontinues treatment, that does not prevent the person who inflicted the initial injury from being responsible for the victim's death.

The concept found further acceptance in *Re A*[44]. The Court, after hearing evidence of *A*'s injuries, the tests carried out on him to ascertain brain stem death, and the opinion of a paediatric neurologist, granted a declaration that *A* was brain stem dead. The Court also held that *A* had been dead since the brain stem tests had been satisfied (some six days prior to the decision of the Court).

The potential for a *Malcherek/Steele*[45] causation argument remains in New Zealand. Given the Code's acceptance of the artificial ventilation of cadavers and the concept of brain stem death it is unacceptable that there is no statutory definition of death that reflects established medical views. If the traditional definition of death is used, a doctor switching off a ventilation machine or removing an organ (from a brain stem dead person) that leads to that person's death might be in breach of ss 151, 160 and 164 of the Crimes Act 1961. These sections deal with the duty to provide the necessities of life, the acceleration of death and culpable homicide. In *Auckland Area Health Board v Attorney-General*[46] Thomas J considered ss 151 and 164 in the context of an application for a declaration that ss 151 and 164 did not apply to doctors who wished to remove ventilatory support from a person suffering from Guillain-Barre syndrome. In granting the declaration the Court held, (in context of s 151) that there was a lawful excuse to discontinue ventilation when to do

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[44][1992] 3 Med L R 303 (Fam D)

[45]Above n 41

[46][1993] 1 NLZR 235

so accorded with "good medical practice".[47] This expression was synonymous with "proper medical standards and procedures".[48] While it is certainly arguable that the *Auckland Health Board* declaration would be applicable to doctors involved in the transplantation process, it would be preferable if there was statutory recognition of brain stem death. The supply of cadaveric organs should not be hindered by any legal uncertainty surrounding their removal from a ventilated donor.

J Removal by a Medical Practitioner

Section 3(4) also requires confirmation of death by the medical practitioner who is to remove the body parts. The Act does not exclude the possibility that the doctor who certifies death might also be the person in lawful possession as well as the transplant surgeon. However, the Code, at paragraph 8.6 prevents the actual transplant surgeon from diagnosing brain stem death. It allows for the determination of death by two suitably experienced doctors acting independently, neither one or whom can be a member of the transplant team or attending on the intended recipient of the organs. One of the doctors should be a specialist in charge of the care of the donor patient.

The requirement that the removal be carried out by a medical practitioner is unnecessarily restrictive. In the United Kingdom the enactment of the Corneal Tissue Act 1986 (UK) acknowledged that skilled technicians were capable of removing corneas; this was previously prohibited by operation of s 2(4) of the UK Act (which is identical to s 3(4) of the Act). It is difficult to understand why a medical practitioner need remove a specified body part when that part is to be used, "[F]or [the] purposes of medical education or research". It is

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[47]Above n 46, 250. The Court also held s 164 to be inapplicable in the circumstances see above n 46, 254-255

[48]Above n 46, 250

perhaps arguable that the words, in s 3(4), "*[E]ffected* by a medical practitioner... ,"[49] are wide enough to encompass a situation where a medical practitioner supervises the removal. Paragraph 9.5 of the Code does not support this interpretation and neither does the fact that the Corneal Tissue Act 1986 (UK) was enacted to avoid the restrictions imposed by the identical wording that appears in s 2(4) of the UK Act.

Sections 3(1), 3(2) and 3(3) state when organs may and may not be removed and, as has just been discussed, provide for the mechanics of removal. In certain circumstances these sections are subject to the consent of the coroner.

VI SECTION 3(5)

Section 3(5) states:

> Where a person has reason to believe that an inquest may be required to be held on any body or that a postmortem examination of any body may be required by the coroner, he shall not, except with the consent of the coroner, -
>
> (a) Give an authority under this section in respect of the body; or
>
> (b) Act on such an authority given by any other person.

Sections 7, 8 and 20 of the Coroners Act 1988 stipulate when the coroner may authorise a postmortem examination and/or hold an inquest. Essentially, this will occur where there is reasonable cause to believe that the deceased died a sudden, violent or unnatural death, the cause of which is unknown. Unfortunately, the cadavers that are most likely to attract the interest of the coroner are the very same bodies that are likely to provide good sources of organs. Victims of crime and car

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[49]The author's emphasis

accidents often suffer trauma to a particular part of their body that largely leaves the other parts in good condition. Lanham notes[50] the desirability of a coroner sending a general consent to the hospitals, that authorises the removal of various organs in certain circumstances in order to avoid the unnecessary loss of organs.

The coroner's office in Wellington does not have a general consent form; it is also unlikely that such a form would be developed in the future. The office has stressed the importance of the coroner being notified of a death and being able to make a decision about the removal of organs on a case by case basis[51]. Paragraph 6.2 of the Code suggests that, "[T]he coroner can indicate in advance an intention to consent to the authorisation and removal of parts of the body if death occurs". Unfortunately, paragraph 6.2 does not reflect the practice in the Wellington region. It appears that the coroner is not prepared to adopt an approach that balances the need to supply organs with the duty, under the Coroners Act 1988, to investigate deaths.

The discussion so far has concentrated on an analysis of the meaning and extent of the power to donate. It is, perhaps, not unreasonable to assume that a power will be coupled with a sanction for those who act in contravention of it; this assumption will now be considered.

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[50]Above n 18, 22

[51]This information was supplied by the Coroners Office, Department of Courts, Wellington

VII NON-COMPLIANCE WITH HUMAN TISSUE ACT 1964

K Common Law Crimes

The Act does not make the failure to comply with s 3 an offence.[52] The issue of liability under the UK Act was debated by Skegg and Kennedy in a series of three articles.[53] They considered the ancient common law crimes of preventing the lawful disposal of a body, indecency with a body and disobedience of a statute, and agreed that the common law crimes would not apply to a situation where there is an unauthorised, but limited, interference with a corpse for medical purposes.[54]Section 9 of the Crimes Act 1961 abolishes common law crimes.

L Section 150 of the Crimes Act 1961

Although you cannot be convicted of the common law crimes relating to the disposal of (and interference with) bodies the offences are now in statutory form. Section 150 of the Crimes Act 1961 states:

> **Misconduct in respect of human remains - everyone is liable to imprisonment for a term not exceeding two years who -**
>
> (a) neglects to perform any duty imposed on him by law or undertaken by him with reference to the burial or cremation of any dead human body or human remains; or
>
> (b) improperly or indecently interferes with or offers any indignity to any dead human body or remains, whether buried or not.

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[52]The failure can be compared with s 12 of the Act which makes the performance of a post-mortem and an anatomical examination by anyone other than a medical practitioner, or licenced person an offence.

[53](i) PDG Skegg "Liability for Unauthorised Removal of Cadaveric Transplant Material" (1974) 14 Med Sci Law 53
(ii) I McC Kennedy "Further thoughts on Liability for Non-Observance of the Provisions of the Human Tissue Act 1961" (1976) 16 Med Sci Law 49
(iii) PDG Skegg "Liability for the Unauthorised Removal of Cadaveric Transplant Material: Some Further Comments" (1977) 17 Med Sci Law 123

[54]See Skegg above n 53 (i), 56 and Kennedy and Grubb above n 17, 1157

The section reflects societal respect for the dead human body and the tradition of a decent burial. From a more utilitarian perspective s150(a)[55] protects the public's health by ensuring the disposal of a body by burial or cremation.

The section is silent on the requirement of mens rea. Although a comprehensive discussion is beyond the scope of this paper, it is submitted that the section should be read so as to require mens rea. The use of the adverbs "improperly" and "indecently" and the words, "interferes with" and "or offers" all imply a mental element. The fact that a conviction renders someone liable to imprisonment for a maximum of two years and that it would (particularly s150(b)) carry a good amount of stigma are a strong indicator of Parliament's intention to create an offence with mens rea. This was Parliament's intention with ss 145, 147, 148 and 149 of the Crimes Act 1961. These sections immediately precede s150 and all require proof of mens rea. The sections, along with s150, all appear under the title "Crimes Against the Public Welfare".

Although it is difficult to envisage every way in which there might be a failure to adhere to s 3 of the Act, it is possible to speculate that the most likely scenario will be when there is a removal of a body part contrary to the wishes of the dead donor and/or the dead donor's surviving spouse or relative.

This might occur when a relative or the person in charge of the hospital ignores a donor's subsequent withdrawal of a request to remove a body part and authorises the removal, which is then carried out. In this situation s 150(b) would not be applicable to the relative, or the person

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[55]Section 150 is one of four sections that appear under the title, "Crimes Against Public Welfare" in the Crimes Act 1961

in charge of the hospital, as it could not be said that either person has interfered with or offered any indignity to the dead body.

If a transplant surgeon removed the organ in ignorance of the relative's unlawful authorisation, and believing that the removal was authorised in accordance with the Act, it is unlikely that the surgeon could be said to have, intended to improperly interfere with or offer an indignity to the dead donor's body. If the person in possession of the body was also the transplant surgeon (a situation which the Act does not appear to exclude) a conviction under s150(b) may succeed, if it could be proved that the surgeon ignored an instruction under the Act not to remove an organ and then proceeded to remove the body part.

A successful conviction would be just as much dependent on the meaning of "improperly" and "offers any indignity" as it would require proof of mens rea. The most obvious purpose of s 150 is to prevent necrophilic acts and gross physical abuse. The words "indecently" and "indignity" support such an interpretation. In ascertaining the meaning of "improperly" a purposive approach to the subsection suggests that the words are interpreted to mean indecent. If such a view was adopted it is difficult to understand how the removal of organs (in a clinically acceptable way) for the ultimate benefit of a patient could be described as improper, indecent and/or amounting to an indignity. It is accepted that it is arguable that s150(b) is capable of having as one of its purposes, the prevention of disfigurement or mutilation of a dead body. Such a view would accord with a wider aim of enforcing respectful conduct towards the dead and not just the specific act of necrophilia. In these circumstances, the unauthorised removal of organs might amount to a disfigurement or, perhaps, an indignity to a dead body. Even so, it would still be necessary to prove mens rea; to do so would be difficult if it was the transplant surgeon's intention to provide an organ for the benefit of a renal patient.

Section 150(b) is of less use when considering more "technical" breaches of the Act. The section is of little assistance where:

(i) Contrary to s 3(4) someone other than a medical practitioner removes an organ, as occurred in *R v Lennox-Wright*[56];

(ii) Contrary to s 3(4) a medical practitioner removes an organ without personally confirming that life is extinct;

(iii) Contrary to s3(5) the person in possession authorises the removal of an organ where that person knew that a post-mortem or inquest may be required;

(iv) Contrary to s3(5) a transplant surgeon acts in accordance with the authorisation in (iii).

It is clear that s 150(b) is an unsatisfactory mechanism for ensuring compliance with s 3.

M Section 107 of the Crimes Act 1961

The most likely means of ensuring compliance will be a prosecution under s 107 of the Crimes Act 1961. Section 107(a) and (b) states:

> **Contravention of Statute** - everyone is liable to imprisonment for a term not exceeding one year who, without lawful excuse, contravenes any enactment by wilfully doing any act which it forbids, or by wilfully omitting to do any act which it requires to be done, unless -
>
> (a) some penalty or punishment is expressly provided by law in respect of such contravention as aforesaid; or
>
> (b) in the case of any such contravention in respect of which no penalty or punishment is so provided, the act forbidden or required to be done is solely of an administrative or a ministerial or procedural nature, or it is otherwise inconsistent with the intent and object of the enactment, or with its context, that the contravention should be regarded as an offence.

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[56][1973] Crim L R 529

The section is the statutory embodiment of the common law crime of disobedience of a statute. In *R v Lennox-Wright*[57]. The Defendant, who had failed medical examinations, was charged with, "doing an act in disobedience of a statute by removing parts of a dead body contrary to s1(4) of the Human Tissue Act 1961".[58] Section 1(4) of the UK Act (which is equivalent to s 3(4) of the Act) prevents anyone other than a medical practitioner removing a body part. The Court confirmed the existence of the ancient common law crime except where it is specifically excluded by the statute. *R v Lennox-Wright* was effectively overruled in *R v Horseferry Road Justices ex p Independent Broadcasting Authority*[59] Lloyd J said:[60]

> [I]n the case of a modern statute it is easier to infer that Parliament does not intend to create an offence unless it says so. There is no longer any presumption, if indeed there ever were, that a breach of duty imposed by statute is indictable. Nowadays the presumption, if any, is the other way; although I would prefer to say that it requires clear language, or a very clear inference, to create a crime.

Despite the demise of its common law ancestor s 107 remains. Section 107(a) and (b) clearly require mens rea but its application to the Act is conceptually difficult. The operative words require a wilful doing of a forbidden act or the wilful omission of an act required to be done. However the language of s 3 of the Act is not that of the prohibitory or mandatory kind encountered in penal or regulatory statutes. The words of ss3(1), 3(2) and 3(5) of the Act are discretionary and passive in nature. They are compound sections that allow for the exercise of an

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[57]Above n 56

[58]See above n 53(ii), 52

[59][1986] 2 All ER 666

[60]Above n 59, 674

option (eg removal of an organ), subject to a reasonable belief (on the part of a second party) that a third party may not want the removal to be carried out. This method of drafting does not rest easily with the wilful doing or omission of an act or requirement as set out in s 107 of the Crimes Act 1961. With the exception of s 3(4)[61], s 3 is not expressed in terms of forbidden or mandatory acts; it occupies a poorly delineated territory between a rights orientated section and a regulatory, prohibitory section. Perhaps with the possibility of s 107 of the Crimes Act potentially applying to a broad category of statutes, it has been suggested[62] that s 107 applies to only two categories of statutes. The first category is where a statute creates or defines an offence and contemplates prosecution by indictment but fails to provide for a punishment. This category also applies where summary prosecution is provided, as an option, and a penalty is also provided. The second category applies to those statutes which contemplate a person being criminally responsible for the breach but fail to create an offence or a punishment. Section 155[63] of the Crimes Act 1961 which imposes a duty to have and use reasonable knowledge when carrying out a medical procedure, is cited as an example of the latter category. It was concluded[64] that s 107 of the Crimes Act 1961 should be construed

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[61]Section 3(4) states:

> No such removal shall be effected except by a medical practitioner, who must have satisfied himself by personal examination of the body that life is extinct.

[62]The Honourable J Bruce Robertson (ed) *Adams on Criminal Law* (Brooker & Friend Limited, Wellington, 1992) 1G-9

[63]Section 155 of the Crimes Act 1961 states:

> **Duty of Persons Doing Dangerous Acts** - everyone who undertakes (except in case of necessity) to administer surgical or medical treatment, or to do any other lawful act the doing of which is or may be dangerous to life, is under a legal duty to have and to use reasonable knowledge, skill and care in doing any such act, and is criminally responsible for the consequences of omitting without lawful excuse to discharge that duty.

[64]Above 62, 1G-9

restrictively and where the statutory provision has, "[T]he clear indicia of imposing criminal responsibility..."[65].

The closest s 3 comes to imposing criminal responsibility is the implication in s 3(3)[66] that the removal and use of body parts without authority is unlawful. It is submitted that given the failure of s 3(4) to create an offence and to provide a punishment[67], s 107 of the Crimes Act 1961 would not apply.

It is concluded that a breach of the s 3 is unlikely to result in a conviction under any statute. The discussion will now turn to civil liability for breaches of the section.

N Civil Liability

To bring a claim for common law damages it is necessary to avoid s 14 of the Accident Rehabilitation and Compensation Insurance Act (ARCIA). Section 14 bars proceedings for damages arising directly or indirectly out of a personal injury as defined in the ARCIA. Section 4 of the ARCIA restrictively defines "personal injury" to mean, "[T]he death of, or physical injuries to, a person, and any mental injury suffered by that person which is an outcome of those physical injuries to that person... .". Section 3 of the ARCIA defines mental injury as "[A] clinically significant behavioural, psychological, or cognitive disfunction." Section 8(3) acknowledges (but does not define) another form of mental trauma when it extends the

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[65]Above n 62, 1G-9

[66]Section 3(3) states:

> Subject to subsections (4) and (5) of this section, the removal and use of any part of a body in accordance with an authority given in pursuance of this section shall be lawful.

[67]The failure can be compared with s 12 of the Act that creates an offence, prescribes a manner of prosecution and sets a penalty for anyone who contravenes the sections of the Act relating to the performance and conduct of post mortems and anatomical examinations

meaning of personal injury to include mental or nervous shock which is an outcome of a sexual crime listed in the first schedule of the ARCIA. A third category of mental trauma that does not fit within the two earlier categories is that of transient emotional trauma which is characterised as being fear, anger, humiliation and distress.[68] In summary[69]

> A mental injury alone, even if it is of serious type defined in s 3 or a lesser type such as nervous shock or a transient emotional disturbance, is outside the definition and therefore a damages action is not barred.

Both Skegg and Kennedy[70] discussed the possibility of a claim in tort for negligently causing nervous shock by removing tissue without authority. As any nervous shock suffered in this situation would not be the outcome of a physical injury or sexual offence, a claim in negligence would not be barred. A final barrier to proceeding with the claim might be s 14 of the ARCIA which prevents proceedings for damages, "[A]rising directly or indirectly out of personal injury covered by this Act... ."

It is unlikely that this barrier would prevent the claim. The nervous shock suffered cannot be defined as a personal injury because it is not the outcome of a physical injury. The nervous shock would be a consequence of: the person in possession failing to make a reasonable and practicable enquiry of relatives that were known to exist and the subsequent authorisation and removal of the organs.

The scope of the s 14 bar has not yet been the subject of a substantive

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[68]D A Rennie and J M Miller (eds) Brookers *Accident Compensation in New Zealand* (Brookers Limited, Wellington, 1992) Volume 2, 2A-6

[69]Above n 68 2A-7

[70]See above n 53(i) 53 and 54, n 53(ii), 50 and 51 and n 53(iii) 1 - 4

decision; although existing defendants have been unsuccessful in using it as a ground to strike out plaintiffs' claims for nervous shock.[71]

The most recent House of Lord's decision concerning psychiatric injury is *Page v Smith*.[72] Page was involved in a car accident caused by the negligence of Smith. Page did not suffer a physical injury but suffered a worsening of his existing chronic fatigue syndrome. Page claimed that his condition was now permanent and that it was unlikely that he would be able to continue his employment. The Court considered whether foreseeability of physical injury was sufficient to enable Page to recover damages for psychiatric damage or whether foreseeability of the psychiatric injury would be necessary. In reaching its conclusion the Court held that it was necessary to distinguish between primary and secondary victims. Primary victims are identified as suffering from a psychiatric illness because of their actual involvement in an accident. Secondary victims are those who suffer psychiatric damage because they passively and unwillingly witnessed an accident.

Page was a primary victim. In respect of primary victims[73]:

> [I]t was enough to ask whether the defendant should have reasonably foreseen that the plaintiff might suffer physical [personal] injury as a result of the defendant's negligence, so as to bring him within the range of the defendant's duty of care. It was unnecessary to ask, as a separate question, whether the defendant should reasonably have foreseen injury by shock; and it is irrelevant that the plaintiff did not, in fact, suffer any external physical injury.

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[71]See *Boe v Hammond* Unreported, 26 May 1995, High Court, Wellington Registry, M3/95 and *McDonnell v Wellington Area Health Board* Unreported, 16 December 1994 and 13 March 1995, High Court, Wellington Registry, CP250/93

[72][1995] 2 WLR 644

[73]Above n 72, 669 and 668H

Because of the danger of a negligent defendant, "[B]eing liable to all the world,"[74] policy mechanisms were imposed to limit the number of secondary victims that could claim. In cases involving psychiatric damage to secondary victims it will be necessary to prove that the psychiatric injury was foreseeable in a person of normal fortitude, that the victim was sufficiently proximate in time and space to the accident and the victim enjoyed a proximate relationship (based on love and affection) with the primary victim.[75]

In *McLoughlin v O'Brian*[76] the plaintiff claimed damages for the psychiatric illness suffered as a consequence of her learning about a car accident in which her husband and three children were involved and subsequently visiting them in hospital where she was told one of her children had been killed. Wilberforce LJ excluded the possibility of being compensated for psychiatric damage brought about by communication by a third party.[77]

In the context of an unauthorised removal of an organ it is likely that the person in possession, and/or the transplant surgeon, would reasonably foresee personal injury being caused to those relatives or spouses known to him or her. Implicit in this test is the assumption that those relatives would be primary victims. The classification of the plaintiff in any claim of this nature would be one of fact. Suffice to say, that it is unlikely that any relatives who find out about the removal as a

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[74]Above n 72, 668

[75]Above n 72, 668 and 675. See also *Alcock v Chief Constable of South Yorkshire* [1992] 1 AC 310 (HL). *Alcock* involved a claim by the relatives (the secondary victims) of victims (the primary victims) of the Hillsborough Football Stadium Disaster who had suffered nervous shock as a consequence of seeing the disaster either while at the stadium or while watching television footage

[76][1983] 1 AC, 410

[77]Above n 76, 423

consequence of a communication from a third party funeral director or another relative will be successful. These people would fit within the *McLoughlin*[78] prohibition and, or, find it difficult to prove their claim as secondary victims because of the *Page*[79] policy mechanisms working against them.

Another tort that may impose liability is that of a breach of statutory duty. *Solomons v R Gertzenstein Limited*[80] concerned a breach of the London Building Acts (Amendment) Act 1939. It was held that while the duties under the Act were for the general good of the public, the particular duty under s 133:[81]

> [W]as imposed for the benefit of a particular ascertainable class, namely, the persons in the building, and those persons have a right of action for a breach of statutory duty, notwithstanding that penalties are also provided for breaches.

The first question must be whether s 3 of the Act imposes a duty on someone. Kennedy[82] argues that s 1(2) of the UK Act (which is identical to s 3(2) of the Act) imposes a duty on the person in possession to authorise the removal of parts only after a reasonable and practicable enquiry is made to ensure that neither the deceased nor the

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[78]See text at n 76

[79]See text at n 75

[80][1954] 2 QB 243

[81]Above n 80, 261. There exists another test which is called "the alternative modes of enforcement test". It requires an investigation into whether the statute expressly provides for a remedy. If a remedy is not provided for it is possible that a claim might be allowed. However the test remains vague and difficult to apply. In *Dominion Airlines Limited v Strand* [1933] NZLR 1, a claim was allowed despite the statute allowing a penalty, see also *Gardiner v McManus* [1971] NZLR 475. As the test still requires a specific class and breach to be established it is unlikely to assist in establishing a civil remedy for a breach of the Human Tissue Act 1964

[82]Above n 53(ii), 51

surviving spouse or relatives would object. Similarly, s 3 (5) of the Act imposes a duty on the person in possession not to authorise removal where the person has reason to believe that the body may be needed for an inquest or post-mortem.

Skegg[83] argues against s 1(2) of the UK Act creating a duty. He says that s 1 of the UK Act does not require people to act in a particular way, rather s 1(3) of the UK Act (s 3(3) of the Act) simply makes the authorisation and removal of an organ lawful if the section is adhered to. Skegg ends his argument by noting that s 1 of the UK Act (s 3 of the Act) is by no means consistent in the creation of duties. It is unclear if the passive, "Reason to believe...", in s 3(1) of the Act creates a duty and to whom that duty is owed. The same uncertainty exists if, contrary to s 3(4) of the Act, someone other than a medical practitioner removes an organ. Kennedy's analysis of s 1(2) of the UK Act (s 3(2) of the Act) is to be preferred; a reading of the subsection clearly indicates the creation of a duty. However, Skegg's reservations carry some force in respect of the balance s 3 of the Act.

If the class test is applied to ss 3(1), 3(2) and 3(5) of the Act it is necessary to ask if they are for the benefit of the general public or for a specific class of people. Section 3(1) of the Act appears to convey a benefit to the public. It allows "[A]ny person... ", to not only donate an organ, but to have any subsequent withdrawal of the authorisation obeyed. The section does not envisage a specified class of people.

Section 3(2)(a) and (b) envisages a benefit to the deceased in that an objection against removal is honoured after death, and to the surviving spouses and relatives insofar as they have a right to object to the removal. At first blanch it appears that these people fit within a specific

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[83]Above n 53(iii), 124 and 125

class, but on closer analysis they constitute a general body of people; as all people will one day be eligible to fit within the "deceased" category. Similarly, most people will, at some stage, be a "surviving relative", and a significant number will be accorded the status of a "surviving spouse". It is possible to counter by saying that the class is defined and specific because they are limited in scope by the reasonably practicable enquiry that is to be carried out by the person in possession. Such an argument concentrates on the individual circumstances of each death and assumes that the enquiry (by the person in possession) would restrict the class. A proper approach is to concentrate on the wording of s 3(2)(a) and (b) which is all encompassing. There is also an absence of any statutory intent to protect a particular class of people.[84] If s 3(2)(a) and (b) did create a class of people who could issue proceedings, it is still necessary to prove a breach of duty. Potentially this is difficult[85] because the reasonably practicable nature of the duty is not absolute. Should this hurdle be cleared the harm done will need to be that which the subsection was designed to prevent. Any harm suffered is likely to be a form of psychiatric injury. It is by no means certain that s 3(2)(a) and (b) created a duty to protect the class from this harm. The duty is far more likely to exist to strike a balance between the demand for (and the freedom of the deceased to donate) organs and the right of relatives, spouses and the deceased to object to donation.

A breach of s 3(5) is likely to provide the best chance of success for the tort. This section identifies a specific class of person (the coroner) and imposes a duty on the person in possession not to authorise the removal of organs if the person has reason to believe that a post-

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[84]This can be compared with the principal object of the Health and Safety in Employment Act 1992 which is to prevent harm to employees at work

[85]See Kennedy above n 53(ii), 52

mortem or inquest might be held. The duty is for the benefit of the coroner in that it allows for an enquiry into violent and/or unexplained deaths. The people most likely to have a reason to believe are those employees of the hospital that is in lawful possession of the body. The failure of the person in possession to ascertain, in advance, the coroner's requirements or to inadequately inform the coroner of the nature of death and the organs needed (contrary to paragraph 62 of the Code)[86] would help prove a breach of the statutory duty. It is unlikely that the coroner would suffer any mental injury or experience anger or humiliation. It would, however, be open to the court to award exemplary damages to punish the person in possession. The practical use of the tort is that it would allow the coroner to claim a prohibitory injunction against the person in possession. This would be of use in stopping any threatened breach of s 3(5) which is likely to be of greater significance to the coroner than any subsequent award of damages which could never compensate for the loss of an intact body.

The final civil remedy to be considered is that connected with the cadaver itself. Relying on the common law right to possession of a corpse for burial Skegg[87] considers that the unauthorised interference[88] with a cadaver that prevents burial would amount to a cause of action giving rise to damages. The development of an additional cause of action occurred in *Edmonds v Armstrong Funeral Home Limited*[89]. In *Edmonds* a husband sued a funeral home on whose premises an unauthorised post-mortem had been carried out on his wife. Importantly, there was no evidence that the body was detained

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[86]See text at n 50 and n 51

[87]Above n 53(iii) and see text at n 10 and n 11

[88]Skegg suggests that a person may wish to ventilate the cadaver so that it may be maintained as an organ bank

[89][1931] 1 DLR 676

longer than it would have otherwise been. The husband claimed damages for the mutilation and removal of parts from the body. It was held by the appellate division of the Alberta Supreme Court that the, "[U]nlawful mutilation of the body and the removal of certain parts... constituted a violation of the plaintiff's right of custody and control and would consequently give a right of action... ."[90] It is clear from this judgment that a cause of action exists even if the interference does not have the effect of preventing the disposal of the body. However, it is important to note that the ability of the husband to sue depended on him having the right to the custody and control of the body.[91]

This limitation has the effect of preventing other relatives, who are not entitled to possession, from suing. In the context of s 3 of the Act this is anomalous. The section allows surviving relatives to object to the removal but the common law denies the same people a cause of action.

The survey of the way in which non-compliance with s 3 might be remedied has revealed that there are no simple and inexpensive means to ensure obedience with the section. Having discussed the absence of compliance provisions and analysed the meaning and purpose of s 3 it is now necessary to investigate the policy behind the section.

VIII THE POLICY OF SECTION 3

There are two broad policy alternatives to be considered in the context of organ transplantation legislation; contracting in (opting in) and

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[90]Above n 89, 681

[91]Above n 89, 680. See also Skegg at n 53(iii), 51 and 52 and Kennedy at n 53(ii), 60. Kennedy interprets the facts in *Edmonds v Armstrong Funeral Home Limited* to constitute an interference with the right of burial. This view of the facts is not supported by the report of the decision

contracting out (opting out). Contracting in allows the removal of organs from those who specifically request such removal during their lifetime. Contracting out allows for the removal of organs from everyone except from those who, before death, register an objection to the removal. The policy of s 3 of the Act is a hybrid, in that it combines the two approaches. Section 3(1) represents a contracting in scheme which allows for removal, if requested in the correct form, subject to the donor's right to withdraw the request.

Section 3(2) of the Act is an example of a diluted contracting out scheme. It allows for the removal of organs (where there has been no prior request) unless the person in possession has reason to believe the donor, or one of the relatives or spouses objects. Kennedy[92] has stated that ss 1(1) and 1(2) of the UK Act (ss 3(1) and 3(2) of the Act) are a compromise between the five competing interests in organ transplantation. He lists the interests in the form of questions, namely: should the deceased have a right to dictate how his or her body is used after death?; should the deceased's relatives or spouses views on removal prevail over those previously expressed by the deceased?; should a potential donee have a right to an organ irrespective of the donor's or relative's views?; should religious and/or cultural groups have a right to say how a deceased's body is to be treated?; should society have to bear the economic and emotional cost of maintaining potential donees on expensive dialysis machines, when many useful organs are being buried or cremated?

Having identified the interests, Kennedy[93] is of the view that ss 1(1) and

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[92]Ian Kennedy "The Donation and Transplantation of Kidneys: Should the Law be Changed?" (1979) 5 Journal of Medical Ethics 13, 15. For a reply see Robert A Sells "Lets Not Opt Out: Kidney Donation and Transplantation" (1979) 5 Journal of Medical Ethics, 165

[93]See above n 92, 15 and 16

1(2) of the UK Act rank the deceased's expressed view as the first priority and the spouse's and relatives' power to object (where the deceased has not made an earlier request) as the second priority. This power also provides a means by which cultural and religious beliefs can be expressed. Kennedy concludes by saying:[94]

> The dying and society at large play very much third fiddle in having their interests and needs satisfied, a rather surprising result when the stated aim of the Act in the long title [is to allow "the removal of human tissue for therapeutic purposes and for purposes of medical education and research"].

It is difficult to disagree with Kennedy's criticism. Section 3 is an unhappy compromise between the need to secure organs and rights of the donor and relatives to determine what will happen with the body. The confused drafting and the absence of any penalty provisions are both hallmarks of legislation devised without a dominant policy objective, other than that which sought to please everyone. The ineffectiveness is only exacerbated by the fact that advances in medical technology have created clinical possibilities beyond the contemplation of legislation drafted in the early nineteen sixties.

Reform can be carried out by adopting a new policy towards organ transplantation[95] or by accepting the existing policy and amending s 3.

IX REFORM OF SECTION 3(1)

The following changes would clarify s 3(1).

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[94]Above n 92, 16 and the long title of the Act

[95]See text at n 109

O A Written Request

The donee should be required to sign and date a clear request to donate, or a pre-printed standardised request form. The provision of a minimum set of requirements for any written request would also assist in the development of a single national database of those prepared to donate organs. The following sub-section could be added:

> 3(1)(B) For the purposes of sub-section (1) of this section a request "in writing" shall be either a request in the hand of the person or a printed form; the request shall be signed by, and include the age of, the person and record the date on which the request is made.

It is interesting to note that Part IV of the Human Tissue Act 1983 (NSW), (the New South Wales Act) does not require the deceased's request to be in writing. Sections 23(1) (a) and 24(1)(b) allow a designated person to remove tissue where, "the deceased person had, during the person's lifetime, expressed the wish for, or consented to, the removal... ." In contrast, Part IV of the Human Tissue Act 1982 (Vict) (the Victoria Act), requires writing. Sections 26(1)(c)(i) and 26(2)(c)(i) allow for the removal of tissue where, "the deceased person - had at any time, in writing;... expressed the wish for, or consented to, the removal... ."

Neither of the two Australian Acts provide for the establishment for a national database. Given the existence of two computer systems in New Zealand[96] it is important that the records are consolidated. Any re-appraisal of s 3 should incorporate a provision establishing one national computer register.

There is no reason why s 3(1) should limit an oral request to being spoken during the person's last illness. As it stands s 3(1) is too

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[96]See text at n 14 and n 16

restrictive. It is non-sensical that s 3(1) only allows an oral request to be made by an ill person and not a healthy person. The deletion of the words, "[D]uring this last illness... ." would not alter the contracting in policy of s 3(1).

P The Power to Donate

The fixing of 16 years as the age to be obtained before consent can be given for the removal of organs would remove any doubt about the capacity of minors to donate body parts. It is accepted that the fixing of any age is, by its nature, arbitrary. A requirement that competents only be allowed to donate will exclude persons suffering from psychiatric illness.

Q The Extent of the Power to Donate

The existing statutory anomaly[97] that prevents the person in possession carrying out the donee's request to have his or her entire body used for therapeutic purposes or medical education or research could be remedied by the deletion of the following italicised words:

> "[A]uthorise the *removal from* the body *of any part or, as the case may be, the specified part, for use* in accordance with the request".

and the insertion of the following words in italics:

> [A]uthorise the *use of* the body, *or any part of it* in accordance with the request.

These words could also be used to remedy the same anomaly that appears in ss 3(1A) and 3(2).

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[97]See text at n 26

X REFORM OF SECTION 3(2)

R The Concepts of Reasonableness and Practicability

The Skegg/Dworkin debate[98] about the meaning of practicability would be resolved if the word was removed from s 3(2). Sections 23 and 24 of the New South Wales Act and s 26 of the Victoria Act all require the designated person to make, "[S]uch enquiries as are reasonable in the circumstances... ." in relation to the wishes of the deceased and the next of kin. The need for a reasonable enquiry is wide enough to encompass the need to mount an enquiry and the nature of the enquiry itself. The word "circumstances" suggests that what is reasonable will, in part, be linked to the need to move quickly to ensure the best use of the organs.

However, the favoured approach, that promotes the availability of organs, requires reasonableness to be read in the context of time. The following wording is suggested:

> [T]he person may authorise the removal of any part ... if having made such enquiries as are reasonable (in the time before the part must be removed so that it remains in optimum condition for transplantation purposes) he/she has no reason to believe... .

S The Surviving Spouse or any Surviving Relative

The meaning of "relative" is unclear, however when read with the words "[O]r any surviving..." and the Code's[99] directive to confer with the "family" and/or "whanau" a broad interpretation is likely.[100] The approach of the New South Wales and Victoria Acts is to identify and

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[98]See text at n 31 and n 34

[99]Paragraph 4.4

[100]See text at n 37

rank the next of kin who may object to the proposed removal. The interpretation sections[101] of the New South Wales and Victoria Acts rank the "senior available next of kin" in ascending order, namely:

(i) The spouse of the deceased

(ii) A son or daughter (over 18 years) of the deceased where the deceased was not married or the spouse is not available

(iii) A parent of the deceased where the next of kin at (i) and (ii) are not available, and

(iv) A brother or sister where the next of kin at (i), (ii) and (iii) are not available.

Section 22 of the New South Wales Act deems a de facto partner who, "[W]as at the time of the deceased person's death living with the deceased person as the deceased person's spouse on a bona fide domestic basis..." a spouse. The Victoria Act does not include a similar provision.

The adoption of the identifiable next of kin in the place of the ill defined "relative" is a workable alternative. It is also likely to accord with commonly held views on the seniority of close family relations, and is sufficiently wide to enable (via the senior available next of kin) the influence of cultural and religious views on the removal of organs. The reasonable enquiry that is to be undertaken by the doctor would be made infinitely easier, simply because the doctor would know who he or she would have to approach.

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[101]Section 3(1) of the Victoria Act and s 4(1) of the New South Wales Act

XI REFORM OF SECTION 3(4)

T Life is Extinct

A statutory definition of death in New Zealand is overdue. The brain stem/cessation of all brain function definition of death is now well accepted.[102] Sections 33 and 41 of the New South Wales and Victoria Acts both state that death occurs when there is, "[I]rreversible cessation of all function of the person's brain; or irreversible cessation of circulation of blood in the person's body." The Acts also allow for the certification of death by two medical practitioners, neither of whom can be the person giving the authority to remove the organ, or the person acting on the authority.[103] The adoption of similar provisions would clarify s 3(4) and, at the same time, reflect paragraph 8 of the Code which recognises irreversible cessation of brain function as death. Paragraph 8 also prevents the donee's doctor (or the transplant surgeon) diagnosing the death of the donor.

U Removal by a Medical Practitioner

The New South Wales and Victoria Acts only permit the removal of tissue to be performed by a medical practitioner[104]. Section 1 of the Corneal Tissue Act 1986 (UK)[105] allows corneas to be removed by a person

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[102]See text at n 40 and n 44

[103]See ss 26 and 27 of the New South Wales Act and ss 25 and 26(7) of the Victoria Act

[104]See ss 27 and 25 of the New South Wales Act and the Victoria Act

[105]Section 1 of the Corneal Tissue Act 1986 (UK) amends s 1(4) of the Human Tissue Act 1961 (UK). The relevant portion of the amended s 1(4A) states:

> No such removal of an eye or part of any eye shall be effected except by ... (b) a person in the employment of a health authority acting on the instructions of a registered medical practitioner who must, before giving those instructions, be satisfied that the person in question is sufficiently qualified and trained to perform the removal competently and must also either -
>
> (i) have satisfied himself by personal examination of the body that life is extinct, or

other than a medical practitioner. It requires that the person be in the employment of a health authority and that the medical practitioner who has certified death be satisfied that the person is sufficiently qualified and trained. A simple amendment to the Act would allow the removal of parts by skilled technicians in addition to medical practitioners.

XII REFORM OF SECTION 3(5)

V The Coroner's Consent

There exists the possibility that organs will not be able to be removed because of the failure to secure the coroner's consent to their removal. Section 3 and the New South Wales Act do not provide for the coroner issuing an advance directive setting out the circumstances when removal can be performed without the permission of the coroner. Section 27(3) of the Victoria Act does, however, state that:

> A coroner may give a direction either before or after the death of a person that his consent to the removal of tissue from the body of the person after the death of the person is not required... .

It is uncertain whether the sub-section envisages the coroner having any prior knowledge of a particular person or a general class of persons. The use of the indefinite article suggests that the sub-section may contemplate a class of people which the coroner may identify as being able to have certain organs removed in certain circumstances. If this interpretation was adopted an advance directive could be issued. An amendment to s 3(5) allowing for an advance coroner's directive to a category of deceased, or terminally ill, persons would remove any

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(ii) be satisfied that life is extinct on the basis of a statement to that effect by a registered medical practitioner who has satisfied himself by personal examination of the body that life is extinct.

residual doubt or uncertainty about the coroner's requirements. It would remove the potential for the loss of organs that may well be irrelevant to any subsequent post mortem or inquest.

XIII AN ADDITIONAL SECTION

The failure to make non-compliance with the Act an offence is an anomaly. The New South Wales Act makes it an offence[106] for the senior next of kin to authorise the removal (contrary to the instructions of the deceased or another next of kin) of organs, where the deceased is at a place other than a hospital; the penalty is $1,000.00. Curiously, an offence[107] doesn't appear to have been committed in New South Wales if a designated person authorises the removal of organs while the deceased is in a hospital and contrary to the wishes of the deceased or the next of kin. Both the New South Wales Act and the Victoria Act[108] make it an offence to remove tissue from a body without sufficient authority. The penalty prescribed in New South Wales, on summary conviction is $4,000.00 and/or six months imprisonment. An offence section in the Act would need to encompass acts done by the person in possession and the transplant surgeon that are contrary to s 3 of the Act.

The foregoing discussion has considered reforms that would make section 3 a more satisfactory mechanism for the procurement of organs for therapeutic purposes. The reforms did not involve a change to the underlining hybrid policy of the section.

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[106]Section 24 of the New South Wales Act

[107]Section 23 of the New South Wales Act

[108]Section 36 of the New South Wales Act and s 44 of the Victoria Act

XIV OTHER REFORM OPTIONS

W Contracting Out

This theory presumes the consent of the deceased to the removal of tissue unless the consent has been specifically withheld. The presumption of consent has its origin in the belief that it is necessary to save the lives of others and that it is otherwise "[R]easonable on the basis of the community altruism... ."[109] In its purest form the system will allow the removal of tissue unless the deceased has expressed an objection.

In 1976 France enacted contracting out legislation. The law authorises the retention of a deceased's organs or tissues for therapeutic and scientific uses unless the deceased has objected to such a use.[110] The family is not permitted to refuse when such refusal is based on their own objections. Specially exempted from the contracting out law are minors, the mentally disabled and other incompetents. However it is reported,[111] that it remains the practice of French doctors to obtain the consent of the next of kin. This is largely due to custom and the "[C]linical and psychological reality of sensitively dealing with bereaved families".[112] The difficulty in applying the strict contracting out legislation has been suggested as having "[H]ad little positive impact on organ scarcity".[113]

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[109]Law Reform Commission of Canada *Procurement and Transfer of Human Tissues and Organs* (Canada Communication Group Publishing, Ottawa, 1992) 181

[110]Loi number 76-1181 and see above n 109, 147

[111]Above n 17, 1167 and above n 109, 149

[112]Above n 109, 149

[113]Above n 109, 148

In contrast the contracting out legislation enacted in 1986 in Belgium has lead to a doubling of the number of organs recovered.[114] The legislation is wider than the French law as it allows for the removal of tissue from minors. However, the Belgium law does reflect the French law in that the family may not object to the removal if the objection is based on their own views, rather than those of the deceased.

Italy and Spain have enacted diluted contracting out legislation[115] that acknowledges the reality that close family members will often insist on some control over what happens to a deceased's body.

The Council of Europe (established after World War II to promote human rights) has sought to harmonise organ transplantation and tissue transfers between its member states. In 1987 it recommended a contracting out system, and reported that 13 of the 22 members states had adopted this approach to the removal of organs from cadavers.[116] The Council of Europe also acknowledged that the practice in most member states was to consult, to a greater or lesser extent, with members of the family before removal occurred.[117] This view was confirmed in early 1993 with the statement:[118]

> Legislation on post-mortem donation in Europe differs from country to country. Some apply the opting in system (explicit consent), others the opting out system (presumed consent) and there are also mixed

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[114] *Law of 13 June 1986 on the Removal and Transplantation of Organs* (Belgium), above n 109, 151 and see P Mitchielson "Organ Shortage - What to Do" (1992) 24 Transplantation Proceedings 2391

[115] Above n 22, 304

[116] Above n 109, 152

[117] Above n 109, 153

[118] H D C Roscam Abbing "Transplantation of Organs: A European Perspective" (1993) 21 Journal of Law, Medicine and Ethics 54

> systems. Often relations are given a decisive voice, if not through the law, then in daily practice.

In New Zealand, paragraph 4.1(a) of the Code emphasis the desirability of the relatives being involved in the decision to remove an organ even when the deceased has requested removal.

The extent to which the deceased's family is allowed to play a role in the removal decision may never be solved. It is unrealistic to ignore it and accordingly, necessary to incorporate a restrictive familial role in any contracting out legislation. Adoption of this approach would involve people who have a right to inform the doctor of the deceased's, or their own, objection to the removal of tissue. The first category is that of the spouse, or de facto spouse, living with the deceased at the time of death. If such a person exists then that spouse shall have the sole right of objection. In the absence of a spouse the doctor may receive an objection from the next category. The parents of the deceased would occupy the second category, if the objection was not unanimous the doctor could authorise the removal. If neither of the two classes existed or conveyed an objection, and in the absence of an objection from the deceased, removal could be authorised. A doctor would not be under any obligation to make any enquiries about the existence of the spouse and/or parents and whether or not any objection existed. While acknowledging that the two categories are arbitrary, it is noted that arbitrariness is often a hallmark of any legislative compromise.

There remain two further policies on organ procurement.

X Required Request

Required request places hospital staff under a statutory obligation to ask the deceased's relatives for permission to remove organs. Required enquiry statutes embody a softer approach; they simply require a doctor

to inform the family of a potential donor of the opportunity to donate. Both approaches have been adopted by at least 44 states[119] in the United States. The approach reflects the view that organ donation should be encouraged by altruism and voluntarism. It is premised on the belief that doctors find it difficult, if not impossible, to approach grieving relatives to ask for permission to remove organs. Required request and enquiry compel the doctor to ask in the hope that the family will consent to the removal. However, a recent survey[120] conducted in the United States concluded that the required request model was not increasing the available number of organs. The survey revealed that the failure of doctors to approach a family and ask for permission to remove, only accounted for 13.4% of lost donors. The major impediment to donation were the families who refused (50%) and the families that placed conditions on the donation (22.2%).[121] It was concluded that the two assumptions of required request; that doctors fail to ask families and that if asked, the families would consent, were erroneous.

The policy's apparent lack of success in the United States provides one reason for not adopting it as an organ procurement policy. Nonetheless, required request appears to add little to ss 3(1) and 3(2) of the Act, as the person in possession is already obliged to enquire into the existence of objections to the proposed removal. This process is essentially the same as requesting permission for the donation of organs; it is highly likely that if a person is given an opportunity to object, they will, if so inclined, consent.

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[119]Above n 109, 151 and the National Organ Transplant Act 1984, 42 USCS 273, 274, 1320B-8

[120]L A Siminoff, R M Arnold, A L Caplan, B A Virnig and D L Seltzer "Public Policy Governing Organ and Tissue Procurement in the United States, Results from the National Organ and Tissue Procurement Study" (1995) 123 Ann Intern Med 10

[121]Above n 120, 15

Y Compulsory Procurement

Compulsory or routine procurement of organs regardless of the intentions of the deceased, or his or her family, has found little favour. It ignores the autonomy of the living potential donor and religious, cultural and familial beliefs and practices. The approach has, as its principal tenet the belief that the use of organs for the saving of life is paramount, and that no-one has the right to deny another the right to life. It draws a comparison with an autopsy in arguing that there already exists a statutory right to deal with a deceased in a manner contrary to the wishes of the deceased or the deceased's family. As laudable as the policy's ethical basis is, it is contrary to the current medico-legal environment that emphasises patient autonomy and consent to medical procedures. It is unlikely to be viewed as a workable alternative to the present policy of the Act.

The reforms discussed all have the shared purpose of increasing the supply of organs. The exists a potential for an over supply; with this in mind it is necessary to consider the difficulties that may arise in the context of the storage of removed tissue.

XV THE STORAGE AND USE OF EXCISED TISSUE

The increasing using of tissue for bio-technological research and developments in the preservation of excised tissue prompt an examination into the rights and obligations that arise in these circumstances.

The prospect of the preserved tissue remaining the property of the estate of the deceased is remote. The common law "no property

rule"[122] in a cadaver would, almost certainly prevent, an estate claiming a proprietary interest in the unburied tissue. If a dead body cannot be the subject of ownership then, a fortiori, the tissue making up the body cannot be owned.

The way various legislatures have dealt with the storage and use of reproductive tissue provides further evidence of a reluctance to attach full ownership rights to human tissue. The Human Fertilisation and Embryology Act 1990 (UK) and the Human Assisted Reproductive Technology Bill, (the Bill)[123] do not vest ownership of human embryos and/or gametes in anyone. The Bill prohibits their storage and use by anyone that is not licenced by an authority established under the legislation.[124] The authority is empowered to establish rules and procedures[125] regulating the storage and use based on the clause 3 principles of dignity, the right of individual autonomy and the right to know one's genetic background. The principles do not include ownership. Further assistance can also be obtained from the English and Australian legislation[126] that makes it an offence to sell or purchase human tissue. A similar prohibition appears in clause 9(d) of the Bill. While accepting that the prohibition does not directly address the issue of whether tissue can be owned[127] it is likely that the legislature would not accept proprietary rights in cadaveric tissue. It

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[122]See text at n 4 - n 11 inclusive

[123]Introduced to the New Zealand House of Representatives on 27 June 1996

[124]See clause 11 of the Human Assisted Reproductive Technology Bill. The name of the authority is the Human Assisted Reproductive Technology Authority

[125]The draft rules and regulations are not yet available

[126]Section 1 of the Human Organ Transplants Act 1989 (UK), the Human Tissue Act 1983 (NSW), the Human Tissue Act 1982 (Vic) and s 27(1) and (2) of the Human Tissue Act 1985 (Tas)

[127]J W Harris "Who Owns My Body" (1996) 16 Oxford Journal of Legal Studies 55, 75

must follow that if a living person cannot trade his or her tissue then neither can that person's Estate.

The Supreme Court of California's decision in *Moore v Regents of University of California*[128] lends further support, albeit it in the context of a living person, for the proposition that the common law will not recognise proprietary rights in human tissue. The facts concerned the removal of Moore's spleen and the subsequent use of its cells. As a consequence of genetic engineering, the cells became a self developing "cell-line". By 1990 the cell-line was considered to be the basis of a three billion dollar industry. The Supreme Court of California reversed the finding (in the Court of Appeal's[129]) that Moore had a property right in his tissue and that any unauthorised use of that tissue amounted to conversion. The majority of the Supreme Court concluded that no full property rights existed in human tissue and that the patient's right to be fully informed about the nature and consequences of an operation,[130] would be protected by the imposition of a duty on the doctor to fully disclose the potential of, and the use of, the tissue.[131] If the common law as a consequence of *Moore* is not prepared to recognise a right of full ownership in tissue removed from a living person then, a fortiori, it will not recognise the same right in tissue from a cadaver. This would be consistent with the no property rule. There are many problems[132] with the *Moore* decision not the least of which is the potential for a

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[128](1990) 271 Cal Rptr 146

[129](1988) 249 Cal Rptr 494 (Court of Appeals)

[130]In the decision this was defined as being a right to bodily privacy and the right against uninvited bodily invasion

[131]Above n 128, 150-154, 156-158, 160 and 163-164

[132]Further exploration of the *Moore* decision is beyond the scope of this paper. For an analysis of the Court of Appeals' decision see P M Parker "Recognising Property Interests in Bodily tissue" (1989) 10 Journal of Legal Medicine 357, and for a discussion of body ownership, and the Supreme Court decision in *Moore* see Harris above n 127

hospital to make considerable sums of money as a consequence of the use of another person's tissue. The fact that the University of California did not own Moore's spleen cells, still did not prevent it earning a significant amount of money from the cell-line. Given the uncertainty and undeveloped state of the common law in New Zealand and the development of legislation that excludes a full ownership interest in reproductive tissue, legislation should be enacted to define the status of retained tissue from cadavers and living donors. Any such legislation would:

(i) Prohibit a proprietary interest in human tissue whether obtained from a living donor or a cadaver.

(ii) Require the donor to give informed consent to the removal, storage and use of tissue.

(iii) In the manner of the Human Assisted Reproductive Technologies Bill, create an authority to make rules to govern the storage and use of tissue.

(iv) Stipulate that those who store and use the tissue would need to be licenced by the authority.

(v) Provide for compensation to the donor and developer for any commercial success of the product developed from tissue.

In his dissenting judgment in the Supreme Court of California, Broussard J stated:[133]

> It is certainly arguable that, as a matter of policy or morality, it would be wiser to prohibit any private individual or entity from profiting from the fortuitous value that adheres in a part of a human body, and instead to require all valuable excised body parts to be deposited in a public repository which would then make such materials freely available to all scientists for the betterment of society as a whole.

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[133]Above n 128, 172

An authority governing the use and storage of human tissue would give effect to the sentiments expressed by Broussard J.

XVI CONCLUSION

Section 3 has the effect of restricting the supply of human tissue for therapeutic purposes. This occurs because of the confused policy objectives of the section. The section fails to strike a balance between the supply of organs and the sanctity of a dead body. The generous rights of familial objection when combined with the emotional nature of cadaveric transplantation create a strong bias in favour of organ retention, not donation. Confused drafting manifests itself in a section that has poor structure and vague and largely undefinable terms. These problems are compounded by a lack of common law principles and advances in medical technology that have increased the demand for organs.

Reform is needed, if only to clarify the meaning of s 3 within its existing hybrid policy. The preferable course is to enact new, contracting out legislation which emphasises the procurement of organs for the healing of the sick. Strong legislative guidance is required in an area that is clouded by emotion and death.

Appendix 1

THE NATIONAL
KIDNEY FOUNDATION
OF NEW ZEALAND

National Office : Betty Campbell Complex, Wakefield Street, Wellington
P O Box 11-141, Manners Street, Wellington N.Z. Tel & Fax 0-4-382 9333

NATIONAL ORGAN DONOR REGISTER
FORM FOR DONATION OF ORGANS FOR THERAPEUTIC PURPOSES

(SURNAME) (Please Print)

(FIRST NAME OR INITIALS) (Please Print)

(PREVIOUS OR MAIDEN NAME(S)) (Please Print)

TITLE (Mr,Mrs,Miss,Ms) Sex Male or Female

OF (ADDRESS) (Number) (Street)

(Town or City)

TELEPHONE NUMBER STD CODE

DATE OF BIRTH (Day) (Month) (Year)

PLACE OF BIRTH (Town or City) (Country)

REQUEST THAT AFTER MY DEATH:

ANY PART OF MY BODY BE USED FOR THE TREATMENT OF OTHERS
MY KIDNEYS BE USED FOR TRANSPLANTATION
MY EYES BE USED FOR TRANSPLANTATION
MY HEART BE USED FOR TRANSPLANTATION
MY LUNGS BE USED FOR TRANSPLANTATION
MY LIVER BE USED FOR TRANSPLANTATION
MY BONES BE USED FOR TRANSPLANTATION

(Please indicate your wishes concerning organ donation by writing "yes" or "no" in the boxes alongside)

SIGNATURE _____

PLEASE TELL YOUR FAMILY OF YOUR DECISION TO BECOME AN ORGAN DONOR

Please post your completed form to the:

National Kidney Foundation of New Zealand
FREEPOST 4283
PO Box 11-141
Wellington
Telephone/Fax 04 382-9333

THANK YOU FOR EXPRESSING YOUR WISH BE AN ORGAN DONOR

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