Similar practical judgments may suggest policy options on tissue sales. Beyond the debate over formal and consequentialist objections to sales, tissue sales might simply be judged to be a policy alternative that is ethically less preferable, especially if it can be shown that human tissue may be adequately supplied by less ethically costly options. If searching for a global prohibition or authorization proves unhelpful, drawing pragmatic distinctions between the least and most ethically offensive tissue sales might reveal viable, morally acceptable public options. Of course, because even pragmatic distinctions demand moral choice, policies based on them will also stir and touch those core societal values that seem so embedded in tissue procurement ethics.

CHAPTER THREE

Existing Tissue Transfer Law — Rights, Duties and Ambiguities

The law offers some answers to questions provoked by the increasing medical use, transfer and storage of human tissue and bodily substances. The following examination of relevant criminal, civil and common law legislation and constitutional principles addresses the major consent, property and sales issues identified in chapter 1. Because the law often concerns itself with the rights and duties of competing players, much of the focus centres on how the law allocates the interests of donors and their families, recipients, medical professionals and the community or state.

I. Common Law and Civil Law Perspectives

What rights and duties do the common law and the civil law provide as to the donation and transfer of human bodies, tissues and bodily substances from living and deceased donors? Answers to the question are not only important for historical purposes. They inform and sometimes govern legal relations regarding tissue storage and sales, consent to autopsies and like areas where legislation may be ambiguous or absent.

A. Bodily Integrity and Consent

Bodily integrity, the Supreme Court of Canada recently declared, ranks high on our scale of societal values and implicates basic rights. Not surprisingly, the law gives practical effect to these values. Non-consensual touching may ground civil or even criminal liability. Thus, the principle of informed consent and the Quebec Civil Code principle of the inviolability of the human person generally provide that health providers may invade a patient’s person after securing his or her consent.

366. For criminal law protection of the right to bodily integrity, see the discussion of assault in section II, below.
The principles are of ancient origin. Indeed, the law has for centuries recognized the obligation of physicians to seek the consent of their patients prior to initiating treatment.\(^{367}\) First articulated as an action in trespass,\(^{368}\) and later as an action in battery, the legal doctrine today requires physicians to disclose the purpose, the material risks and options to a proposed medical procedure, so that patients may consent voluntarily, knowingly and intelligently.\(^{369}\) Patient consent generally includes the right to decline treatment.\(^{370}\) Yet, the consent requirement is not absolute. It does not apply in emergencies,\(^{371}\) when the patient waives the right or, in rare instances, when it is unequivocally contrary to the patient’s medical interests for the health professional to disclose information.\(^{372}\)

Consent requirements are designed to effect personal autonomy, preserve bodily integrity, promote patient-physician understanding and, so favourably affect medical outcomes. Conceptually, these requirements envisage the patient-physician relationship as a forum for a candid, mutual exchange of information,\(^{373}\) one that thus becomes a partnership in rational decision making. It is presumed that patients will, despite their fears, comprehend the choices before them with the help of expert medical advice. They would likely be more co-operative and engaged in the treatment process, by virtue of heightened participation. The doctor is thought to benefit as well from the shared decision making,\(^{374}\) because a more comprehending, participating patient is thought to increase the likelihood of effective treatment. Conceived as such, the right is at once functional and humanistic. It has both “an instrumental value in achieving subjectively defined well-being and an intrinsic value as an element of personal worth and integrity.”\(^{375}\)

Consent principles apply to the range of the medical and surgical procedures involved in the tissue donation and transplantation process, including the use of innovative or experimental therapy.\(^{376}\) If the ideals behind the model of informed medical choice do not easily translate into clinical practice,\(^{377}\) the theory itself encounters difficulty with regard to minors\(^{378}\) and mentally disabled persons when they lack the capacity for exercising choice.\(^{379}\) In such instances, the parents of the minor or a legal guardian may have authority to consent to the medical procedure. Under the Quebec Civil Code, for example, a minor “capable of discernment” may donate tissue, if the risk assumed is not disproportionate to expected benefits, those having parental authority consent and a court authorizes the procedure.\(^{380}\)

Parental or judicial power to authorize transplant-related medical interventions involving incompetent minors is not without its limits, however. The risks to the donor, any potential psychological benefits to the donor and the expected benefits to the recipient must be closely weighed in a justification of invasive, irreversible procedures such as the donation of a kidney by one minor sibling to another:

The discretion is to be exercised for the benefit of the person, not for that of others. It is a discretion, too, that must at all times be exercised with great caution, a caution that must be redoubled as the seriousness of the matter increases. . . . Marginal justifications must be weighed against what is in every case a grave intrusion on the physical and mental integrity of the person.\(^{381}\)

B. Bodily Property and Possessory Interests

In the transplantation and biotechnological age of the late twentieth century, should the law affirm or abandon the seventeenth-century legal maxim that there is no property in a body? Modern medical practice and the evolution of the law have called into question

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374. See Katz and Capron, supra, note 281 at 79, 87.
380. C.C.L.C., art. 20. See Cayouette et Mathieu, [1987] R.J.Q. 2230 (Sup. Crt) (authorizing 5-year-old to donate bone marrow to brother suffering from leukemia under C.C.L.C., art. 20). Amendments to these provisions have been proposed. See Robert P. Kouri, “Le consentement aux soins médicaux à la lumière du projet de loi 20” (1987) 18 R.D.U.S. 27, and Bill 125, Civil Code of Quebec, 1st Sess., 34th Leg. Que., 1990, which received Royal assent while this working paper was in preparation for publication. See S.Q. 1991, c. 64.
the validity of that rule. Human bodies, bodily parts, tissues and substances are increasingly given, transferred, taken and preserved for years, for a variety of therapeutic uses and purposes. Some bodily substances are sold. If we cannot own our bodies or bodily parts, what may we do with them?

Our analysis suggests that the common law recognizes limited property interests in the human body for particular purposes. Seeking to avoid abhorrent ethical and commercial connotations, the common law reiterates the no-property rule. At the same time, it recognizes an executor’s or a family’s rights of possession to the body of a deceased potential donor. Such limited possessory interests protect familial, moral and religious sentiment. For living donors, the law has also been loath to recognize property concepts in the body. It tends to depend on important, but sometimes limited, principles of informed consent and emotional distress damages, to govern the control, transfer or non-consensual use of extracorporeal tissue. In the face of the new biomedical and biotechnological imperative, our legal concept and definition of property seem increasingly critical. New developments challenge the traditional legal ambivalence of the no-property rule. They invite society to rethink its choices for a tissue transfer regime that continues to advance human dignity, privacy and bodily integrity in this new age.

(1) Deceased Donors

Both the common and the civil law have traditionally maintained that the human corpse is not the subject of property.382 The sacrosanct nature of the dead human body understandably traces much of its origins to religious custom. The Civil Code of Lower Canada refers to burial matters to dead bodies as “sacred by their nature.”383 Similarly, the common law no-property rule is traced to the sixteenth- and seventeenth-century English case law and Sir Edward Coke’s commentary that burial matters were within the domain of the Church, and the burial of cadavers is nullis in bonis (among the property of no one).384 As the courts of England began to hear matters formerly within the jurisdiction of the courts of the Church, they imported Coke’s statement into English jurisprudence concerning dead bodies.385

Despite the no-property rule, the common and civil law still recognized a number of interests that continue to enjoy legal protection today. For example, although the common law did not grant an absolute right to the control of one’s body after death through one’s will,386 it and the civil law have long recognized one’s right to a decent burial.387 To effect the deceased’s right to a decent burial, the law imposed on the deceased’s executor or for burial:

In Canada, this duty of burying a dead body falls upon the executors of the deceased’s estate. In the absence of a will naming executors, the right to possession for burial goes to the surviving spouse . . . If no spouse survives, the right belongs to the next of kin.388

Some courts and jurisdictions refer to the right of possession as a “quasi-property” right.389 It empowers spouses or the next of kin who are wronged by interference to sue for damages. The essence of such suits is damages for injury to the emotional or mental tranquility of the next of kin, in the legal form of the wrongful infliction of emotional distress.390 Thus, instances of interference with the right of possession arise in diverse cases, including the negligent handling or transporting of dead bodies;391 the withholding of a body for payment of funeral expenses;392 the unauthorized removal of hair from the deceased by a funeral home;393 the withholding of a body for an unreasonable length of time to determine organ donor status394 and the mutilation of the deceased during the course of an unauthorized autopsy.395

Indeed, the cases involving unauthorized autopsies in Canada and foreign jurisdictions suggest that the next of kin’s right to possession for burial may include the right to receive the body generally free of mutilation. The issue sometimes arises in the context of hospital autopsies, which are distinct from the forensic autopsies ordered by a medical examiner or coroner in cases of sudden, unexpected, unnatural or suspicious deaths.396

383. C.C.L.C., art. 2217.
386. Ibid.
393. Mensinger v. O’Han, 189 Ill. App. 48 (1914).
396. See generally Christopher Granger, Canadian Coronor Law (Toronto: Carswell, 1984).
Forensic autopsies are governed by provincial statute.\textsuperscript{397} Because a coroner's duties are quasi-judicial, the societal interest in the determination of unusual deaths and the administration of justice may authorize coroners to order forensic autopsies without the consent of the deceased's family.\textsuperscript{398} Non-forensic or hospital autopsies generally require the consent of the deceased or his or her next of kin.\textsuperscript{399} To the extent that hospital autopsies are within the scope of provincial gift-tissue legislation provisions authorizing next of kin consent to donate for transplant or "medical education and research," the consent and liability provisions of the legislation may also govern hospital autopsies.\textsuperscript{400}

The common law principles suggest that any autopsy exceeding either normal autopsy procedures or the scope of consent may give rise to a claim for mental distress damages by the deceased's spouse or next of kin.\textsuperscript{401} The issue apparently has yet to present itself in a reported Canadian decision. But other jurisdictions have invoked the right-of-possession principle recognized in Canadian law to decide claims of unnecessary retention of bodily parts after an authorized autopsy. Thus, the wrongful removal, destruction or unnecessary retention of organs from a body for which the family has authorized an autopsy has been found to inflict compensable mental shock and distress on the spouse or next of kin.\textsuperscript{402} Even a coroner’s retention of organs excised in a forensic autopsy has been the subject of liability when the scope of a legislatively authorized autopsy has been exceeded.\textsuperscript{403} A recent case in the United States illustrates how the right of possession may also protect religious beliefs. In awarding damages against the hospital’s unauthorized retention and cremation of organs, the court declared:

Most religions in the world hold that the remains of a deceased must be treated with honor and respect. Judaism believes in the principle that body and soul are sacred because both are the handiwork of God and hence are entitled to reverence.\ldots

\textsuperscript{397} See, e.g., \textit{An Act respecting the determination of the causes and circumstances of death}, R.S.Q., c. R-0.2. See also Granger, supra, note 396.

\textsuperscript{398} See Davidson v. Garrett (1889), 5 C.C.C. 200 (Ont. H.C.). See also \textit{Religieuses Hospitalières de l'Hôpital-Dieu de Montréal v. Brouillette} (1943), II R. 441. For cases discussing when autopsy laws may unconstitutionally burden fundamental religious beliefs, see section IV.C, below.

\textsuperscript{399} See Ducharme v. \textit{Hôpital Notre-Dame} (1933), 71 C.S. 377; Edmonds, supra, note 389 and Philippa, supra, note 389. See also C.C.L.C., art. 20.

\textsuperscript{400} See Rozovskiy, supra note 388. See also section III, below. For consent to autopsy requirements in foreign jurisdictions, see Einar Svensson and Rolla B. Hill, \"Autopsy Legislation and Practice in Various Countries\" (1987) 111 Arch. Pathol. Lab. Med. 846.


The applicable law thus requires those who deal with the body to do so with due regard to the feelings and beliefs of the next of kin. In other words the next of kin have an interest in the respectful treatment of the corpse, and in the case of those holding the views such as the plaintiff's, an interest akin to that protected by the First Amendment [Constitutional protection of religious freedom].\textsuperscript{404}

The unauthorized autopsy cases suggest that the law protects the bodily integrity of the deceased as it relates to the emotional and religious interests of his or her spouse or next of kin.

The familial right to possession of the deceased is not absolute, however. Since the right to possession of the deceased is a function of the duty to bury, treatment of the body of a deceased in a manner inconsistent with burial may subject the possessor of the body to liability.\textsuperscript{405} Moreover, reasonable legislation that advances the interests of the state may also supersede the right of the spouse or next of kin to possession. Forensic autopsies and their role in the criminal justice system have been discussed. The state's public health interest in embalming and, in some instances, destroying dead bodies may also override a spouse's or next of kin's right of possession.\textsuperscript{406} Societal interest in the preservation of life may justify the procurement of organs or bodies under exigent circumstances or when no identifiable family member may reasonably be found.\textsuperscript{407}

The non-absolute right of possession means that families of a potential donor have, through custom and law, a long-recognized right of possession to the deceased's body. In the absence of statutes modifying that right, it generally imposes a duty on hospitals and physicians to respect and accommodate the interests of the family of a deceased patient who has been identified as a candidate for organ donation. These rights and duties highlight a conspicuous ambivalence in the law. Technically, possession is a legal property interest that includes the basic rights of dominion and control. On the one hand, the traditional rule maintains that there is no property in the corpse; on the other hand, the law recognizes formal possessory or property interests in the dead.

The ambivalence springs, in part, from competing, evolving notions of property. One view of property focuses on how we relate to things. Another view emphasizes how people legally relate to other people, regarding things:

\begin{quote}
In modern western societies, the property right is no longer regarded as absolute if, indeed, it ever was.\ldots
\end{quote}

The term "property" is used in a wide variety of meanings. It may refer to a person's physical assets, to his real property, or to the totality of his wealth which consists of physical objects and various incorporeal rights which he is entitled to exercise, such as debts due


\textsuperscript{405} See Matthews, supra, note 385.


\textsuperscript{407} See discussion of unclaimed bodies legislation and C.C.L.C., art. 22 (authorization of non-consensual organ procurement) in section III, below.
to him, rights in a trust fund, stocks, patent rights, and so on. Thus it may refer to physical objects and to rights. It may also refer to the legal relations between persons and such objects and rights . . .

It is, therefore, the content of the property right, namely, the several rights, privileges, powers and immunities which comprise it, that is of significance in law and not the physical thing or right itself. The physical objects or rights may, after all, be multifarious, while the powers or rights are definite. . . . This simple generic list can be broken down further to give a list of specific powers, rights, privileges and immunities with respect to property. Property, therefore, is not just a single right; but a bundle of rights or powers.408

The distinction proves subtle and important. To define property in terms of rights and duties between people with regard to things makes the apparent ambivalence of the law more coherent. The distinction also frees society to rank and define, broadly or narrowly, particular rights, duties and powers. For example, if human tissue should generally be an object of neither commerce nor inheritance, does this mean that the law should not recognize any property interests in human bodily parts and substances? The answer depends, in part, on how property is conceived and defined, and for what purposes. Necessities of bodily property may conjure up ethically abhorrent images of slavery — the ownership of human beings. The law of cadavers has shown, however, that a next of kin's right of possession does not include the right to sell. Nor does a housing tenant's right of possession normally include the right to sell the apartment. While property and commerce, overlap, a right to sell may or may not be added to the bundle of property interests that the law confers.409

The no-property rule may suffer other limitations in the modern context. Both society and the medical use of the body have evolved significantly in the 300 years since the no-property rule was fashioned, when most bodies were buried in the consecrated grounds of a church cemetery.410 Do the logic and utility of the rule fade centuries later, when confronted with unburied whole bodies and bodily parts, substances or tissues preserved as anatomical specimens, preserved in tissue banks for therapeutic use or transplanted into the living?

(2) Living Donors

Does the no-property rule encompass living donors? In Canada, there appears to be no case that specifically addresses the issue. In cases in the United States, the courts have tended to apply the no-property rule to tissue disputes involving living donors, although there are recent trends to the contrary. Four general areas in which property concepts have been at issue involve the non-consensual discarding of donated tissue, the control and transfer of deposited bodily substances, the use of non-consensually extracted bodily tissue or substances and the commercial value of bodily substances and tissue.

(a) Non-consensual Discard Cases

Cases in the United States have arisen over the discarding of donated or deposited human tissue without the consent of the patient-depositor. In two cases, one involving lost eye tissue that was being examined for cancer and another involving the disposal without consent of reproductive matter in an infertility clinic, courts have avoided resolving patients' damage claims in terms of property. Instead, they have preferred to analyze them in terms of mental shock or distress to the patient.411 These cases seem to suggest that some courts in the United States have extended the no-property-in-a-corpse rule to a no-property-in-bodily-parts rule.

Commentators have criticized the no-property-in-bodily-parts tendency for living donors.412 Some jurisdictions significantly limit nervous shock claims.413 It is argued that even when nervous shock claims and damages are available, they do not address instances when the return of valuable human tissue or material is sought.414 The suggestion is that property concepts would better protect an individual's autonomy and person, in addition to clarifying legal rights and duties regarding the control of human tissue in particular circumstances. For example, when an institution destroys valuable human tissue without consent in a jurisdiction that limits mental damages, common law property principles concerning the destruction or spoilage of materials rightfully in one's possession might prove helpful in defining legal rights, duties and grounds of recovery.415

(b) Control and Transfer Cases

The issue of rights and duties regarding the control and transfer of living tissue has arisen most acutely in some recent cases involving human reproductive material. While there are no reported Canadian cases on this point, an American couple was recently successful in litigating the control of and right to transfer their frozen embryo from an

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408. A. H. Oosterhoff and W.B. Rayner, Anger and Hondehger Law of Real Property, vol. 1, 2d ed. (Toronto, Ont.: Canada Law Book, 1985) s. 102 at 5-6 (emphasis added).
409. See also chap. 2, section IV.B, above.
410. See text accompanying note 384, above.
412. See, e.g., P.D.O. Stegg, Human Corpses, Medical Specimens and the Law of Property" (1975) 4 Anglo-Can. L. Rev. 412 at 418 n. 39 ("The reason behind the traditional refusal of the common law courts to consider property in a corpse does not apply to parts removed from living bodies. Property should vest initially in the person from whose body the part has been severed. However, he would often be taken to have abandoned or transferred his interest.").
east-coast infertility clinic to a west-coast clinic. In France, the wife of a deceased sperm depositor argued that she had a right to her husband’s frozen sperm, which he had deposited for preservation after learning that he would undergo cancer treatments that risked making him sterile. The court expressly rejected the argument that frozen semen was property, on grounds that human reproductive material was neither inheritable nor an object of commerce. Nevertheless, it ruled that the sperm bank must return the frozen semen to the wife of the depositor, as a result of an understanding between the depositor and the sperm bank. That decision suggests that agreements between tissue banks and depositors, as reflected in well-drafted informed consent forms, might help minimize disputes over the control of deposited tissues, in the absence of legislation or professional standards that sufficiently address the issue.

Disputes over reproductive substances are helpful in identifying concerns and values at issue in potential disputes over other human tissue and substances. For example, the growth in tissue banking may make the rights and duties in controlling other deposited, valuable human tissue a more prominent medical-legal issue. Consent forms for autologous blood banking in Canada have referred to deposited blood in terms of property, as have professional protocols for the banking of reproductive and genetic materials in the United States.

(c) Non-consensual Invasion Cases

As the consent doctrine of medical malpractice law protects against the non-consensual invasion of a patient’s body, so too might bodily-property principles help protect against the non-consensual use or disposition of bodily substances or tissues that have been removed from the body. The idea was recently broached by the Supreme Court of Canada.

The court held a physician’s non-consensual taking and use of a patient’s blood to be an unreasonable seizure under the Canadian Charter of Rights and Freedoms. After taking a blood sample from an unconscious, hospitalized patient who had been injured in an automobile accident, the physician gave the sample to a police officer. The blood was analysed and later offered as evidence of drunken driving. The opinion may suggest a relationship between bodily property, patient autonomy, physical integrity and human dignity:

As I have attempted to indicate earlier, the use of a person’s body without his consent to obtain information about him, violates an area of personal privacy essential to the maintenance of his human dignity. It was a perfectly reasonable thing for a doctor who had been entrusted with the medical care of a patient to do. However, I would emphasize that the doctor’s sole justification for taking the blood sample was that it was to be used for medical purposes. He had no right to take Mr. Dymant’s blood for other purposes. I do not wish to put the matter on the basis of property considerations, although it would not be too far-fetched to do so. Some provinces expressly vest the property of blood samples in the hospital, a matter I consider wholly irrelevant. Specifically, I think the protection of the Charter extends to prevent a police officer, an agent of the state, from taking a substance as intimately personal as a person’s blood from a person who holds it subject to a duty to respect the dignity and privacy of that person.

(d) Property and Personhood Cases

The concept of property as a protectotate of fundamental values of personhood has been debated in a recent American case of international significance. In Moore v. Regents of the University of California, a leukemia patient claimed that, without his knowledge or consent, his university doctors used his cells and tissue to develop and patent a commercially valuable anticancer drug. The drug is based on a cell line derived from the patient’s diseased spleen which had been surgically removed for treatment. The patient argued that he is owed a rightful share of money generated by the patent, owing to the misappropriation of his bodily tissues.

Important aspects of the case were recently decided by the California Supreme Court. A lower court had upheld the patient’s right to sue on the basis of a property interest:

We have approached this issue with caution. The evolution of civilization from slavery to freedom, from regarding people as chattels to recognition of the individual dignity of each person, necessitates prudence in attributing the qualities of property to human tissue. There is, however, a dramatic difference between having property rights in one’s own body and being the property of another.

The essence of a property interest — the ultimate right of control — therefore exists with regard to one’s own human body.

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416. York, supra, note 415 at 425-27, especially n. 5 (upholding patients right to sue on contractual and property intercasa bases, finding implied bailment contract within informed consent form governing frozen reproductive matter). Shortly after the court upheld the infertile couple’s right to sue on the above grounds, the parties to the suit agreed to a settlement under which the couple transferred the embryo.


418. See Jones, supra, note 163 at 528-29.

419. See ibid. at 529.

420. See chap. 1, pages 22-27 above.

421. Ethics Committee of the American Fertility Society, “Ethical Considerations of the New Reproductive Technologies” (1986) 46:3 (Supp. 1) Fertil. Steril. 89 (“It is understood that the gametes and concepti are the property of the donors”).

422. See autologous blood banking consent forms used by Autologous Inc., a company discussed in Gilmore, supra, note 183. See also ASHIL, supra, note 167 at 782 (“Banked DNA is the property of the depositor unless otherwise stipulated”).

423. See Dickens, supra, note 144.


425. Ibid. at 431-32 (emphasis added).

426. 793 P. 2d 479 (Cal. 1990) (en banc), cert. denied 111 S. Ct 1388 [hereinafter Moore (1990)]. Weeks after the Commission had finalized its recommendations on tissue “ownership” and other issues discussed in this document, the California Justices decided Moore (1990) on principles consistent with Commission recommendations. See pages 188-89 below.
A patient must have the ultimate power to control what becomes of his or her tissues. To hold otherwise would open the door to a massive invasion of human privacy and dignity in the name of medical progress.427

In reviewing the lower court decision, the California Supreme Court agreed that the patient may sue for violations of bodily integrity and human dignity, but it limited the basis for doing so to more conventional medico-legal grounds.

The majority of the court held that the patient may sue for a breach of informed-consent duties and for a breach of the duties of loyalty to the patient. The majority reasoned that if the patient’s claims were proven true, those claims would show that the doctor had an undisclosed commercial interest in the patient’s tissue at the time he recommended the surgical removal of the spleen, that this non-therapeutic interest might influence the doctor’s recommended course of treatment and that a reasonable patient in those circumstances would generally want to be informed of potentially conflicting interests before treatment.

Accordingly, we hold that a physician who is seeking a patient’s consent for a medical procedure must, in order to satisfy his fiduciary duty and to obtain the patient’s informed consent, disclose personal interests unrelated to the patient’s health, whether research or economic, that may affect his medical judgment.428

A minority of the court agreed that the patient should be able to sue on informed-consent and fiduciary-duty grounds, but insisted that property grounds would best protect a patient’s bodily integrity, privacy and dignity.

The divergent conclusions on the property claim flow, in part, from divergent views on existing law. The majority and minority views differed sharply over: (1) whether a state law that regulates the disposal of excised tissue extinguishes, or lets survive, patients’ pre-excision proprietary rights to control post-excision use of the tissue; (2) whether the patented cell line and resulting drug were distinct proprietary products invented from raw materials, or the fruits of Moore’s unique cellular qualities, qualifying him as a joint inventor; and (3) whether the protections of federal patent law affect a property-based claim for unauthorized use of excised tissue — especially for the six-year post-surgical, pre-patent era, when Moore’s bodily substances were periodically extracted allegedly to supply the defendants’ research and commercialization efforts.429

The majority and minority opinions also sharply diverged on broader policy concerns, such as the role of the courts and legislature in judging whether novel patient bodily-property claims would create liability destructive of beneficial medical research. Without absolutely ruling out such claims, the majority found “no pressing need” to recognize them, given the protection it perceived in the informed-consent and fiduciary-duty remedies. The minority rejected this view, arguing that the equities of preventing unjust enrichment and physical and moral exploitation of patients outweighed overstated liability concerns. It argued further that the commercial relations and ambiguities in the case — over whether informed consent or fiduciary duties extend to biotechnological and drug companies — meant that patients would be insufficiently protected without bodily property claims.430

The sharply contrasted opinions in Moore may help crystallize the issues for legislative or judicial deliberations in jurisdictions beyond California.431 For the case is not an isolated incident. A United States government report has documented other disputes over the patenting of human biological materials.432 More recently, a female patient claimed that her blood, placenta and umbilical cord were, without her knowledge or consent, transferred from a hospital to a California biotechnological company to develop an rDNA drug, Tissue Plasminogen Activator (TPA), which has been patented and is now licensed in Canada for use in dissolving blood clots after heart attacks.433 While disputes over the development and commercial use of human tissues and biologics are noteworthy in the United States434 the cases may have import for other jurisdictions.

Is Moore relevant to Canada? Several developments and parallels in Canadian society may suggest so. The development of blood and drug products from human placenta and of vaccines from fetal tissue indicates that the therapeutic and commercial development of human biologies is part of Canadian medical history.435 The Canadian biotechnological and drug industries are working on human biologies for commercial and non-commercial uses.436 Biotechnology is accelerating the rate at which medical science may convert formerly useless human tissue into therapeutic substances with a commercial value. The traditional legal maxim “the law cares not for trifles” — de minimis non curat lex — may no longer apply to excised tissue and secreted substances long regarded as valueless and abandoned:


429. Moore (1990), supra, note 426 at 491-93, 501, 503. Paralleling the competing majority and minority property views, property law on the one hand recognizes principles under which one is entitled to the value added to his or her property by others; and, on the other hand, recognizes principles under which one acquires title by transforming raw materials into a new form or species of property, as in the conversion of wine from grapes. Compare Firestone Tire v. Industrial Acceptance Corp., [1971] S.C.R. 357 (accession); Jones v. De Marchant, [1916] 10 W.W.R. 841 (C.A. Man.) (accession); C.C.L.C., arts 429, 430, 433-35; Scottish Law Commission, Corporeal Movable: Mixing Union and Creation (Edinburgh: The Commission, 1976) (specification).


432. See White, supra, note 91 at 23-27.


434. See, e.g., United States v. Garber, 807 F. 2d 92 (5th Cir. 1979) (taxability of “donor’s” income from blood plasma sales).

435. See section III.A(1), below, and chap. 1, section B. above.

Until recently, the physical human body, as distinguished from the mental and spiritual, was believed to have little value, other than as a source of labor. In recent history, we have seen the human body assume astonishing aspects of value. Taking the facts of this case, for instance, we are told that John Moore’s mere cells could become the foundation of a multi-billion dollar industry from which patent holders could reap fortunes. For better or worse, we have irreversibly entered an age that requires examination of our understanding of the legal rights and relationships in the human body and the human cell.

Parallel legal developments have also emerged. Legal recognition of the patenting of life forms in the United States, which increased by 300 percent the number of patent applications for inventions involving human biologies, has also proceeded in Canada, where human cell lines have received patent protection since the early 1980s. Human genetic and cellular materials manipulated into therapeutic products thus appear to have been granted intellectual-property protection for exclusive commercial exploitation under Canadian law as well.

The confluence of these unprecedented legal and medical developments accentuates the potential for conflicts between the sources and the users or explotters of human cells and tissues. Cultural and legal differences between the United States and Canada may help Canadian society avoid such disputes in transit through the biotechnological age. At the least, however, the parallel medical and legal developments challenge society to rethink its choices for a tissue-transfer legal regime consonant with this new age. Moore-like disputes are perhaps symptomatic of technico-legal revolutions which so jar pre-existing legal structure that society must endure a period of confusion and conflict before creating new, or recalibrating old, legal regimes. In this instance, biotechnology calls into question what the moral and legal integrity of the human body will continue to mean.

Taken together, Moore, Parpalaix and Dyment further suggest that these biotechnological developments should proceed in a manner consistent with human rights. Will the recognition of limited property interests protect against non-consensual commercial use or development in those presumably rare, compelling circumstances in which bodily resources have been commercially exploited without the express and specific authorization of the patient? While individual rights cannot be absolute in a pluralist society, what legal tools will help maintain the sovereignty of human rights? Will it help to reform patent law or to require doctors or researchers to disclose commercial or non-commercial potentials in research on excised human tissue? Will limited bodily-property interests help? Viewed from an eighteenth-century perspective, such thoughts may seem ethically and legally abhorrent. Both law and medicine are dynamic enterprises, however. A Canadian commentator has written that “[t]he meaning of property is not constant. The actual institution, and the way people see it, and hence the meaning they give to the word, all change over time.”

Viewed from a late twentieth-century human rights perspective, society might ponder whether a legal notion of limited property interests in human tissue may best serve to protect physical integrity, individual autonomy and the fundamental values of personhood.

To minimize disputes between the sources and commercial users of human cells and tissues, fiduciary principles may provide initial guidance. Patients seek medical care with the expectation and trust that medical interventions on their bodies will be undertaken for their benefit. Some courts have deemed this patient expectation to be a right, which imposes a corresponding duty on physicians to act with utmost good faith and loyalty. The ethical and legal rights that attach to this patient-centred ethic have long been the hallmark of doctor-patient relations. When an interest arises that potentially conflicts with a doctor’s duty to exercise independent professional judgment on behalf of the patient, the duty of loyalty requires a disclosure of the conflict and the informed consent of the patient to continue medical treatment. Applied here, the principles require a doctor to disclose a potential commercial interest in the patient’s tissues or bodily substances. Full disclosure and the patient’s informed consent would permit the patient to continue treatment. If the patient declines further involvement, or if it becomes reasonably clear to the doctor that his or her commercial interest compromises the exercise of independent professional judgment, the doctor would have an obligation to transfer care of the patient.

Yet, even a broad range of common law concepts — from fiduciary duties, to informed consent, to property interests — may not provide sufficient clarity or certainty on the competing interests, rights and duties of patients, doctors, researchers, hospitals or biotechnology firms. The complexity of the issues and interests indicate that they merit further multi-disciplinary study to discover how society may best balance the need to encourage creative biotechnological therapeutic human tissue development with the need to protect basic human rights.

438. See infra, note 977.
439. Ibid.
440. See the discussion of federal patent law, pages 123-24 below.
442. The inclination or resistance to invoke property rights as a legal tool to protect human rights in this domain would seem to depend much on whether one accepts, rejects or perhaps ascribes to a personhood, labour, possession or like theory of property in this context. See M.R. Cohen, “Property and Sovereignty” (1977) 13 Cornell L.Q. 8. See also Margaret Jane Radin, “Property and Personhood” (1982) Stan. L. Rev. 957 at 966.
445. See Picard, supra, note 364 at 3 (“The doctor . . . is in a fiduciary or trust relationship with his patient. This means the doctor has a duty to act with utmost good faith: he must never allow his professional duty to conflict with his personal interests; he must not mislead his patient.”). See also Rowe v. Grand Trunk Railway (1866), 16 U.C.C.P. 500 at 506 (C.A.); Kenny v. Lockwood, [1932] 1 D.L.R. 507 (Ont. C.A.).
C. Bodily Sales

If two parties strike a bargain for the sale and purchase of fine red hair, is the contract enforceable in the courts? Should a court reach a similar or different result if the subject-matter of the agreement is blood, cells, milk, bone marrow, organs or corpses? Does it matter that hair and teeth "have been traded for centuries" while the potential for organ and bodily part exchanges has arisen most dramatically only in the last few decades?448

Some answers to these questions are contained in provincial legislation or codes.449 Principles of contract law, however, also provide insights into evolving societal thought and public policy on the sale of human tissue, organs and bodily parts or substances. Moreover, contract law principles may govern the sale of human milk, blood, sperm, cells and like substances excluded from provincial legislative or Civil Code prohibitions on tissue sales.450

Perhaps because the societal use of and value in bodily substances and parts have increased most in recent decades, there are few cases involving the sale of the body or bodily parts. Still, the existing cases and the general workings of contract law indicate that the validity of bodily sales contracts depends on two general principles: first, whether the parties to the agreement give free, uncoerced consent; and secondly, whether the agreement violates public policy or order by its illegality, immorality or clear injury to the public good.451

(1) Contracts, Consent and Fairness

The law has a long tradition of leaving individuals free to enter into agreements; indeed, it generally premises in favour of enforcing agreements.452 However, when circumstances arise in which a person has made promises under severe distress, the courts may inquire into those circumstances to see whether the parties made their promises free of coercion:

[A] Court of Equity will enquire whether the parties really did meet on equal terms; and if it be found that the vendor was in distressed circumstances, and that advantage was taken of that distress, it will avoid the contract.453

The law of contracts also has long required that individuals strike their agreements within broad bounds of fairness and equality. The fairness principle is applied by asking whether an agreement was oppressive when the parties first reached their agreement, or whether it was made under duress of circumstances or undue influence. Similarly, in civil

law the reasonable and present fear of un mal sérieux may invalidate consent and be a cause of nulity of a contract.454 Thus, a court may find that the principle of fairness requires an agreement to be unenforceable.

There are no reported Canadian cases involving the validity of agreements to sell bodily parts. Yet so-called baby-selling cases in Canada and the United States illustrate some of the principal concerns. In some American adoption cases, for example, the courts have focused on whether biological mothers have exercised their free will in consenting to have their children adopted.455 In one instance, in which an adoption agreement was found unenforceable, the mother's poor financial status and the payment she received as part of the adoption process persuaded the court that the biological mother had been subjected to sufficient "undue influence" or "duress" that she could not have voluntarily consented to the adoption.456 Similar concerns motivated a court to strike down a surrogate-motherhood contract in the celebrated Baby M case.457 By contrast, a Canadian court found that a biological mother "had made a free decision" to consent to her child's adoption, after receiving from the adopting parents reasonable legal and travel expenses incurred in the adoption process.458

Do the principles and concerns expressed in those adoption cases apply to agreements to sell human tissue, bodily parts or substances? On the one hand, the sale of human tissue does not involve the legal transfer of a human being and the necessity for safeguarding the child's best interest. In the absence of an innocent third party, it might be argued that competent adults should generally be free to consent to some bodily sales agreements, and that it is illegitimately paternalistic for society otherwise to interfere.459

On the other hand, the paternalism argument tends to equate economic freedom with the enhancement of personal liberty; if liberty is also seen as the power to foster and

448. See Scott, supra, note 268 at 180.
449. For a discussion of provincial legislative and Quebec Civil Code sales prohibitions, see pages 131-36 below.
450. Ibid.
451. See text accompanying note 466, below.
455. See generally Jack W. Shaw, "What Constitutes Undue Influence in Obtaining a Parent's Consent to Adoption of Child" 50 A.R.L. 3d 918.
456. See In Re G, 389 S.W. 2d 63 at 69 (Mo. App. 1965). See also Gray v. Maxwell, 293 N.W. 2d 90 at 95 (Neb. 1980). But see Barwin v. Reidy, 307 F. 2d 175 at 185 (New Mex. 1957) ("not duress of a type which renders void contracts").
459. Bernard M. Dickens, "Legal and Ethical Issues in Buying and Selling Organs" (1987) 4 Transplantation/Implantation Today 15 at 20 ("The view that the freedom of choice enjoyed by the poor is protected or enhanced by denying them means to avail themselves of such an opportunity for earning is itself ethically objectionable, however, on several grounds. It denies the poor a means of income available to others, it is in no way mitigates the poverty it finds an offensive cause of exploitation, and it is unjustifiably paternalistic. The poor are in no greater need of protection against exploitation than others, and can be no less trusted than others to decide for themselves to accept or decline means of earning lest their freedom of subsequent decision may be reduced.")
protect personhood, then justifying the non-saleability of tissue on grounds of fostering personhood might be seen as freedom enhancing. In this sense, the legal terms ‘duress’ and ‘undue influence’ might describe both the medical and economic desperation which disables some persons from freely choosing or voluntarily consenting to tissue sales. When one’s adolescent child is suffering from fatal leukemia, an offer of $5,000 to attract a matching bone marrow donor may seem reasonable to the parents. Similarly, an offer to sell a kidney for $32,000 might seem reasonable to someone unemployed for three years in a society with hundreds on recipient waiting lists for a kidney transplant. Indeed, analysts and task forces in Canada, the United States and Europe have argued that the sale of organs and bodily parts invites, and may result in, the economic exploitation of the poor. In a broader sense, the dispute over whether sales aggravate or ease economic desperation reflects divergent views on redistributive justice — that is, how a tissue sales prohibition or authorization specifically affects the underlying problem of gross distributions of wealth in society.

(2) Agreements Contrary to Public Policy or Order

Some bodily sales agreements may not be enforceable because the law regards them as void and contrary to public policy:

It is the duty of the courts to give effect to contracts ... since we are under a reign of law; but there are cases in which rules of law cannot have their normal operation because the law itself recognizes some paramount consideration of public policy which over-rides the interest and what otherwise would be the rights and powers of the individual. It is, in our opinion, important not to forget that it is in this way, in derogation of the rights and powers of private persons, as they would otherwise be ascertained by principles of law, that the principle of public policy operates.

The Quebec Civil Code recognizes a similar principle by requiring that contracts not be contrary to ‘good morals or public order.’

Whether a particular agreement is contrary to public policy or order depends on whether it offends several established legal principles or more general and evolving legal criteria. A contract to commit a crime, for example, is both void and illegal.

The eighteenth-century British common law crime of selling a corpse appears to have been adopted into the Canadian Criminal Code if so, an agreement to sell a corpse is void and contrary to public policy as an illegality. Other illegalities in modern Canadian society are often defined in statutes such as provincial laws prohibiting the sale of organs or babies. Such agreements would also be generally unenforceable because they are contrary to public policy.

But what of human blood, skin, bone marrow, semen, hair and like tissues or bodily substances that may not be prohibited from being sold by provincial statutes or codes? It is not clear whether such bodily sales agreements are ‘contrary to public policy and order.’ That some Quebec Civil Code provisions are suggestive of bodily sales being hors du commerce while others appear to contemplate the non-gratuitous exchange of regenerative tissue suggests that the Code has not definitely solved the matter.

Tissue sales contracts clearly do not fit within such other established areas of unenforceable agreements as ‘restraint of trade’ or ‘sales of public offices.’ They come closer to fitting within other established areas of unenforceable contracts such as ‘immoral bargains’ or ‘agreements that impair family relations.’

It might be argued, for example, that the sale of sperm or gametes should be contrary to public policy because it violates public morals and impairs family relations. A Paris court has found a contract involving the sale of tattooed skin to be [TRANSLATION] ‘illicit, immoral, and against the public order.’ Typically, though, ‘immoral bargains’ have referred to sexually reprehensible conduct. Whether the sale of semen for use in infertility treatment is immoral or sexually reprehensible conduct today is open to question. While courts in the nineteenth and early part of the twentieth century regarded artificial insemination as adultery, immoral and a threat to family relations, they now tend to regard it as medical treatment with particular legal consequences.

468. See pages 109-10 below, discussing Criminal Code s. 182.
469. See Waddams, supra, note 453 at 412.
470. See note 499, infra (babies) and section III, below (organs).
471. See Waddams, supra, note 453 at 421.
472. See pages 134-35, below.
were once considered immoral now tend to be enforced and may even be advisable.479 In short, legal and societal views of what is an acceptable or an immoral agreement and public policy are not static:

Decisions on a question of this sort cannot be crystallized into categories established at some date in the past for, as an American court said, the public policy of one era may be wholly opposed to that of another. A society’s view of public policy does not alter only by radical political change, but also by gradual evolution. ... These categories reflect the values of the era. An evolving society must, however, have changing values, and the law falls in its service to society if it cannot also evolve.480

Absent determinative legislation or common law or civil law principles, the answer to whether some bodily sales agreements are contrary to public policy or public order may depend on the merits of the competing considerations that follow:

— **Physical integrity versus medical risks:** On the one hand, selling human tissue, bodily parts and substances may invite sellers to compromise their health and take undue physical risks; on the other hand, the physical and medical risks associated with giving some bodily parts or substances — hair, blood, sperm, sweat, milk or cell lines — arguably are so minuscule that they diminish concerns about physical exploitation or risks that may result from some authorized bodily sales.481 In the latter instances, the legal maxim "The law cares not for trifles" — *de minimis non curat lex* — applies to such sales.

— **Medical disclosure and recipient safety:** Some argue that because sellers fear that payments will not be made for defective tissues, the lure of money discourages sellers from disclosing damaging medical information — diseases, genetics, medical history — that medical authorities need to evaluate whether the tissue should be used for transplant.482

— **Autonomy and privacy:** Arguably, the ethical and legal presumptions of autonomy, privacy and liberty properly include the right to exchange bodily substances or parts, when such exchanges visit no material harms on third parties.483 Some have even argued that such rights attain a constitutional dimension.484 On the other hand, it is argued that individual privacy and liberty do not include a right to sell bodily parts or substances.485

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480. See Waddams, supra, note 453 at 409-10. See also Jaeger, supra, note 479 at 93 ("Agreements having an immoral object are unenforceable on the ground of public policy which, in some instances, is dependent upon the attitudes prevailing at the time").


484. See supra note 873.


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486. See *Adoption of B.A.B.*, 534 A. 2d 1050 at 1052 (Pa. 1987) (human beings not merchandise); Radin, supra, note 400 at 1899.


489. See Blake and Cardella, supra, note 121 at 774; Buskard, supra, note 51.

490. See Sharpe, supra, note 201; Dickens, supra, note 459 at 21. See also French milk bank regulations, supra, note 934.


493. Titmuss, supra, note 244 at 225-29; USTF, supra, note 29 at 96, 98. See generally chap. 2, section I.A, above.
illness.\textsuperscript{494} If the failings of pure altruism need not necessitate pure commercialism, modified altruism – a mixed public policy recognizing an appeal to both non-monetary and monetary personal benefits — may be in order to increase supplies.\textsuperscript{495}

Many of these considerations, such as the impact upon safety and the enforcement of tissue sales agreements, address the practical consequences of authorizing or prohibiting tissue sales. Other considerations, such as the impact on altruism, echo the deeper ethical debate on defining emerging tissue transfer regimes for bodily substances that have not traditionally been associated with the marketplace.\textsuperscript{496} For some analysts, allowing even limited tissue sales, or applying market rhetoric to the human body, does violence to how we think of human dignity, our bodies, our selves and concepts of personhood.\textsuperscript{497}

(3) Payment of Reasonable Expenses

The public policy and legal considerations on bodily sales should also be guided by an understanding of the precise purposes of allowing or forbidding payments to donors. The purposes have important practical, legal and ethical consequences.

The practical consequences are plain. The transfer of human bodily tissue, parts or substances may be done: (1) gratuitously, meaning that the donor receives no payment; (2) for profit, meaning that the donor receives payment beyond expenses incurred; (3) for reasonable out-of-pocket expenses, meaning that the donor receives a nominal payment to cover associated travel, meal, lodging and like expenses; or (4) for reimbursement to the donor for expenses, lost income and pain and suffering. How does and should the law and public policy account for these different purposes and levels of payment?

If society deems profiting from the exchange of human bodily substances abhorrent, should it flatly prohibit all payments associated with the donation process? If yes, implementation may have undesired consequences that may prove counter-productive in practical terms. For those already undergoing medical procedures involving the removal of donated tissue, donation may simply involve an extension of planned procedures. Otherwise, the donation process requires donors to spend time and money and undertake medical risk to effect their charitable or altruistic intentions. Depending on the donor’s financial situation, the lost income and travel and meal expenses may erect financial barriers that so severely tax the donor’s charitable intentions that donation may become, in practice, unfeasible.

The frequency of donation and the time and travel necessary to make the donation vary according to the tissue to be donated. Still, these considerations suggest that a policy or law that flatly forbids any payments in the donation process may itself undermine donations, because of the associated expenses, lost income, pain and suffering and the medical risks which donors often incur.

An alternative approach, as a federal working group on organ transplants has urged, is “that the donor should neither gain nor lose financially by the donation.”\textsuperscript{498} There are pros and cons to that approach. On the one hand, it arguably departs from the principle of charitable and gratuitous donations, creates a financial incentive for donation and, in the extreme, might attract and exploit the poor; moreover, it may offend and discourage the truly altruistic from donating. By recognizing the validity of some payments, it may also draw society into considerations about what are good and reasonable or bad and unreasonable payments.

On the other hand, several advantages may flow from a public policy principle that tissue donors neither gain nor lose financially from the donation process. Depending on what donation expenses are covered as “reasonable,” the principle helps eliminate financial barriers to the donation process. Donors from all financial strata of society might thus have an equal opportunity to donate. Moreover, donations from reimbursed donors need not necessarily erode altruism. They might be seen as promoting it. A policy that aims at reimbursing donors for reasonable expenses and lost income still does not compensate for voluntarily assumed medical risks, pain and suffering. The uncompensated assumption of risk and pain still expresses altruism.

Finally, the approach may preserve altruism by its emphasis on payment for reasonable expenses incurred in service for society, as opposed to payment for the tissue itself. Such considerations have proven persuasive to policy makers in several jurisdictions. The distinction between reimbursement for reasonable service expenses and sales has thus been recommended for or incorporated into provincial adoption law, provincial gift tissue legislation, national ethical guidelines on research, laws prohibiting organ sales in Great Britain and the United States, and in European legislative guidelines on tissue and semen donation.\textsuperscript{499}

A policy of reimbursing for reasonable expenses incurred in a voluntary service, in contrast to payment for the tissue itself, does have limits. In the extreme, the policy may

\textsuperscript{498} FEDS, supra, note 29 at 65.

\textsuperscript{499} For the distinction in the adoption laws, see Re Female Infant, supra, note 458 (construing B.C. Adoption Act, R.S.B.C. 1979, c. 4, and baby-selling prohibitions); see also Child and Family Services Act, 1984, S.O. 1984, c. 55, s. 159; Child Welfare Act, R.S.O. 1980, c. 66, s. 67. In the medical research context, see MRC, supra, note 118 at 24-25 (“Remuneration limited to compensation for expenses actually incurred and losses reasonably assessed, including loss of wages, is ethically acceptable, provided that it does not distort freedom of choice but facilitates collaboration by indemnifying subjects for their direct and indirect expenditures. Payments for time and inconvenience, if nominal, are similarly acceptable. Excessive remuneration, or other advantages or benefits, however, are an improper inducement to participate in a research project.”). In the provincial tissue law context, see pages 151-36 below. For the U.S. and European legislative context, see chap. 4, below.
create a de facto sales market such that the voluntary-services versus commercial-sales-of-tissue distinction pales to a fiction. Still, the distinction may have other important legal consequences. It may prove significant in negligent screening suits. A negligent screening claim would likely be tested by general principles of negligence: namely, whether a tissue bank owed a transplant recipient a duty or standard of screening, had violated that standard and so caused the transmission of diseased tissue and illness or injury to the recipient. If the tissue bank were regarded as being involved in the buying and selling of tissue, legal theories regarding the selling of "defective products" might also apply. In this sense, some courts in the United States have debated whether tissue banks that behave more like commercial entities should be held to a stricter standard of liability.

II. Criminal Law Perspectives

As an expression of fundamental societal values and as a regulator of individual conduct, criminal law also offers guidance on several tissue transfer and procurement issues. It defines some of the standards, duties and responsibilities of living donors and transplant professionals in the medical treatment process. It has long played a modest but noteworthy role in the sales and provision of bodies for medicine. Moreover, although common law crimes were largely abolished in Canada in 1955, the common law criminal heritage exerts a quiet, abiding influence on notions of societal harms and the mistreatment of deceased donors. Beyond its historical traditions and evolution, criminal law principles may help clarify the status of anencephalic infants and other potential donors who lie on the life-death line.

In this sense, the Criminal Code protects rights and defines duties and criminal liability in three general areas of tissue procurement and transplantion: (1) donations from living donors; (2) donations from deceased donors; and (3) the standard that divides those two donor pools, the legal criteria for the determination of death. How do the Criminal Code provisions on assault, surgical and medical treatment, assault causing bodily harm, duties to provide necessaries of life, criminal negligence and homicide apply to tissue donation from living donors to recipients? Do they appropriately balance the underlying values of promoting autonomy, protecting bodily integrity and preserving life? Proposals previously made by the Commission for the general reform of some of the Code provisions prove helpful in resolving apparent conflicts or ambiguities.

For deceased donors and their families, what is the modern meaning of the eighteenth-century-based Criminal Code offence of indecent interference with or indignities to the dead human body? Is it an indignity to sell bodily parts? How do or should this mistreatment provision apply to medical interventions on the brain-dead, mechanically maintained cadaver, which is the source of most organ transplants? Perhaps because these latter questions are unprecedented, they have received scant attention in the Canadian criminal literature. Accordingly, they are explored, as is the historic role played by criminal law in directly providing dead bodies to medical science.

In these life-death contexts, the definition of death has obvious importance. If the donor is alive, the criminal law provisions governing live donations may apply. If not, the provision relating to mistreatment of the dead body might apply. In the face of new calls that the definition of death be amended to facilitate organ procurement from a particular group of dying infants, the Commission's decade-old recommendation on criteria for the determination of brain death is revisited. Applying the pertinent medical and ethical considerations to the principles and policies on which the Commission based its initial recommendation persuades us that current invitations to amend the brain-death criteria should be declined.

A. Living Donors and Recipients

Criminal law imposes a "rule of beneficence" on some tissue transfer procedures, meaning that the benefits derived from the tissue donation and transplanting should not be disproportionate to the harms. By imposing such standards on consent procedures, the donation process and surgical operations, the criminal law protects and promotes bodily integrity, life preservation and autonomy.
(1) Donor Rights and Responsibilities

Concerns about bodily integrity and the value of life are expressed in the responsibilities of the living donor. While the Criminal Code provision on assault\(^\text{516}\) gives effect to the common law right and ethical imperative to consent to the physical invasion of one's person, other legal considerations help govern the existing model of tissue donation. For example, the recent criminal conviction of a Canadian donor for creating a common nuisance by knowingly donating HIV-infected blood underlines the concern for protecting the lives, health and safety of the public.\(^\text{517}\) In contrast to the concern for the public health, criminal law provisions against consenting to death\(^\text{518}\) and maiming or unlawfully causing bodily harm\(^\text{519}\) express a concern for protecting the autonomy, health and bodily integrity of both donors and recipients, by defining the outer extremes of consent to the physical invasion of one's person. The implication of the consent-to-death prohibition is clear:

This principle would thus preclude the altruistic donation of a liver or other organ without which the donor cannot live.\(^\text{520}\)

The implications of the principles against maiming and unlawfully causing bodily harm have historically been more clouded in the surgical context. This principle derives from the medieval crime of mayhem, which involved permanently disabling or weakening an individual.\(^\text{521}\) Some have argued that such principles should not be extended to organ transplants because of their significant social benefits.\(^\text{522}\) Do such social benefits justify

516. Criminal Code s. 265 provides in pertinent part, that: "A person commits an assault when (a) without the consent of another person, he applies force intentionally to that other person, directly or indirectly; . . . ." See also Report 31, supra, note 116 at 61-63. For a recent medical case involving a criminal assault conviction for unauthorized rectal examinations of institutionalized mentally disabled persons, see R. v. Wiens (22 June 1985), (Ont. Prov. Crt) [unreported], discussed in Harvey Savage and Carla McKague, Mental Health Law in Canada (Toronto: Butterworths, 1987) at 202-203. The case further demonstrates that in protecting bodily integrity, consent requirements protect human dignity and privacy.

   Every one who commits a common nuisance and thereby
   (a) endangers the lives, safety or health of the public, or
   (b) causes physical injury to any person,
   is guilty of an indictable offence and liable to imprisonment for a term not exceeding two years.

518. Criminal Code, s. 14:
   No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.


521. Scott, supra, note 268 at 63, and Innes, supra, note 519 at 547-48.


kidney donation from a living donor who may be related or unrelated to the recipient, when "an estimated twenty donors have died after the removal of one kidney" in transplant procedures at established institutions?\(^\text{523}\) Some argue that a restriction against such donations is overly paternalistic, denies some donors the privilege of exercising altruism and counters the public interest in overcoming organ scarcity problems.\(^\text{524}\) These considerations suggest that public necessity generally justifies the practice as lawful and immunizes one against the potential offence of unlawfully causing bodily harm.\(^\text{525}\) Other concerns about potential assaults on the bodily integrity of the donor, exploiting the vulnerable and organ sales have led to recent proposals to prohibit such donations, save in limited, strictly regulated circumstances.\(^\text{526}\) The current practice in most transplant centres is still restrictive of the use of living unrelated donors.\(^\text{527}\)

Concerns over bodily integrity, preservation of life and harm-benefit calculus intertwine in considerations about a legal duty to donate. Are there circumstances in which the criminal law imposes a duty to donate? The Criminal Code requires spouses or parents to provide "necessaries of life" to their spouse or child.\(^\text{528}\) The unexcused failure to provide such necessaries as routine tissue replacement procedures, insulin injections or blood transfusions may thus constitute a criminal offence.\(^\text{529}\) The Commission has extended these principles

525. See Mason and McCall Smith, supra, note 520 at 221. See also Criminal Code, s. 45, in text accompanying note 540, infra; Report 31, supra, note 116.
528. Criminal Code, s. 215, provides, in pertinent part, as follows (emphasis added):
   (1) Every one is under a legal duty
   (a) as a parent, guardian or head of a family, to provide necessaries of life for a child under the age of sixteen years;
   (b) as a married person, to provide necessaries of life to his spouse; and
   (c) to provide necessaries of life to a person under his charge if that person
      (i) is unable, by reason of detention, age, illness, insanity or other cause, to withdraw himself from that charge, and
      (ii) is unable to provide himself with necessaries of life.
   (2) Every one commits an offence who, being under a legal duty within the meaning of subsection (1), fails without lawful excuse, the proof of which lies on him, to perform that duty, if
      (a) with respect to a duty imposed by paragraph (1)(a) or (b),
         (i) the person to whom the duty is owed is in destitute or necessities circumstances, or
         (ii) the failure to perform the duty endangers the life of the person to whom the duty is owed, or
         causes or is likely to cause the health of that person to be endangered permanently; or
      (b) with respect to a duty imposed by paragraph (1)(c), the failure to perform the duty endangers the life of the person to whom the duty is owed or causes or is likely to cause the health of that person to be injured permanently.
   (3) Every one who commits an offence under subsection (2) is guilty of
      (a) an indictable offence and is liable to imprisonment for a term not exceeding two years; or
      (b) an offence punishable on summary conviction.
in a proposal that individuals be obliged to take "reasonable steps to assist" a person "perceived to be" in immediate danger of serious harm or death. Such a duty has been imposed by penal code in Belgium, France, Greece and Vermont; it addresses such classic situations as when an individual who is clearly in the process of drowning receives no assistance from companions who might help without jeopardizing their own well-being. There is no duty where the rescue involves a risk of serious harm or where the would-be rescuer has other valid reasons.

Applying these principles to the tissue donation process would seem to indicate that organ donation is seldom, if ever, legally required. There are no reported Canadian cases on a duty to donate per se. Five North American cases involving the donation of bone marrow, in the non-criminal law context, illustrate the complexity of the problem. In one, a man suffering from aplastic anemia sought a court order compelling his first cousin, who was the only identified suitable donor, to donate bone marrow. The anemic man was unlikely to survive without the transplant. Despite the exigencies of the circumstances, the court denied the order on the grounds that the forceable extraction of living bodily tissue would violate the autonomy and physical integrity of the cousin. The man died shortly thereafter. While this case appeared to be decided on the basis of autonomy, the risks associated with bone marrow transplantation might constitute a risk of serious harm or otherwise constitute a lawful excuse sufficient to relieve one of any duty to donate. For tissue donation involving less bodily invasion and fewer medical risks to the donor, concerns about a risk of serious harm seem less compelling.

530. See Report 31, supra, note 116 at 67, cl. 10 (c) ("(a) General Rule. Everyone commits a crime who, perceiving another person in immediate danger of death or serious harm, does not take reasonable steps to assist him. (b) Exception. Cl. 10(c)(2) does not apply where the person cannot take reasonable steps to assist without risk of death or serious harm to himself or another person or where he has some other valid reason for not doing so."). See also Working Paper 46, supra, note 513 at 17-20.


534. The risks associated with bone marrow transplantation have been recently summarized: The procedure requires hospitalization; it is performed under spinal or general anesthesia with little associated morbidity other than moderate to significant pain at the aspiration sites that persists for several days. Lift-threatening complications occurred in only 9 of 3,290 reported procedures, yielding a frequency of .027 percent. These complications included nonfatal cardiac arrest, pulmonary embolism, aspiration pneumonia, ventricular tachycardia, and cerebral infarction. The death of a donor was reported due to cardiac arrest during induction of general anesthesia. Other adverse consequences of marrow donation included bleeding, which required transfusion, one case of a broken aspiration needle where surgical removal was necessary, and a few transient episodes of hypotension, atrial arrhythmia, and laryngospasm.


Four other cases raise the issue of what a duty to take reasonable steps may encompass, short of donation. A court in the United States recently denied a petition to order three-year-old twins to submit to tests for possible bone marrow donation to a half sibling. The court was asked to decide the issue when an estranged couple disputed whether the twins, who were in the custody of the mother, should submit to blood tests that would indicate their compatibility for bone marrow donation to their dying thirteen-year-old half brother whom they had never met. In an earlier case, a cancer patient sought to compel a transplant centre to disclose information, and to take further steps to recruit Mrs. X, a potential bone marrow donor with apparently compatible bone marrow. The court refused the request. It found the tissue type information contained in the centre's computer to be a confidential medical record to which the cancer patient had no special right of access. In other disclosure cases, involving leukemia patients' access to confidential records, courts have both denied and granted access. A Quebec court granted a child’s petition to access sealed adoption records for the narrow purpose of determining whether the patient’s biological parents might be potential bone marrow transplant donors. An American court denied such access.

The results in most of these cases may seem harsh. Laws in the jurisdictions in which the courts denied access generally do not recognize a duty to rescue. If nothing else, the cases help illustrate that, beyond concerns for respecting the bodily integrity of would-be donors, competing needs for privacy and confidentiality also inform considerations on any duty to donate. Jurisdictions seeking to impose a reasonable duty to rescue while respecting confidentiality might, as the Quebec court held, require efforts to contact potential donors on the understanding that identities not be disclosed.

(2) Reasonable Harms and Benefits

The Criminal Code generally protects from criminal responsibility doctors who undertake organ transplants involving reasonable patient benefit.

Every one is protected from criminal responsibility for performing a surgical operation on any person for the benefit of that person if

(a) the operation is performed with reasonable care and skill; and

(b) it is reasonable to perform the operation, having regard to the state of health of the person at the time the operation is performed and to all the circumstances of the case.


537. Head v. Colloton, supra, note 536.


539. Application of George, 630 S.W. 2d 614 (Mo. App. 1982).

540. Criminal Code, s. 45 (emphasis added).
How is the provision that surgical transplantation must benefit the patient to be reconciled with the reality that blood, bone marrow or kidney donations do not physically benefit the donor? First, by applying to surgical operations, the provision appears not to extend to blood or like donations that generally are considered medical procedures. Secondly, while the provision may appear to exclude tissue and organ transplants between family members, a number of approaches have been proposed to resolve the tension.

One approach involves construing "patient benefit" broadly, to include the psychological benefits presumed to accrue to the donor in organ transplantsations and donations involving family members. Yet, the psychological-benefits theory may be limited by circumstances in which presumed psychological benefits appear reduced, where, for example, donations are from unrelated donors. Moreover, some commentators question the validity of the psychological-benefits theory. An alternative approach stresses that the requirement of donor benefit is presumed when consent is present. This approach stems from a view that the Criminal Code's fundamental premise is the protection of the person, and that it is reasonable to presume that persons act self-protectively to benefit themselves, as evidenced by consent. The Law Reform Commission has adopted this view, meaning that the Criminal Code provisions defining intentional crimes against bodily integrity should not apply to tissue and organ donation undertaken with properly obtained informed consent and involving risks not disproportionate to expected benefits. Since the Code seems not to contemplate these medical procedures undertaken for another's benefit, appropriate reforms would seem advisable. The more a procedure tends towards non-therapeutic benefit to the donor, the more stringent would seem the physician's duty of disclosure to promote consent.

Neither the psychological-benefits nor consent and risk-benefits approach easily resolve the intractable complexities of organ donations from minors and mentally disabled individuals. A mature minor who has the capacity to understand and appreciate the risks, benefits and consequences of donating an organ to a sibling would seem to parallel an adult in similar circumstances. The deep emotional consequences of donation or non-donation in such circumstances make consent for even the mature a delicate, trying process.

For potential donors judged incompetent to consent, and thus unable to act self-protectively, the net "benefits" of the donation may justifiy transplants on grounds of necessity in exceptional circumstances. The ethical principles of doing no harm and of beneficence indicate that donations that pose no serious risks and that offer a likelihood of psychological benefits to the donor and life-saving benefits to the recipient may be justifiable. The beneficence requirement that the risk of harm not be disproportionate to expected benefits is most likely ensured by a restriction of such transfers to members of the same family. Thus, a minor sibling's donation of bone marrow to his or her brother may be seen as consistent with ethics, public policy and law. However, as the invasiveness, irreversibility and risks of the transplant procedure increase — as in the case of a kidney transplant — so do concerns for the bodily integrity of all donors. To ensure that incompetent donors are protected from potential harms and that their particular vulnerability is not exploited, donations might best be considered only after other reasonable medical alternatives have been exhausted, and only if the guardian's consent has been obtained. To accord full respect to potential donors' wishes, their consent should be sought and their refusal respected. Such considerations have moved foreign analysts, such as the Australian Law Reform Commission and the Council of Europe, to restrict donations from incompetent persons to those that can be made under similarly circumscribed conditions. Such concerns have more recently prompted the Uniform Law Conference of Canada to recommend a requirement of an "independent assessment" for

553. See supra, note 283 and section II.B, below.
554. See, e.g., Cayouette et Mathieu, supra, note 380. Though no criminal law issue was raised in this case, it suggests that transplants not physically benefitting the donor may be consistent both with public policy and criminal law and ethical principles of necessity and beneficence. See Working Paper 26, supra, note 370 at 57.
555. See Australian Law Reform Commission, infra, note 1010 at 50-51 (recommended (1) that donation of regenerative tissue from minors be lawful, if the minor is of sound mind and consents to donation, a parent consents, and independent medical advice is provided; (2) that donation of non-regenerative tissue be generally prohibited, subject to exception when the following conditions are met: the donor and recipient are members of the same family, independent medical advice is provided on the nature and effect of the donation and transplantation, written parental consent, the donor has sufficient mental capacity and agrees to donation, and an independent committee unanimously agrees to the donation; and (3) that it be unlawful to take tissue from mentally disabled persons).
556. See Final Text, infra, note 965 at 276 (recommending a general rule against procurement from the "legally-incapacitated, subject to (1) an exception for regenerative tissues, when justified on therapeutic grounds for the recipient, the legal representative consents, and the donor consents, if the donor has the capacity to do so (s. 10); and an exception for (2) the donation of a single kidney, when neither dialysis nor a cadaveric organ is, respectively, "feasible" or "available," the donor and recipient are "genetically closely related," the legal representative and appropriate authorities consent, and the donor consents, if the donor has the capacity to do so (s. 10). The recommendation generally precludes procurement that "presents a significant and foreseeable risk to the life, health or functioning of the donor." (s. 13)).
all donors of non-regenerative tissue, as well as for all tissue donors under sixteen years of age. The Law Reform Commission of Canada’s recommendation that decisions for such interventions proceed on a case-by-case basis would seem consistent with the Uniform Law Conference approach. Even when the donation of a kidney by an incompetent minor seems ethically justified by beneficence and is immune from criminal sanction on grounds of necessity, recent concerns expressed by the Supreme Court of Canada still raise questions as to whether and when invasive, irreversible medical interventions performed on one person for the benefit of another person are legally justified.

(3) Reasonable Medical Skills

Finally, the criminal law protects the bodily integrity of transplant donors and recipients, by requiring medical professionals to perform transplants and related medical procedures with reasonable knowledge, skill and care; surgical-medical procedures must not be done with wanton or reckless disregard for health and safety. Otherwise, performance of the procedures theoretically risks subjecting a medical practitioner to criminal negligence charges for causing bodily harm or death.

In practical terms, medical malpractice seldom subjects health care professionals to criminal liability. Most claims of negligence arise in civil disputes between an injured patient and a hospital or physician. In rare instances when medical mistreatment invokes potential criminal negligence, the conduct is judged by a standard that differs from that of civil lawsuits. Generally, criminal negligence requires “a marked departure” from the ordinary standard of reasonable care. The standard theoretically applies to grave deviations from acceptable medical practices in diagnosing brain death or to other aspects of the transplant process.

B. Living or Deceased Donors — Anencephalic Newborns

In 1981, the Law Reform Commission of Canada proposed an “irreversible cessation of all . . . brain functions” standard for the determination of death in matters of federal jurisdiction, including the Criminal Code. Developments in the last few years have led to calls to amend the whole-brain death standard or to exempt from that standard a pool of patients who are born “incompatible with life”: namely, anencephalic newborns. The proposal implicates criminal law principles and policy in two general respects. First, as with any potential organ donor, if the anencephalic newborn is not dead, the criminal law provision concerning medical treatment duties, failure to provide necessities of life, criminal negligence, acceleration of death, homicide and like criminal law provisions governing live organ donors and recipients apply. If live-born anencephalic infants do not meet the criteria for death, this provokes a policy question in criminal law. Should the definition of death be modified for these infants who are born without most of their upper brain and who usually die within seventy-two hours after birth? Or should they be exempted from the definition so that their organs may be transplanted into those who might live? This question arises in part from the medical demand for the organs of newborns and in part from the poor medical status of the newborn anencephalic infant.

Anencephaly, which literally means “without brain,” refers to a birth defect characterized by the “absence of a major portion of the brain, skull, and scalp.”

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557. See text accompanying note 834, infra.
558. See Working Paper 26, supra, note 370 at 59. See also 1989 Uniform Act, ss 6, 7, discussed, infra, notes 833 ff. (providing that (1) those under 16 may donate only if the results of an independent assessment indicate that the transplant should be carried out (s. 6(4)); (2) the tissue to be donated is not regenerative (s. 6(1)); and (3) the minor understands the nature and consequences of the donation — a rule that is excepted by bone marrow that may be donated on behalf of the minor to the minor’s biological sibling, by a guardian (s. 6(5)).
559. See Ebe, discussed in text accompanying note 362, supra.
560. Criminal Code, s. 266.
561. Ibid., ss 219, 220.
563. See generally Picard, supra, note 364.
564. Report 31, supra, note 116 at 25. The Supreme Court of Canada remains divided over whether an objective (reasonable person) standard or more subjective standard should govern criminal negligence. See R. v. Waite, [1989] 1 S.C.R. 1426. See also Tutton, supra, note 529. See generally Stuart, supra, note 506 at 183-98.
565. See People v. Exlo, 472 N.E. 2d 286 at 297 (N.Y. 1984) (“If, however, the pronouncements of death were premature due to the gross negligence or the intentional wrongdoing of doctors, as determined by a grave deviation from accepted medical practices or disregard for the legally cogent criteria for determining death, the intervening medical procedure would . . . become the legal cause of death.”). Compare R. v. Kitching (1976), 32 C.C.C. (3d) 159 (Man. C.A.) (adopting brain-death definition of death, holding that organ procurement from brain-dead patient, who had been criminally assaulted, did not cause death).
566. Report 15, supra, note 1 at 25. (“For all purposes within the jurisdiction of the Parliament of Canada, (1) a person is dead when an irreversible cessation of all that person’s brain functions has occurred. (2) The irreversible cessation of brain functions can be determined by the prolonged absence of spontaneous circulatory and respiratory functions. (3) When the determination of the prolonged absence of spontaneous circulatory and respiratory functions is made impossible by the use of artificial means of support, the irreversible cessation of brain functions can be determined by any means recognized by the ordinary standards of current medical practice.”). For a discussion of its proposed application to the Criminal Code, see Report 15, ibid. at 23. See also Kitching, supra, note 565.
567. For a discussion of Criminal Code provisions affecting living organ donors and recipients, see text accompanying note 516, supra.
568. Such infants generally receive death certificates, suggesting that they are considered born “alive.”
condition, of still unknown causes, affects a reported one in 3,226 newborn infants; 40 to 60 per cent of anencephalic infants are born alive. Tragically, even those born alive survive for only a few hours or days, although in rare instances some live for weeks or months. Some fifty newborns appear to die from anencephaly and like anomalies annually in Canada; the number ranges from 300 to 600 annually in the United States. More frequent prenatal screening may reduce the incidence of anencephalic births. The estimated 500 to 600 newborn livers and 1,200 hearts needed annually in the United States may suggest a corresponding need for fifty to sixty newborn livers and 120 newborn hearts for Canada.

The poor medical status of the infant, parental desires to make some good of the circumstances and the need for organs have led to proposals and initiatives to facilitate organ procurement from live-born anencephalic infants. Some of the initiatives appear to have been medically successful:

Baby Gabrielle, born in Canada and subsequently transferred to the Loma Linda University Medical Center in California, was anencephalic. When her parents learned of her daughter's condition and of the devastating ramifications of anencephaly, they faced the inescapable reality that their daughter would be born into a process of imminent dying.

In the hope that their infant daughter "would touch others and contribute to life in some way," Baby Gabrielle’s parents arranged for their daughter’s organs to be donated to infants who were in dire need of healthy organs for transplantation. One such infant was Baby Paul Holc, who was afflicted with hypoplastic left-heart syndrome. Baby Paul received Gabrielle’s heart; one month after the successful transplant operation, he was discharged from Loma Linda with a second chance for a healthy, productive life.

Other medical initiatives have proven less fruitful.

Practically, the dilemma presents at least four options for attempting tissue and organ procurement from anencephalic infants. Each raises varying criminal law and ethical concerns:

1. Customary Care and Comfort: Provide customary care and comfort until the infants expire, which would reduce the likelihood of procuring viable organs, but permit the donation of tissue.

2. Brain Dead: Consider live-born anencephalic infants as brain dead, or "brain-absent" or stillborn, to exempt them from the traditional heart-lung or the newer whole-brain-death standard, and thus permit a greater range of medical interventions likely to increase the number of viable organs procured for transplantation.

3. Medical Protocols: Work within the whole-brain-death standard, by developing medical cooling or ventilator support protocols, in an attempt to maximize the likelihood of successful organ procurement.

4. Special Category: Consider living anencephalic newborns to be a special category of beings — non-persons, who warrant special treatment.

The customary-care and medical-protocol options generally involve medical practices. While the legal issues they raise are not negligible, many of them may be addressed by examining the brain-death and special-category proposals.

1. Redefining Brain Death

The proposals to deem live-born anencephalic infants to be brain dead, brain absent, or exempt from the brain-death standard invite reconsideration of the brain-death standard. In doing so, they also invite modification or reaffirmation of the purpose, functions and principles underlying the existing whole-brain-death standard.

It has been twenty years since the first landmark proposal was made in North America to change the traditional definition of death from heart and lung cessation to the irreversible


574. Ibid. Deaths from "anencephaly and similar anomalies" (int’l listing No. 740) have been reported as follows for the respective years: 1986-52; 1985-66; 1984-52; 1983-76; 1982-76; 1981-87.

575. Botkin, supra, note 572 at 251. See also D. Alan Shewmon et al., "The Use of Anencephalic Infants as Organ Sources — A Critique" (1989) 261:12 JAMA 1773 at 1774.

576. Botkin, supra, note 572 at 255.

577. Ibid.

578. This assumes a Canadian need equal to 10% of the U.S. need.


581. Shewmon et al., supra, note 575 at 1778.

582. See Conference of Medical Royal Colleges (Great Britain), The Working Party on Organ Transplantation in Neonates (1988) 14:3 J. Med. Ethics 164 ("In the adult the diagnosis of brain death plus apnoea is recognised as death. The working party felt by analogy that the absence of the forebrain in these infants plus apnoea would similarly be recognised as death.").

583. Scott, supra, note 579 at 1565. See also Jay A. Friedman, "Taking the Camel by the Nose: The Anencephalic as a Source for Pediatric Organ Transplants" (1990) 90 Colum. L. Rev. 917.


587. See Peabody et al., supra, note 580.
cessation of all brain functions. Like the old definition, the new definition was based on the medical technology and needs of the day. Mechanical respirators and circulators had joined the stethoscope as standard tools of medicine. Yet, if a patient could be maintained indefinitely on an artificial respirator and have no responsiveness and no brain functions, what was the legal status of the patient? Under traditional definitions of life and death, both law and medicine tended to regard the patient as alive, despite the absence of spontaneous respiration and circulation.

In 1970, Kansas became the first North American jurisdiction to pass a law adopting a brain-death definition. Manitoba legislatively adopted a brain death definition in 1975. By the time that the Law Reform Commission of Canada studied the issue five years later, a medical, legal and ethical consensus had largely emerged in North America that the irreversible cessation of all brain functions was the equivalent of the death of the person. The new standard was designed to supplement the traditional standard. Today, Canadian criminal case law, the amended uniform tissue law and the medical profession have adopted a brain-death standard. Some forty-nine jurisdictions in the United States and most of Western Europe have similarly done so.

A primary purpose behind the whole-brain-death standard was to clarify legal rights and duties with a legal standard more consonant with the times. A clear definition of death reduces uncertainty and confusion over when a person is legally dead. It gives families a contemporary societal standard for making difficult decisions concerning treatment and non-treatment; it clarifies professional duties, patient rights and the limits of criminal liability. A clear definition of death thus facilitates organ procurement and transplantation.

The Law Reform Commission of Canada was convinced that a reform of the legal standard of death should adhere to several legal and public policy principles. First, the reform must be aimed at eliminating confusion; it should provide clarity and guidance to professionals and the lay public. Secondly, it must advance uniformity and apply equally in all circumstances in which the determination of death is at issue. This principle borrows from the reliability and uniformity of the traditional heart-lung cessation standard, and aims to reduce a proliferation of conceptions and definitions of death, which would foster confusion. As the U.S. President’s Commission has stated, a new standard “ought not to reinforce the misimpression that there are different ‘kinds’ of death, defined for different purposes, and hence that some people are ‘more dead’ than others.”

Thirdly, the reform must “recognize standards and criteria generally accepted by the Canadian public.” The consensus-building process that had unfolded in North American society in the decade before the Commission announced its proposal meant that the public had already benefitted from the debate and deliberations of the medical, legal and biochemical community on a brain-death standard of death. The acceptability principle, in fact, was an influential factor in the Commission’s view that adoption of a higher-brain-death standard would be ill-advised:

In the opinion of the Commission, many members of the public and many professionals are definitely not prepared to consider as dead a person whose cortex [brain] is irreversibly destroyed, but who still enjoys spontaneous cardiac and respiratory functions. The Karen Quinlan case in the United States appears to be a good illustration of that point.

591. See Kitching, supra, note 565. But see R. v. Green (1988), 43 C.C.C. (3d) 413 (B.C.S.C.). Green involved the rather “exceptional” circumstances of a defendant claiming that he could not be charged with murdering someone already dead. See Stuart, supra, note 506 at 109. Defendant Green had fired two shots into a victim’s head, shortly after another defendant had first shot the victim in the head. Apparently all three shots, if fired alone, would have proved fatal. Green’s claim that the victim was already dead presented the court with a legal question over the time and determination of death for purposes of liability for homicide. When the time of death is legally controverted, courts properly attempt to resolve the question on the basis of expert medical testimony. See Defining Death, infra, note 594 at 78.
In Green, the court rejected applying brain-death criteria to help answer the question. It chose to use the traditional criteria for death — heart/lung cessation — for two apparent reasons. First, there was some indication that while the victim had stopped breathing after the first shot, his heart may have still been beating when he received defendant Green’s two shots. Secondly, owing apparently to brain trauma the victim had suffered, the court seemed concerned that the Crown might not be able to prove that the victim was still alive (“brain alive”) if the brain-death standard were used. The court characterized brain-death criteria as “a completely impractical standard to apply in the criminal law.”
The medical evidence presented in the case is limited. Still, we would emphasize three points about “brain death.” First, the LRC proposal refers to whole brain death (versus brain death), and the irreversible cessation of brain functions (versus brain function). Secondly, under the LRC standard, whole brain death may be “determined by the prolonged absence of spontaneous circulatory and respiratory functions.” See Report 15, supra, note 1. Depending on the precise medical facts, then, a beating heart may be evidence that whole brain death has not occurred. See Defining Death, infra, note 594 at 15.
Thirdly, Canadian, British and American courts have, in fact, adopted the brain-death standard to aid in determining the time and cause of death in more typical modern homicide cases: namely, when a homicide victim enters an emergency room of the hospital, is placed on mechanical life support which is withdrawn after the pronouncement of death, and the defendant argues that the withdrawal of life support was either the cause, or determined the time, of death. Kitching, supra, note 565; R. v. Matchek et al. (1981) 2 All E.R. 422; Eula, supra, note 565. See generally David B. Swee, “Homicide by Causing Victim’s Brain-Dead Condition” 42 A.L.R. 4th 742. The courts’ uniform rejection of defendants’ arguments in these cases, and their adoption of the brain-death standard to clarify the cause or time of death, would seem to indicate that the brain-death standard does prove helpful in establishing liability in homicide cases. Fuller examination of such criminal liability concerns may be afforded by future cases and commentary.
592. See infra, note 835.
593. Canadian Congress on Neurological Sciences, supra, note 194; Canadian Congress on Brain Death, supra, note 194.
595. See chaps. 4, section II.C, below.
597. Ibid. at 53.
598. Defining Death, supra, note 594 at 60.
600. Report 15, supra, note 1 at 16.
Karen Ann Quinlan, who lay in a persistent vegetative state with no likelihood of recovery and whose parents requested court permission to turn off her respirator, had lost higher brain functions but retained brain-stem activities.601 Whereas patients who are brain dead can neither breathe spontaneously nor respond to light, pain and sound stimuli, patients having lower brain-stem activities do breathe spontaneously.602 Indeed, after the removal of life support, Karen lived for years. Today, there is still no consensus in North American or even in Canadian society that higher brain death is or should be equated with the death of the person.603 Adoption of a higher-brain-death standard would mean that anencephalic newborn infants and an estimated 1,000 to 10,000 patients who, like Karen Quinlan, lie in a persistent vegetative state in Canada would become candidates for organ donation, although they enjoy spontaneous heart and lung activity.604

Finally, the Commission was and still is of the opinion that the criteria for death should not be determined "by reference only or mainly to the practice of organ transplantation."605 The neutrality principle—that the reform be conceived neither to hinder nor to aid organ transplantation—recognizes the equality of other legitimate competing social interests in the determination of official death and seeks to avoid undue bias in the definition of death.

These principles bear directly on current considerations to exempt anencephalic newborn infants from, or to amend, the whole-brain-death standard. Such proposals violate the neutrality principle because they are motivated specifically to aid organ procurement from a class of severely disabled newborns. Organ transplant benefits alone do not justify shifting the life-death criteria because, beyond its medical implications, death is also a theological, moral and legal concept.606 A redefinition based simply on organ transplant needs, moreover, may create the impression of arbitrariness and unequal treatment, because the law may appear to be trading the interests of potential organ recipients against the interests of severely disabled infants and their families.607 Leading medical texts have, for years, referred to anencephalic children as monsters.608 Given the evolving and heightened attitudes on the rights and protections of minimally or severely disabled individuals, shifting the legal criteria for the determination of death for a particular class of patients "raises troubling questions about evaluating the quality of life as part of the determination of death."609 In the extreme, such an amendment also raises serious legal questions over whether some deaths and some brains are "more equal than others,"610 and whether it would subject anencephalic infants to unjustified discrimination on the basis of physical disability.611 These concerns underscore the need for reforms consistent with, and not violative of, basic human rights.

Secondly, the enactment of such proposals is not likely to clarify or help dispel lingering confusion over the existing brain-death standard. A disturbing minority of health professionals who work in the area still evidence confusion over the diagnosis and determination of brain death.612 Changing the definition of death to apply to one group of patients may thus undermine uniformity, begin a proliferation of standards of death and foster confusion about which criteria do and should apply to what group of patients:

As society contemplates the expansion of the potential donor pool to include other brain-damaged patients, who are clearly alive by today's legal and medical standards, the confusion may be compounded. Those who have accepted the whole-brain criterion because they have a higher brain concept or merely think brain dead patients are hopelessly dying may find it acceptable to take organs from certain patients currently defined as living, e.g. anencephalics or patients in persistent vegetative state, because such patients have clinical characteristics that are compatible with a less conservative concept of death. Some might seek to change the legal standards for death, thereby removing any obstacle to using other types of severely brain-damaged patients as donors. Without a greater consensus on a concept of death, such "conceptual gerrymandering" will only sow further confusion about, and perhaps resistance to, organ retrieval.613

Thirdly, a change will not satisfy the acceptability principle. That the medicolegal literature on anencephalic infants abounds with brain-absent, brain-dead and born-dead proposals suggests that medicine, bioethics and the law are still in the early phases of seeking a consensus on the legal and moral status of anencephalic infants. While the diversity of opinions, interests and alternatives is necessary for and healthy to proper debate on the

603. See NYTF, supra, note 594 at 10.
604. See Taylor, supra, note 250. See also David Randolph Smith, "Legal Recognition of Neocortical Death" (1986) 71 Cornell L. Rev. 480.
605. Report 15, supra, note 1 at 12; Working Paper 23, supra, note 596 at 56.
606. NYTF, supra, note 594 at 6. But see Edward W. Keyserlingk, "A Legal Definition of Death: Can It Affect Supply of Tissue and Organs?" (1985) 17:6 (Supp.) Transplant. Proc. 47 at 48-49 ("None of which is to deny that organ transplantation claims are a major, if not the major, justification and reason for these statutes. Nor is there any good reason for the frequently expressed or implied fear that it is somehow unethical that this should be so. After all, as has been observed, preserving life and health is the highest of values in our society, transplanting organs is one way of achieving those goals in some cases.").
607. See World Medical Association Adopts Declarations and Statements on Bioethical and Other Matters" (1988) 39:1 Int'l Dig. Health Log. 267, excerpted in appendix A, infra at 200-201. ("A potential organ transplant offers no justification for a relaxation of the usual standard of medical care. The same standard of care should apply whether the patient is a potential donor or not.").
609. NYTF, supra, note 594 at 10.
611. See section IV, below.
612. Stuart J. Youngner et al., "Brain Death and Organ Retrieval: A Cross-sectional Survey of Knowledge and Concepts among Health Professionals" (1989) 261:15 JAMA 2205 (of 195 health professionals surveyed, 35% correctly identified brain death, 58% failed to use a coherent concept of death consistently, 19% had a concept of death consistent with changing whole-brain standard to classify anencephalic infants and PVs patients as dead). See also O'NT, supra, note 29 at 235.
613. Youngner et al., supra, note 612 at 2210.
issue, it provides little basis for erecting a new legal standard. The lack of consensus at this societal juncture also means that adoption of any of the current alternatives would not be based on "standards and criteria generally accepted by the Canadian public." 614 For by either the traditional heart-lung or more modern whole-brain-death criteria, a live-born, severely neurologically impaired anencephalic infant is born living:

> Manipulating the definition of death — by including anencephalic infants, whose spontaneous breathing, sucking, crying, and the like separate them from the dead bodies that society is usually willing to label cadavers and bury — may undermine the public's already tenous confidence in brain-based determinations of death. The predictable result will be a decline in the donation of organs from all categories of potential donor, as occurred in England following a highly publicized television program that called into doubt the accuracy of brain-death diagnoses. 615

Some might be inclined to dismiss such remarks as overstated. Yet, there is evidence that the public is reluctant to participate in the organ donation process, in part, because of fear about premature determination of death. 616 While the standard of death may work to facilitate organ transplantation, undue bias in the standard setting may itself erode public confidence in both the law and the organ donation process. 617 Thus, concern about the relationship between medical practice, the legal definition of death and the public's confidence and willingness to participate in the organ donation process is legitimate. The delicacy of that relationship itself would seem to suggest prudence and caution. 618

(2) Redefining Persons

The opportunity to bring about an immediate, tangible good for potential recipients and for the donor parents, and the apparent "lack of harm" to the anencephalic infant, prompt some analysts to assign them a unique status:

>>[I]n the most unfortunate condition should be viewed as in a class that is entirely sui generis, and one for which special rules and laws should apply." 619

This approach would permit organs to be taken although the criteria for brain death are not satisfied.

From the criminal law perspective, the special-category option raises several general concerns. On the one hand, the Commission's view that it may sometimes be acceptable to withdraw "therapeutically useless" care 620 from and to administer palliative, life-shortening care 621 to the dying may offer guidance in treatment decisions. On the other hand, the Commission has expressed its views on the criminal law as proposed reforms; they remain unenacted. Accordingly, medical treatment that causes 622 or accelerates death 623 or that involves a premature diagnosis of death 624 for any living human being, risks running afool of the existing Criminal Code. 625

In such instances, it has been suggested that the medical status of the anencephalic infant and the life-saving purposes of the initiative might establish a "necessity" defence to excuse criminal liability. 626 Others are unpersuaded by the argument. 627 The tenor of the criminal liability concerns and the general difficulty of applying brain-death criteria to anencephalic and other newborns 628 would seem to undermine the utility of designing and medically implementing a special-category option.

The special-category option also raises ethical concerns 629 involving a clash between beneficence and non-maleficence, and contested views on the relation between the body and self.

In terms of the ethical duty to do good, the special-category approach may hold promise. For potential recipients, although the long-term success and quality of life of infant

614. See Report 15, supra note 1 at 12; Working Paper 23, supra, note 596 at 55.
615. Shewmon et al., supra, note 575 at 1788.
616. See Nolan and Spanos, supra, note 225om. See also USTF, supra, note 29, and Azen, supra, note 226 at 562.
617. Even apart from possibly slighting other legitimate legal interests that are influenced by the determination of death, such as inheritance rights, criminal law prosecution, civil suits and withdrawing artificial life support for non-transplant purposes. See Keesling, supra, note 606 at 47-48.
621. Report 31, supra, note 116 at 60.
622. See Kitching, supra, note 565. See also Criminal Code, s. 269 (unlawfully causing bodily harm).
623. Criminal Code, s. 226: Acceleration of Death—

Where a person causes a human being a bodily injury that results in death, he causes the death of that human being notwithstanding that the effect of bodily injury is only to accelerate his death from a disease or disorder arising from some other cause.

625. Some of these concerns may also apply to the medical protocols option.
627. See Dickenson, supra, note 585 at 51 ("It is doubtful that causing homicide by precipitation of death of an anencephalic could be justified or excused by the defense of necessity to save the recipient's life. The wrong done must be objectively minor in comparison with the benefit sought, but even saving a salvageable life of a child may be insufficient to excuse ending the life of another, even an anencephalic likely to die relatively soon thereafter.").
628. See MTPA, supra, note 570 at 672; Canadian Congress on Neurological Sciences, supra, note 194 at 200B ("Brain death has not been sufficiently well studied in neonates, infants and young children to determine whether the ethical criteria listed above apply to these groups"). See also Task Force for the Determination of Brain Death in Children, "Guidelines for the Determination of Brain Death in Children" (1987) 37 Neurology 1077; David L. Coulter, "Neurologic Uncertainty in Newborn Intensive Care" (1987) 316:14 N. Engl. J. Med. 840.
629. As indicated above, the ethical aspects of organ procurement from anencephalic newborns are discussed here to provide a more concentrated analysis.
transplants remain uncertain. The initiative may still mean life. For parents, the opportunity to donate the organs of their dying anencephalic child to help save life likely offers them solace and some meaning from the tragedy. Such prospective benefits appear compelling.

The above-mentioned benefits may not prove conclusive, however, as detractors are quick to underline, because of the possible related harms. Possible harm springs from medical-ethical uncertainty, slippery-slope concerns and potential intrinsic moral wrongs associated with categorizing anencephalic infants as non-persons. First, claims that anencephalic infants lack the neurologic capacity to feel pain, and that the diagnosis of anencephaly is determined with near 100-per-cent accuracy are not beyond dispute. Leading authorities agree that the diagnosis of anencephaly is not infallible, but is best made following precise criteria. The claim that anencephalic newborns have no capacity to feel pain, moreover, rests on a comparison of them with older patients in a persistent vegetative state — a comparison that some continue to question. Analysts also argue that because anencephaly leaves some newborns with more intact brain-stems than others, degrees of consciousness or unconsciousness may vary. Doubt about these medical premises may make potential harms to anencephalic newborns more appreciable than some special-category enthusiasts would seem to allow. To the extent that the medical premises of the position present problems, those problems may infect the ethical analysis.

Secondly, the special-category proposal raises consequentialist concerns. Will the procuring of organs from newborns before they are dead undermine public confidence in the procurement and transplant process? Will women diagnosed with an anencephalic fetus find their autonomy compromised by pressure to carry the fetus to term for transplant purposes? Will it lead to a denial of the respect ordinarily given to non-disabled infants and parents? If anencephalic newborns are deemed non-persons, will other individuals also lose their status as human beings, to slip into an expanded organ donor pool? Potential candidates include infants with other neurological malformations (for example, spina bifida and hydrencephaly), severely mentally retarded persons and the Karen Anne Quinlan type of hospital patients who, although not brain-dead, lie in a persistent vegetative state.

Lastly, treating anencephalic infants as a special category may raise intrinsic wrongs by violating a Kantian-inspired ethical duty. The injunction — treat people as ends and never as means alone — applies to potential recipients, health professionals, parents of anencephalic newborns and society at large. Proponents of anencephalic infant organ procurement argue that the duty to respect persons does not apply to these infants, because of their "uncertain moral status." The claim rests on a view that moral respect is owed to "persons," not merely because they are members of the human species, but because of their "sentience, consciousness, or self-awareness," and "the capacity for autonomy and choice." The claim is buttressed by the further argument that since anencephalic newborns lack mental capacities that generate interests, they have none or few of the interests that usually command respect:

"It becomes difficult to know how to interpret the desire to respect the interests of such children. Those who wish to respect the dignity of all human beings must show why such a principle is violated when it is not extended toward children who lack any possible means of having interests."

Thus, the duty to respect persons has been reduced to the duty not to harm persons by infringing their interests — that is, to the duty of non-maleficence.

Paralleling the ethical debate over harms to the dead, proponents and detractors of the special-category or non-person approach to anencephalic newborn organ procurement


633. Caplan, supra, note 632 at 48; ESIC, supra, note 619 at 29.

634. See MTFA, supra, note 570 at 760; Shewmon, supra, note 631 at 15.

635. Shewmon, supra, note 631 at 14.


637. See Shewmon, supra, note 631 at 15.

638. Ibid. at 14.

639. See, e.g., Caplan, supra, note 632 at 43-44. See also supra, notes 225-227.

640. See Leggans, supra, note 636 at 455.
seem to differ fundamentally in their views on the relation between the body and self. Proponents tend to reduce persons to their sentient or cognitive capacities, by equating persons with their rational selves. The body tends to become morally irrelevant. Those reluctant about taking organs from anencephalic infants seem more inclined to view persons as embodied selves, wherein moral respect is owed to the body as well as to its sentient, rational attributes. A conception of persons as embodied selves may not be amenable to rational justification, because the respect it accords the body likely derives from fundamental sentiments that transcend rational argument.

In all, currently declining the options to create a special category of “non-persons” and declining to amend the brain-death criteria essentially means that anencephalic infants will generally be treated like other potential organ “donors.” This still leaves medicine free to explore potential benefits from tissue and organ transplantation from anencephalic infants through the customary-care and reasonable-medical-protocols options.

C. Deceased Donors and Crimes against the Dead

Criminal law protects interests and defines duties regarding the dead. Historically, criminal law has for centuries played the dual role of mandating respect for the dead human body and of directly contributing to the supply of dead human bodies for medical science purposes. Indeed, the existing Criminal Code offences of improper interference with or offering indignities to the dead derives from that tradition. The tradition has now begun to exert its influences in the modern context of the procurement and transplant process, which depends on the dead as the major source of donated organs.

(1) Dissecting and Donating as Punishment

An American doctor recently proposed that condemned prisoners pay their debts to society by donating organs for transplantation upon execution. The proposal to supply medical science with the bodies or bodily parts of the malefactors of society has historical precedent. The idea dates from the third or fourth century B.C. when, at the University of Alexandria, bodies of executed criminals were supplied to university physicians for the study of anatomy. Even the vivisection of condemned criminals was practised.

The approach of using the criminal law to provide bodies for human dissection eventually made its way to Europe and North America. In 1376, King Louis d’Anjou granted the University of Montpellier permission to receive one executed criminal annually for dissection. When the London Barber-Surgeons’ Guild received its Royal Charter in 1540, the Act uniting the two crafts authorized the Guild to receive four executed felons annually for dissection and anatomical study. The law gave the Guild the exclusive right to conduct anatomical demonstrations, and the United Company of Barbers and Surgeons “jealously guarded” the privilege for some 175 years. As anatomical practice eventually became the sole province of surgeons and physicians, the number of bodies of executed criminals was later increased from four to include all murderers executed in London and Middlesex.

The purpose behind such laws appears to have been twofold. First, it appears that some of the laws were intended to add dissection as a “peculiar infamy” to the punishment for murder. This purpose was expressed in the Lord Justice-Clerk’s 1829 sentencing of William Burke, who was convicted and executed for murdering several individuals whose bodies he sold to Scottish anatomists:

William Burke, You now stand convicted, by the verdict of a most respectable Jury of your country, of the atrocious murder charged against you in this indictment... if ever it was clear, beyond all possibility of a doubt, that the sentence of a Criminal Court will be carried into execution, in any case, yours is that one... I am disposed to agree that your sentence shall be put in execution in the usual way, but accompanied with the statutory attendant of the punishment of the crime of murder, viz. — that your body should be publicly dissected and anatomized. And I trust, if it is ever customary to preserve skeletons, yours will be preserved, in order that posterity may keep in remembrance your atrocious crimes.

The surgeon to whom Burke had supplied many of the bodies performed a public dissection of Burke, whose skeleton may now be viewed at the University of Edinburgh Anatomy Department. It stands as an irony of history that one of the most infamous criminals in the trafficking of dead bodies for anatomical study in the nineteenth century was ultimately
snared and punished by provisions permitting the dissection of criminals executed for murder. The punishment purpose is echoed in the recent proposal that executed criminals in the United States serve as organ sources.665

A secondary purpose of such criminal law provisions was to help provide medical science with bodies, which were in scarce supply. Not surprisingly, some of the settlers in the New World brought this cultural and legal tradition with them. Thus, a law to supply the bodies of executed criminals for anatomical dissection was enacted in the Massachusetts Bay Colony in the mid-1600s.666 The practice was adopted into federal criminal law in the United States and remained in effect until 1987.667 It was also considered in Canada,668 although there is no apparent evidence that the practice was pursued.669 While the supply theory behind the enactment of such laws may have relevance to current organ scarcity in Canada, the general abolition of the death penalty in the 1970s means that the proposal can have little current application in Canadian society.570

(2) Mistreating and Stealing the Dead

Humankind has long accorded respect to the dead human body and its remains.671 Although the bodies of some non-citizens or persona non grata have, on occasion, not benefited from such respect,672 the general attitude is reflected in the burial customs, religious practices and moral customs of Western civilization. The criminal law has not escaped these influences. In a nineteenth-century criminal case involving the neglected burial of a child, a Canadian judge echoed these sentiments by stating that "[e]very dead human body is entitled to a decent burial."673

Today, the Canadian Criminal Code requires respectful treatment of the dead. In doing so, it reflects abiding and evolving attitudes on respect for the dead. It specifically reflects societal expression of the Judeo-Christian tradition of according decent burials to the dead, by making it an offence to neglect, without lawful excuse, one's burial duties.674

The Criminal Code also penalizes indignities to or indecent interferences with a dead body or human remains:

Everyone who...

(b) improperly or indecently interferes with or offers any indignity to a dead human body or human remains, whether buried or not,

is guilty of an indictable offence ... 575

There are several overlapping purposes behind the provision. It expresses the long-held view that the dead human body is entitled to respect. Furthermore, it expresses respect for the emotional and religious sentiments of the next of kin and the moral tranquility of society at large. In practical terms, the provision aims at preventing physical abuse of the dead body, protecting the public health and minimizing public nuisances. A review of the common law heritage of Canada, Great Britain and the United States shows how courts have articulated these purposes in cases involving sales of bodily parts, sexual indecency and theft, and even in the modern contexts of medical experimentation.

Concern over the moral integrity of the community has been a traditional basis in definitions of criminal mistreatment of the dead body or human remains. Leading British jurists and Continental thinkers of the eighteenth and nineteenth century regarded the mistreatment of corpses as a high moral offence.676 The existing Canadian offence derives directly from an unenacted 1879 draft British criminal code, which essentially codified British common law criminal misdemeanours against dead bodies.677 While preventing the commission of sexual indecencies678 upon the dead is an example of the obvious moral

665. See supra, note 656.
666. Waiter, supra, note 663 at 717.
668. See Debates, infra, note 803 at 467 n. 33, discussing Anatomy Act debates.
669. The first federal criminal law of Canada, in 1869, simply provided that criminals sentenced to death be executed "in the manner provided by law." Their bodies were to be buried within the prison walls, As Act respecting Procedure in Criminal Cases, and other matters relating to Criminal Law, 32 & 33 Vict., c. 29, ss 106, 117.
671. See generally Lasse, supra, note 15 at 20.
672. Kervorkia, supra, note 17 at 26 ("Slaves were no different to the Romans than mere material objects of their environment; and killing a slave was not murder, but simply damaging an object. Dead slaves and prisoners of war were often left unburied and thus offered a good source of material for the sporadic dissections which were done.").

674. Criminal Code, s. 182(a). The Commission has proposed that the failure-to-bury provision be repealed, as archaic. See Report 31, supra, note 116 at 102.
675. Criminal Code, s. 182(b).
676. See James Fitzjames Stephen, A Digest of the Criminal Law: Crimes and Punishments, 4th ed. (London: Macmillan, 1887) art 175 (morality offence); William Blackstone, Commentaries on the Laws of England, Book the Fourth (Oxford: Clarendon Press, 1779) at 236 ("a matter of great indecency"). Compare 1983 Criminal Code Act of Northern Territory of Australia, art. 140 (misconduct regarding corpse as morality offence); New Zealand Crimes Act, 1961, s. 150 (crimes v. human remains and crime against person); and crimes against sequestrers, under s. 360 of the French Penal Code. As a morality offence, s. 360 has broadly been interpreted to extend to the cemetery monuments, buried bodies, and bodies not yet buried, Code penal, 88th ed. (Paris: Dalloz, 1991). See Dierkens, supra, note 382, para. 311. In this respect, see also the potential use of French criminal assault and battery provisions, infra, note 717.
basis of the existing criminal offence, the common law crime actually arose in the context of supplying dead bodies for medical science. In the 1788 English case that established the rule, a man was fined five marks for unburying a dead body he intended to sell to a doctor for anatomical dissection. The historic no-property-in-a-corpses view meant that the man could not be convicted of having stolen the body. Nor was unburying a dead body for dissection found by the court to be explicitly forbidden by a law prohibiting disinterment for purposes of witchcraft. Still, the court found the practice highly indecent, against good morals (contra bonos mores), and therefore a criminal offence. The case illustrates how the common law historically sought to prevent the sale of dead bodies: namely, by criminal "indecency or mistreatment" offences, rather than the more direct route of a criminal theft rule. With the historic exception of criminalizing the theft of bones from Indian graves, the Canadian Criminal Code seems to have continued this tradition through section 182(b).

Before the enactment of the Canadian Criminal Code, British courts extended the common law crime to physicians who received and possessed dead bodies known to have been illegally disinterred. This view was also apparently applied in mid-nineteenth-century Canada before the Canadian Criminal Code was enacted. Medical professors who paid $30 to $50 for bodies obtained from local cemeteries were fined $50 for committing "offences against decency." Such sales practices apparently resulted in harsher punishment in the United States as, for example, when a county undertaker was fined $750 and sentenced to eleventh months in prison in 1900 for selling bodies for dissection. These cases and the historic legal basis of the existing mistreatment offence indicate that the sale of human remains or of a dead body may still fall under the existing criminal offence of mistreating the dead. To the extent that sales of the human body or human bodily parts and tissues continue to be seen as violating basic human integrity and dignity, the offence enforces the commonly shared sentiment that the dead human form is entitled to respect.

An offence of "criminal mistreatment of the dead" body also expresses concern for protecting the public health and preventing nuisances. Leaving dead bodies exposed in public places, or casting them into rivers, may expose the public to disease or contaminated water, and for this reason has been regarded as improper treatment. Such conduct may constitute a common nuisance by creating material annoyances and discomforts to the public. In fact, the Canadian Criminal Code has always classified indignities or mistreatment of corpses as nuisances.

Beyond protecting the interests and sensibilities of the community, criminal rules against mistreating dead bodies promote respectful physical conduct toward the dead. As such, they protect the bodily integrity of those who are deemed worthy of respect but who cannot protect themselves. This purpose is illustrated in some American jurisdictions which criminalize mutilation or abuse of a dead body. The provisions guard against the unlawful and unnecessary disfigurement, physical invasion or abuse of the dead. They have recently been invoked to prosecute a physician, funeral home and hospital morgue workers for the mutilation or abuse of corpses and trafficking in human bodily parts.

Finally, the offence against mistreatment of, or offering indignities to, the human body and human remains protects the next of kin's emotional and religious interests, which may stringently oppose physical invasions of the dead body. Those interests may be violated by physical abuse, mutilation, sexual indecency or like conduct that would outrage ordinary family sensibilities. In this sense, the criminal law protections parallel and reinforce familial interests recognized in common law and civil law.

In many respects, then, the existing criminal offence of visiting indecencies or indignities on a corpse, or mistreating it, expresses abiding, fundamental values about

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682. See Lynn, supra, note 680, discussing Witchcraft Act of 1735.

683. See The Larceny Act, R.S.C. 1866, c. 164, s. 98, codified in Criminal Code, R.S.C. 1927, c. 36, s. 385, as rep. Criminal Code, S.C. 1953-54, c. 51, s. 745.

684. See R. v. Cumdick (1822); R. v. Davies (1828) (Lancaster assizes), described in Select Committees, supra, note 22 at 6, 7.

685. See text accompanying note 809, infra.


687. For more recent cases of bodily sales as a criminal offence, see People v. Bullington, 80 P. 2d 1030 (Cal. 1938) and Commonwealth of Pennsylvania v. Spector (28 October 1988), Philadelphia 87-01-2441-2445 (Court of Common Pleas). See also infra, note 694.

688. See Criminal Code, s. 182(b), in text accompanying note 675, supra.

689. See section I.C, above, and chap. 2, section IV.B, above.
death and human dignity. The offence practically functions to protect diverse affected societal interests. It commands simple respect for the dead human form, encourages respect for the sensibilities and emotional interests of family members, helps curtail public nuisances and curbs unlawful and unnecessary disfigurement, mutilation or physical abuse of the dead. Historically, the moral concern for indecency has targeted necrophilic tendencies and the sale of dead bodies.

To the extent that these concerns — historically addressed by the Criminal Code offence — would be more directly and clearly covered by modern statutes, modification of the existing offence may be advisable. Burial duties, public health and nuisance concerns and legal regulation of the supply of bodies for medical science are now addressed in provincial anatomy, public health and cemetery Acts. Some of the sales prohibition functions arguably may also be served, or complemented, by effective statutory sales offences. Yet, the role of the offence in encouraging respectful conduct, and in policing physical abuse and moral harms, remains. For if unlawful and knowing mutilation, desecration, sexual assault or general abuse of the dead body or human remains violate the physical integrity of the dead body, they also violate the dignity of the dead, violate humanity and are repugnant to fundamental moral values.

Lastly, in an examination of how and why the mistreatment offence has historically functioned as a surrogate for what might otherwise be sales and theft offences, it becomes evident that a notable ambiguity has survived the centuries. Can skeletons and anatomical specimens that are prepared from parts of dead bodies, or that were once part of the human body, technically be stolen? Leading British and Canadian analysts have been asking the question since the nineteenth century. The historic basis of the offence arguably suggests that even human remains that have been lawfully procured and transformed, by dint of skill and labour, into museum mummies, human anatomical specimens or similarly processed, preserved human tissue are not protected from theft by the criminal law today; if historically they could not be subject of property, they could not be stolen. Indeed, the logic of the 300-year-old common law view that one cannot steal a dead body, only its burial sheets, continues to suggest, by the same token, that one cannot steal a laboratory skeleton, only the wire that binds it together, nor extracorporeal bodily substances, only the vials or test tubes containing them. Today, this would seem contrary to common sense, the basic values of the criminal law and broader contemporary concepts of property that now include, within criminal law protections against theft, things animate or inanimate, telecommunications services, wild animals and even electricity, all of which were not formerly within concepts of property.

(3) Respecting the Newly Dead

Many of the concerns for respecting the dead, the wishes and beliefs of the family and the community sense of acceptable conduct merge into considerations on a "new class of dead patients": so-called "neonorts." Modern medicine may now maintain a brain-dead individual for hours or days for transplant purposes, or for weeks or months for purposes of delivering the child of a brain-dead, pregnant woman.

What is criminal mistreatment of the dead body in this context? The answer is clouded partly by the ambiguous moral status of neonorts. Should they be treated as dead bodies, "dead patients" or respiring, heart-beating cadavers, even though they seem neither alive nor dead by conventional standards? Under what conditions, if any, is it acceptable to practice clinical instruction techniques, medical research or experimentation on the neonort? Does or should the offence against mistreatment require consent for such medical interventions? The questions are intriguing and unsettling. Moreover, they transcend the strict confines of the criminal law. The literature suggests that the answers depend largely on competing views as to the level of respect or dignity that should be accorded to the newly dead and the medical benefits of their use.

The newly dead may help advance medical science, treatment and education. A patient who has recently died from a heart attack in a hospital emergency room may afford medical

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698. See, e.g., Bodies of Deceased Persons Amendment Regulation, Alta Reg. 298/86; Bodies of Deceased Persons Amendment Regulation, O.C. 82/18, A. Gaz. 1918.II.991; Cemeteries Act, R.S.O. 1980, c. 59. See also section III.B.(i), below.

699. See section III.B, below.

700. Compare Stephen, supra, note 676, art. 292; G.W. Burbidge, Digest of the Criminal Law of Canada: Founded by Permission on Sir James Fitzjames Stephen's Digest of the Criminal Law (Toronto: Carswell, 1890) at 284, 288 (things not capable of being stolen) and Matthews, supra, note 385 at 219-20.

701. Ibid. Compare Doodward v. Spence (1907), 7 S.R. 727 (N.S.W. Austr.) (although there is no property in a corpse, skill and labour significantly modifying body may establish protocutable possessory interest); J.W. Cecil Turner, ed., Kenny's Outlines of Criminal Law, 19th ed. (Cambridge: Cambridge University Press, 1966) at 294-95 ("It is not entirely certain whether the rule must be taken to be 'once a corpse, always a corpse'; if so the protection of the criminal law would perhaps not extend even to skeletons and similar anatomical preparations on which great labour has been expended or to ethnological collections of skulls or mummies — a conclusion which does not seem reasonable"); and J.C. Smith and Brian Hogan, Criminal Law (London: Butterworths, 1983) at 490-91.

702. See Haynes's Case, supra, note 384.


705. See Report 31, supra, note 116, chap. 1(2) at 10; Criminal Code, s. 322.

706. See Youngner et al., supra, note 266 at 323.


708. See Criminal Code, s. 182(6), in text accompanying note 675, supra.

709. Youngner et al., supra, note 266 at 323.

students an opportunity to practice resuscitation, drug administration\textsuperscript{711} or intubation (breathing-tube insertion) techniques.\textsuperscript{712} Such practices are justified by arguments that they make for effective education, and that the health and safety of society are advanced by medical training on "non-persons" whose entitlement to respect in this context means "avoiding disfigurement or ridicule."\textsuperscript{713} Similar concerns are offered to justify medical research and experimentation on cadavers ranging from blood sample collection\textsuperscript{714} to the testing of organ transplant anesthesiology, artificial respirators\textsuperscript{715} and hearts.\textsuperscript{716} In the public debate and criminal charges that followed experimentation on a brain-dead man hospitalized after being killed in an automobile accident in France, it was noted that medical science cannot advance without clinical research and experimentation.\textsuperscript{717}

The benefits to medicine and to society from the use of neonates must be weighed against competing concerns about respecting the dead and the meaning of mistreatment. In the debate following the French experimentation incident, the French national bioethics committee called for "the primacy of respect" of the person and his or her human remains; the President of France echoed those sentiments, asking society [TRANSLATION] "never to forget that the human being is not an instrument."\textsuperscript{718} Those remarks seem to stem from a view that accords more respect to the dead because holders of that view value the symbolic dignity and humanity of the body. Moreover, they may be more apt to regard a heart-beating, respiring dead body as being more like a person than a corpse.\textsuperscript{719}

What emerges from these competing considerations over medical benefits, potential mistreatment and respect for the dead is disagreement over the necessity for consent as a means of balancing the concerns. Minimally invasive experimentation or medical education techniques may not disfigure or mutilate the newly dead or otherwise violate their bodily integrity. However, even marginally invasive techniques such as intubation might be considered an indignity or mistreatment, if consent is not obtained from a family that considers such techniques offensive, outrageous or violative of religious beliefs.\textsuperscript{720}

Should consent to such procedures be required, or should it reasonably be presumed? On the one hand, few palatable options appear to be available. Seeking consent from family members may seem awkward, inhumane and time-consuming. Moreover, these minimally invasive practices derive public health and safety benefits. All of these considerations are said to justify a policy that presumes consent to such techniques, unless there is evidence that the deceased or the next of kin object.\textsuperscript{721}

On the other hand, other considerations mitigate in favour of a more express-consent requirement. First, by failing to ask a practitioner runs the risk of violating the religious and moral beliefs, or simple preference, of the next of kin. Such a practice seems inconsistent with the normal expectations of a grieving family. Even a signed general hospital consent form\textsuperscript{722} likely fails to address what the typical, reasonable patient or next of kin would expect of, or find material to, post-mortem hospital treatment. Some, therefore, argue that presumed consent rests on an unjustified deception that may well erode doctor-patient and hospital-community trust and confidences.\textsuperscript{723}

Secondly, non-disclosure of the practice arguably contravenes the general duty of loyalty owed by a doctor to the patient.\textsuperscript{724} A patient gives his or her body, trust and confidences to a doctor in the belief that the doctor's medical expertise will be exercised, and interventions will be undertaken for the patient's benefit. Intervention practices that proceed without inquiry into the dead patient's or the next of kin's wishes undermine the spirit of these duties and the balance of trust. The practices reflect a unilateralism that risks denigrating or violating the legitimate interests, rights and confidences of others intimately affected. From this perspective, death does not convert the rightful possession of a patient for treatment purposes into a right to intervene on the dead patient's body for non-treatment purposes.

Thirdly, even if in some instances there are clear benefits that would justify a policy of presuming consent for use by medical science of the dead body, the benefits from medical education and research are significantly less immediate and tangible.\textsuperscript{725} Presumed consent to organ and tissue transplantation might be legitimized, for example, because procurement has the immediate, likely and identifiable benefit of saving lives or healing.\textsuperscript{726}

\begin{thebibliography}{9}
\bibitem{713} Orlowski, Kanoti and Mehlmans, supra, note 279 at 440-41.
\bibitem{715} Veatch, supra, note 710.
\bibitem{716} See Susan R. Martyn, "Using the Brain Dead for Medical Research" (1986) 1 Utah L. Rev. 1 at n. 37.
\bibitem{717} See "L’expérimentation sur les cœurs" Le Monde (21 December 1988) 22. See also D. Dickson, "Human Experiment Revises French Medicine" (1988) 239:4846 Science 1370. Criminal assault and battery charges have apparently been brought, under s. 309 of the French Penal Code, supra, note 567, for [TRANSLATION] "voluntarily wounding and striking persons who, by reason of their physical or mental condition, are incapable of defending themselves"; Jean-Yves Nau, "Un texte sur les comas dépassés est à l’étude" Le Monde (8 March 1988) 12.
\bibitem{719} See chap. 2, sections I.C and IV, above. See also John La Puma, "Discovery and Disquiet: Research on the Brain-Dead" (1988) 109:8 Ann. Intern. Med. 606 at 607 ("The dignity and humanity of the body should never be violated, even in the pursuit of the most valuable scientific knowledge.").
\bibitem{720} Compare American Law Institute, supra, note 696; Orlowski, Kanoti and Mehlmans, supra, note 279 at 441, and Strachan, supra, note 354 at 351 (hospital failure to honour family members' request to return son's body impinges familial dignity and autonomy and imposes unnecessary distress).
\bibitem{721} Orlowski, Kanoti and Mehlmans, supra, note 279 at 441.
\bibitem{722} See Picard, supra, note 364 at 43.
\bibitem{723} See Iserson and Culver, supra, note 711 at 29 (Culver's commentary).
\bibitem{724} See text accompanying note 445, supra.
\bibitem{725} See La Puma, supra, note 719 at 607.
\bibitem{726} See infra, note 842.
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However, the benefits from direct therapy are not morally equivalent to those from research and training. The French bioethics committee so concluded in rejecting the application of the presumed-consent provisions of tissue transplant law to experimentation on neonorts. The Committee recommended that such experimentation should only proceed where the individual had bequeathed, in writing, his or her body to medical science.

Lastly, a presumed-consent policy of using neonorts for either medical or experimental purposes seems to counter the medical-legal ethic in Canada. While this need not prove binding, prevailing public policy often enshrines the fundamental values which so animate criminal law, Anatomy and tissue donation law, and medical experimentation guidelines that may apply to medical interventions on neonorts generally rely on consent as the societal means for individuals or the next of kin to donate the human body to medical science. These policies are, in turn, an extension and refinement of common law principles that recognize executors and the deceased’s family as proper custodians and guardians of the deceased’s body.

As such it appears that, absent laws that clearly authorize non-consensual interventions, the medical circumstances and benefits that would result from the use of neonorts are neither so unique nor so compelling as to justify an exception to normal consent requirements. Typically, consent means asking the family. Such a requirement seems a practical way to balance traditional criminal law and ethical concerns about respect for the dead and for familial and community interests against the evolving needs of medicine. Such a condition for use of the deceased’s body may be refined in statutory and institutional requirements.

Under this analysis, evidence of lawful consent to the medical intervention would raise a presumption of legality for the existing Criminal Code offence of mistreating the dead human body. The difficulties of a consent requirement include the time frame and the manner of asking. The delicacy of the process has been summarized in the context of experimentation on a brain-dead child:

It would be essential that the experiment honor the mechanically sustained body and the parents’ memory of the person who was (is, still — death is not “the end” for the parent) their child. What is likely to matter above all will be the attitude and tone of voice of the investigator seeking the parents’ permission. If he bears in mind that he is a suppliant, that he is asking for something precious, and incorporates that knowledge in the asking, there is no reason not to ask. The decision is the parents’.

The challenge lies in how and when to ask.

The trust, confidence and loyalty that have long been the bedrock of the provider-patient relationship thus would seem to impose special duties on medical professionals, and the families of patients. There may be an obligation on health care providers and hospitals to develop, refine and constantly reassess humane methods of obtaining consent in these delicate circumstances. As well, health care consumers, who will become patients, may have a moral duty to reflect on and discuss the giving of their bodies to science. These needs and deligacies strongly parallel those of the voluntary organ donation system. The use of neonorts for medical education and research would seem to be permissible “when an important social purpose is being served, when consent from a suitable guardian [e.g., family member] is obtained, and when the invasion is done in a way that seeks to avoid desecration and preserves respect for the human form.”

III. Federal and Provincial Laws

For over a century, the federal and provincial governments have shared legal responsibilities for regulating the transfer and use of human tissue. Beyond its duties in defining relevant Criminal Code offences, the federal government is charged with ensuring the safety and efficacy of tissue replacement technology through the Food and Drugs Act. Other statutes, for example, the Quarantine Act, Customs Tariff, Immigration Act, Income Tax Act and Canada Health Act, impose on the federal government, on behalf of all Canadians, diverse roles and public responsibilities that bear on national tissue transfer issues. At the provincial level, anatomy, corneal and gift tissue Acts have largely defined the rules in Canada for the tissue donation process.

A. Federal Tissue Transfer Laws

(1) Drug and Medical Device Law

The Food and Drugs Act (FDA) aims at ensuring the safety and efficacy of drugs

References:


737. Norman Post, “Research on the Brain Dead” (1980) 96:1 J. Pediatr. 54 at 56. Accord Iserson and Culver, supra, note 711 at 29 (Culver’s commentary); Colier et al., supra, note 714 at 638; Comité, supra, note 718; Veatch, supra, note 710 at 190. But see Ofiowski, Kaoiri and Mehlman, supra, note 279 at 441 and Iserson and Culver, supra, note 711 (Iserson’s commentary).

or devices intended for medical use by the consuming Canadian public. Administered by Health and Welfare Canada, the Act is based on the federal criminal law power. Its historic purpose and functions have been to prohibit or regulate the manufacture or sale of adulterated or misbranded food, drugs, medical devices and like products potentially "injurious to health" and safety. Cosmetics and medical devices have been regulated by the Act since 1939. That such devices and drugs are designed, represented and intended for therapeutic, often internal, use in the treatment of illness and injury would seem to indicate a more compelling need for strict controls than is the case with cosmetics:

It is obvious ... that as the potential health hazard, both as regards constituents, as well as representations to the public as provided by drugs is greater, the control which must be exercised in the interest of the consuming public is necessarily more complete and strict, than would be necessary in the case of foods or cosmetics.

In practical terms, the FDA sets out minimum uniform, national standards for tissue, mechanical and synthetic tissue replacement technologies. Older tissue replacement technologies — for example, blood products — are subject to the historic FDA authority to regulate biologics. "Biologics" refers to a special category of drug products, such as the polio vaccines or anti-hemophilia factors, that are derived from human and animal tissue. Thus, Health and Welfare Canada's Bureau of Biologics administers FDA regulations that outline requirements for donor consent and screening, frequency of donation and the processing, labelling, licensure and sales of blood products in Canada. Indeed, for decades the FDA has required that placenta used for therapeutic purposes be contaminant-free. Such requirements have helped ensure the safety of albumin, a blood derivative historically processed from placenta and used in the treatment of shock, burns and hemorrhages. The safety and efficacy of newer biotechnologies, such as genetically engineered human growth hormone and insulin, are also ensured by having them meet the regulatory standards for new drugs. Other new transplant technologies — like donated, excised organs — may be indirectly regulated, when the solutions in which they are preserved contain articles or drugs subject to FDA regulations.

The FDA also imposes health and safety responsibilities for medical device tissue replacement technology through Health and Welfare Canada's Bureau of Medical Devices. The artificial kidney and heart machines are perhaps the most familiar examples of such technology. For instance, the recent Health and Welfare Canada decision to continue to authorize the use of the American-made Jarvik-7 artificial heart — after the Government of the United States suspended its use for reasons of manufacturing quality control — directly affects research, clinical practices and patients at Canadian hospitals using the device. The Medical Devices Regulations now also cover "implants." These are devices intended for implantation in the human body for thirty days or more, such as cardiac pacemakers, implantable infusion pumps, nylon sutures, silicone breast implants and synthetic blood vessels. To be allowed to sell an implant in Canada, a company must generally provide substantial evidence that the implant may be produced with adequate quality and performance controls, is effective, poses no undue risk when used as intended and has proper labelling. In recent years, Health and Welfare Canada has partially relied on its implant safety duties to oversee the recall by manufacturers of defective mechanical heart valves and processed brain tissue implant material.

When and whether the FDA directly applies to other tissue replacement technology is less clear. Does treated, preserved or frozen bone marrow, tissue, human heart valves or semen fall within the statutory definitions and scope of the FDA so as to be subject to its requirements? Are those substances and tissues "drugs" or "medical device implants" to the extent that they are represented, sold or manufactured for use in treating disease or disorders or in correcting bodily or organic functions? The answer seems to


741. See Food and Drugs Act Amendments, R.S.C. 1939, c. 3, discussed by Curran, supra, note 740 at 180, 289. See also current FDA, supra, note 738, at 16, 17.

742. Curran, supra, note 740 at 1071.

743. See Regulations under the Food and Drugs Act, P.C. 1942-9056, C. Gaz. 1942.1.2151 at 2172 (hereinafter P.C. 9056).


745. A manufacturer shall obtain human placenta and cord used in the manufacture of preparations from human sources only from women confined in public hospitals, and the donor of such placenta and cord shall be free from the toxemias of pregnancy, and the placenta and cord shall not show gross evidence of any pathological condition." FDA reg., supra, note 744, s. C.04.234. The regulation at least dates from the early 1940s. See P.C. 9056., supra, note 743 at 2179.

746. Hagon, supra, note 38 at 93. The Institut Mérieux of France, which recently purchased Connaught Laboratories of Toronto, specializes in placental blood derivatives. Canadian albumin today is derived from fractioned plasma.

747. See FDA, supra, note 738, at 19-21. See also Medical Devices Regulations, C.R.C., c. 871 [hereinafter Devices].

748. See chap. 1, section II.C, above.


752. See ibid., s. 29. See also page 161 below.

753. Section 2 of the FDA, supra, note 738, defines drugs:

1. "drug" includes any substance or mixture of substances manufactured, sold or represented for use in
   (a) the diagnosis, treatment, mitigation or prevention of a disease, disorder, abnormal physical state, or the symptoms thereof, in man or animal,
   (b) restoring, correcting or modifying organic functions in man or animal, ... .

Section 2 also defines medical device:

"device" means any article, instrument, apparatus or contrivance ... manufactured, sold or represented for use in
depend on the use of the particular tissue or substance and on the interpretations given the Act.

On the one hand, one may argue that the language, structure and intent of the Act indicate that such tissues or substances fall within the scope of the Act. They all treat or mitigate diseased, disordered or non-functional human tissues; the Act does not require curative use. Some of the tissues, such as blood products and sperm, are sold in the normal sense of the term. Almost all are sold under the FDA meaning of “sell,” which requires that the object be available for exchange, distribution or sale, regardless of whether the transfer involves money or value. Increasing types of human tissues gain broad, safe and effective use in the treatment of bodily disorders, as a result of extensive processing, preservation and preparation through multi-step derivation processes that, in essence, yield “manufactured” therapeutic agents not unlike more conventionally manufactured therapeutic agents. The classic example is anti-hemophiliac factors manufactured by the international plasmapheresis industry. The living contact lens — which results from sculpting procured, processed and preserved human eye tissue to the individual patient’s specification before implantation — is a lesser known example. Under this view, then, the broad remedial purposes of the Act — to protect the public health — and the suggestive, as opposed to exhaustive, definitional language, combine to indicate that Parliament intended the definitions and reach of the Act to be interpreted broadly.

An opposing view imparts more restrictive meaning to the language and reach of the FDA. One may argue that tissues are distinct from conventional therapeutic agents, which directly interact with human physiology, and which are commonly recognized by the drug industry and the public as conventional drugs or medical devices. Moreover, while some of the tissues are processed, few are manufactured in the normal commercial sense of the term. Such considerations have, in the past, divided American courts over whether particular tissues fall within the meaning of language that is nearly identical to that used in the FDA. Table 2, below, illustrates some tissue replacement technologies that are, or may be, subject to the FDA.

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**Table 2**

**Health and Welfare Canada:**

**Ensuring the Safety of Tissue Replacement Technologies**

**Pre- and Post-Market Controls on Drugs and Devices**

- issuance, suspension, revocation
- safety and efficacy standards
- seizure of adulterated goods
- advertising restrictions
- pre-market testing
- prosecutions
- inspections
- labelling
- recalls

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**Bureau of Biologies**

- Vaccines
- Blood Products
- whole blood
- human plasma
- albumin
- clotting factors
- Tissue-derived rDNA drugs
- growth hormone
- insulin
- EPO, Factor VIII

**Bureau of Medical Devices**

- Artificial Heart and Kidney Implants
  - mechanical heart valves
  - artificial joints
  - cardiac pacemakers
  - intraocular lenses
  - nylon sutures
  - silicone breast implants
  - synthetic blood vessels
  - implantable insulin pumps

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(a) the diagnosis, treatment, mitigation or prevention of a disease, disorder or abnormal physical state . . .
(b) restoring, correcting or modifying a body function or the body structure of man . . .

754. See ibid., definition “sell.”


756. This approach was adopted in *United States v. Bacto-Unidisk*, 394 U.S. 784 (1969) (antibiotic sensitivity disc subject to federal food and drug regulations).

757. Although the Act does not define “manufacture,” Division 2 — Good Manufacturing Practices, adopted under the Act, defines “produce” to mean “manufacture, prepare, preserve, package, label, test or store a drug for the purpose of sale.” See FDA regs, *supra*, note 744, s. C.02.002.

The biotechnological innovations of the last decades have expanded and accelerated the trend from natural to synthetic and biosynthetic tissue replacement technologies and techniques. As the processing and preservation of therapeutic human tissues proliferate, questions over whether the FDA applies to particular tissue products seem likely to become more pronounced, even as the need for minimum uniform national standards becomes more evident. If processed and preserved heart valves, bone marrow and semen and processed cryolathed eye tissue are subject to the Act, then Canadian citizens in every geographic locale are protected by identical, minimum safety requirements. If not, national standards depend on the consistency of pertinent provincial laws and medical professional standards and practice. From a public health and historical perspective, does the frequency and volume of interprovincial and international tissue transfers, for use as therapeutic implantable agents, make a less compelling case for protecting the consuming public than does cosmetics, which became subject to the Act fifty years ago? These considerations would seem to argue in favour of regulating preserved or processed therapeutic tissues and substances that may not strictly fall under the FDA. If construing the FDA to include such tissue unduly strains its language, function and parliamentary purpose, then perhaps the health and safety of Canadians would best be served by legislative clarification.

(2) Import-Export Laws

The FDA generally requires imported tissue replacement technology to meet the same safety and efficacy standards as do Canadian technologies. Again, technologies not clearly within the scope of the FDA — such as currently imported, processed and preserved human heart valves — may escape these requirements and protections. The general FDA exemption of exports from Canadian standards, as discussed below, raises basic questions about the duties owed by Canada to foreign importing nations and international consumers. FDA controls are complemented by those in the Quarantine Act and the Customs Tariff. Established pursuant to the authority of the Parliament of Canada to enact laws regarding quarantine, the Quarantine Act empowers Health and Welfare Canada to inspect and detain imported goods reasonably suspected of being inimical to public health. Thus, regulations made under the Quarantine Act currently provide that imported bodily parts enter Canada on the condition that they be accompanied by a medical certificate indicating that the bodily part is free from disease. Customs regulations also provide for the expedited entry into Canada of human organs. Regulations made under the Customs Tariff impose duties on imported goods and set out the tariff treatment that is to be accorded to Canada's trading partners. Under existing Customs Tariff Schedules, for example, while blood plasma, bones, organs and other human tissue for transplantation enter Canada duty free, hormonal extracts from human glands are subject to a duty. Similarly, immigration regulations provide that medical teams accompanying brain-dead mechanically assisted cadavers or organ retrieval teams be granted expedited entry through Customs.

(3) Patent Law

Federal patent law is designed to encourage public ingenuity, by generally granting to inventors an exclusive right to make, use or sell an invention for twenty years in Canada. In theory, this helps to promote the development of inventions that may require years of intellectual labour and financial investment. Patent law may also help seed other inventions, by requiring patent holders to disclose into the public domain technical information on which an invention is grounded.

Inventors of mechanical heart valves, new extended organ preservation solution and the rDNA human growth hormone that has replaced cadaveric pituitary human growth hormone, have availed themselves of these incentives and protections, to bring therapeutic tissue replacement technologies to market. Patents have also recently been granted in the United States, and seem likely to be filed in Canada, for synthetic blood and genetically engineered hormones that help grow cartilage and bone. Thus, the patent law system has helped confer health benefits on the public.

Such health benefits do not seem to come without disputes and novel questions, however. Even as Health and Welfare Canada was in the process of approving the licensure and sales of erythropoietin (EPO) — the biotech drug that stimulates red blood cell

759. See text accompanying note 1027, infra.
760. Ibid.
761. The FDA, supra, note 738, s. 30, empowers the Governor in Council to make regulations on the importation of drugs (s. 30(2)) and medical devices (s. 30(1)(d)).
762. See ibid., s. 30(1)(d); Devices, supra, note 747, ss 14, 16-22; FDA regs, supra, note 744, s. G.002.008.
763. See text accompanying note 1027, infra.
764. See the discussion of international trade, chap. 4, below.
765. See Constitution Act 1867, supra, note 506, s. 91(11).
766. See Quarantine Act, R.S.C. 1985, c. Q-1, s. 5.
767. See Revenue Canada Customs and Excise, Memorandum D19-9-3, "Bodies and Body Parts for Internment in Canada" (1 June 1986).
769. R.S.C. 1985, c. 41 (3rd Supp.).
770. See Tariff Items 3001.90.20 and 3001.90.90, Canada-United States Free Trade Implementation Act, S.C. 1988, c. 65, s. 106 (Sch., Part B).
771. See Immigration Regulations, 1978, s. 19(1) (j) as am. SOR/84-849, Sch., subitem 1(1).
773. See Pioneer Hi-Bred, infra, note 777.
774. See supra, note 137.
production and helps reduce blood transfusion needs for kidney dialysis and kidney transplant patients — biotechnology firms in the United States were in the court-house trying to resolve patent rights over EPO and its $300 million in annual sales. While such disputes may be a conventional incident of the patent law system, other questions presented by biotechnology are novel. It may be asked whether there is something intrinsically wrong with patenting life, particularly human life forms. That human cell lines have formally been patentable subject-matter in Canada since the early 1980s may suggest that it is not. If not, the Moore case nonetheless underlines a need to address the consequences of patenting some human life forms. How do we protect the bodily integrity and dignity of such human tissue sources as patients, and still provide proper incentives and protection for the creative genius of biotechnologists who cultivate potentially lucrative therapeutic fruits that benefit the public?

(4) The Canada Health Act

Parliament has deemed that access to high quality health care is “critical” to the continuing health and welfare of the people of Canada. Accordingly, it has proclaimed “reasonable access” to health services without “financial or other barriers” to be a primary objective of Canadian health care policy. The tissue transfer context suggests at least two instances in which financial and non-financial barriers might deny access.

First, tissue scarcity may erect a non-financial barrier. Patients on transplant waiting lists across Canada understandably view organ scarcity as life-threatening. If national demand for blood products, corneal tissues or kidneys repeatedly outpaces available supply so that shortages become persistently acute, then scarcity imperils individual lives and national objectives. Scarcity may thus become a significant barrier to continuing health. While some analysts may dispute whether these dynamics have attained national dimensions in Canada, they surely have inspired national law reform initiatives in foreign jurisdictions. As such, legal reforms that successfully erode the scarcity barrier may save lives and advance national health policy.

Secondly, scarcity of funds may impose a barrier to access. The Canada Health Act (CHA), and provincial health insurance plans adopted in conformity therewith, announce a commitment to minimizing financial barriers through universal health insurance. The CHA specifically imposes a statutory duty on the provinces to provide “reasonable access” to “medically necessary” hospital and health services on a uniform basis. Reasonable access is not synonymous with absolute access, however. As well, recent transplant funding litigation in the United States suggests that the term “medically necessary” is open to interpretation. Still, a provincial funding choice — such as a decision to terminate funding for kidney transplants — that precludes or impedes reasonable access to transplant procedures judged medically necessary, risks subjecting the province to a loss of federal health moneys.

Given these financial and scarcity concerns, it is not surprising that transplant cost data, the establishment of a national organ waiting list and the supply and demand of Canadian tissue and organ replacement technology have, in recent years, been on the agenda of federal-provincial committees that advise on administration of the CHA.

(5) Health Services Laws

The Canadian government has certain responsibilities for the medical care of individuals not covered under provincial health insurance plans and for that of other specific populations in Canadian society. These groups range from active military personnel and


779. See Moore (1990), supra, note 426.

780. See Preamble to Canada Health Act, R.S.C. 1985, c. C-6 [hereinafter CHA].

781. Ibid., s. 3.

782. See chap. 1, above, especially table 1 at page 9, and section V.
the Royal Canadian Mounted Police,\(^{789}\) to federal prisoners\(^{790}\) and veterans,\(^{791}\) to native peoples.\(^{792}\) Some of these responsibilities are made explicit in federal law.

The federal Penitentiary Act\(^{793}\) and Criminal Code,\(^{794}\) for instance, require Correctional Services Canada to provide necessary or essential medical care to some 10,000 inmates under its charge. This statutory duty, which may be buttressed by fundamental human rights obligations,\(^{795}\) encompasses such medically necessary tissue replacement technologies as the artificial kidney, blood transfusions, bone marrow and like tissue transplants.\(^{796}\) Similarly, the Ministry of National Defence’s medical responsibilities for some 100,000 members of the Canadian Forces has resulted in its overseeing some two dozen tissue or organ transplant procedures performed on its personnel in recent years.\(^{797}\) When such tissue and organ replacement technologies are medically indicated, but unavailable at federal health facilities, the need typically will be addressed through contractual arrangements with, or medical referrals to, non-federal hospitals. Thus, military personnel in need of heart transplants are sometimes referred from the National Defence Medical Centre to the Ottawa Heart Institute.

(6) The Income Tax Act

The Income Tax Act is relevant to tissue transfers because of its potential to provide tax incentives for donation:

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\(^{789}\) Ibid.

\(^{790}\) Ibid.

\(^{791}\) See Veterans Treatment Regulations, C.R.C., c. 1585, and Veterans Health Care Regulations, SOR/90-594, adopted under the Department of Veterans Affairs Act, R.S.C. 1985, c. V-1, s. 5(4).

\(^{792}\) An 1876 Treaty, for example, obligates the Canadian government to provide medical services to native peoples on reserves in parts of western Canada. See Treaty No. 6 between Her Majesty the Queen and the Plains and Wood Cree Indians and other tribes of Indians discussed in R. v. Swimmer (1970), 17 D.I.R. (3d) 476 (Sask. C.A.). Indian Health Regulations, C.R.C., c. 955, have been adopted under the Indian Act, R.S.C. 1985, c. I-5, s. 73(1)(a), by virtue of the federal responsibilities outlined in s. 91(24) of the Constitution Act 1867, supra, note 506. See also the Department of National Health and Welfare Act, R.S.C. 1985, c. N-10 (federal health responsibilities for the people of Canada). Through the trend is towards transferring health and hospital administrative responsibilities to native peoples, HWC still runs seven native peoples’ hospitals, including the only acute-care facility in the Yukon, Whitehorse General Hospital.

\(^{793}\) R.S.C. 1985, c. P-S, s. 37. Section 16 of the Penitentiary Services Regulations, C.R.C., c. 1251, mandates that “[e]very inmate shall be provided, in accordance with directives, with the essential medical and dental care that he requires...”


\(^{795}\) See section IV.B, below.

\(^{796}\) See Correctional Service Canada, “Commissioner’s Directive 800: Medical, Dental and Health Care Services” (1 January 1987), para. 26 (major surgery); Correctional Service Canada, “Commissioner’s Directive 800: Prostheses and Appliances” (1 January 1987), para. 1 (“To ensure that offenders are provided with artificial devices as appropriate, which compensate for defective bodily functions”).

\(^{797}\) National Defence Headquarters statistics indicate that 9 bone marrow, 7 cornea, 2 kidney, 1 heart/lung, 2 heart transplants, and a kidney dialysis procedure were performed on its personnel from 1984-88. Source: Department of National Defence, Office of the Surgeon General, 1990.

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Payment offered by the government might be in the form not of cash payments or credits, but through having confirmed offers as posthumous donation stand as charitable donations for taxation purposes. A taxpayer submitting a completed organ donor card might receive a receipt which, when filed with the next following annual statement of income for taxation purposes, would entitle the named recipient to an income deduction of a given amount.\(^{798}\)

It is far from clear, under existing provisions of the Income Tax Act, whether the donation of an organ or tissue would meet the qualifications for a charitable gift or deduction.\(^{799}\) The question has prompted legislative consideration in the United States.\(^{800}\) While tax incentives for donation might increase the supply of scarce human tissues and organs, the economic benefits of such a policy may accrue largely to higher income taxpayers. Moreover, it could well undermine deeply held public sentiments on altruism.\(^{801}\)

B. Provincial Tissue Transfer Laws

In contrast to the general focus of federal law on safety and commerce, provincial law structures the procedural framework for the donation and transfer of human bodies, organs, tissues and bodily parts. The laws result from three waves of legislation that began in the mid-nineteenth century.

(1) Anatomy Acts

The first wave of legislation started in 1849, with the enactment of a Bill designed to supply medical schools with cadavers for anatomical dissection and medical education. When the Medical Board of Montreal petitioned the Legislative Assembly of the Province of Canada, in 1843, the Board sought a legislative solution to a medical and societal dilemma, which was summarized in the Preamble to the legislation:

WHEREAS it is impossible to acquire a proper or sufficient knowledge of Surgery or Medicine, without a minute and practical acquaintance with the structure and uses of every portion of the human economy, which require long and diligently prosecuted courses of dissections; And whereas the difficulties which now impede the acquisition of such knowledge amount almost to a prohibition of the same, and it has become necessary, in consideration of the rising importance of Medical Schools in this Province, and for the relief of suffering humanity, to make some legislative provision, by which duly authorized teachers of Anatomy or Surgery may be provided with the bodies necessary for the purpose of instructing the pupils under their charge ... \(^{802}\)

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\(^{798}\) Dickens, supra, note 459 at 21.


\(^{801}\) See Dickens, supra, note 459 at 21.

\(^{802}\) Anatomy Act, supra, note 8 (Preamble).
Proponents of the legislation described the study of anatomy as "legally impossible."1803 To receive a licence, medical students needed to have undertaken "cadaver surgery," when the supply of cadaver specimens was scarce. The scarcity prompted students to resort to body-snatching from local cemeteries, thereby running the risk of criminal punishment for desecrating human remains.1804 Those opposing the legislation suggested that it would legalize a traffic in corpses and make public property of some of the dead. They also suggested that executed criminals would be a preferred source of supply.1805

The Legislative Assembly was persuaded by arguments that legislation would aid the healing arts in their life-saving ethical and rid communities of the nuisance of, and black markets created by, grave-robbing. The legislation adopted the principle that unclaimed bodies, publicly exposed or in such public institutions as hospitals or prisons, should be available to medical schools.1806 The unclaimed-bodies principle derived directly from an administrative practice developed in Paris1807 in the nineteenth century, which had in turn been adopted into anatomy Acts of a decade earlier in Great Britain and Massachusetts.1808

If the incidence of grave-robbing after 1843 is indicative of the success of the unclaimed-bodies legislation, it would seem that the Act did not prove immediately successful. As late as the 1870s, a demonstrator of anatomy at McGill University Medical School was fined for receiving dead bodies through the black market:

Occasionally they prosecuted me for receiving the body. Now, as there is no property in a dead body and no clothes were taken, the only count on which they could summon me was, "Offence against decency," and I was usually fined $50. The judge, a Mr. Council, recognised the necessity of obtaining material for dissection, always fined me and nothing more was said.1809

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804. See Lawrence, supra, note 4 at 409. See also Lynn, supra, note 680 (grave-robbing as common law criminal misdemeanour).

805. See Debates, supra, note 803 at 464-66.

806. "Be it therefore enacted . . that the bodies of persons found dead publicly exposed, or who immediately before their death have been supported in and by any public Institution receiving pecuniary aid from the Provincial Government, shall be delivered to persons qualified as hereinbefore mentioned, unless the person so dying shall otherwise direct: provided always, that if such bodies be claimed within the usual period for interment, by bona fide friends or relatives, or the persons shall have otherwise directed as aforesaid before their death, they shall be delivered to them or decently interred." Anatomy Act, supra, note 8 (Preamble).

807. See Debates, supra, note 803 at 466.

808. Anatomy Act (U.K.), 2 & 3 Will. 4, c. 95; An Act more effectually to Protect the Sepulchres of the Dead and to Legalize the Study of Anatomy in Certain Cases, 1831 Laws of the Commonwealth of Massachusetts, c. 57. See also Report of the Select Committee of the House of Representatives, on Legalizing the Study of Anatomy (Boston: Eaton and Wentworth, 1831).

809. Francis J. Shepherd, Reminiscences of Student Days and Dissecting Room (Montreal, 1919) at 25. See also Edward Dagge Worthington, Reminiscences of Student Life and Practice (Sherbrooke, Que.: Walton, 1897).

While such prosecutions may have been isolated events, the activity apparently was not. Dead bodies were even reportedly smuggled in from the United States.1810 Increases in the number of both medical schools and medical students increased the demand for anatomical subjects. In Quebec, municipalities went to extraordinary lengths to police local cemeteries from grave-snatching.1811 Non-enforcement of the Act, non-compliance by hospitals, legislative ambiguity as to the period that must elapse before a body is declared unclaimed, the absence of a clause prohibiting medical schools from receiving "black market" bodies — all purportedly contributed to undermining the workings of the legislation.1812

Today, provincial anatomy Acts or their equivalents help supply medical schools with some 600 bodies annually for medical education and research.1813 Amendments since the nineteenth century have clarified the ambiguities and weaknesses of the initial legislation. Thus, most Acts now specify twenty-four to forty-eight hours as the waiting period after which the body becomes unclaimed.1814 With the introduction of a bequeathal principle into tissue transfer legislation, individuals are now authorized to donate their bodies to medical science.1815 In fact, the vast majority of bodies used by medical schools today are donated.

(2) Cornea Acts

A century after Canadian, British and American jurisdictions enacted laws to facilitate the medical need for anatomical studies, a second wave of legislation began. In the 1950s, medical science started to treat some forms of blindness and severely impaired vision by the surgical transplantation of eye tissue from cadaver donors.1816 Since anatomy Act provisions for the donation of one's body for "anatomical examination" neither contemplated nor authorized the retention of tissue for transplantation, legislative reforms were in order.1817 Thus Great Britain enacted The Corneal Grafting Act, 1952, to authorize the removal of corneas from corpses, for "therapeutic purposes."1818 Five years later,
New Brunswick enacted legislation drawing largely on the British model. The Canadian Conference of Commissioners on Uniform Legislation subsequently proposed a Uniform Cornea Transplant Act which was eventually adopted by eight provinces and two territories.

The Uniform Cornea Transplant Act both drew on and departed from the unclaimed-bodies principle. It introduced a donation principle by authorizing living donors to indicate an intention to donate one’s eyes, effective after death. The donation principle extended to situations where a person had made no intention to donate known, by providing that the deceased’s spouse, children, parents or siblings could authorize donation. A variant of the unclaimed-bodies principle took effect when family members of the deceased could not be located by permitting a person “lawfully in possession of the body” to authorize the procurement of corneal tissue.

The term “lawfully in possession” was defined so as to exclude medical examiners and funeral directors. Those otherwise in lawful possession of the body could be an executor of the deceased’s estate or, in the absence thereof, a surviving family member. The language also meant that when an unclaimed body was in the lawful possession of a hospital, then theoretically a hospital administrator or medical physician had the authority to consent to corneal tissue procurement. In this sense, the Act introduced a narrow version of presumed consent. In those limited circumstances when an undocumented donor died in a hospital with no identifiable family who might lawfully claim the body, society presumed consent to authorize corneal donation. This provision appears to have modified traditional private law rights and duties respecting the next of kin’s right of possession.

(3) Human Tissue Laws


Today, the major sources of provincial law governing the transfer of bodily parts and tissues are provincial versions of the 1971 Uniform Human Tissue Gift Act. Because the 1989 revision to the Uniform Act was so recently adopted by the Uniform Law Conference and proposed to the provinces, it has yet to receive widespread legislative enactment. While the 1989 Act introduces important clarifications and amendments, it continues a general commitment to consent and altruism as the uniform model of tissue donation from living and deceased donors.

For living donors, both the 1971 and 1989 Uniform Acts predicate donation on prior consent. The 1989 Act further proposes an independent assessment, by a three-person panel, of cases involving the donation of non-regenerative tissue and those involving minors donating either regenerative or non-regenerative tissue. For post-mortem donation, both Acts require a pre-transplantation determination of death. The 1989 Act also makes clear that “death includes brain death as determined by generally accepted medical criteria.”

Both generally predicate post-mortem procurement on prior consent by the deceased. For unclaimed donors, consent by the deceased’s “family” is substituted. When the family of an unclaimed donor cannot be located, the 1989 Act authorizes coroners or hospital administrators to consent; the 1971 Act precludes coroners or hospital administrators from such consent, but generally authorizes consent by others “lawfully in possession of the body.” Finally, both Acts forbid the sale of tissues, organs or bodily parts, but not blood.

828. See chap. 1, section II.C(1), above.
831. For a description of this process through the 1970s, see Castel, supra, note 821 at 397-99.
835. Compare 1989 Uniform Act, supra, note 833, ss 1, 11 and 1971 Uniform Act, supra, note 832, s. 7.
837. Compare 1989 Uniform Act, supra, note 833, ss 4(4) and 1971 Uniform Act, supra, note 832, s. 5.
nine provinces and two territories that have based their tissue donation laws on the 1971 Act may be expected to study the 1989 Act for possible legislative amendment of their respective laws.839

In Quebec, the Civil Code establishes a process of tissue donation that is similar to that of the Uniform model, but with notable exceptions. Living donors may consent to donation and transplantation, if the risks assumed are not disproportionate to the expected benefits.840 An individual may provide for the post-mortem disposition of his or her remains; in the absence of such instructions, the spouse or family of the deceased may consent.841 The Civil Code provides a narrow exception to donor or familial consent, by authorizing physicians to procure organs or tissues from a recently deceased individual without consent in exigent circumstances:

This consent is not necessary when two physicians attest in writing to the impossibility of obtaining it in due time, the urgency of the operation, and the serious hope of saving a human life.842

Finally, the Code requires that tissue transfers from living donors be done gratuitously, unless the tissue is regenerative.843

Taken together, the Quebec Civil Code and Uniform Acts represent the general model for the donation and procurement of human tissues and organs in Canada today. First, the model is generally premised on consent of the living donor or of the family of the

undeclared deceased potential donor. There are exceptions. The Civil Code provides for non-consensual organ procurement from a deceased donor in exigent circumstances. The anatomy Acts presume consent to the procurement of dead unclaimed bodies. The 1989 Uniform Act appears to have introduced a similar provision for tissue and organ procurement from unclaimed bodies.844 Legislative provisions in the provinces of Alberta, Manitoba, Ontario, Prince Edward Island and Nova Scotia presume consent to the removal of pituitary glands in cases involving the medical examiner or coroner in which the examining physician or coroner has no notice of objection.845 Saskatchewan, Prince Edward Island and Manitoba have similar provisions for corneal tissue.846 While the existing provincial presumed-consent provisions are limited to particular tissues and circumstances, they may afford models for broader legislative reforms intent on increasing the general supply of scarce tissue and organs.847

Secondly, the general-consent model indicates that, thus far, Canadian society has struck a balance between the interests of donors, their families and potential recipients. The statutory provisions are largely consistent with the allocation of possessory interests, rights and duties under private law. As organ or tissue scarcity becomes more critical or prominent,848 the life-saving potential likely from increased organ availability exerts pressure on the principles of autonomy, voluntarism, bodily integrity and respect of the dead—all of which underlie the existing tissue and organ procurement system. In the two decades since the formal introduction of the existing voluntarism model, advances in medical sciences have increased the demand for organs and tissues. Heart and liver transplants have now joined kidney and corneal transplants as effective therapies. Transplant waiting lists of over 2,500 people at the end of 1989 may seem indicative of a national scarcity. If such statistics are seen as reflecting the limits of the existing system, the societal interest in the preservation of life and health argues cogently for a reconsideration or potential reform of the system. From this perspective, calls for reform translate into an opportunity to reaffirm and modify or reallocate the principles, rights and values of the current system.

Thirdly, the current Canadian system of tissue and organ procurement is based largely on the gift ethic. Organ and tissue sales are generally prohibited in Canada. However, if pure altruism is responsible for some of the existing tissue scarcity, then non-altruistic


840. C.C.L.C., art. 20.

841. C.C.L.C., arts 21, 22. Art. 21 provides:

A person of full age may, in writing, determine the nature of his funeral and the disposal of his remains. A minor capable of discernment may do likewise with the consent of his father or mother. The consent must be in writing; it may be revoked in the same way. In the absence of instructions by the deceased, usage is followed.

842. C.C.L.C., art. 22:

A physician may remove a part of the remains, if in the absence of instructions by the deceased, he obtains the consent of the consort or nearest relative of the deceased. This consent is not necessary when two physicians attest in writing to the impossibility of obtaining it in due time, the urgency of the operation, and the serious hope of saving a human life. The death of the donor must be ascertained by two physicians who do not participate in any way in the removal or in the transplantation.

843. C.C.L.C., art. 20:

A person of full age may consent in writing to disposal inter vivos of a part of his body or submit to an experiment provided that the risk assumed is not disproportionate to the benefits anticipated. A minor capable of discernment may do likewise with the authorization of a judge of the Superior Court and with the consent of the person having parental authority, provided that no serious risk to his health results therefrom. The alienation must be gratuitous unless its object is a part of the body susceptible of regeneration. The consent must be in writing; it may be revoked in the same way (emphasis added).

Compare Bill 125, supra, notes 380, 473.

844. See text accompanying note 837, supra. This provision parallels the presumed-consent provision for medical examiner cases recently introduced into the revised anatomical gift law in the U.S. See notes 1004 and 1007, infra.

845. See Fatality Inquiries Act, R.S.A. 1980, c. F-6, s. 27; HTA, supra, note 839, s. 6.1; Coroners Act, R.S.O. 1980, c. 93, s. 29; Human Tissue Gift Act, S.P.E.I., 1980, c. 27; Fatality Inquiries Act, R.S.N.S. 1989, c. 164, s. 20. The development of rDNA human growth hormone would seem to call into question the continuing need for such provisions. See page 17, above.


848. See chap. 1, above.
incentives, including cash or tax benefits, might boost supplies. Any such reforms of the existing system, given the values and interests implicated, would seem to be of national importance.

The existing procurement system also suffers from some practical and legal ambiguities. If the family of a recently deceased, potential donor objects to a donation of the organs, even though the donor has signed his or her donor card, whose wishes are legally required to prevail? Respect for the individual's autonomy may suggest that the deceased individual's wishes ought to prevail; legislative clarifications directed at eliminating this uncertainty should provide both declared donors and transplant teams with greater assurance of the authority to act on the express consent of the donor. Yet, even if the declared donor's wishes are legally entitled to prevail, will not or should not continued family objections dissuade the hospital from effecting those wishes? Hospitals that seek to avoid conflict in such scenarios may decline to act on the consent despite the legal authority to do so. As such, the law has its limits.

There are ambiguities, as well, in the area of tissue sales. Does the Quebec Civil Code sales provision, which requires that the alienation of regenerative tissue by living donors be gratuitous, affect or apply to the sale of organs procured from the dead? Are the nullity provisions of the Civil Code a sufficient deterrent against organ sales, as contrasted with the penal sanctions incurred for sales under the 1971 Uniform Act? Should advertising for the purchase or offer of organs be prohibited? Both the Civil Code and the 1971 Uniform Act are silent on the latter question.

What is the precise legal meaning of "sales" under the Uniform Act? For example, the 1989 Uniform Act proposes to prohibit and penalize, with a fine of $100,000 or one year's imprisonment or both, tissue sales:

No person shall buy, sell or otherwise deal in, directly or indirectly, any tissue, body or body part for the purpose of a transplant or for a therapeutic purpose, medical education or scientific research.

The 1989 Uniform Act deletes the former common law definition of sales — that is, exchanges "for valuable consideration." By providing no definition, the 1989 Act appears to leave the precise legal meaning of tissue sales to court interpretation. Manitoba and many foreign jurisdictions have diverged from this approach by specifically incorporating sales definitions into their reforms.

The 1989 Uniform Act does offer clarity on the scope of the sales prohibition. The redefinition of "tissue" helps remove ambiguity over whether semen and like human reproductive substances are subject to the Act as "tissue." By expressly excluding them, the 1989 Act invites legislators either to address directly human regenerative tissue sales or to allow common law principles to govern. The new definition of "tissue" would also appear to remove ambiguities over whether the Act prohibits regenerative tissue sales, because the 1989 Uniform Act prohibits all tissue or bodily parts sales, save blood, gametes or human concept.

Even these clarifications, however, may not prevent modern developments from provoking questions on the meaning and scope of the tissue sales prohibition. That a jurisdiction in the United States has opted to exempt cell lines from its prohibition raises a parallel query — whether the Uniform Act tissues sales ban is intended to apply to cellular or sub-cellular entities. Moreover, since both the 1971 and the 1989 Uniform Acts prohibit sales only for "therapeutic purposes, medical education or scientific research," do they proscribe sales for more strictly commercial purposes such as cosmetics? Some jurisdictions have adopted broader language by prohibiting tissue sales "for any purposes."

(4) Provincial Tissue Law Reform

Recent legislative initiatives have been undertaken to address some of these questions and shortcomings. Beyond the 1989 revision to the Uniform Act, reforms have been undertaken by such jurisdictions as Ontario, Manitoba and Quebec. Ontario and Manitoba, for example, have pursued legislative and regulatory initiatives that parallel organ donation law reform in the United States. In 1990, Ontario began requiring hospitals to adopt "procedures to encourage the donation of organs and tissues," including

854. See 1971 Uniform Act, supra, note 832, s. 1.
855. See 1989 Uniform Act, supra, note 833, s. 1.
856. Relevant provisions of the 1971 Uniform Act sales prohibition are excerpted in appendix B, infra at 207. Under one view, the s. 10 sales prohibition applies only to non-regenerative tissue, because the s. 1 definition of "tissue" includes organs but excludes "tissue that is replaceable by natural processes of repair." As such, one may argue that skin, bone marrow, bone and like regenerative tissues are not covered by the prohibition. Under another view, the specific language of s. 10 controls, to prohibit both regenerative and non-regenerative tissue. Arguably, the language "any tissue for a transplant" refers to both regenerative and non-regenerative tissue, and is not qualified by the definition of tissue. Had the intention been to exclude all regenerative tissue, the provision would not explicitly and redundantly exclude blood. The exclusion phrase "other than blood or a blood constituent" may be seen to rely on language and structure apparently indicative of broad intent. 1971 Uniform Act, supra, note 832.
857. 1989 Uniform Act, supra, note 833, ss 1, 15.
859. See 1971 Uniform Act, supra, note 832, s. 10; 1989 Uniform Act, supra, note 833, s. 12; and Dickens, supra, note 414 at 166.
860. See discussion of Manitoba law reforms, section III.B(4), below.
861. See 1989 Uniform Act, supra, note 833.
obliges government-related tissue procurement initiatives to meet a new requirement: they must be consistent with constitutionally protected human rights and fundamental freedoms.

Of course, the novelty of the Charter means that its influence on many aspects of Canadian society is just beginning to be appreciated. Tissue transfer law and policy issues are no exception. They provoke challenging human rights questions. Does liberty or privacy encompass a constitutionally protected right of the next of kin to be free from state-sponsored mutilation of the body of a deceased relative? Does liberty include a constitutional right to sell bodily substances? Does a prohibition on advertising related to organ sales infringe rights of free speech? Does the body of a recently deceased person, who may be a potential donor, enjoy Charter protections? Or, do constitutional rights end upon death?

Settled answers to many such questions must await the developing Charter jurisprudence. While some recent cases have implicated tissue replacement technologies, none has directly presented the constitutional aspects of organ transplantation in Canada. Nor do any cases appear to have done so under analogous provisions of the European Convention for the Protection of Human Rights and Fundamental Freedoms. Nevertheless, some of the basic Charter principles may be explored to understand their relevance to tissue procurement and transfer laws. Moreover, initiatives to deal with tissue and organ scarcity in the United States have provoked a number of cases in recent years involving presumed-consent statutes. By drawing on such cases, the Charter principles may be given a context. Not surprisingly, the analysis reveals recurrent tension between the principles of religious freedom, privacy, bodily integrity and fair treatment of the individual, on the one hand, and the governmental or societal interests in preserving life and protecting the public health, on the other.

### A. Government Initiatives

The Charter generally applies to government action — that is, it binds both federal and provincial legislative, executive and administrative activities. Thus, organ donation

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870. See Arnaud v. Odom, 870 F. 2d 304 (5th Cir. 1989) (medical examiner’s unauthorized head-drop experiments on infant bodies do not violate constitutional interests of parents). Compare Kirker, supra, note 403.

871. See Karen L. Johnson, “The Sale of Human Organs: Implicating a Privacy Right” (1987) 21 Val. U.L. Rev. 741. In this respect, it should be noted that some jurisdictions would limit applicable sales prohibitions to post-mortem sales. See, e.g., UAGA, infra, note 1004, s. 10.


873. See, e.g., Dymant, supra, note 424 and Re L.D.K. v. Children’s Aid Society of Metropolitan Toronto, infra, note 883.

874. For a discussion of the European Convention, see infra, note 964.

875. Charter s. 32(1) provides that:

32. (1) This Charter applies
(a) to the Parliament and government of Canada in respect of all matters within the authority of Parliament including all matters relating to the Yukon Territory and Northwest Territories; and
(b) to the legislature and government of each province in respect of all matters within the authority of the legislature of each province.

legislation must conform to the Charter, as must the tissue-procurement activities of provincial coroners and medical examiners. While a recent Supreme Court decision indicates that the internal policies of Canadian hospitals may generally not be subject to the Charter, hospital practices must nonetheless conform to provincial human rights law. As such, hospital organ-procurement policies and initiatives are still required to meet the basic commands of human rights.

B. Bodily Integrity and Privacy

The Charter protects bodily integrity and privacy through its protections of "life, liberty and security of the person," and its prohibition against "unreasonable search or seizure" and "cruel and unusual treatment." For example, the non-consensual administration of a blood transfusion has been deemed violative of a twelve-year-old child's bodily integrity and the security of his person. In the criminal law context, the Supreme Court of Canada has applied the search and seizure provision of the Charter, and found that the non-consensual taking of a blood sample from an unconscious patient violated personal privacy and human dignity. The court has construed the right to security of the person to include protection of one's physical and mental integrity. Other Canadian courts have declared that for the state to incarcerate an individual, and then deny him, or her meaningful access to essential health services, constitutes cruel and unusual treatment or contravenes the fundamental right to security of the person. These principles may encompass medically necessary tissue replacement technology.

As such, the right to security of the person applies to and protects living donors and potential recipients. Some commentators query whether it also applies to deceased donors — that is, whether the non-consensual taking of organs from a cadaver violates security of the person. The concern may have particular force in considerations over the exemption of minors or mentally disabled persons from post-mortem presumed-consent laws. Such laws generally permit individuals to rebut the presumption of consent, by registering an objection. However, applying those laws to persons incapable of meaningfully registering their intentions might deny them an equal opportunity to protect the bodily integrity or security of their persons after death.

Assuming that the right to security of the person applies to both living and deceased donors, where a governmental law or policy infringes that right, the infringement still may or may not be constitutionally permissible. For while the right to bodily integrity ranks high on the scale of societal values, it is not absolute. It may be abridged if this is done in accordance with principles of fundamental justice, or if the right is reasonably limited by a law "demonstrably justified" by the needs of a "free and democratic society." The balancing of human rights and basic democratic needs, under the Supreme Court of Canada jurisprudence, requires the government to show (1) an important legislative purpose that bears on a "pressing and substantial concern," and (2) proportionality — the means chosen to advance the government objective must relate rationally to the purpose, impair the right in question as little as possible and show proportionality between the government objective and the actual effects of the means chosen to advance that objective. Those requirements are designed to give constitutional rights breathing space even when they are infringed, by stipulating that infringements be done with alternatives that are less restrictive of fundamental freedoms.

Analogous principles have guided courts in the United States in examining whether presumed-consent practices and legislation violate human rights. In the few cases that have directly presented the question, the courts have upheld the constitutionality of the practice or law. Some courts have differed over whether the underlying right in question — for example, interference with the next of kin's right of possession for burial purposes — arises to a constitutional dimension. Other courts have emphasized that narrowly drawn

880. Charter, s. 7.
881. Ibid., ss 8, 24(2).
882. Ibid. s. 12.
884. See Dyment, supra, note 424 and accompanying text.
886. See R. v. Downey (1990), 42 C.R.R. 286 (Ont. Dist. Ct) (holding deprivation of essential medical treatment from a prisoner with AIDS to be cruel and unusual treatment); McNamara v. Caras, [1978] 1 F.C. 451 (T.D.); Collin v. Lasster, [1981] 1 F.C. 218 at 237 (T.D.) (prisoner's right to security of person includes protection of bodily integrity and right to medical care and other necessities of life), partially rev'd on other grounds (1985) 1 F.C. 124 (A.D.). Federal prisoners also have a statutory right to "essential medical . . . care." See Perinatal Services Regulations, supra, note 793, s. 16. The U.S. constitutional analogue of security of the person, the due process clause, entitles pre-trial unconvicted detainees to necessary medical care. See City of Revere v. Massachusetts General Hospital, 463 U.S. 239 (1983). See also Thompson v. City of Portland, 620 F. Supp. 482 (D.C. Me. 1985). For convicted, incarcerated individuals in the U.S., "deliberate indifference to a prisoner's serious medical needs" constitutes "cruel and unusual punishment." Estelle v. Gamble, 429 U.S. 97 at 103-104 (1976) ("An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical 'torment or lingering death', . . . In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose. . . The infliction of such unnecessary suffering is inconsistent with contemporary standards of decency."). For general commentary on prisoners' Charter rights see A. Wayne MacKay, 'Inmates' Rights: Lost in the Maze of Prison Bureaucracy?' (1987-88) 11 Dalhousie L.J. 698.
887. Thompson v. City of Portland, supra, note 886 (failure to provide necessary medical care to former transplant recipient in police custody contravenes the constitutional protection of due process).

888. See Picard, supra, note 364 at 132 n. 649.
889. For a discussion of the French exclusion and Belgian inclusion of minors from presumed-consent law, see text accompanying notes 961-962, infra.
890. See Eve, supra, note 362.
891. See Charter, ss 7, 1.
legislation reasonably advances the state interests in the promotion of health and preservation of life:

Our review of section 732.9185 reveals certain safeguards which are apparently designed to limit cornea removal to instances in which the public’s interest is greatest and the impact on the next of kin the least: corneas may be removed only if the decedent is under the jurisdiction of the medical examiner. . . .

In conclusion, we hold that section 732.9185 is constitutional because it rationally promotes the permissible state objective of restoring sight to the blind. In so holding, we note that laws regarding the removal of human tissues for transplantation implicate moral, ethical, theological, philosophical, and economic concerns which do not readily lend themselves to analysis within a traditional legal framework.905

C. Freedom of Conscience and Religion

Adopting narrow, proportionate means to advance legitimate government and societal interests may prove equally important in governmental tissue procurement and transfer initiatives that burden religious beliefs. The Charter protects the exercise of religion as a fundamental freedom:

Freedom must surely be founded in respect for the inherent dignity and the inviolable rights of the human person. The essence of the concept of freedom of religion is the right to entertain such religious beliefs as a person chooses, the right to declare religious beliefs openly and without fear of hindrance or reprisal, and the right to manifest religious belief by worship and practice or by teaching and dissemination.897

Thus, the compelled transfusion of blood into Jehovah’s Witnesses, whose religious dictates do not permit them to receive transfusions, may burden their religious beliefs.898 Orthodox Judaism forbids post-mortem dissection and like invasions of the body.899 The tenets of other believers, for example, adherents to some Far Eastern religions, strictly forbid any mutilation of the body after death, including organ procurement or autopsy.900

Still others’ religions, such as those of some native peoples, orthodox Islam and Shintoism, may proscribe either post-mortem organ procurement or the receipt of cadaveric tissue.901

These views of conscience and religion may well be held by the minority in Canadian society. Should the numbers matter, and disentitle minority adherents of conscience from a right to exercise their beliefs on the integrity of the dead human body as a necessity for ensuring passage to an afterlife?902 To the contrary, part of the purpose of the Charter guarantee is to entitle all individuals — be they in the minority or in the majority — to freedom of conscience and religion.903 Indeed, to protect against coercion and to provide meaningful equality of religious autonomy, more protection may be warranted for those holding unfamiliar, non-majoritarian religious views.904 Such concerns appear to have prompted the Alberta Office of the Chief Medical Examiner to exclude Hindus, Christian Scientists, orthodox Jews, Moslems, native Canadian Indians, Metis and Inuit peoples from its five-year-old practice of routinely consulting the families of deceased individuals, under its jurisdiction, to inquire whether they wish to donate tissue.905 The exemption would seem responsive to Charter duties to accommodate and to minimize the impairment of the free exercise of religion.906

This is not to say that religious freedom in a pluralistic, democratic society is absolute and cannot be restricted:

Freedom in a broad sense embraces both the absence of coercion and constraint, and the right to manifest beliefs and practices. Freedom means that, subject to such limitations as are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others, no one is to be forced to act in any way contrary to his beliefs or conscience.907

Thus, a compelling societal interest in determining the cause of unusual deaths, for the administration of criminal justice or to safeguard public health, may justify the performance of a forensic autopsy, despite the religious beliefs of the decedent or surviving family.908 State interests in the preservation of life and protection of health, particularly

902. See John Dwight Ingram, "State Interference with Religiously Motivated Decisions on Medical Treatment" (1988) 93 Dick. L. Rev. 41 at 65 ("The very essence of most religious beliefs is the relationship of a person to a supreme being and the determination of the relative value of one’s physical life on earth and a potential spiritual life hereafter").
903. Big M Drug Mart Ltd., supra, note 897 at 337.
906. See Oakez, supra, note 892 at 136 and Hogg, supra, note 893 at 712.
of those who cannot protect themselves, have motivated the prosecution and conviction of Christian Scientists for failing to provide dependent minors with customary, life-saving medical treatment.909 These interests have also persuaded courts to uphold the authority of the state to administer life-saving blood transfusions to infants, over parental religious objections.910

In essence, then, the Charter seeks to strike a dynamic balance to give effect to the principle of religious freedom. When societal interests of paramount importance are at issue that cannot be advanced by other viable alternatives, the government-chosen objective and means may necessitate infringing or overriding individual religious practices. Otherwise, the societal valuing of religious freedom as a fundamental human right bespeaks a duty to accommodate individual beliefs and acts of conscience. A particular instance of societal balancing may depend, delicately, on the degree and effects of religious infringement, and on the strength of the government objective, means of achieving its objectives and its accommodation of the religious beliefs. Hence, in the United States constitutional transplant and autopsy jurisprudence, the degree to which state legislation burdens and accommodates the exercise of religion has proved important. When a woman contended that her religious beliefs were violated by a medical examiner’s retention of her husband’s organs following an autopsy, the court upheld the law by finding it accommodated religious beliefs in providing the family with an opportunity to object in advance to any such retention.911 More recently, a court initially found that state autopsy law violated religious beliefs, in part, because it failed to adopt less burdensome alternatives for achieving the government goal.912

D. Non-discrimination and Equality

The constitutional requirement of equality protects against government discrimination by mandating the equal benefits and burdens of the law:

Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.913

A compliant alleging discrimination must show unequal treatment, or the effects and discriminatory impact of a government initiative, based on one of the above-enumerated grounds or on one analogous thereto.914 The Supreme Court of Canada has indicated a willingness to construe the constitutional requirement of equality broadly.915

The requirement imposes on government a duty to act impartially and to avoid arbitrary and unreasonable classifications of or actions against individuals. Government decisions to fund or not fund a particular transplant procedure might discriminate, if they are sufficiently arbitrary and irrational as to deny equal protection of the law.916 If hospitals are subject to the Charter or statutory human rights protections, then criteria for organ transplant waiting lists must comport with basic human rights principles.917 Thus, criteria that give priority on a basis such as ethnic or national origin, or “medical” criteria that effectively exclude particular classes of disabled transplant recipients, must offer cogent reasoning to withstand legal scrutiny.918 Similar equality concerns may apply to initiatives to apply a different criterion of death for anencephalic infants, to the extent that it unreasonably and disproportionately discriminates against them on the basis of physical disability. If the government interest in the preservation of life might be advanced by organ procurement initiatives less burdensome of the right to life or security of the person, the Charter may well require such alternatives.

Indeed, that approach should, perhaps, inform all governmental tissue transfer and procurement initiatives, including law reform options and recommendations. For if one such initiative challenges the human right to equality, and another challenges the freedom of religion or security of the person, the Charter would seem to oblige all to respect at least one human rights lesson: If, in the choice between competing law reform options, one emerges that (1) least burdensome of fundamental human rights, (2) likely to prove relatively more accommodating of those rights, and (3) depends on rational, narrowly tailored means that substantially advance a pressing and substantial government objective, then that option would seem constitutionally preferred.

909. See R. v. Lewis (1993), 7 C.C.C. 261 (Ont. C.A.) (affirming manslaughter conviction for Christian Scientist’s failure to provide medical necessities for son who died of diphtheria). See also Tutt, supra, note 529.


912. You Yang Yang, supra, note 900 at 857.

913. Charter, s. 15.


915. Ibid.

916. See Brillo v. Schaller (13 June 1986), Arizona 233587 (Sup. Ct) (ordering state funding of adult liver transplant after holding denial thereof to be irrational and violating of equal protection). This argument was also advanced in litigation that helped persuade the state of Vermont to amend its policy of non-funding of adult liver transplants. The intended transplant recipient in the case died before she could avail herself of the funding change. See Schmoke v. Secretary of State (6 December 1988), Washington 5-576-88 (Sup. Ct). See also Sally Johnson, “Vermont Care May Uplift Transplant Policy”, New York Times (15 January 1989) 34.

917. For example, transplant waiting list procedures that seem not to discriminate on the enumerated or analogous grounds of s. 15, arguably may abridge s. 7 protection of life and security of person, by denying an equal opportunity to life in a manner inconsistent with principles of fundamental justice. Compare Stoffman, supra, note 879 and Turpin, supra, note 914 at 1334-35. See also text accompanying notes 221-224, supra.