Question 4

A first issue I would like to address in this context is that the question should be answered from the situated, embodied and emotionally charged perspectives of the individuals or families who are actually confronted with decisions to donate part of their bodies, be it for scientific research or for immediate medical purposes. A second issue of concern is the issue of ownership of human body tissues. Let me explain the issue at the case of human embryos. As my research on embryo donation in China has indicated, frozen IVF embryos are not only conceived as part of the individual who is asked to donate, but in fact, these tissues seem closely intertwined in the web of social, bodily and emotional relations of the family and wider kinship group. To whom the embryo belongs can thus be an ambiguous matter and – at least among a certain segment - of potential embryo donors in China the opinions of family members seem to play an important role in decision making processes. Consider the following quotation. Such a decision [to donate the embryo] must be discussed with the family as a whole and the opinions of the others must be respected. If there is a member who disagrees, I will think about this. But it really depends on the attitude of this person. If his or her opinion is very strong, that means, opposes donation very strongly, I would not donate. I do not want to hurt the relationship between family members just because of donation. (Female IVF patient, 32 years) It is clear that such patterns of inter-familial respect and obligations are closely intertwined with culturally mediated conceptions of the human body and notions of physical interrelatedness between the generations. As one of the researchers I interviewed explained it to me: You know, in Chinese cultural tradition people regard their bodies as coming from their parents, and it is seen as very precious, so we have to take good care of our bodies, we cannot give any part of it to others. So in the Chinese tradition it is forbidden to give away… to donate your tissues or organs to others, including your cells, your gametes, which include oocytes and sperm. Therefore, [many] people cannot agree, if their embryos shall be used for research. I: What would happen if someone believes in these ideas but would still donate? This would be an activity that means that you do not respect your parents. Your parents gave you your hair, your body, your organs, this…, the whole of you. The parents gave this to you and you did not take good care of it, you gave parts of it to others. So you don't respect your parents. From this perspective, donation of embryos without prior consent of the donors' parents forms an obvious violation of culturally mediated social norms and represents an act of disrespect and disloyalty. I think this example exemplifies the importance of taking into account the plurality of culturally mediated assumptions of the body, relatedness, responsibility and obligations to others: husbands, spouses, parents, siblings, neighbors, friends, imagined spiritual entities, doctors, scientists, the state, etc. While the embryo may be a particularly pronounced example, of how tissues and body parts can be endowed with multiple and also contradictory layers of meanings, value, values, emotions, etc. I think that the

general point at stake here is valid and transferrable also for other kinds of tissues, and obviously beyond the context of China. Regarding the multicultural character of contemporary societies, especially Britain, as well as the global nature of contemporary tissue economies, such openness for cultural plurality regarding perceptions of the body, body-parts etcetera seems of particular importance. A comment I would like to make in this context, concerns the definition of "dignity" you handle in the document. The definition you propose is Dignity: encapsulating ideas of the special status of the human body and associated with concerns that putting a price on any part of a human body would 'commodify' it in a way incompatible with its unique status My critique here is that defining dignity in terms of "commoditization" is obviously a very one-sided reading, and itself the expression of a culturally mediated preference and normative position. I think however, that – if thinking about dignity – a more open definition should be handled, that allows integrating evaluation and discussion parameters for the term, beyond a mere problematization of the issue of commoditization. More space should be given for cultural pluralism, in particular with respect to diverging and plural ideas of the body and bodily relatedness.

Question 5

Four issues shall be addressed: a) the motivations of patients to participate in a first-in-human clinical trial, b) disappointment resulting from the absence of positive treatment effects, c) the concept of Phase 0 trials, d) guarantee to receive the tested treatment, once efficiency and safety have been proven. According to doctors I interviewed recently, who are involved in the setting up of a Phase 1 clinical trial for SCI patients, altruistic motives play only a minor role in patients' motivations to participate in the trial. What the patients really want – is improvement of their conditions. The problem in this particular trial (phase 1 dose-escalating) is, however, that – only one-fifth of all recruited patients shall receive the dose that is expected to possibly bring some benefits. Result: the recruitment process is significantly delayed, patients refuse to participate, and prefer waiting to a Phase II or III trial, where the likelihood for cure is higher. Considering this, I think that the issue of "disappointment", i.e. of the psychological consequences and symptoms related to failure of first-on-humans trials has to be taken seriously! Of relevancy in this context is the following: 40% of all Phase 1 trials, that test a drug or device whose efficiency and safety has been proven in preclinical studies on animals, fail to show effects in humans. A related issue is conceptual – but its consequences in terms of physical risks and psychological impact are likely to be significant. Due to the high failure rate in translation processes from animals to humans, and the significant material costs of this, a new trial concept has emerged since the early 2000s. The Phase 0 trial. Phase 0 refers to first-on-humans experiments with drugs whose safety and efficiency has not yet been reliably tested on animals, but for which efficiency indications exist for use in humans. Phase 0 trials work with very low dosages – so as to reduce potential risks. That means also however, that the likelihood of obtaining medical benefits in Phase O

trials is even lower than in Phase 1trials. While this approach makes sense in terms of ruling out inefficient treatment methods faster, and reducing R&D costs significantly, it means also that more patients are required in first-on-humans trials that shall not experience medical benefits! Considering that risks of adverse effects might be slightly higher in phase 0 trials, compared to Phase 1 trials (with positive safety studies on animals), it is clear that Phase 0 requires special consideration and careful regulation. "Disappointment", thus, and related psychological states and symptoms must be sufficiently addressed here. My proposition in this context is to regulate by law that patients who participated in Phase 0 or 1 trials receive a guaranteed and free treatment of the tested method – if it has proven to be effective and safe! While this models is occasionally practiced however, it is as far as I am informed not anchored in law, and is thus not mandatory. In this way – a long-term incentive may reliably be offered to first-in-human participants, but immediate financial returns can be avoided. While financial compensations of costs related to trial participation in first in human trials should of course be permitted. Payment should be prohibited, so as to reduce luring patients into high-risk patients, and to elevating first-in-human trial participation to a kind of "labor".

Question 11

There should in any case be compensations – in particular of time invested by donors, and reimbursement of travel costs and missed work-hours. Compensation should not be another word, for incentives, even though in case of low-income groups the boundaries between the two - may indeed be blurring once in a while. In case of "first-in-human trials" no financial incentives should be provided. However, good compensation arrangements should be in place. Even though a form of "payment" for participation would be justified, in particular in case of trials that include surgical procedures, longer term stays in hospitals, pain, etcetera, in order to rule out participation in high-risk phase 0 or 1trials for financial purposes, it should not be permitted.

Question 13

No, with one exception. Even though good reasons for first-in-human participation are many-fold, the individual who exposes his future body and life to risk must take the ultimate decision. Support for ideas of "moral duty" are highly problematic I think, because they may give rise to inappropriate forms of social pressure and shifting definitions of normality, that in the final instance – are likely to delimit the independency of decision making processes. Exception – the only exception I can imagine is the emergence of an epidemic disease that threaten to eradicate large numbers of people within short amount of time. Here definitions of "duty" that invoke altruism are permissible. However, they should never go beyond the level of that definition. The invocation of ideas of "moral duty" should never be accompanied by the use of force or absence of consent!