British Medical Association

1. Nature of human bodily material and first-in-human trials

Human bodily material

1. Are there any additional types of human bodily material that could raise ethical concerns?

Most types of human bodily material that potentially raise ethical concerns appear to be included. In addition, shed tissue components, such as urine, which can contain cells, and therefore DNA, may raise ethical concerns. There may also be some moral grounds for distinguishing facial tissue, donated for the purpose of facial transplants, as a specific tissue type.

2. Should any particular type(s) of human bodily material be singled out as 'special' in some way?

While not necessarily 'special' types of human bodily material, some types raise more specific ethical issues than others within the context of donation for medical treatment or research. In addition to the distinctions outlined, the BMA would suggest that stem cells can also be considered as distinct from other types of donated material. As with reproductive material (sperm, eggs and embryos), donated stem cells have at least the theoretical potential to be used to create new life at some future point.

3. Are there significant differences between providing human bodily material during life and after death?

A key distinction between providing bodily material during life and after death is the risk to the donor. Living donation carries a varying degree of risk, depending on the material being donated. Blood donation, for example, carries very little risk, while egg donation involves associated physical risks, including ovarian hyperstimulation syndrome (OHSS), which is most common in its mild form, but can be fatal.[1] Living donors also experience a varying degree of invasiveness and inconvenience, depending on the type of donation involved, neither of which are as relevant to donation after death. Invasive procedures necessary to the retrieval of bodily material for donation after death may, however, be a barrier to obtaining consent from the family of potential deceased donors.

[1] In the UK there have been two fatalities from OHSS; only one of these involved an IVF cycle (out of 425,000 stimulated IVF cycles). Quoted in Balen A. Ovarian hyperstimulation syndrome – A short report for the HFEA, February 2005:12-13.

4. What do you consider the costs, risks or benefits (to the individual concerned, their relatives or others close to them) of providing bodily material? Please distinguish between different kinds of bodily material if appropriate.

This is not a question that can be answered in the abstract. Risks and benefits vary depending on the nature of the intervention required to remove the bodily material and the purpose to which the material is to be put. Depending on the circumstances, donors or their relatives may experience psychological harm or benefit, as well as physical sequelae. Similarly, the experience of pain and harm is very subjective and interpreted differently in individual cases.

Participation in first-in-human trials

5. What do you consider the costs, risks or benefits (to the individual concerned, their relatives, or others close to them) of participating in a first-in-human clinical trial?

Despite the existence of safeguards in relation to clinical trials, exceptional untoward incidents, such as those in the TGN 1412 research on monoclonal antibodies at Northwick Park in 2006, show that phase 1 trials carry some risk. The specific nature of the risks involved is dependent upon the particular trial concerned. Although the vast majority of research does not involve risk of this magnitude, and more scrutiny is now in place, all trials inevitably involve some risk for those volunteering their body. Before trials go ahead, it is necessary to ensure that: all pre-human trials have taken place, to minimise the potential risks; ethics committee approval has been obtained; and clinical best practice procedures are followed.

2. Purposes of providing bodily material/volunteering in a trial

6. Are there any additional purposes for which human bodily material may be provided that raise ethical concerns for the person providing the material?

The BMA does not have any comment to make on this question.

7. Would you be willing to provide bodily material for some purposes but not for others? How would you prioritise purposes?

The BMA does not have any comment to make on this question as it is aimed at individual respondents.

8. Would your willingness to participate in a first-in-human trial be affected by the purpose of the medicine being tested? How would you prioritise purposes?

The BMA does not have any relevant knowledge in relation to this question. We would envisage that many individuals would probably take the purpose of the trial into account, but some might be more drawn by the remuneration offered.

3. Ethical values at stake

9. Are there any other values you think should be taken into consideration?

No.

10. How should these values be prioritised, or balanced against each other? Is there one value that should always take precedence over the others?

All of these values need to be taken into consideration but may weigh differently in relation to different types of donation, and the factors specific to a given type of donation, for example, the level of risk involved and the relationship between donor and recipient. Within the context of a public health system, such as the NHS, which is not based upon financial exchange, the BMA favours an altruistic model. It is also relevant to consider whether the focus of this question is moral or legal. In legal terms, autonomy will always be prioritised over and above the other values, while, morally, the relative importance of autonomy will vary depending on the aforementioned factors, which are specific to the type of donation concerned.

11. Do you think that it is in any way better, morally speaking, to provide human bodily material or volunteer for a first-in-human trial for free, rather than for some form of compensation? Does the type or purpose of bodily material or medicine being tested make a difference?

The BMA supports altruistic donation and believes that in an ideal situation, donation should be unpaid. Clinical trials pose a somewhat different scenario to other types of donation. Where payment has always been the norm, as with clinical trials, it would be difficult to withdraw payment without having a detrimental impact upon the numbers of people donating their bodies for this purpose; as a result, demand may not be met. Retaining an altruistic system of giving for other types of donation, that have not traditionally been paid, would be unlikely to have similar implications. There may also be additional moral grounds on which to differentiate between donation for treatment and donation for research. In donation for treatment (whether blood, organs or gametes), the donation provides a direct benefit to one or more individuals, the 'need' that is being met, and therefore the benefit that accrues, is easily recognised, and the situation more closely reflects the 'gift relationship' of one person helping another without the expectation of reward. With donation for research, the benefit is not to a particular individual but

is for society more generally; the benefit is also less obvious and more distant from the donation (in fact, there may be no benefit at all).

12. Can there be a moral duty to provide human bodily material, either during life or after death? If so, could you give examples of when such a duty might arise?

The BMA does not have policy on this issue but recognises that generally people should be free to choose whether to donate or not. It is generally recognised that we all owe some moral obligations to others. In the BMA's view, however, donation is a matter of personal choice and, with the exception of providing bodily material for certain forensic purposes, should not be legally enforced. Nevertheless, all citizens should be encouraged to donate if they can do so at no detriment to themselves, such as cadaveric donation for transplantation. (The BMA favours an opt-out system of consent for organ donation after death, and this policy is explained in detail on its website.)

13. Can there be a moral duty to participate in first-in-human trials? If so, could you give examples of when such a duty might arise?

The BMA does not have policy on this issue. The Association's general position is that people should be free to donate and there should be no pressure upon them to do so. Again, where there may be general moral duties, donation should still be a matter of personal choice.

4. Responding to demand

Supply and demand

14. Is it right always to try to meet demand? Are some 'needs' or 'demands' more pressing than others?

Where there are legitimate health needs, it is appropriate to take reasonable steps to meet them. The question of what constitutes a 'want' or 'demand', as opposed to a 'need', and what makes a 'need' reasonable, are matters of interpretation, and perceptions will inevitably differ.

Current regulatory framework

15. Should different forms of incentive, compensation or recognition be used to encourage people to provide different forms of bodily material or to participate in a first-in-human trial?

'Incentive' is often used to mean payment, but an incentive does not have to involve remuneration or compensation. Asking people to donate, or raising

awareness of the need for donation, can be considered incentives. In addition, it is necessary to differentiate between different types of incentive; for example, those that would make an individual act against their better judgement and do something they would not otherwise have done, which may be exploitative, as opposed to those that encourage an individual to decide in a particular way but do not fundamentally affect that individual's free choice.

The BMA favours an altruistic system of donation in preference to payment (we accept payment for research). Where such a system is inadequate to meet the demand for a particular type of bodily material, however, the BMA has considered the implications of different types of compensation. Although its general opposition to payment remains, in the light of the shortage of donor eggs, the BMA does not oppose egg sharing, 'payment in kind', on the basis that any risks taken by the woman are for her own benefit and not for the benefit of the recipient. In addition, the motivation of the donor is not commercial, but to receive a health benefit herself. On the grounds of justice, recognising that some people can afford to have IVF treatment and others cannot, egg sharing provides a way of helping this latter group while not exposing them to any additional risk.

There are a number of factors that might justify making a distinction between different types of donation in terms of payment, including the level of risk and invasiveness involved in donating, issues of supply and demand, and the implications of a shortage in the material concerned. It may be necessary to consider these distinguishing factors when assessing why different types of donation would be treated differently in terms of the provision of incentives, compensation or recognition.

Increasing supply

16. Are there forms of incentive that are unethical in themselves, even if they are effective? Does it make any difference if the incentive is offered by family or friends, rather than on an 'official' basis?

Where an incentive is deliberately designed or intended to make someone act contrary to their better judgment, or where payment is intended as compensation for taking a particular risk, the BMA would consider this to be unethical. Moral or emotional pressure within families, not involving reward but going further than encouragement, would also pose ethical concerns where it induces individuals to act contrary to their better judgement. A useful analogy here is consent. Any incentive or pressure that would render consent for treatment invalid, is also likely to invalidate consent for donation.

17. Is there any kind of incentive that would make you less likely to agree to provide material or participate in a trial? Why?

The BMA does not have any comment to make on this question.

18. Is there a difference between indirect compensation (such as free treatment or funeral expenses) and direct financial compensation?

Despite the BMA's general position, which opposes payment for donation on the basis that donated material should be a gift, freely and voluntarily given, we recognise that there may be, in theory, a number of grounds for differentiating between different types of donation in terms of payment in cash or kind. These grounds include the level of risk and invasiveness associated with donation, issues of supply and demand, and the implications of shortage. The BMA supports egg sharing arrangements, for treatment and research, on the basis that any risks taken by the woman are for her own benefit and not for the benefit of the recipient. The motivation of the donor is not commercial, but to receive a health benefit herself. On the grounds of justice, recognising that some people can afford to have IVF treatment and others cannot, egg sharing provides a way of helping this latter group while not exposing them to any additional risk.

Direct financial compensation, or payment, is more morally problematic. Arguments against payment include:

- Some people see voluntary donation, with its emphasis on altruism, human dignity and minimisation of exploitation, as preferable to paying 'donors'.
- Where the donation is for use in treatment, payment for donation can be seen as treating people as commodities, and might undermine the moral obligation to show respect for persons.
- If payment is introduced, people will begin to expect it and this will change the nature of the act of donating. Those who have previously donated on altruistic grounds may feel that their altruism is undermined and it may deter them from donating in the future. This could lead to an overall reduction in altruism in society and a demand for payment for other acts currently based on altruism.
- Payment, in money and kind, may constitute exploitation. Individuals who need money will be more likely to expose themselves to physical or psychological risk and may be tempted to dismiss any concerns they have in order to gain the money they need.

19. Is there a difference between compensation for economic losses (such as travelling expenses and actual lost earnings) and compensation/payment for other factors such as time, discomfort or inconvenience?

The BMA does not have policy on this issue, but believes that people should not lose out financially as a result of donating, and supports reimbursement of

legitimate expenses, including, in the case of organ donation, actual loss of earnings.

Alternatives to increasing supply

20. Are you aware of any developments (scientific or policy) which may replace or significantly reduce the current demand for any particular form of bodily material or for first-in-human volunteers? How effective do you think they will be?

Developments in stem cell technology, which enable tissue to be grown from stem cells in order to repair damaged organs, suggest that it may eventually be possible to use an individuals' own cells and tissue, rather than that of a donor, for medical treatment of this nature.

5. The role of consent

Valid consent

21. In your opinion are there any forms of encouragement or incentive to provide bodily material or participate in first-in-human research that could invalidate a person's consent?

Misinformation, such as downplaying the risks and highlighting the benefits of donating or taking part in research, would invalidate consent. In its deliberations, the BMA has attempted to distinguish between 'incentives' and 'undue pressure', or 'inducements', which lead people to act contrary to their better judgement.

22. How can coercion within the family be distinguished from the voluntary acceptance of some form of duty to help another family member?

The existence of a perceived moral duty does not mean an individual must help. Coercion is never appropriate and the individual must still give consent freely. In practice, however, it may be difficult for health professionals to identify whether a person has been subject to coercion. In the case of living organ donation, for example, it is always important to have a discussion with the donor, separate from his or her family.

Consent for future unknown ('secondary') uses of bodily material

23. Are there circumstances in which it is ethically acceptable to use human bodily material for additional purposes for which explicit consent was not given?

The BMA believes that if the bodily material is 'left over', following diagnostic procedures, surgery or use for other research purposes, anonymised and its use has

received research ethics committee approval, it is generally ethically acceptable to use it for additional purposes for which explicit consent has not been obtained. In the case of certain types of controversial research, where it can be anticipated that some people may object to the use of their bodily material, it should only be used after explicit consent has been obtained, even where this is not a legal requirement. Women opposed to abortion, for example, may not want any fetal material from a miscarriage used in research on abortion.

Role of families: living donation

24. Is there a difference between making a decision on behalf of yourself and making a decision on behalf of somebody else: for example for your child, or for an adult who lacks the capacity to make the decision for themselves?

Competent individuals are able to agree to take risks for themselves. Decisions made on behalf of those lacking capacity must be made in their best interests, based on an evaluation of the risks and benefits of a given procedure or treatment.

Role of families: donation after death

25. What part should family members play in deciding whether bodily material may be used after death (a) where the deceased person's wishes are known and (b) where they are unknown? Should family members have any right of veto?

Where the wishes of a deceased individual are known, they should be respected; where those wishes are unknown, the person's family should be encouraged to make a decision about whether bodily material should be used after death in light of what the person would have wanted. In the case of strong and sustained opposition by the family to the use of the material, it would be both practically difficult to resist, and would undermine the support health professionals can offer to the bereaved. In the case of organ donation, for example, resisting such family opposition would be likely to cause significant, wider damage to the organ donation programme.

6. Ownership and control

Property rights

26. To whom, if anyone, should a dead body or its parts belong?

The BMA does not have policy on this issue but notes that the notion of 'ownership' does not fit well in such situations.

27. Should the laws in the UK permit a person to sell their bodily material for all or any purposes?

The BMA's general position is that the donation of such material should be a gift, freely and voluntarily given, and does not support payment for donation or individuals being able to sell their bodily material. The BMA does not believe that people should lose out financially as a result of donating, and so supports reimbursement of legitimate expenses, including, in the case of organ donation, actual loss of earnings. The Association has not specifically considered the issue of payment for donation for research but expects all financial aspects of any research to be scrutinised by a research ethics committee.

28. Should companies who benefit commercially from others' willingness to donate human bodily material or volunteer in a trial share the proceeds of those gains in any way? If so, how?

The BMA does not have any policy in relation to sharing commercial profits, but it would be equitable for patients involved in research to receive any health benefits from treatments or procedures developed as a result of that research.

Control

29. What degree of control should a person providing bodily material (either during life or after death) have over its future use? If your answer would depend on the nature or purpose of the bodily material, please say so and explain why.

Individuals should be able to control which particular parts of their bodily material are used, whether it is used and, generally, the purposes for which it is to be used, with the exception of left over, anonymised material. In respect of exerting control over who the material should be used for, and other conditions attached to its use, the BMA would distinguish between different types of bodily material. Where gametes are donated, the donor should be able to specify the uses to which they are put. In the case of organs, there is a distinction to be drawn between living and deceased donation. Donation after death should never be conditional, but where a preference can be accommodated, for example by meeting the requirements of Department of Health policy on requested allocation of a deceased donor organ, it should be. In the case of material to be used for research, donors should be free to state that the material can be used for *any* purpose, without having to give explicit consent for every use to which it may be put.

7. Any other issues

30. Are there any other issues, connected with our Terms of Reference, that you would like to draw to our attention?

The BMA suggests that it may be appropriate for the Working Party to consider surrogacy, as an additional 'transaction' involving the human body. Surrogacy, like clinical trials, involves a person giving over her body for a period of time and remuneration for a 'service', with payments of £10-15,000 being the norm.