Christian Medical Fellowship

Question 1
No type has been omitted, but we note no mention is made here of the genetic significance of material – there are potential implications for others should genetic testing be performed.

Question 2
Yes. 'Reproductive material' intended to 'result in the birth of a child genetically related to the person providing the material' has a whole further dimension of significance. The 'provider' is potentially becoming a parent, and the relationship responsibilities of this are, or should be, enormous. The products of conception from aborted fetuses deserve respect amounting to legal protection in that they represent parts of an individual made in the image of God (see response at Q30) who has no say in their use.

Question 3
Yes. In life consent can be given, modified, and removed. These possibilities disappear at death, so any prior permission for use must be clear, valid, and applicable.

Question 4
Living donors Costs and risks: Blood: minor inconvenience. Bone marrow, kidneys, other organs: involves considerable risk including anaesthesia, surgical procedure, pain, morbidity, time off work. Kidney: the individual puts self at risk of renal failure should the one remaining kidney become diseased. Reproductive material: knowing that a child could be born who is related to oneself, but whom one may never know or have a relationship with, and knowing that any such child will not know one or both of his/her biological parents. Benefits: Blood, tissues, organs: knowing that one's donation is being used to benefit another. (Jesus said 'It is more blessed to give than to receive'.) The altruistic sense of satisfaction is probably proportional to the type of material/organ donated, and perhaps the 'cost' involved. Reproductive material: for those who have fully considered all ethical aspects, knowing that one has helped an infertile couple to have a child. The relatives of post-mortem donors Costs: for some, depending on their worldview, distress at the thought of material being removed from their loved one's body. Benefits: knowing their loved one has not died in vain, but that something good has come from it.

Question 5
Costs and risks: being exposed to a new drug with unknown risks which could be

serious; undergoing monitoring procedures which may be invasive or unpleasant. Benefits: financial reward; knowing one may be helping future patients if the research is successful.

Question 6
We can think of no additional purposes. The differentiation of the 4 purposes has been useful. It is perhaps worth pointing out that for all 4 purposes, there will be cases where no benefit will be obtained – eg donated material is found to be unfit for purpose, reproductive material may be donated but a live birth not achieved, in-human research may lead to the conclusion that the drug does not work or is not safe. Donors and volunteers should be made aware of the statistical likelihood of such possibilities in order that their involvement may be fully informed.

Question 7
Because of the importance we place on human relationships, and parental responsibilities in particular, the donation of 'life-creating' material belongs in a special category. We would anticipate that some might be willing to donate for treatment purposes but not for research.

Question 8
Increasingly the pharmaceutical industry has moved into so-called 'lifestyle' drugs aimed at trivial conditions for which there may well be more appropriate interventions. People putting themselves potentially at risk have a right to expect a good purpose which is aimed at treating genuine threats to health.

Question 9
See response at Q30. A significant number of important concepts have been omitted:
• The traditional concept of deontological ethics (duty based) where the rule determines the result
• The more recent concept of consequentialist ethics where the results determine the rule • Virtue ethics where the character of the decision maker is critical
• Utilitarianism should be named, as much of the consultation indicates the potential for a future crude cost-benefit calculus
Absent values include:
• Protecting the vulnerable – relevant to the question of financial incentives being more likely to cloud judgment in the poor
• Sanctity of life – life begins at conception, and embryos must be treated as full human beings worthy of respect and legal protection
• The importance of family relationships – taking responsibility for individuals created Even the 'ethical values' mentioned are merely listed and no coherent ethical framework is apparent.

Question 10
At Q30 we argue that there must be a serious consideration of worldviews, before a coherent ethical framework can be agreed. We present our worldview, and indicate the ethical framework that follows. However, we single out here 'first do no harm'.

Question 11
At Q30 we argue that the altruistic gift aspect of donation (which has genuinely arisen from fully informed consent) fulfils our Christian obligation to love our neighbour as ourself. Christians therefore support the principles of organ and tissue donation and emphasise the primacy of altruism as a selfless gift to others. In performing the altruistic act of living donation, the greater the risk involved, the greater the personal sacrifice and therefore the greater the gift. (As a corollary, where compensation/payment are involved, the greater the risk, the more important it is to evaluate the motives involved.)

Question 12
No. Taking Christ's free sacrifice of himself for all mankind as our example, the concept of freewill offering transcends all concepts of moral 'duty', or obligation. Any obligation at all diminishes the worth of the act, which is then no longer a donation, a gift.

Question 13
While individuals who have the condition being investigated may want to give special consideration to any obligation they feel, there can be no over-riding moral duty. See 12.

Question 14
No. 'Needs' and 'demands' are not necessarily the same thing. The concept of 'need' has a substantial objective element; 'demands' are more subjective – what individuals and groups perceive they need and therefore ask for (see for example the growing move towards 'lifestyle' treatments). Some form of 'rationing' will always be necessary, and the danger of moving to ever more extreme measures to increase supply is that demand will be stimulated and rise even faster. There has to be greater societal agreement about what constitutes 'need'.

Question 15
In principle we would have no objection to considering different forms. A key issue is whether vulnerable people are put under particular pressure (eg the poor being offered financial rewards) such that their involvement no longer follows fully informed consent. There are well documented examples in 'transplant tourism' of poor people in the developing world selling organs.

Question 16
Yes. It depends on the nature of the incentive. We support altruism and regret moves towards commodification. Excessive financial incentives lead society towards the buying and selling of human material, which from respect for human dignity we resist. It will never be possible in practice to prevent private arrangements within families and between friends.

Question 17
See 16. We should not commodify the human body. Over-generous offers of financial reward might raise suspicions of a disregard for safety and desperation to recruit.

Question 18
In an ultimate philosophical sense, no. However, we recognise that they may be perceived differently, and this may affect acceptability. For example, indirect compensation is specifically directed, eg to funeral expenses. It is not just money in the pocket open to the financial choices of the recipient.

Question 19
Some losses are clearly quantifiable, others are not. By compensating loss but no more, the sacrificial 'gift' element remains, and altruism is an important concept that should be encouraged. Payment moves the process towards commodification, which we resist.

Question 20
Structural changes in transplantation services following the Organ Donation Task Force report should increase supply and reduce demand by meeting need. A generation or so from now, adult stem cells may be providing ethical and effective treatments. The consultation document mentions new mechanical technologies. Xenotransplantation (to which we have no fundamental ethical objection but only safety concerns) should be encouraged. We recognise these latter possibilities are all some way away, but would counsel against any rush into short term measures intended to increase supply but which also cause serious ethical concern.

Question 21
Yes. As the consultation document acknowledges, it will be very difficult to assess 'undue influence'. Is there significant 'influence'? If so, would it be 'undue' in general, to all or most people? Would it be 'undue' to that individual?

Question 22
It cannot. The worldviews of different cultural and ethnic groups would be very

relevant. Even a trained independent assessor (a psychiatrist, psychologist, lawyer) interviewing the potential donor alone would sometimes find it impossible.

Question 23
We accept the concept of 'generic consent' and the additions in the Human Tissue Act.

Question 24
Yes. It is far more difficult to exercise 'substituted judgment' on behalf of others and the responsibility is thereby heightened. For the Christian, the love for others which Christ commands means that the moral responsibility is also greater, when compared with making a decision for oneself.

Question 25
While we uphold mutual responsibilities within marriage and within the family, after death family members should not be able to veto the clear wishes of the deceased. As we argue at Q30, the Christian position is 'My body is God's, to be used for his worship and to serve others' and if that individual has clearly wished to serve others by donating after death, their autonomy should be upheld. Where wishes are unknown, then discussion should be held with families in as sensitive and worldview-respecting a manner as possible, to seek their fully informed consent to donation.

Question 26
A dead body belongs to God, its Creator, but in a temporal and legislative sense, it belongs to no one. However, where known, the clear wishes of the deceased should always be respected.

Question 27
No. See 16.

Question 28
We reiterate that the Christian position is that 'My body is God's, to be used for his worship and to serve others'. It may be entirely appropriate for an individual to enter into an arrangement with a commercial organisation, and the terms of that should be clear to both parties from the beginning, but direct reward should not return to that individual. It would be appropriate and good if the agreed arrangement stipulated that some return from the 'profit' went altruistically into patient care or further research into the condition in question.

Question 29
We support the concept of consent, thus providing some degree of control, but

without granting any legal right of ownership. Following proper ethical discussion there should be societal and governmental agreement about the limits individuals can set on use of their material. For example, a blanket refusal to donate to any member of another race would not be acceptable. If the potential donor cannot after discussion accept that limit, then their offer should be refused.

Question 30

The remit is huge Several years ago, Parliament tried to combine in a single piece of legislation human tissue matters with human fertilisation and embryology matters. Thankfully they realised that this was too complex and broke the contents down into two separate (and lengthy) bills. This consultation seeks to combine even more... Frustration with the format We understand the convenience of online consultations and have responded thus, but unfortunately the format of this one has not allowed us to describe at the beginning who we are, in order to set a context for our response. We have felt uncomfortable answering some questions, which have been theoretical or almost 'academic', in a vacuum. We now describe ourselves and then move to other substantive comments. Who are we? The Christian Medical Fellowship (CMF) is an interdenominational organisation with over 4,000 British doctors as members. All are Christians who desire their professional and personal lives to be governed by the Christian faith as revealed in the Bible. Members practise in all branches of the profession, and through the International Christian Medical and Dental Association are linked with like-minded colleagues in over 100 other countries. CMF regularly makes submissions on ethical and professional matters to Government committees and official bodies. All submissions are on our website (www.cmf.org.uk/ethics/submissions/). We have recently responded to Nuffield Council consultations on Dementia: ethical issues (2008) and on The Ethics of Prolonging Life in Fetuses and the Newborn (2005), as well as to several House of Lords Select Committee consultations on the Inquiry into The EU Commission's Communication on organ donation and transplantation: policy actions at EU level (2007 and 2008). Omitting to consider worldviews Worldviews are the understandings each one of us has about the way the universe is. All our thoughts, beliefs and actions are based on these fundamental presuppositions about reality, and although often unacknowledged they are therefore critical in medical ethics and practice. Different worldviews will sometimes lead to radically different decisions. With respect, we are not convinced that those who have constructed this questionnaire have fully taken on board the significance of the many different worldviews at play. The belief system implicit within the questionnaire seems to assume some kind of secular humanist, neutral, value-free objectivity which does not actually exist. Although it is doubtless unintended, there appears to be a 'one size fits all' approach to the many wide ranging issues covered in the consultation, and we counsel against this. Worldviews are not just to do with philosophical questions about belief. They are inextricably tied to the way we behave, the choices we make, and the way we interact with others. The

UK has rapidly and recently become very pluralistic and multicultural. Although 72% of the population chose in the 2001 Census to describe themselves as ‘Christian’, in reality the UK of today contains many different belief systems which apply to individuals’, families’, and communities’ understanding of the issues in this consultation. CMF’s worldview The Bible’s Old Testament gives Christians (and Jews) the over-arching themes that God is the Creator, Sustainer and Lord of all life and that we are accountable to him for what we do in the world. All human life is made in the image of God, belongs to God, and should be treated with the utmost respect from its beginning to its natural end. Jesus summarises the entire Law in the command to love, applied in two dimensions: 'Love the Lord your God with all your heart and with all your soul and with all your strength and with all your mind' and 'Love your neighbour as yourself'. The famous Parable of the Good Samaritan makes clear that we should respond compassionately as best we can to anyone we come across in need, and has been taken by Christian health professionals as a paradigm for care. This obligation to love is heightened when Jesus Christ says, just before giving his life for all mankind – 'My command is this: Love each other as I have loved you'. He continues with the text that above all has inspired Christians to give sacrificially: 'Greater love has no-one than this, that he lay down his life for his friends'. The altruistic gift aspect of donation which has genuinely arisen from fully informed consent fulfils our Christian obligation to love our neighbour as ourself. Christians therefore support the principles of organ and tissue donation, and this position is the foundation for our answers to the preceding 29 questions. We would urge the Council to consider what positions underpin the answers of other groups or individuals. Critique of ‘3. Ethical Values at stake’ See Q9. Not only have a significant number of important concepts been omitted but the ones mentioned are merely listed and not held coherently. No ethical framework is apparent. This perhaps illustrates the failure to appreciate the fundamental importance of considering worldviews. Conclusion As will be apparent from our brief individual answers to the specific questions, we wish to uphold the principles of altruism and to resist moves towards commodification. We detect within the consultation the danger of a shift from ‘My body is God’s, to be used for his worship and to serve others’ to ‘My body is mine and I trade it as best I can’ or perhaps even ‘My body is the State’s and I accept they will do with it what they wish’. With this in mind, it would be possible for our society unwittingly to move towards fulfilling the aphorism: ‘We know the price of everything and the value of nothing’. We wish the Council well in their continuing deliberations and encourage them to recognise both the breadth and depth of the vitally important issues involved.