Rob Warwick

Question 2

If any human material were to be singled out I think it should be on the general issue of "identity". By this I mean material where there can be a clear emotional thread between the donor and the recipient, for example eyes, the face, limbs or other material that can be thought of as altering the nature of the recipient over and above the clinical reasons why the transplant was required.

Question 6

If there were a situation where safety and quantity of material was less of an issue I believe that the hierarchy between Live-Saving and Life Creating will become extended to include something along the lines of "Life – Enriching", which would include human material possibly for cosmetic purposes.

Question 9

The list of ethical issues seems a little one-sided towards the "good" side of the continuum. I think both "Wealth" and "Preferential access for treatment" should both be included.

Question 10

I think that there should be recognition that any values or priorities that may be thought of in an abstract intellectual sense, for example sitting here at my desk as I write this, are likely to be very different from the actual emotional experience when a family has a conversation immediately after the death of a loved one.

Question 12

As a layperson the words "moral" and "duty" don't sit well together; the former implies a sense of free will, the latter doesn't. Therefore, I think it is important to recognise a sense of paradoxical tension otherwise the question could be reduced to a form of bullying.

Question 14

If we get to a position where there is excess supply of organs for demand there will inevitably be other constraints. For example, does it provide good value for money and will it use too much resource (ICU capacity). Also, what will this say about personal responsibility, particularly in the case of liver transplantation and alcohol abuse. When it comes to prioritization I don't think you can have a different form of deciding priorities than with other healthcare provision; however imperfect that may be.

Question 16

I think there are all sorts of tangles awaiting anyone who wants to develop a price list or formula covering: demand for tissue; inconvenience to the donor or their family; time off work etc. I don't think there is anything that is off limits per se. The focus should be on setting up a group that can decide what to sanction as and when issues arise so that they can weigh up actual cases, not abstract theory.

Question 20
In the US the current economic downturn has, I understand, reduced demand for tissues. This has been an opportunity to increase quality by reducing the upper age limit for donation. Therefore; it is not only scientific progress that affects this dynamic and should this occur it can be used to improve patient outcomes.

Question 23
No.

Question 25
If a family were to say no to donation then it shouldn't go ahead. Firstly, it is the family that has the closest connection with the deceased. Secondly, they may well know more about the wishes of the donor. Thirdly, practically, is there really an expectation that material will be removed with a distraught family banging on the doors of an operating theatre? Finally, it will only take one public case of a weeping family on the news for it to undermine public confidence.

Question 26
On the issue of property the current approach seems to work. Is there a risk in "over codifying" this by removing a sense of imperfect pragmatism that has developed over the years.

Question 29
For all material, the donor or their family should have full control over the material up until the point it has been "clinically committed" to another. At this point there can be no control, even if mistakes in consent etc have been made during the process.