University Hospitals of Coventry and Warwickshire Clinical Ethics Committee

Question 2

A number of members thought there was a difference between regenerative, e.g. blood, and non-regenerative material, e.g. kidney. Members found it difficult to determine the reasons for the difference. Some argued that it was riskier to donate solid organs as opposed to regenerative material such as blood. Some argued that altruistic donors, because of their deep motivation, would more likely embrace the entailed risks. Others argued that some people might be prepared to put themselves at risk if there was promise of financial gain. Would submission to the risks associated with organ donation be different in kind from other widely accepted forms of risk-taking, e.g. clinical research trials or dangerous occupations such as firefighting? However, risk analysis does not explain differences in perception between regenerative and non-regenerative materials. Nor does it explain why we are less concerned with the provision of incentives to increase donation of regenerative material.

Question 3

There is an important distinction between live and cadaver donation. Although a dead donor cannot personally benefit, the donor's estate could. This prospect might encourage people to join the donor register. This system of remuneration would need to apply to all registered donors whether or not they intended to donate organs altruistically provided the scheme was cost-effective overall. The introduction of a system of remuneration should be accompanied by appropriately rigorous assessment to ensure voluntariness, perhaps using a system comparable to IMCA's under the Mental Capacity Act.

Question 9

While not strictly speaking an ethical value, attention might be paid to 'gut instinct' as a source of moral knowledge. This would address the sense of inarticulate, but persistent, unease, many feel about the concept of commercial organ donation, even if the face of the kinds of conceptual clarification that ethical analysis offers. Gut instinct might be dismissed as a species of distorted thinking. But it might point to deeper sources of ethical concern.

Question 14

Whether or not it is right to meet demand depends on the purpose for which donated organs or tissue are needed. There is a hierarchy of demand ranging from the strong public interest in preserving life through the arguably less strong public interests in life-enhancement and life-creation. For example, a lack of available gametes for an IVF programme might not have the same urgency as a dearth of livers, hearts or kidneys. While as a society we are prepared to offer incentives to

increase the gametes supply, there is presently no comparable urgency to offer incentives for solid organ donation. While many solid organs are non-regenerable, others, e.g. livers (although live transplants are high-risk), are.

Question 21
There are forms of encouragement and incentive which could invalidate consent. Encouragement and incentives may well result in provision and participation which would not otherwise have occurred. Some Committee members wondered whether incentives were by definition coercive, although other Committee members recognised that forms of pressure within family contexts already occur. Distinguishing genuine consent from coerced agreement would require distinguishing 'persuasion' or decisions borne of a sense of obligation, from unreasonable pressure. In borderline cases, such distinguishing is necessarily intuitive.

Question 22
Distinguishing genuine consent from coerced agreement will often be a matter of delicate judgment. Genuine consent should demonstrate an 'inner freedom' which may well involve endorsement of one's perceived obligations within the network of family relationships. One mark of voluntary acceptance will be evidence of a genuinely personal contribution to family discussion about the propriety of provision or participation, i.e. a personal voice being heard amongst the discussants and a personal justification for the decision to provide or participate as opposed to simple duplication of the opinions of another family member.

Question 27
The answer to this question is closely related to the answer to the question on control (Question 29). If human body parts and tissue are essentially fungible (i.e. tradeable things, then there is no reason why UK laws shouldn't permit their commercial exchange, unless there is a good countervailing public interest. If, however, human body parts and tissue form part of integrated personhood, then additional justifications for breaching this integrity on commercial grounds need to be supplied. For example, there might be good duty-based grounds for weighing the public interest in increasing the organ supply more heavily in the balance than the public interest in preserving bodily integrity. This could cut the other way. The public interest in underscoring personal autonomy might be outweighed by the public interest in preventing harm to others, i.e. for the greater good of the whole society. There are, for example, legal constraints on assisted suicide.

Question 29
The Committee agreed that this question raised profound questions of philosophical and theological 'anthropology'. If the human person were principally conceptualized as a 'choosing' being, then there is an intelligible corresponding emphasis on the principle of personal autonomy. The right to choose would embrace a right to be

'selfish' and to achieve one's own self-interest. However, if the human person is conceptualized as an 'integrated totality' of body, mind and spirit, then the notion of there being some limits to what one can properly do with human bodily material becomes rationally defensible, e.g. according to a 'principle of integrity' (i.e. viewing the truly human as an embodied 'whole' rather than as a disembodied 'will'). It is easier to ask, within the 'holistic' as opposed to the 'voluntarist' paradigm, whether there are some thing which simply shouldn't be done with bodily material, e.g. commercial organ donation.

Question 30

The distinction between regenerative and non-regenerative material is not easy to determine. There could be a risk-based distinction, i.e. there are greater risks entailed by solid organ donation than blood or gametes. But if risk was the key distinction, then altruistic donation would be suspect. Moreover, we do pay for risky behaviour in other medical contexts, e.g. participation in clinical research trials, or non-medical contexts, e.g. firemen. Another basis for distinction has been alluded to earlier. Solid organ donation represents a breach of the 'principle of integrity' in a way that donation of regenerable material does not. Arguments from human dignity are easier to run within this anthropological framework that they would be if we conceptualize the human person as an essentially 'choosing being'. The presumption against breaching integrity might be overridden for altruistic organ donation which allegedly redounds to the common good. However, organ donation might contribute to the common good whether or not the donor financially benefits. Currently, patients are dying because of the dearth of transplantable organs. The NHS is economically harder pressed as a result, treating ill patients on the waiting list. The best supply-increasing schemes, e.g. Spain, are de jure opt-out- but de facto opt in. Perhaps pressure for a more sophisticated organ procurement scheme is required first before commercial organ donation is seriously entertained.