

Hoffenberg Lecture

I am delighted and honoured to be invited to give this inaugural lecture in memory of Bill Hoffenberg.

I knew Bill first through his very significant role as President in involving the Royal College of Physicians in the ethics of research on human subjects. The College led the way in developing thinking in an area which had been hitherto neglected. Under Bill's leadership, the College produced a Code which served as the starting point for all that followed: no-one could say now that the area is neglected, nor should it be. The College was also greatly involved in wrestling with the determination of death, in the face of developments in artificial respiration and intensive care. Here again, under Bill's leadership, the College produced a set of guidelines which led the world. I had the privilege and pleasure of working with Bill and other giants, such as Brian Jennett, and considered myself very fortunate.

Out of the involvement in the determination of death grew the interest in transplantation. We were all keen to point out that they were entirely separate subjects: death needed to be determined in some circumstances, whether transplantation was an option or not. But, that said, the growth of interest in transplants and the hopes that transplantation held for people otherwise very sick and often destined to die before their time, drew many to the subject. Of particular interest to Bill and those he gathered around him, were the ethical challenges thrown up by the possibilities of transplantation. This was typical of Bill: he was a deeply moral man who saw medicine as a moral as well as a technical endeavour. Through his enthusiasm and that of colleagues such as Robert Sells and Janet Radcliffe Richards there was created the International Forum for Transplant Ethics. It met regularly, sometimes in the UK, sometimes in Europe or North America. It was a serious business. Papers were circulated, discussed, rethought, re-circulated. Many ended up in the Lancet and the like. All the hot topics of transplantation were taken on.

What characterised these meetings apart from the fact that we were all volunteers and made the time within our day jobs, was the sense of camaraderie and fun which Bill did so much to engender. We were serious, indeed very serious when it came to matters such as the link between executions and transplants. But we were also good friends, enjoying each others' company. Indeed, when I was in Australia on one occasion I made a side trip to the Gold Coast north of Brisbane, just to touch base with Bill and Margaret, because I so liked and admired him. We talked of his enthusiasm for the new South Africa and what he was doing to help Mandela's government to meet the massive challenges of health and healthcare. I remember walking on the beach with him, this big bruiser with the broken nose (the product of boxing, not rugby), and thinking how much he had done to humanise medicine and make ethical issues a central part of the discourse. He was, if I may use a very English term, a very nice man.

He was also a giant of a man in spiritual as well as physical terms. No-one reading L Ross Humphreys' biography can come away without a

sense of wonder at all he achieved. A fierce opponent of apartheid, he was made subject to a banning order which put an end to his career as a doctor and teacher. He, like many others, was forced out of his beloved South Africa. When he left in 1968, over 2000 medical students came to the airport in white coats to say their farewells – that was the measure of the man. Leaving your home with a family to start again would overwhelm many. But this man just went from strength to strength. A Chair in Birmingham University, a distinguished career in research, the summit of his profession as President of the Royal College of Physicians, and the President of Wolfson College Oxford. He threw himself into the issues of the day with energy and intellectual rigour: they included the prison medical service, medical ethics, from research, to euthanasia, to transplants, to torture. His condemnation of research on South African miners showed him at his most humane and courageous, as his previous mentor in South Africa attacked him and only later and grudgingly apologised. And, of course, he was deeply involved in the politics of healthcare as the NHS struggled to come to terms with the

Conservative Government's view on life in the 80s. And finally, as in all good stories, the wheel came full circle. Apartheid collapsed, Mandela began the task of guiding South Africa out of the darkness of the previous decades and Bill was invited back to help. You can imagine the pleasure that gave him.

And, before I close this tribute, may I share something with you that I found out only recently? Why was Sir Raymond known to all as Bill? Well, Bill had a sister, Elaine, who, at the age of four, Bill being three, developed an imagined attachment to one Billy Ryan who went to the school next door. Unable to make contact with the real Billy, she converted her brother into a surrogate Billy. The rest is history.

This evening I am invited to explore some of the ethical challenges thrown up by transplantation. I shall do so in very general terms. I shall do so with one eye on the legacy of Bill Hoffenberg.

Let me indicate the topics I'm going to touch on. They are:

the determination of death

the allocation of organs

strategies to increase the supply of organs:

commerce in organs

transplants and state execution

Each of these topics deserves a lecture, or a series of lectures, in its own right. Here I will fly high and fast and hope not to be thought too perfunctory. I will be looking at the various topics from the perspective of asking what is the right way to think about them as a guide to asking what we should do about them.

Before an audience such as this, I do not need to rehearse the development of transplantation over the past 50 years since the first transplant at Peter Bent Brigham Hospital in 1954. I notice in passing that corneal grafts anteceded the development of organ transplants as we think of them, but they do not detain us here this evening. Transplantation has long been accepted into the armamentarium of

treatments in response to patients suffering from the failure of one or more organs. It was not always so. The first heart transplant, as some will recall, provoked considerable public concern, on two grounds, both of them ethical. The first concerned the experimental nature of the procedure. On the death of the first and subsequent early recipients, the question was asked whether it was ever right to use very sick people as, effectively, guinea pigs. This is not, of course, a problem particular to transplantation and it continues to raise its head.

The ethical response which emerged was one of the early examples of the rise of autonomy as a fundamental guiding concept in medical ethics. The argument went that if the patient was made aware (informed) of what was at stake – his current condition, the proposed intervention and the likely outcome – then the transplant was ethically justifiable. The fact that the patient was close to death made it appear easier. There was no real choice: it was certain death against the faintest of hopes of continued existence for some

unknown period of time. The counter argument that the patient was being used merely as a means to an end – the development of this area of surgery – and that such use of him was contrary to the public interest, did not get very many takers. It was his life, his body, his heart, and he could do what he liked with it. Of course, such a claim is question begging: there are and should be limits to what it is proper to do with your body. Was agreeing to a heart transplant one of them? But, as I've said, this strand of argument did not gain much currency. Autonomy ruled.

The second ground of public concern which attended the early heart transplants was a concern that has dogged transplantation ever since, even though, strictly speaking, it is entirely unrelated to transplantation. It may be as well to recognise it early on and deal with it. I refer to the determination of death. This is not the place to explore the issue in depth. Indeed, if I do, it would mean that, again, it has captured the discourse about transplants. So, instead, I will

offer a series of propositions, which move from the scientific to the ethical.

First, whether people/patients are dead is a question which has to be answered in certain circumstances, quite apart from any question of transplantation. It arises because a patient's vital signs can be maintained independently of the patient's current capacity to do so. At some point the question must be asked, out of concern for the patient, for the patient's family and friends, for the staff caring for him/her and for the proper use of scarce resources, whether the patient has died.

Of course, the determination of death is not a scientific question, though an understanding of medical science is important. It is an ethical question, a question not about the meaning and determination of death, but about the meaning of life. We must understand what we regard as being alive, so as to settle on an understanding of death. I cannot rehearse here all of the arguments. By way of shorthand, the philosophical has been intertwined with

the scientific. The debate, which still runs hot in some quarters, centres on the brain versus the heart. These serve as surrogates for one conception of being alive which looks to a continued capacity to sustain vital functions, the irreversible loss of which constitutes death, and one which looks to the complete absence of vital functions, the cessation of heartbeat. In the UK, after careful deliberation, the former definition was adopted, as long ago as the late 1960s. The scientific criterion chosen to establish death was the irreversible loss of brain stem function. The continuing commitment to this approach was signalled only last year again in the latest update by the Royal College of Anaesthetists' Working Group on Brain Stem death. Elsewhere, as is well known, the commitment to a definition based on the presence or absence of heart beat, or the rather curious half-way house based on the absence of all cerebral function, are still argued for.

As we shall see, this discourse continues to have implications for the practice of transplantation. But, I repeat, of itself, it is an entirely

separate ethical and scientific discourse, arising not from the development of transplantation but from the development of techniques of intensive care. That said, the two issues have been brought together in a debate which I ought to notice here before moving on.

The argument is as follows. A patient is near death and will not recover (assume the facts). The patient's organs would be suitable for retrieval and transplant. Can the patient's treatment be managed differently so as to ensure that the organs are kept as viable as possible for transplant, even if that means that the nature of the patient's care changes, more in the interests of the organs than the patient? The initial answer should be, No. The patient is living until dead and thus is owed the same duty of care as any other patient. To modify treatment so that its purpose is not to put the patient's interests first is, on this reading, unethical and probably unlawful. Some find this an unfortunate conclusion. It means that organs may deteriorate in the process of dying and not, therefore, be usable for

transplant. So, one modification to the hard line advanced above has therefore been advanced. It has something of the Jesuitical about it, but can, I think, be defended. It is described as the non-heart-beating transplant, meaning that the patient's organs are removed after death and the cessation of heartbeat, but measures are taken in advance of death to ensure that the organs are viable for transplant. The argument is that the general rule remains sound and should be followed. The basis is the duty always to act in the patient's best interests. But enter the more subtle point. What if the patient had signed a donor card or expressed a documented wish that his organs be used for transplant? In these, and perhaps other circumstances in which there is evidence that the patient was willing to donate his organs, it may, in fact, be in the patient's best interests to manage his care so as to give effect to his wish, if he is inevitably going to die. I can see the power of this argument in terms of advancing the cause of transplantation in the context of scarcity. It needs to be said however that it is an approach which must be adopted with great care and monitored scrupulously.

But, this conclusion compels me, in turn, to grasp a nettle which has been around for some years. How does this argument affect the question of what is known as elective ventilation. This involves placing a person who has suffered massive brain damage and whose prognosis is hopeless, on a ventilator in an ICU for around 48 hours until brain-stem death takes place. Developed in Exeter in the late 80s, it was discontinued in 1994 on the basis of legal opinion that it was unlawful. The unlawfulness lay, it was said, in the fact that the patient had not consented and that the intervention was non-therapeutic and thus not in the patient's interests. Can we deploy the argument that we have just seen, that if the person was registered as a donor, it would be giving effect to his wish if he were taken to the ICU and ventilated? My answer is no: the argument cannot be deployed. The reason is that consent to elective ventilation must be specific and cannot be assumed from a general agreement to be a donor. This is because elective ventilation carries a risk, albeit small, that the patient will not die but enter a persistent vegetative state. It is unlikely in the extreme that someone would

explicitly agree to take this risk, both for himself and his interests and for those of his loved ones. Certainly, no such consent could plausibly be implied. Thus, I still hold to the position I took when asked in the 80s: elective ventilation is both unethical and unlawful.

There are, of course, other ethical objections, having to do, for example, with the use of a bed in an ICU for two days and thereby potentially denying care to others, and the use of the scarce resources involved. I do not rely on them here but note them.

Allocation of organs

Now, let me turn to the next of the issues that I mentioned earlier: the allocation of organs. Of course, we must begin by asking why this is an issue to be discussed. As you all know, we ask it because, within varying degrees, there are not enough organs to transplant into those who could benefit from a transplant. So, since the advent of transplants, choices have had to be made. And, choices call for criteria, and given what's at stake, sometimes the patient's life, always the possibility of improved health, the criteria need to be

ethically justifiable. You can, of course, and some did and do say that there is nothing of ethics here: the criteria guiding the choices are wholly medical. But, even if “wholly medical” intrinsically meant free of ethical content, which is difficult to sustain, the proposition does not hold water, as I sought to suggest many years ago.

We are in the world of rationing and there is no escape. This is not something bad, of itself: all health care is rationed to a greater or lesser extent. What occupies us is the consequence of not being selected for transplant and the consequent need to have a system of allocation which is ethically sound.

Let’s remind ourselves of the strategies for allocating what is a scarce commodity. I confine myself initially to organs retrieved from the dead. Initially, age was frequently used: an unstated rule that very young patients and those over 55 would not be considered for transplant. There were some plausible medical justifications, having to do with the likely success of the transplant, but the reasoning was essentially ethical: that a chance of life or better health should be

given to those who could still enjoy a fruitful and productive life. Or, more crudely, were not past it. The reasoning was not, however, altogether about fitness for a transplant. Transplantation before a patient had been put on dialysis was virtually unheard of at that time. It was the scarcity of dialysis machines, a further ethical twist, that was, at least in part, responsible for the rationing of transplants. Nephrologists, for their own reasons, part medical, part social, tended not to offer dialysis to the over 55s. The over 50s, therefore, often did not even get into the transplant queue.

As the outcome of transplants became more successful, it became clear that selecting recipients on the basis of age was a pretty desperate strategy and was increasingly hard to defend medically. Other approaches were mooted, on the assumption that the prospective recipients were otherwise equal both in terms of the likely success of the transplant and the prospects of benefitting from it. A lottery was proposed, as was queuing, that quintessentially British device. Now the wheel has turned again, prompted by

increasing understanding of the reasons for success and failure. Allocation is made on the basis of a number of physical criteria, so as to ensure the best possible match between the recipient and the person from whom the organ has been obtained. We appear to be back to the position in which ethics can be sidelined in the minds of some.

But, insisting on the best possible match means that the person who could, perhaps, benefit but is pipped by someone with a marginally better match, loses out. The consequences could be fatal. Unsurprisingly, this person doesn't want to take no for an answer. Re-enter ethical debate.

Faced with a shortage of organs for transplantation, a range of responses can be made to the person who cannot gain access to the needed transplantation. The state can take action to increase the supply, and the individual can take action. These twin approaches can and do, of course, co-exist.

The state can do a number of things aimed to increase the supply of organs. It can also take action with the aim of limiting the supply, if the proposed means of increasing supply are considered ethically undesirable.

Increasing the supply

In Britain, the access to organs for transplant has been based on the fundamental premise that they should be freely given. The ethic is one of solidarity and collective concern for the welfare of all. It was the inspiration behind the National Health Service and is reflected in the seminal and hugely influential work of Titmuss on blood donation, *The Gift Relationship*. It is no surprise that it was the approach adopted in relation to organ donation. People were encouraged to carry donor cards and register as potential donors, to opt in, as the argot has it. When need began increasingly to outstrip supply, the response of the state from time to time has been, in effect, to urge more people to carry donor cards and enrol on the voluntary donor register. This was the fundamental message which

emerged from the Organ Donation Taskforce which reported at the beginning of 2009. The principle of the gift, characterised by voluntary donation, opting in, was endorsed. This principle was to be surrounded by a series of administrative measures to make it work better. But, from the point of view of the state, it was to remain the central ethical pillar of the system. The fact that it had not produced the goods over the past decades was shrugged off: we just have to try harder was the message.

There are, of course, other things that the state could do. They are deemed to be ethically contentious. Let's look at some of them and then take a view.

Presumed consent or opting out

Currently, the system established by English law is that known, broadly speaking, as opting in. As we all know, this system has increasingly failed to bridge the gap between supply and need. Presumed consent, or opting out, represents an alternative. The state, through its law, would establish a system whereby a deceased

person is presumed to consent to the removal of an organ, if otherwise suitable for transplant, unless a contrary intention has been expressed. Clearly, the notion of presumed consent is an oxymoron, and, as such, is capable of being confusing. The term opting out, therefore, is seen as preferable. In contrast to the current system which requires members of the public to opt in, that is positively to indicate their agreement to the removal of organs for transplant, opting out would shift the onus and allow the state to assume that an organ may be removed unless an objection has been registered during the deceased's lifetime. The result under both terms is the same. The required conduct is the same, a positive act of refusal, but to some the language of opting out sends a more acceptable signal than presumed consent: that the decision is in the control of the citizen.

I must here declare an interest. I first advocated "presumed consent" over thirty years ago. I have never seen any reason to change my mind. Indeed, I have never understood the objections raised. Clearly,

there are administrative issues, which would need to be addressed. And, there would be the need to respect certain beliefs. This latter concern can readily be met by focussed information and a suitable time-scale before implementing the system. But, over the years, other objections have been raised. They have included references to the rights of the family, the rights of the deceased, and the interests of those caring for the dying potential donor. To my mind, none is ethically persuasive. Indeed, they could be said to be ethically perverse. For me, the most critical ethical concern is for the patient who could benefit from the organ. His or her claim to the organ, which will otherwise be burned or buried, should be recognised by the state as far stronger than any other's. The deceased has no claim, unless s/he has opted out and the opting out was ignored (the claim would be that of the executor). As for the family, its claim that the organ be destroyed rather than used to benefit another does not rest on any sense of ownership: the organ does not belong to them. It can only rest on a claim that their sensitivities should prevail. And, while ordinarily, the state should seek to respect such sensitivities,

the state also has an obligation to those who are ill and could be made better. Rescuing the living, in my book, takes precedence: it should be the ruling ethical principle.

It came as a surprise to many, therefore, when the Taskforce, having deferred a decision in its original Report, subsequently announced that they opposed opting out. It came as a surprise and a huge disappointment. Volunteering was the only game in town. More donor cards had to be carried: this, despite decades of evidence that donor cards and registering as a potential donor alone had not reduced the shortage of organs. Even more surprising was the reason given. Those caring for patients whose organs might potentially be used after death for transplantation opposed opting out and their view was accepted. Their opposition was based on the fear that their relationship with the patient's family and loved ones might be compromised, that they may not be trusted to devote their total commitment to the patient because the possibility of transplanting the patient's organs was on their minds or in the background. This is,

of course, a legitimate concern. But there are at least three responses. First, it is expressed as a concern or fear. It is not expressed as a proposition of fact. No evidence is adduced that families have taken or would take this view, if the situation were appropriately managed. Secondly, if it is a real concern, the response ethically is to ensure that all means are used to dispel any concern or fear, so that the family may be reassured, rather than use it to prevent the introduction of a policy which is otherwise ethically justified. Thirdly, it is of some concern that the ethics and policy of transplantation should be decided by one particular clinical constituency. Of course, their views and values deserve respect. But, in my view, the challenge is for them to adapt and help others to do so, rather than veto change because it might be temporarily challenging.

But, presumed consent, or opting out, remains off limits in the UK. Ethically, this can be regretted.

It could be objected that I have failed to acknowledge that there are, in fact, two types of opting out: “hard” and “soft”, one of which may be more acceptable. “Soft” opting out refers to the practice that, while the law allows organs to be removed without seeking permission, in fact the family are asked for their permission. This is the practice in Spain. Obviously, the notion of “soft” opting out is a subterfuge. It undermines, even frustrates, the policy behind the law. That said, I do not object to this ethical fudge, provided two criteria are met. First, it must be understood that it constitutes a temporary accommodation, allowing for the gradual shift in culture. Secondly, the number of refusals must fall over time. Otherwise, the needy patient will see the claims of compromise and “pragmatism” once again raised as barriers to meeting his need.

I recognise that some may protest that while the ethical reasoning behind this argument may be sound, it fails to take account of the emotions that swirl around death and the relationship that the family has with the body of the recently dead relative. Let’s be clear:

this is not the same as the previous objection, based on a suspicion that those caring for their loved will be looking over their shoulders towards the prospect of using an organ for transplant. Rather, it arises, in my view, from a deeper, even superstitious attachment to the body. And, of course, the revelations of Bristol and Alder Hey have only fuelled a concern that, if they are not vigilant, the family will find that the body has been desecrated. This, the argument goes, is what causes families to withhold consent to the use of organs in the UK and explains why in Spain, which has a law based on opting out, the family is still asked, as a matter of practice. And, this, in turn, it is said, persuades pusillanimous governments not to legislate for fear of offending these fears and superstitions.

I understand the argument but do not accept it. The UK's government, in the person of the Prime Minister, was persuaded of the need to change the law. It was not popular sentiment but the Task Force, swayed by a group of clinicians, which caused him to stay his hand.

Mandated choice

The Chairman of the Royal College of Physicians' Ethics Committee recently urged the adoption of a policy called mandated choice. This would again require action by the state. It contemplates that each citizen should be required to register an answer to the question whether s/he is willing to have his/her organs removed after death for transplantation. Much hangs on the answers allowed. In some early examples of this policy in the United States, the citizen was given only two choices: Yes or No. Such an approach was subsequently thought to be too limiting and thereby not sufficiently respectful of the individual, who may, for example, support the notion of transplantation, but may be ill-at-ease in confronting a decision in his own particular case. For this reason, the Royal College of Physicians proposed a third possible answer, namely, "Ask my relatives". This answer, it was argued, allows the citizen to avoid the question, without undermining the possibility that his organs could be used, on the say-so of his relatives.

The proposal was not widely welcomed. It was rejected, for example, by the British Transplantation Society and the British Medical Association. The Organ Transplant Taskforce also rejected it, despite a submission from the College. The College complained, however, that the Taskforce had only considered it on the basis of there only being two answers available. The Task Force's opposition was, therefore, understandable because, if only the two answers are allowed, it becomes just a variant of opting out and so attracts the same opposition.

But, does the addition of the third possible answer make any difference? Essentially, it becomes the same as the existing system, whereby, in the absence of any expression of intention by the patient, the relatives decide. To that extent, it's hard to understand why it would be opposed. Equally, given that it largely reflects the current system in the absence of an express wish to donate, it's hard to see how it would improve the supply of organs.

The Israeli option

One recent innovation is the position recently adopted in Israel. There, priority in access to an organ for transplant will be given to those carrying donor cards. As a rationing device, its intention is political. It is clearly intended to increase the number of citizens who carry donor cards. In terms of ethics, it constitutes a continued commitment to the principle of voluntariness and social solidarity. It merely goes further in its commitment by rewarding those who demonstrate through active engagement their solidarity, rather than just passively support it. It could be said by critics that it discriminates against those who are unaware of the policy. The answer lies in placing on the state the obligation to use all appropriate means to make the law known. It also discriminates against those who oppose the removal of their organs for transplant, but who may, if they come to need a transplant, ask for one. To them, the response must be that social solidarity means what it says. In the context of scarce resources, it is entirely defensible to prefer first those who are prepared to give as well as to get.

Designated or conditional donation

This term is used to refer to the situation in which a person before death indicates his willingness to be an organ donor but seeks to specify the person, or class of persons, into whom the organ may be transplanted. The stated intention is that the organ should go to that person, or group, and no other. When this circumstance arose in recent cases, the decision was taken that the specific designation should have no force. The reason given was that organ donation must be seen and operated as an altruistic endeavour (the Gift principle again). Laying down conditions, designating a recipient, violated this principle and so could properly be ignored.

I must say that I find this reasoning unpersuasive. Certainly, it is desirable that organ donation be based on altruism in its most general form. But, this does not mean that it must be exclusively altruistic.

It will be a relatively rare case in which someone will seek to direct who may receive his/her organ. If the direction amounts to some

religious or racial bar, then it will be ethically legitimate to prohibit such a bar, based on principles of fairness and hostility to adverse discrimination. An attempt to direct that an organ should not be given to members of a specific racial group was the immediate cause of the ban on designated donation. Of course, in such circumstances, the organ might still be used for transplanting, on the ground that the underlying consent to donation can be separated from the specific objectionable instruction and acted on accordingly.

But, this exception need not necessarily rule out all forms of designation. Indeed, designated donation is deemed entirely acceptable from an ethical standpoint in the case of a living donor who provides an organ for a relative (or even a friend). If it is ethically acceptable among the living, it is not at all clear why the intervening death of the designating party changes anything. Of course, it may be said that to allow designated or conditional donation limits the pool of available organs. But, this is obviously not the case. It increases the pool and reduces the number waiting.

What then of the argument that the designated donor has allowed the favoured recipient to jump the queue: that there are potential recipients who have waited longer and are just as good a match? There are at least two replies. First, the person waiting would not have received the organ because it would not be offered save as designated. Secondly, if, once available, the organ is then given not to the designated person (or to a member of a class of designated persons, eg a child) but rather to someone else who has been on the waiting list longer, this not only offends a general principle of our society that we should seek to respect the expressed views of the deceased, but also gives greater weight to the principle of the queue than to the expressed wishes of the donor. And, of course, allocating resources by reference to the queue, though a long-established British principle, ignores any special circumstances which may make a particular case more ethically compelling than that of the person who is first in the queue. For example, we let the mother with her child jump the queue, just as we let someone join the queue, when the person he is joining says that “she is with me”.

Commerce in organs

We enter now a very complex area, replete with ethical challenges. And, in contrast to what has gone before, the discussion here is about transplants from living donors. This is not to say that transplants from the deceased cannot raise concerns about commerce. Rather, it is to say that the problems largely relate to living donors.

It will be clear that the British approach to transplants, based on altruism and the notion of the Gift Relationship, would have difficulties with the notion of a trade or commerce in organs. Indeed, such commerce is unlawful in the UK, under the Human Tissue Act 2004. But what of the ethics?

I begin by noticing perhaps the most important element in the discussion, though superficially at a tangent to what is being discussed. I refer to the internet. No consideration of commerce in organs can ignore the powerful coming together of an unmet need for organs and the desperation that comes with it, and the creation

of a virtual global market. Notions such as transplant tourism and trafficking in organs have entered the debate. But before I address them, let's look briefly at the arguments surrounding commerce; the sale of organs.

Classically, objections are raised against commerce because of the circumstances in which it arises. Someone seeks to raise money by selling an organ, let's say a kidney. (Suicide donation though not unknown, and carried out willingly for perhaps the financial benefit of a family, must on any analysis be unethical, since it necessarily involves the person taking the organs in the act of killing.) The argument has it that, under normal circumstances, no-one would be willing to part with a vital organ, even though he can function perfectly well on, for example, one kidney. The only reason, therefore, that he is doing it is out of a need for money. The argument immediately lurches to the conclusion that he is being exploited. Exploitation, it is said, is wrong. So, such commerce is unethical.

The difficulty with this argument, which, I repeat, I pursue so as to set the parameters for the wider discussion to follow, is that it does not take account of the fact that there is exploitation and exploitation: much of what people with no or limited money do could be described as a form of exploitation. They work in dangerous jobs, live in unsafe places in an environment which has many dangers. They make their way through these hazards. Choices are rarely open to them. In such a context, if someone were to say that a person could earn enough money to get a house or educate his children by agreeing to have his kidney removed, he may well jump at the offer. It's not what he might want, but little of his life is. At least it brings a significant reward. And, I assume in this scenario that the operation will be properly carried out and the person treated till ready to be discharged and then followed-up.

On this, somewhat idealised, version of events, a case can be made that the purchase of the person's kidney is not unethical. Both parties recognise their respective needs and reach an accord. This

would compel the argument that there is nothing intrinsically unethical in commerce in organs, provided that the conditions having to do with the welfare of the donor are met. Nor would the clinical team be behaving unethically. The person has made his assessment of his needs and has made his decision. The surgery admittedly is carried out on a healthy person and is mutilating. But this is no different from consensual live donation where no payment is involved. The patient's consent and the general public good served by transplantation provide ethical cover.

The difficulty is that this idealised picture is not what we are currently dealing with. Through the internet, those needing organs, often in countries where there is no or a very limited transplant programme, seek out those who will secure organs. It is largely the domain of the wealthy sick. The organs are secured from the (relatively) healthy poor. Trafficking in people and organs is the order of the day. The reality is one of reexploitation, of the very poor being tricked or trapped into "giving" their organs, of illegal

operations (since many countries, particularly in the middle and far east ban commerce), of botched operations, of people left with no after-care, and of the rich clutching at a chance of life denied their poorer fellow citizens.

This may also be something of a caricature. But, it is certainly close to the truth of what has happened over the past few years. And ethically there can be no room for doubt. Those involved in recruiting “donors”, in operating on them, and in oiling the wheels of the enterprise have much to answer for. In terms of ethics, and here I mean a universal ethic, they are to be condemned. What they do is wrong. What should be done about them and the practice they are part of is a separate question. Clearly, given the international nature of the trafficking, only international action will do. The recent Declaration of Istanbul is one example of such action. But, ultimately, such trafficking will only cease when the supply of organs meets the need. In the meantime, the greatest force for limiting trafficking is the clinical professions. They have already shown remarkable

leadership. They should continue, making it clear that someone who carries out a transplant in the circumstances I have described deserves condemnation and rejection from the ranks of caring clinicians. And because this is the reality of commerce in organs, rather than the arms length agreement between two consenting parties which is the theoretical model of the commercial exchange, commerce in organs has no place as a response to scarcity.

But, is there a way round these objections? Would commerce be acceptable if it was controlled by the state? The supply of organs could be increased, but, through the engagement of the state, exploitation could be avoided, the welfare of the donor could be addressed, as could the quality of the organ removed for transplant. These are the justifications advanced. How to respond?

There are two ways in which the state could be involved. The first is through what economists call a monopsonistic market, whereby there is only one purchaser. This could be the NHS, as is largely the case with pharmaceutical products. The NHS would purchase the organ at

an agreed rate and make it available, free at the point of need, in accordance with the overarching principle of the NHS. The same approach to allocation would be followed as is now the case: there would just be more organs to allocate, it is said. And the rich would fare no better than the poor, at least in the receipt of organs, because the organ would be free.

Of course, the rich would donate far fewer organs than the poor because they would have no financial reason to donate. The risk, indeed, the reality of exploitation, therefore, would still remain. Moreover, and this may be the fundamental objection to the introduction of such a policy, it would constitute an abandonment of the principle of the gift. I am prepared to depart from that principle in the case of “opting out”, where the organ is removed from someone who has died. But, to do so as between the living donor and donee is to take the state into troubling and troubled waters. It would commodify us. It would constitute an admission that altruism, coupled with the far less contentious “opting out”, cannot deliver all

that we need. It would mean that the state was prepared to see its more economically vulnerable citizens expose themselves to a serious non-therapeutic intervention out of need (and make no mistake, it would only be the needy who would be persuaded to come forward by the financial motivation). I cannot see, therefore, that this form of state involvement in creating a market for organs is ethically acceptable. I leave aside the additional question of whether the removal of an organ for payment would be lawful. I would only add that the law recognises limits to that which a person may consent to. Those limits reflect a sense of the public's view as to what should be regarded as morally permissible. I would hazard that a court would find the surgery unlawful.

Another way in which the state can become involved is to allow for commerce in organs but seek to regulate the market, through such conditions as fixed prices for organs, quality control, and safe care for the donor. Those who believe in the market as a solution to our problems, the perfect regulator of our affairs, have recently argued

strongly in favour of a regulated market in organs. Supply will be increased, waiting lists will disappear. Supply will be brought into contact with demand through the agency of money.

There are at least three difficulties with this approach: the supplier, the purchaser and the context. As regards the context, it is one of significant scarcity (which will never be completely eliminated) in which the scarcity threatens the life of the person wanting the transplant. Scarcity colours the transaction.

As regards the supplier, he is someone who needs the money and sees or has no option but to submit to surgery. We are back to the exploitation point. It is fine for commentators to say that the operation is standard and the loss of a kidney (and perhaps these days, part of a liver, pancreas or lung) poses virtually no threat to continued health (we are not obviously talking about hearts). For my part I would be more persuaded of their concern for their fellow human if they were at the front of the queue to have their kidney removed.

As regards the purchaser, he is by definition able to pay the price. The principles of fairness and equal access to care which inform the approach to healthcare in the UK fall by the wayside. The rich inherit the earth, sponsored by the state.

And, if these difficulties were not enough, there is a further difficulty with this approach. In the context of scarcity, regulated markets soon spawn unregulated markets (commonly known as a black market). The state-ordained safeguards are sidestepped or simply ignored as needy donor (wanting money) pursues and is pursued by the needy donee (wanting a transplant). Even with a well-staffed and vigilant inspectorate, the black market will thrive. And with it, the problem of the exploitation of the economically vulnerable already alluded to will, if anything, be exacerbated. The recent experience of Iran offers clear evidence of this.

Organs from the executed

I have left till last the grisly issue of transplanting organs from the recently executed. Allegations have been made that this is a practice

carried out in a number of countries. I do not intend to spend a great deal of time on it. Capital punishment is outlawed throughout Europe. This is because capital punishment is judged to be ethically indefensible in a civilised state. It follows that states which continue to practice capital punishment already take themselves outside the league of the civilised, at least in this respect. Of course, some argue that each nation has the right to determine its policy in this as in any other area. The answer is that, unless we are to accept a notion of unbridled subjectivity in moral affairs, nations' rights are circumscribed by the need to pay due respect to certain transcendent norms. The rejection of capital punishment is one such norm.

This means, of course, that the consideration of the ethics of using the organs of the recently executed never gets off the ground. It cannot be justified, because capital punishment cannot be. And that is where the argument should be focussed. That nations may base their policy of execution on the need to meet the demand for organs

for transplant is merely a further illustration of the wrongness of state execution. Thus, in my book, it is not worthwhile to complain about of the links between execution and transplantation. To do so misses the bigger point.

Conclusion

I recognise that, not least for reasons of time, I have not addressed all the myriad ethical challenges thrown up by organ transplantation. Equally I recognise that I have given but a poor imitation of the analysis and argument that Bill Hoffenberg would have offered you. But, I have felt hugely privileged to be invited to add my voice to the many who remember this fine man. And, if I may end on what some may see as a controversial note, and I can see him in mind's eye egging me on, I would leave ringing in your ears the need to introduce a policy of opting out at the earliest opportunity. Bill came round to supporting the idea and I know he'd want me to remind you.

Thank you.

