

ESTABLISHING A MARKET FOR HUMAN ORGANS* IN SOUTH AFRICA PART 2: SHORTCOMINGS IN LEGISLATION AND THE CURRENT SYSTEM OF ORGAN PROCUREMENT**

Magda Slabbert
BA(Hons) HED BProc LLB LLD
Senior lecturer, Department of Jurisprudence
University of South Africa

Hennie Oosthuizen
Bluris LLB LLD LLD
Professor and Head of Department
Criminal and Medical Law
University of the Free State

SUMMARY

The present shortage of transplantable organs in South Africa may be attributed to inadequate legislation and the current system of organ procurement. The Human Tissue Act 65 of 1983, in the interim phase, still prohibits the sale of organs for transplantation. Chapter 8 of the new National Health Act 61 of 2003 will take over this function once it is promulgated. Although the new Act allows the reimbursement of costs incurred in the donation of an organ, it may still not be sufficient to motivate more donors to donate organs in an effort to alleviate the organ shortage. The purpose of this article is to illustrate that the sale of organs and a change in the current system of organ procurement may be a solution. It is also submitted that, should legislation be changed to legalise organ sales, it will be neither an encroachment on the basic principles of medical ethics nor a violation of fundamental rights.

* Organs in this article means vital solid organs: Kidney, heart, liver, lungs and pancreas.

** This article is based on Slabbert's LLD dissertation *Handeldryf met Menslike Organe vir Oorplantingsdoeleindes* (2003) University of the Free State, Bloemfontein.

1 INTRODUCTION

As indicated in Part 1, transplanting organs is a well-established and growing practice. However, in order to perform transplantations, organs are needed. As is the case in the rest of the world,² South Africa has a shortage of transplantable human organs. In 2005 only 1 084 transplants were performed in the public and the private health sectors, while approximately 5 000 people were waiting for an organ.³ Of the 1 084 transplants undertaken, 799 were corneas, 27 hearts, 1 heart-lung, 4 lungs, 7 pancreas, 14 livers and 232 kidneys. According to the Organ Donor Foundation, there is a need to transplant at least 1 000 kidneys per year. However, in 2005 less than a quarter of these necessary transplants were performed. The main reason for this was the shortage of available kidneys for transplantation.

In this article references to living donors focus on kidneys. Although parts of a liver can also be transplanted from a living donor this is not yet common practice in South Africa. Donations by deceased donors include all the solid organs. It will be submitted that the problem of kidney and other organ shortages cannot be resolved by medical science and that the solution lies in the hands of legislators as acute and persistent shortages of organs and many deaths resulting from organ failure are no longer the result of an inexorable fate that must be accepted, but mirrors the inadequacy of existing laws.⁴

The legislation in South Africa regulating organ procurement, namely the Human Tissue Act 65 of 1983, and in future the National Health Act 61 of 2003, will be examined in order to determine in which instances the legislated method of organ procurement fails. Recommendations, which to our minds will improve the efficiency of the present system, namely, to deliver more organs and to develop a new approach that will not encroach on personal autonomy⁵ and will recognise fundamental rights, will be suggested. Other systems of organ procurement – “opting-out”, required request, xenotransplantations and cloning, as well as illegal ways of procuring organs – were evaluated in Part 1. None of them proved to be a solution for the organ shortage in South Africa. In this respect it will be

² Erin and Harris “An Ethical Market in Human Organs” 2003 (29) *J Med Ethics* 137; Savulescu “Is the Sale of Body Parts Wrong?” 2003 (29) *J Med Ethics* 138; Slabbert and Oosthuizen “Commercialisation of Human Organs for Transplantation: A View from South Africa” 2005 (24) *Med Law* 192; Taylor *Stakes and Kidneys: Why Markets in Human Body Parts are Morally Imperative* (2005) 23; Friedman and Friedman “Payment for Donor Kidneys: Pros and Cons” 2006 (69) *Kidney International* 960-962 (published online 2006-02-15 www.kidney-international.org).

³ There is no official waiting list for patients waiting for an organ in South Africa. The figure of 5000 is therefore only an estimate. “2000 Mense in SA Wag op Nierskenking” 2001-08-29 *Beeld*; “Nuwe Lewe na 30jr nog Gevier” 2002-11-09 *Beeld*; “Duisende Wag op Organe” 2004-05-26 *Beeld*.

⁴ Jefferies “The Body as Commodity: The Use of Markets to Cure the Organ Deficit” <http://www.law.indiana.edu/glsj/vol5/no2/13jeffer.html> (accessed 2002-06-01).

⁵ The term autonomy is derived from the Greek words “outos” meaning self and “nomos” meaning rule of law. In a medical sense autonomous means a personal ability to act in a self-directed manner consistent with one’s interests: Garwood-Gowers *Living Donor Organ Transplantation: Key Legal and Ethical Issues* (1999) 3.

submitted that compensating an organ donor may be the answer. This might be achieved through regulated commercialisation of human organs from deceased donors as well as direct payment for a kidney from a living donor (seller).

2 THE LEGAL POSITION IN SOUTH AFRICA REGARDING ORGAN PROCUREMENT

The Human Tissue Act regulates the procurement of human organs in South Africa for the interim period and the National Health Act will in the near future regulate it.⁶ Provisions relating to organ donations contained in these two Acts will be discussed and analysed. Thereafter it will be submitted that the National Health Act should be amended to allow the donor to be financially rewarded.

2 1 The Human Tissue Act 65 of 1983

2 1 1 Deceased donors

Similar to the United Kingdom and the United States of America, South Africa has a system of voluntary donation, or the so-called "opting-in" method of procuring organs.⁷ The Human Tissue Act provides, in section 2, that anyone competent to make a will (16 years or older) may donate an organ by signing a document attested by two competent witnesses of 14 years or older, or by indicating this wish through a clause in a will or orally before two competent witnesses.⁸ Such an intention can also be displayed by attaching a sticker on one's driver's licence. In other words, it is up to oneself to indicate one's choice to be an organ donor while one is still alive, whereas the actual donation takes place only after death.

The Act further stipulates that in the absence of a donation made by the deceased, the deceased's spouse, major child, parent, guardian, major brother or major sister may, after death, donate usable organs.⁹ This is by far the most common way of procuring organs.¹⁰

⁶ The National Health Act came into effect on 2 May 2005. S 93(1) of the National Health Act repeals the Human Tissue Act in total, but it will only be done on a date fixed by the President in a *Government Gazette*. In the interim the Human Tissue Act and the Regulations issued in terms of this Act remain in force. The expected date for Chapter 8 of the new Act to come into effect is unknown.

⁷ Slabbert and Oosthuizen 2005 (24) *Med Law* 193; Taylor 4-6.

⁸ See also Blackbeard "Consent to Organ Transplantation" 2003 *THRHR* 47-48.

⁹ S 2(2)(a).

¹⁰ Hospital staff always ask the relatives irrespective of whether the deceased has indicated a wish to be a donor. This way of procuring organs also takes place in the USA where, despite a deceased's indications to be a donor, the next-of-kin is asked whether the organs may be harvested or not: Schwindt and Vining "Proposal for a Future Delivery Market for Transplant Organs" 1986 (11) *Journal of Health Politics, Policy and Law* 485.

If the relatives cannot be traced, the Director-General or any person specifically authorised thereto may – after the death of the person concerned, and if satisfied that all reasonable steps had been taken to locate those persons – donate any specific tissue of the body of the deceased.¹¹ A person may thus give permission to have his organs donated prior to his death, whilst his family, or in exceptional cases the Director-General, may grant permission after his death. It remains voluntary, without any pressure, incentive or reward.

The moment of death is not addressed in the Act. The Human Tissue Act does not recognise brain stem death. According to section 7(2) of the Act a person is dead when at least two medical practitioners, of whom one shall have been practising as a medical practitioner for at least five years, certify that the person is dead. The death of the person is determined by the irreversible absence of spontaneous respiratory and circulatory functioning and the absence of any brain stem functions. To determine the moment of death does not have a direct influence on organ procurement, but it is essential to take cognisance thereof since any organ other than a kidney, can only be removed from a person's body for transplantation if he or she is brain dead.

2 1 2 Living donors

Section 18 of the Human Tissue Act determines that only a person who has reached the age of majority may consent to a living organ donation. Such consent must be in writing and in accordance with prescribed conditions.¹² In the case of minors, parents or guardians must give written permission. If the donated tissue is replaceable by natural processes, such as hair or blood, and the minor is old enough to be a competent witness (14 years or older) he or she may consent in writing or orally to the removal of that tissue or blood.¹³

It is practice in South African hospitals to accept donations from living persons only if they are related by blood to the patient seeking a donation, or if the patient's spouse donates an organ. If the source of the donation is a friend or an altruistic acquaintance, an application has to be made to the Department of Health, which will investigate the matter and determine that it is not for financial gain¹⁴ and only then will permission be granted for the operation to be carried out.

¹¹ S 2(2)(b).

¹² S 18. Note that tissue, blood or gametes may only be removed from the body of a living person for a purpose referred to in s 19 of the Act.

¹³ S 18(b)(ii)(aa).

¹⁴ S 28(1)(a) prohibits any payment for human organs.

2 2 The National Health Act 61 of 2003¹⁵

2 2 1 Deceased donors

Section 62 of the Act stipulates the same requirements for an organ donation as the Human Tissue Act. There are only minor differences between the two acts. The Human Tissue Act refers to a "spouse" who may give permission for a donation. In the National Health Act the word "partner" is added to the reference "spouse" to accommodate people in same-sex relationships or people living together.¹⁶

The Human Tissue Act prescribes that the Director-General or a person authorised thereto should take "reasonable steps" to reach a deceased's family.¹⁷ It is not clear what these "reasonable steps" are, but it is accepted that if the identity of the deceased is unknown, the Director-General cannot be regarded as having taken all reasonable steps.¹⁸ The National Health Act provides that the Director-General may only donate specific tissue if all the "prescribed steps" have been taken to locate the family of the deceased.¹⁹ These steps are not explained or described either. This will hopefully be addressed in the regulations to follow.²⁰ To use the organs of an unidentified body or to use organs of a deceased whose relatives have not or could not be traced is an extremely sensitive issue in South Africa because of the country's history of human rights abuses in the past.²¹

The description of death has been improved in the new Act. In section 1 of the National Health Act death is described as meaning "brain death". This will lead to more clarity amongst health care workers concerning the moment of death.

2 2 2 Living donors

Section 55 of the National Health Act dealing with living donations stipulates that a living donor must give written consent for the donation in a prescribed manner prior to the donation.²² The donation must also be "in accordance

¹⁵ See a discussion of this Act by Mcquoid-Mason and Dada "Tissue Transplantation and the National Health Act" 2006 24(3) *CME* 128-130.

¹⁶ S 62(2).

¹⁷ S 2(2)(b).

¹⁸ Blackbeard 2003 *THRHR* 47.

¹⁹ S 62(3)(a) and (b).

²⁰ S 68 authorises the Minister of Health to issue regulations relating to organ donations.

²¹ Schepers-Hughes "Truth and Rumor on the Organ Trail: Many of the World's Poor Believe their Organs May be Stolen for Transplant Surgery" 1998 (10) *Medical Anthropology Natural History* 50-55.

²² S 55(a) and (b).

with prescribed conditions”.²³ The “prescribed manner” of the written consent and the “prescribed conditions” are not addressed in the Act.²⁴

The Organ Donor Foundation has added the following criteria for voluntary donors that apply to living as well as deceased donors, even though living donors are restricted to donating only a kidney and/or part of a liver.²⁵

Any person who is cerebrally dead²⁶ may donate organs if:

- (i) he or she does not have any serious systemic disease such as diabetes;
- (ii) he or she does not suffer from any serious infection;
- (iii) no malignancy is present, except a primary brain tumour;
- (iv) he or she does not suffer from any contagious disease; and
- (v) if tests for Hepatitis B and HIV/AIDS are negative.

The Organ Donor Foundation also lays down certain age restrictions relating to the type of donation. Corneas should ideally be donated by donors younger than 70 years. Kidneys should be harvested from donors younger than 60 years, and a liver from a donor preferably under the age of 50. For the donation of a heart there is a difference between donations from male and female donors. A female donor should be 45 years or younger whereas a male donor should not be older than 40.²⁷

2 3 Problems with the present and future legislative framework

First, a living person who donates a kidney or a deceased person donating any organ, donates it free of charge as prescribed by law.²⁸ It seems unjust that everyone involved in the donation benefits: the patient gets an organ; the doctor, hospital and pharmaceutical company are financially rewarded;²⁹ yet the donor who makes the donation possible has to act out of altruism.³⁰

²³ S 55(b).

²⁴ This will hopefully be included in the regulations that are awaited.

²⁵ Organ donor information package – supplied by the Organ Donor Foundation. Jacaranda Hospital 2000. It is not yet common practice to donate a part of a liver in South Africa.

²⁶ Death of the brain stem is not accepted as “death” in the Human Tissue Act. The National Health Act, however, describes death as “brain death”.

²⁷ Organ donor package supplied by the Organ Donor Foundation, Jacaranda Hospital 2000.

²⁸ S 28(1)(a) of the Human Tissue Act and s 60(4) of the National Health Act, prohibit the sale of organs in South Africa. It is also forbidden in almost every other country. Garwood-Gowers 167-178; World Health Organization *Legislative Responses to Organ Transplantation* (1994) 452; and Taylor 12-13. The only exception is Iran, see fn 34 below.

²⁹ Erin and Harris 2003 (29) *J Med Ethics* 137; Rothman “The International Organ Traffic” 1998 *New York Review of Books* 15; Howard “Organ Donation: Social Policy, Ethical and Legislative Issues” in Rodrigue (ed) *Biopsychosocial Perspectives on Transplantation* (2001) 51 and 53; American Medical Association: Council on ethical and judicial affairs “Financial Incentives for Organ Procurement, Ethical Aspects of Future Contracts for Cadaveric Donors” 1995 (155) 27 March *Arch Intern Med* 584: “[T]he donor is the only party

Secondly, there is ample proof that it is better to transplant a kidney from a living donor than from a deceased person.³¹ Research has shown that the body of a recipient receiving a kidney from a living donor has a better chance of not rejecting the kidney. Better planning can be done before the operation to transplant a kidney from a living person to a patient; for example the recipient can be immunised with the future donor's blood. Furthermore the kidney from a living donor is usually in a better condition than that of a deceased donor. Garwood-Gowers explains that conducting a transplantation prior to dialysis has quality of life benefits to the patient and that it will optimise graft survival.³² Making use of living donors means that these advantages can be exploited.³³ Living donors also have the capacity to fully meet the demand for kidneys. It is therefore a matter of urgency to look at ways of motivating more living donors to donate.

It seems necessary to revise legislation, so as to allow some form of compensation to donors in order to persuade more living donors to donate organs and thereby alleviate the need for organs, particularly kidneys.³⁴ Rewarding donors might also motivate people to think about organ donations while still alive. The knowledge that there will be some kind of reward for organs used after a person's death might encourage people to become donors. Ultimately, the goal is to save more lives. By allowing the "reimbursement of costs incurred", section 60(4)(a) of the National Health Act takes a step in the right direction by rewarding the donor for his or her

involved in the transplantation who does not benefit from the procedure. The recipients of donated organs clearly benefit the most of all the parties involved and the transplant teams are well paid for their services. It seems unfair that the donor, who makes the whole process possible is the one who is not financially rewarded but is expected to act out of altruism alone."

³⁰ Altruism may be defined as acting out of disinterested concern for the well-being of others. Wilkinson *Bodies for Sale: Ethics and Exploitation in the Human Body Trade* (2003) 110. See also Taylor 166-173 for a discussion of altruism.

³¹ Erin and Harris 2003 (29) *J Med Ethics* 137; Garwood-Gowers 18 and 37-39; Johnson "Shortage of Organs for Transplantation: Living Donors Should be Used More Often" 25-05-1996 (312) *BMJ* 1357; and Hansmann "The Economics and Ethics of Markets for Human Organs" 1989 (14) *Journal of Health Politics, Policy and Law* 72.

³² Garwood-Gowers 39.

³³ *Ibid.*

³⁴ "Iran provides an interesting case study of a country where the kidney trade is legal and regulated. The trade is organised and controlled by two government-endorsed NGO's – the Charity Association for the Support of Kidney Patients (CASKP) and the Charity Foundation for Special Diseases (CFSD). The role of CASKP is to put potential recipients and donors in touch with each other, and organise tests to ensure compatibility of donors and recipients and the mental stability of donors. After the transplant the CFSD is required by law to pay the donor a sum of 1,00,000 Tomans (\$1,219), which comes from government funds. Recipients often promise donors secure employment or extra money after the transplant (although CASKP and CFSD have no control over this). Ram "International Traffic in Human Organs" 2002 19(7) *Frontline* <http://www.hinduonnet.com> (accessed 2007-02-22). For a different view see also Abouna Kumar, Samhan, Dadah, John and Sabawi "Commercialization in Human Organs: A Middle Eastern Perspective" 1990 22(3) *Transplantation Proceedings* 918-921.

costs incurred as a result of the donation, but it is still not enough to solve the growing demand for human organs.

Thirdly, the fiercest criticism against the current legislation is that individual autonomy is ignored. Although a patient may have a sticker on his or her driver's license, or a donor card, the transplant programmes follow the wishes of the next of kin. If they refuse consent, their (the relatives') wishes are respected. Similar trends have been observed in Canada, the United Kingdom and Australia.³⁵ The organ donor's family may veto the decision made by a deceased prior to his or her death concerning the donation of organs. The donor's personal autonomy to make a choice concerning his or her organs is thus not respected in the majority of cases.³⁶

Apart from these shortcomings of the "opting-in" method of organ procurement as embedded in legislation, there are also other limitations to this system of organ procurement.

2.4 Limitations of the "opting-in" system in South Africa

A system of "opting-in" where a donor expresses his or her wishes through the use of donor cards or a sticker on a driver's licence, gives an indication of the deceased's choice concerning the use of transplantable organs after death, but it is regrettably inadequate because of the low public participation in the scheme.³⁷ In South Africa the Organ Donor Foundation estimates that only about 35 000 people carry donor cards.³⁸ This is not even 1% of the population. It is difficult to speculate on the estimated number of card carriers as donor cards are only sent out on request. The Foundation has no control over whether a person fills out the card and carries it with him or her or not. South Africa does not have a national register of official organ donors.

This poor performance of the system of voluntary donations is particularly disappointing if the huge amount of money, time and effort spent on the education of the public about the necessity of donating organs, as well as on the recruitment of donors, is taken into account. New medical breakthroughs in the field of organ transplantations always receive wide coverage by the media. The general public should be aware of the advantages of the practice of donating and transplanting organs.³⁹ Despite previous efforts to inform the public, there is still a huge shortage of organs. To spend more time and money on further awareness campaigns will probably not make much of a difference. This state of affairs makes an alternative approach imperative.

³⁵ Department of Health "Framework for the Donation of Human Organs and Tissue in South Africa" 2001 *Discussion Paper* 5.

³⁶ "Dworkin on Autonomy" see Taylor 29-50.

³⁷ Eaton "The Subtle Politics of Organ Donation: A Proposal" 1998 (24) *J Med Ethics* 166.

³⁸ <http://www.odf.org.za>.

³⁹ Eg, "Chirurg Wil Hele Gesig Oorplant" 2006-03-11 *Naweek-Beeld*. See also fn 2 above.

A further problem with the current system of organ procurement is that mainly family members, spouses or partners are accepted as donors. A patient may feel uncomfortable asking a relative for a donation.⁴⁰ If a relative offers to donate, without being asked, the patient may feel guilty if his or her body rejects the organ. For many patients it seems much easier to obtain an organ from an illegal source and pay for it. This, of course, creates a flourishing black market⁴¹ and causes people to lie about relationships.⁴²

South Africa has a public and a private health sector. In the private sector questions are seldom asked and investigations seldom carried out to determine whether people who claim to be related to a patient are in fact a relative of that patient when they donate an organ. There is thus room for possible illegal activities⁴³ that might be phased out if regulated commercialisation⁴⁴ of organs were permitted.

Hospital staff may also be responsible for the "waste" of possible organs from deceased donors. It may be because they are not concerned with the issue or because they are sympathetic towards the bereaved families and do not want to raise the issue of organ donation during times of mourning. In South Africa health care workers are not under an obligation to ask for organ donations. It is therefore possible that a deceased patient may have a donor card but it is ignored in the process following his or her death, since the person dealing with the deceased does not raise the issue. The wish of the deceased is therefore not respected.

At the time of the formulation of the opting-in policy, transplants were still in an experimental phase and the demand was low. Whereas donors were originally mostly blood relatives, recent developments in immunology have made it possible for anyone to be a donor. Other methods to find more willing donors are now necessary and while it may not be required to replace the system of "opting-in", an alternative option is urgently needed.

⁴⁰ Phillips *Heroes: 100 Stories of Living with Kidney Failure* (1998) 119.

⁴¹ Taylor 78, 87-89 and 196-200; Rothman 1998 *New York Review of Books* 14-16; Friedman and Friedman 2006 (69) *Kidney International* 961; Rother "The Organ Trade: A Global Black Market: Tracking the Sale of a Kidney on a Path of Poverty and Hope" 2004-05-23 *The New York Times*.

⁴² Although there is no proof that this happens in South Africa, it does happen in India. Rothman 1998 *New York Review of Books* 14.

⁴³ "Israeli's Financier Glo Orgaan-knoeiery in SA" 2004-01-17 *Beeld*; "Verdagte in Orgaan-saak Wil Oorsee kan Reis" 2004-07-14 *Beeld*; "Israeli's Kry Onwettig Nier" 2005-09-17 *Beeld*. In 2005, five South African surgeons were charged in the Durban Magistrate's Court with performing illegal kidney transplants. The charge arose from investigations which revealed that a syndicate was recruiting kidney donors from Brazil and paying them for their organs. These kidneys were then transplanted into Israeli's who paid \$100 000 to fly to South Africa for the operations. Fraudulent documentation stated the donors and recipients were blood relatives and no money had exchanged hands. Broughton "Top Doctors in Court for Kidney Scam: Suspected of Links to Syndicate Trading in Organs" 2005-08-01 *Pretoria News*.

⁴⁴ It is not within the scope of this article to explain exactly how the regulated commercialisation should be done.

3 TAKING A NEW DIRECTION – PAYING FOR ORGANS

Compensation for donors may be the answer to the organ shortage.⁴⁵ It is a solution that is simple and inexpensive, whilst at the same time respectful of personal autonomy.

Much has been written on the ethical aspects of payment for organs. None of the arguments, however, are convincing to the extent that they justify a total ban on regulated organ sales.⁴⁶ Alternatives such as cloning⁴⁷ or xenotransplants⁴⁸ have also been suggested. These options for meeting the need for transplantable organs are still in an experimental phase and are at present inadequate to meet the demand.

A viable solution seems to be to regulate payment for organ donation and to change the legislative framework relating to organ donations.⁴⁹ Such a change should be viewed with an open mind and it should be clear what it is that makes it objectionable. Is it the payment *per se* which is unacceptable, or the additional factors – for example, the possible assault, coercion, murder, theft or torture that may accompany such a practice – that make it

⁴⁵ For a different view see: Stempsey "Organ Markets and Human Dignity: On Selling your Body and Soul" 2000 (6) *Christian Bioethics* 195–204; and Schreiber "Legal Implications of the Principle *Primum Nihil Nocere* as it Applies to Live Donors" in Land and Dossetor (eds) *Organ replacement therapy: ethics, justice and commerce* (1991) 13-17.

⁴⁶ De Castro "Commodification and Exploitation: Arguments in Favour of Compensated Organ Donation" 2003 (29) *J Med Ethics* 142-146; Savulescu 2003 (29) *J Med Ethics* 138-139; Erin and Harris 2003 (29) *J Med Ethics* 137-138; Wilkinson and Garrard "Bodily Integrity and the Sale of Human Organs" 1996 (22) *J Med Ethics* 334-339; Slabbert and Oosthuizen 2005 (24) *Med Law* 196-200; Rothman *et al* "The Bellagio Task Force Report on Transplantation, Bodily Integrity, and the International Traffic in Organs" 1997 (29) *Transplantation Proceedings* 2739-2745. Richards refers to the example of a Turkish father who wanted to sell his kidney in order to pay for urgent hospital treatment for his daughter. He didn't have any money, nor did he possess any valuables that he could sell to cover the costs of her operation. He was, however, not legally permitted to do so. By prohibiting him from selling one of his kidneys, he was effectively prevented from saving his daughter's life. However, if his daughter had needed a kidney transplant and he was willing to donate one of his kidneys for this purpose, he would have been applauded. Richards "From Him that Hath Not" in Land and Dossetor (eds) *Organ Replacement Therapy: Ethics, Justice and Commerce* (1991) 190-192.

⁴⁷ Daar "Paid Organ Donation – The Grey Basket Concept" 1998 (24) *J Med Ethics* 365.

⁴⁸ Transplants from animals to human beings. See Daar 1998 (24) *J Med Ethics* 365; and Johnson 1996-05-25 (312) *BMJ* 1357. Flynn *Issues in Medical Ethics* (1997) 215-216: Ethical concern about xenografts was crystallized in the famous case of Baby Fae. Baby Fae suffered from a heart disease. In October 1984 a baboon heart was transplanted into the baby. She died in November. There was an enormous amount of media coverage of this case and many ethical questions surfaced in connection with it. For example, people asked whether the transplant surgeon had been motivated to act in his patient's best interest or was seeking to advance his own reputation. These kinds of questions suggest the extent of the ethical unease surrounding animal to human transplants. When the story of Baby Fae's transplant first broke, the American public thought it was about to witness a medical miracle. With Baby Fae's death, however, it became apparent that there were good reasons to argue that what had transpired should never have been allowed to happen.

⁴⁹ Authors from Loyola University, New Orleans have also indicated that people are dying because of legislation regulating organ procurement in the USA. See Clay and Block "A Free Market for Human Organs" 2002 (27) *The Journal of Social, Political and Economic Studies* 227-236.

risky?⁵⁰ Risks such as these could in principle be removed from an organ trading system.⁵¹

The shortage of kidneys, in particular causes much suffering and even death. Dialysis is not always available or an option to all.⁵² To pay a kidney donor a minimum fee would assist many, as it would simultaneously save lives and in many cases alleviate poverty. Donors who are willing to sell a kidney might otherwise never have donated it. The prohibition of sales therefore excludes life-saving kidneys that could otherwise have been available. There should be adequate and rational justification for the resulting harms arising from such a prohibition. It is submitted that in the South African context, taking personal autonomy into consideration, such justification simply does not exist.

The Human Tissue Act prohibits paying or compensating an organ donor.⁵³ Section 60 of the National Health Act, if Chapter 8 is enacted, will also prohibit the direct payment for organs, but at least allows for the "reimbursement of reasonable costs incurred" by the person providing the donation.⁵⁴

As mentioned above, Chapter 8 of the National Health Act will only come into force once the regulations concerning the chapter have been promulgated, but in principle this concession can be viewed as a step forward. At least the donor will be compensated for certain costs incurred.

4 MEDICAL ETHICS, FUNDAMENTAL RIGHTS AND PAYMENT FOR ORGANS

A last argument for the proposed change in legislation to allow for payment for human organs will be to look at the influence payment for transplantable organs might have on medical ethics and fundamental rights. In analysing bio-ethical objections to organ sales the case for legal prohibition will also be assessed.

Because human lives are at stake, this article supports a pragmatic approach to the shortage of transplantable organs.⁵⁵ In other words, one

⁵⁰ Despite extensive investigations overseas, there is no evidence that such abuse has actually taken place; no alleged case of forced removal of organs has yet been substantiated. Hoffenberg "Acquisition of Kidneys for Transplantation" in Levinsky *Ethics and the Kidney* (2001) 130 133; Rothman 1998 *New York Review of Books* 16.

⁵¹ Wilkinson 132.

⁵² People older than 55 years or diabetics cannot be accommodated in the public health sector on dialysis machines. In the private healthcare system, dialysis must be paid for by patients or their medical aid funds.

⁵³ S 28(1)(a).

⁵⁴ S 60(4)(a).

⁵⁵ A philosophical discussion of the ethical aspects of commercialisation of human organs will be dealt with in a separate article. The scope of this article allows only an overview. For a philosophical discussion see Cherry *Kidney for Sale by Owner: Human Organs, Transplantation, and the Market* (2005) Chapter 4. (Cherry carefully examines arguments

should approach the issue not only philosophically. The aim should be to find definite solutions to organ shortages in order to save lives and not merely to speculate about possible ethical objections that might be raised should organ sales be legalised. In an attempt to determine whether payment for transplantable organs is bio-ethically justifiable, it will be meaningful to link it to the four pillars of medical ethics.

4 1 Beneficence

According to the Hippocratic Oath a doctor should act in the interest of his patient. If one applies this principle of beneficence⁵⁶ – to act in the interest of the patient – to organ transplants, it should be clear that the doctor ethically acts correctly. By transplanting an organ into a deserving patient's body – whether or not the organ is paid for – the doctor is improving the patient's quality of life and in some cases offers a second chance at life.

If the focus shifts to the removal of an organ for transplantation, one has to distinguish between the removal of an organ from a deceased body and the removal of an organ from a living person. The test of beneficence cannot be applied to a living donor as he or she is not a patient but a healthy person, and therefore the second principle of medical ethics, non-maleficence⁵⁷ (to do no harm), must be considered.

4 2 Non-maleficence

The removal of an organ from a living person is not a curative surgical operation, but rather a case of physical injury and the principle that a surgical operation may in no way harm the patient, *primum nihil nocere*, becomes relevant.⁵⁸ Removing an organ from a living person is basically a violation of the no-harm principle, but the no-harm principle is by no means an absolute and unlimited one. On the one hand, doctors continually "harm" people to achieve a higher good and on the other the harm/benefit principle has to be seen in a wider perspective, i.e. the focus cannot be on the donor in isolation. A limited amount of danger and risk with regard to the person is acceptable when it takes place in the interest of the life and health of the recipient.⁵⁹

Focusing only on the donor, the actual risk of loss of life during a kidney removal operation has been estimated at approximately 0.03%. This is considerably less than the risks associated with certain paid occupations

against a market for body parts based on the moral views of John Locke, Immanuel Kant and Thomas Aquinas and he shows their claims to be an oversimplification.)

⁵⁶ See Garwood-Gowers 37-41.

⁵⁷ Garwood-Gowers 41-46.

⁵⁸ Schreiber 13-17.

⁵⁹ Schreiber 14. "Before a kidney transfer, the healthy 'donor' has a life expectancy of 50 happy years; the recipient, on the other hand, a miserable 18 months. With the transfer, the donor reduces his life expectancy by say, two years, but the organ recipient increases his by, say 10 years or more." <http://www.organtx.org/sales.htm> (accessed on 2002-04-02).

such as construction work or mining.⁶⁰ The mere fact of payment for the kidney doesn't add any danger to the donor. Donating a kidney is acceptable in most societies, and therefore the principle of non-maleficence should not necessarily have a negative effect on legalising organ sales.

If an organ is removed from a brain dead⁶¹ person, the doctor is not harming anyone, for the person is merely kept "alive" artificially. If it was the deceased's wish to donate (or sell) his or her organs it will be ethically correct to respect his or her autonomy to make such a decision.

4 3 Autonomy

Medical interventions are acceptable provided that a doctor has respect for a patient's personal autonomy. In South Africa, a critically ill patient has the right to refuse to be linked to a life-sustaining apparatus and the doctor has to respect such a choice. Similarly, a woman may, under certain circumstances, elect to have her pregnancy terminated.⁶² A doctor has to respect the woman's choice should she decide to terminate her pregnancy. By analogy, a woman (or a man) should be able to decide on the removal (and subsequent sale) of her (or his) kidney should it be medically acceptable.

It is therefore submitted that there is no real bio-ethical objection strong enough to prevent payment for organs. There will be moral objections by groups and individuals on the basis of, for example, religious convictions, but they have the right to refrain from such dealings and even to advise others against such practices. However, on the basis of autonomy, the individual has to decide and should have the right to do so.⁶³ In *Phillips v De Klerk*⁶⁴ the right of an individual to dispose over his or her own body, in so far as that right is not in conflict with the overriding social interest, was recognised. If it is not against public morals, the mentally competent individual's right to control his own destiny in accordance with his own value system (his "selfbeskikkingsreg") must be rated even higher than his health and life.⁶⁵ There is neither a general right nor a general duty on the part of a person to protect someone against him- or herself.⁶⁶

⁶⁰ Wilkinson 107.

⁶¹ See fn 26 above.

⁶² Choice on Termination of Pregnancy Act 92 of 1996, also see the judgment in *Christian Lawyers Association of SA v Minister of Health* 1998 4 SA 1113 (T).

⁶³ The Constitution of the Republic of South Africa 1996 recognises the right to self-determination in s 12(2)(b).

⁶⁴ TPD March 1983 (unreported).

⁶⁵ Strauss *Doctor, Patient and the Law* (1991) 31. The arguments against the sale of human organs for transplantation, *ie* exploitation of the poor, harmfulness, irreversibility, commodification and possible criminal activities are not discussed in the scope of this article.

⁶⁶ *Phillips v De Klerk* TPD March 1983 (unreported) as quoted in Strauss who submits that the decision must be welcomed.

Section 12(2)(b) of the Constitution reads: “Everyone has the right to bodily and psychological integrity, which includes the right to security in and control over their body.” According to Currie and De Waal this section distinguishes between two components, namely “security in” and “control over” one’s body.⁶⁷ These components are not synonymous. “Security in” denotes the protection of bodily integrity against intrusion by the state and others, whilst “control over” denotes the protection of what could be called bodily autonomy or self-determination against interference. The former is a component of the right to be left alone in the sense of being left unmolested by others. The latter is a component of the right to be left alone in the sense of being allowed to live the life one chooses.⁶⁸ One should therefore be allowed to choose whether to sell a kidney or donate organs or not.

A prerequisite though should be that the living person selling his or her kidney should give informed consent.⁶⁹ It is accepted in South African law that a person may not consent to bodily injury.⁷⁰ One should approach the issue with caution, however, as all bodily injury is not necessarily *contra bonos mores*; for example, the removal of a breast as a result of a malignant tumour, breast enlargements through plastic surgery, or even tattoos. The removal of a kidney with informed consent should therefore not summarily be viewed as offensive to public morals.

Medical aspects concerning the removal of a kidney should be explained in detail and in understandable language to the seller by the doctor before the person can give informed consent. In other words, the doctor is statutorily obliged to warn the seller about the material risks inherent in the proposed procedure.⁷¹ Medical tests should be done and explained to the seller, whereafter he or she may give consent in writing for the operation to be done.

4 4 Justifiability

Lastly it is necessary to look at the justifiability of organ sales. Harris⁷² states that any commercial scheme concerning human organs for therapeutic purposes should be morally defensible. It should, in other words, have

⁶⁷ Currie and De Waal *The Bill of Rights Handbook* (2005) 308.

⁶⁸ *Ibid.*

⁶⁹ Dreyer “Redelike Dokter versus Redelike Pasiënt” 1995 *THRHR* 532; and Garwood-Gowers Chapter 3. See also *Stoffberg v Elliot* 1923 CPD 148; and Van Oosten “*Castell v De Greeff* and the Doctrine of Informed Consent: Medical Paternalism Ousted in Favour of Patient Autonomy” 1995 *De Jure* 164-179.

⁷⁰ *R v McCoy* 1953 2 SA 4 (SR).

⁷¹ *Castell v De Greeff* 1994 4 SA 408 (C) 426F-H: “a risk being material if, in the circumstances of the particular case: (a) a reasonable person in the patient’s position, if warned of the risk, would be likely to attach significance to it; or (b) the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it”. See s 7 of the National Health Act.

⁷² Harris “Clones, Genes and Immortality: Ethics and the Genetic Revolution” in Kennedy and Grubb *Medical Law* (2000) 1772-1774.

safeguards against wrongful exploitation of vulnerable people built into it.⁷³ Furthermore, considerations of justice and equity should be taken into account.⁷⁴ Harris rightly adds that if all of this can be complied with, then a market in human body parts will not *prima facie* be unethical.⁷⁵

He proposes a system of “monopsony” where only one buyer exists for the products of several sellers.⁷⁶ This will prevent the rich from using their purchasing power to exploit the market at the expense of the poor.⁷⁷ In a South African context (with a private and a public health care system) this might also be the answer for fair distribution of transplantable organs between wealthy and poor patients.

If an organisation that buys and sells organs were to exist, better tests may be done concerning donor-recipient compatibility as well as tests for diseases such as HIV/Aids and hepatitis. Recipients will thus be protected against unsafe organs.⁷⁸ Prices can also be fixed by such an organisation to prevent exploitation. To further prevent the exploitation of desperate people from poorer countries, it can be stated that buyers and sellers of human organs must be limited to citizens of the specific country only.

It is fair enough to focus on the possible abuses concerning the sale of transplantable organs, but Harris rightly asks whether those who would choose to sell organs and are volunteers to a small risk,⁷⁹ or patients who will die unless an organ becomes available, are more in need of protection. He also asks whether it is morally preferable to condemn one group of citizens to certain death rather than offer incentives to another group that may be at risk.⁸⁰ The solution he offers is acceptable, namely that it is better to protect the most vulnerable by permitting another group to choose whether or not to run a risk in the hope of both benefiting their fellow human beings and benefiting themselves financially.⁸¹ Currently many societies indirectly allow people to die by not helping those who are in desperate need of an organ. By allowing payment for organs, more patients might be helped and society will therefore act more positively by promoting better health.

When a society maintains fire services, police and ambulance services, military forces and even health professionals, it accepts that it will call upon

⁷³ For comments on the exploitation of the poor see Dworkin “Markets and Morals: The Case for Organ Sales” 1993 *The Mount Sinai Journal of Medicine* (66) 76; Andrews “My Body, My Property” October 1986 *Hastings Center Report* 32; and Taylor 14.

⁷⁴ Harris 1773.

⁷⁵ *Ibid.* See also Beauchamp “Methods and Principles in Biomedical Ethics” 2003 (29) *J Med Ethics* 269-274.

⁷⁶ Harris 1774.

⁷⁷ *Ibid.*

⁷⁸ *Ibid.*

⁷⁹ Concerning the risk involved with organ donations see Hoffenberg 130-134. See also Andrews 1986 *Hastings Center Report* 32; Hansmann 1989 (14) *Journal of Health Politics and Law* 73; and Wilkinson and Garrard 1996 (22) *J Med Ethics* 334.

⁸⁰ Harris 1774.

⁸¹ *Ibid.*

such personnel to run risks, including risks of death in the public interest, and it accepts that such people should be paid for doing so whether or not they are volunteers.⁸² South African society of today is no different. South Africa allows people to perform dangerous jobs such as mining or being a member of the police force or of a peace-keeping force in another country.

Apart from these similarities with England, South Africa has a Constitution in which section 27⁸³ provides specifically that everyone has the right to have access to health care. This right is, however, limited internally by section 27(2) that determines that the state must take reasonable legislative and other measures within its available resources to achieve the progressive realisation of these rights. The Constitution does not guarantee a right to health care, but only the qualified right of access to health care services. In *Soobramoney v Minister of Health KwaZulu-Natal*,⁸⁴ the Constitutional Court had to interpret the scope and content of the right of access to health care services guaranteed under section 27(1)(a) and section 27(3).

Mr Soobramoney was a 41-year-old diabetic suffering from heart disease, vascular disease and irreversible chronic renal failure. His life could be prolonged by means of regular renal dialysis.⁸⁵ He sought dialysis treatment from the public sector at the Addington Hospital in Durban. However, he was not admitted to the dialysis programme of the hospital because the hospital did not have enough resources to provide dialysis to all patients suffering from chronic renal failure. According to the hospital's policy the primary requirement for admission was a patient's eligibility for a kidney transplant. Patients were not eligible for kidneys unless free from significant vascular or cardiac disease. Mr Soobramoney was therefore not eligible for a kidney transplant and thus refused on the dialysis programme.

Relying on section 11 (the right to life) and section 27(3) of the Constitution, he made an urgent application to a local division of the High Court for an order directing the Addington Hospital to provide him with ongoing dialysis and interdicting the respondent from refusing him admission to the renal unit of the hospital. The application was dismissed. He then appealed to the Constitutional Court.⁸⁶

⁸² Harris 1775.

⁸³ Health care, food, water and social security
27(1) Everybody has the right to have access to –
(a) health care services, including reproductive health care;
(b) sufficient food and water; and
(c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.
(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.
(3) No one may be refused emergency medical treatment.”

⁸⁴ *Soobramoney v Minister of Health, KwaZulu-Natal* 1997 12 BCLR 1696 (CC).

⁸⁵ Renal dialysis is a procedure to preserve or extend someone's life when their kidneys have stopped functioning.

⁸⁶ For a discussion of the case see Moellendorf “Reasoning About Resources: *Soobramoney* and the Future of Socio-economic Rights Claims” 1998 (14) *SAJHR* 327; Scott and Alston “Adjudicating Constitutional Priorities in a Transnational Context: A Comment on

In his judgment Madala J⁸⁷ said the following (779):

“The Constitution is forward-looking and guarantees to every citizen fundamental rights in such a manner that the ordinary person-in-the-street ... assumes that every right so guaranteed is available to him or her on demand. Some rights in the Constitution are ideal and something to be strived for. They amount to a promise, in some cases, and an indication of what a democratic society aiming to salvage lost dignity, freedom and equality should embark upon. They are values which the Constitution seeks to provide, nurture and protect for a future South Africa”

Van Oosten finds this approach by the judge confusing and asks whether rights are rights or mere ideals, promises, indications or values, and if they are mere promises are they then unenforceable?⁸⁸ How does one reconcile an unenforceable ideal with the State's obligation in terms of section 27(1)?⁸⁹

The court in summary held that obligations imposed on the state under section 27 of the Constitution were dependent upon the resources available for such purposes, and the corresponding rights themselves were limited by reason of the lack of resources. In the context of budget constraints and cutbacks in hospital services in KwaZulu-Natal, there were many more patients suffering from chronic renal failure than there were dialysis machines to treat such patients. The appellant's case had to be seen in the context of the needs that the health services had to meet. If treatment had to be provided to the appellant, it would also have to be provided to all other persons similarly placed. If all the people in South Africa who suffer from chronic renal failure were to be provided with dialysis treatment, the cost of doing so would make substantial inroads into the health budget.⁹⁰

Concerning Mr Soobramoney's argument of “emergency medical treatment”, section 27(3) should be construed consistently with the right to life entrenched in section 11 of the Constitution. Accordingly everyone requiring life-saving treatment who is unable to pay for such treatment himself should then be entitled to have the treatment provided at a state hospital without charge. The judges argued that such a construction of section 27 would make it substantially more difficult for the state to fulfil its primary obligations under section 27(1) and (2) to provide health care services to “everyone” within its available resources. It would also have the consequence of prioritising the treatment of terminal illnesses over other forms of medical care and would reduce the resources available to the state

Soobramoney's Legacy and Grootboom's Promise 2000 (16) *SAJHR* 206-268; and Van Oosten “Financial Resources and the Patient's Right to Health Care: Myth and Reality” 1999 *De Jure* 1-11.

⁸⁷ Chaskalson P delivered the main judgment (it was a unanimous decision). Madala J and Sachs J handed down supplementary judgments.

⁸⁸ Van Oosten 1999 *De Jure* 3.

⁸⁹ *Ibid.*

⁹⁰ For criticism on this aspect see Van Oosten 1999 *De Jure* 13-14.

for purposes such as preventative health care and medical treatment for persons suffering from illnesses or bodily infirmities that are not life threatening.

Given that the appellant suffered from chronic renal failure, had to be kept alive by dialysis and would require such treatment two or three times a week, his condition was not an emergency calling for immediate remedial treatment. Section 27(3) therefore did not apply in this situation.⁹¹

The state has a constitutional duty to comply with the obligations imposed on it by section 27 of the Constitution. It was shown in *Soobramoney* that the state's failure to provide renal dialysis facilities for all persons suffering from chronic renal failure constituted a breach of those obligations. The judges, however, followed a holistic approach to the larger needs of society and did not focus on the specific needs of particular individuals within society.⁹²

Taking the above view of the Constitutional Court into consideration, it is submitted that the state should allow a patient an alternative. Such an alternative may be to allow a patient to buy a kidney and thereby give him or her another chance at life while at the same time removing such a person from the dialysis programme and being a financial burden to the state.⁹³

It thus seems it may be fairer to legalise the sale of human organs. To allow organ sales may not only help patients in need but it will also acknowledge an individual's right to self-determination, to decide whether to sell an organ or not, rather than to argue that the state has limited resources and by implication that a patient in desperate need of an organ transplant or dialysis cannot be helped.

Miller remarks that ethical issues in medicine are as old as medicine itself, for once one asked "what is wrong" and "what can be done" one also had to ask "what should be done?"⁹⁴ The answer to his question, taking all the above arguments into consideration, is that the sale of human organs should be legalised in an effort to meet the demand for transplantable organs and to save more lives of desperate patients.

⁹¹ See Van Oosten 1999 *De Jure* 11-12.

⁹² Also see *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC) in this case the court made it clear "that it would not prescribe to the state any particular policy option for giving effect to socio-economic rights"; See also *Minister of Health v Treatment Action Campaign (no 2)* 2002 5 SA 721 (CC).

⁹³ According to Discovery Health Medical Aid Fund, dialysis can cost up to R65 000 per annum. It is more cost effective to transplant a kidney as the operation is paid for once. Friedman and Friedman 2006 (69) *Kidney International* argue that money saved by decreasing the number of dialysis patients might fund additional kidney transplants.

⁹⁴ Miller "Ethical Theory and Principles" in Levinsky *Ethics and the Kidney* (2001) 24.

5 CONCLUSION

More than three decades ago Lyons wrote:

“Medical science has mastered the surgical techniques necessary for organ transplantation surgery. What it has not mastered is to provide in the great need for transplantable organs.”⁹⁵

The organ shortage is still acute today. Jefferies is right in saying that the need for more organs to be made available for transplantation represents the inadequacies of existing laws.⁹⁶ The responsibility therefore to ensure that there are more donors willing to donate an organ should be a legal one. The current system of procuring organs in South Africa is not successful partly as a result of inadequate legislation and partly because of citizens' apathy in considering what will happen with their bodies after death. “Human behaviour is also much more responsive to prospects for financial gain than it is to altruism”.⁹⁷

People have been afraid even to talk about payments for organs, but times have changed. The organ shortage has become so public and so critical that people should begin to rethink their objections against rewarding the donor.⁹⁸ In the United States of America where an estimated 18 000 to 20 000 additional organs are required to meet the demand, more aggressive steps toward financial incentives have been suggested. The Council on Ethical and Judicial Affairs of the American Medical Association has proposed futures markets⁹⁹ in cadaver organs,¹⁰⁰ and members of the International Forum for Transplant Ethics have recommended lifting the ban on kidney sales from living donors pending better justification for prohibiting such transactions.¹⁰¹

⁹⁵ Lyons *Organ Transplants: The Moral Issues* (1970) 89.

⁹⁶ Jefferies <http://www.law.indiana.edu/glsj/vol15/no2/13jeffer.html> (2001-06-08).

⁹⁷ Crespi “Overcoming the Legal Obstacles to the Creation of a Futures Market in Bodily Organs” 1994 (55) *Ohio State Law Journal* 27. Cherry (16) states that “When everyday Joe Blows were asked what they think about selling their organs 40-50% of people did not think it was morally wrong. In South Africa a women's magazine did a survey amongst its readers and found that 56% said they would sell their organs, 37% said they would not and 7% said maybe” (2002-04-03 *Sarie* 93).

⁹⁸ Joralemon “Shifting Ethics: Debating the Incentive Question in Organ Transplantation” 2001 (27) *J Med Ethics* 31.

⁹⁹ A term used to indicate that organs from deceased donors are paid for after their death. See Crespi 1994 (55) *Ohio State Law Journal* 27.

¹⁰⁰ See a discussion of this issue in Joralemon and Cox “Body Values: The Case Against Compensation for Transplant Organs” January-February 2003 (33) *The Hastings Center Report* 27-33.

¹⁰¹ Joralemon 2001 (27) *J Med Ethics* 31.

Robert Berman of the Orthodox Jewish Organ Donor Society wrote in the Jerusalem Post of 9 August 2005:

“The choice before us is not between buying or not buying organs. This is happening regardless of the law. The choice is whether transplant operations and the sale of organs will be regulated or not.”¹⁰²

If this is how people in other countries feel about organ procurement, South Africa should also address the issue. Legislation should be amended to allow the organ donor to be rewarded. In a survey testing specialists' ideas on payment for organ donors, a South African specialist said: “Money is all that will give momentum to transplantations, to make it worth the effort.”¹⁰³

¹⁰² Friedman and Friedman 2006 (69) *Kidney International* 961.

¹⁰³ 1 300 questionnaires were sent out by Slabbert as part of the research for the LLD. They were sent to medical specialists in nine fields of practice. 595 responded. 62% were against the commercialisation of organs and 38% were in favour, if regulated. (Statistics verified by the Tshwane University of Technology.)