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AN ANALYSIS OF ORGAN TRANSPLANTATION IN SOUTH AFRICA WITH SPECIFIC REFERENCE TO ORGAN PROCUREMENT

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  "For I know the plans I have for you," declares the LORD, "plans to prosper you and not to harm you, plans to give you hope and a future."
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SUMMARY

Most South Africans die without their organs being harvested for transplantation. In a country where motor vehicle accidents or violent crime are often the cause of death, presumably leaving most of the organs fit for transplantation, it is astounding that the offer of organs doesn't meet the demand. The aim of this dissertation is to find a practical solution for the current shortage of transplantable human organs in South Africa. This is achieved by critically discussing current South African legislation regulating organ transplantation, considering alternative organ procurement methods, as well as the impact that bioethics and the Constitution might have on the success of an organ procurement system. This dissertation is concluded with the realisation that although the current organ procurement method needs to be changed to required request, relieving the organ shortage will only be achieved by combining several proposed legislative changes, including, but not limited to, creating a national donor as well as a national waiting list; launching an educational campaign; limiting the role of relatives; and expanding the definition of death for the purpose of organ harvesting.

KEY TERMS: organ procurement methods; National Health Act; Constitution; organ shortage; bioethics; autonomy; dignity; required request.

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CHAPTER 1

INTRODUCTION

1.1 Background

Organ transplantation can either be seen as a miracle or a curse, depending on how you look at it. For those who receive a lifesaving organ that alleviates suffering, it is a God sent gift, a glimpse of heaven and a sure sign of hope. However, there are also many detrimental aspects regarding organ transplants. For a human organ to be donated, one of two things must happen: a healthy person must die with his or her organs intact, or a healthy person must willingly consent to serious bodily injury in order to donate his/her organs. Whenever the demand for a resource is higher than the offer, there is a risk of a black market forming to compensate for the shortage.[1] This is indeed the case when it comes to transplantable human organs. The organ shortage is by no means a new problem. Since 1980 academics were already looking for a solution to this global problem.[2] In light of this, the writer finds it intriguing that this problem still exists around the world and more specifically, in South Africa. According to the Organ Donor Foundation,[3] the number of solid organ transplants has declined yearly from 376 in 2009 to 319 in 2012.[4] Furthermore, the number of South Africans awaiting an organ transplant increased from 3 500 in 2009[5] to 4 300 in 2013.[6] It has also been said that there are as many as 15 000

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[1] For a discussion on market failure in the context of organ transplants, see Almeida VF *Market failure in health care: The effect of altruism on the supply of blood and human organs in South Africa* 2001 MCom dissertation, University of the Witwatersrand.

[2] Ghods AJ and Sava S *Iranian model of paid and regulated living-unrelated kidney donation* CJASN 2006 1(6) 1136.

[3] The Organ Donor Foundation of South Africa (hereinafter "the ODF") is a non-profit organisation that was established in 1988. Their main website can be found at http://odf.org.za/.

[4] http://odf.org.za/2013-06-11-09-17-45/statistics.html (accessed 1 September 2013).

[5] "Organ transplant statistics" 17 September 2009 http://www.health24.com/Medical/Heart/Heart-transplants/Organ-transplant-statistics-20120721 (accessed 1 September 2013).

[6] http://odf.org.za/2013-06-11-09-17-45/statistics.html (accessed 1 September 2013).

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people only in need of a kidney transplant or renal dialysis.[7] There is, of course, no certain way to determine the actual amount of South Africans in need of an organ transplant, since there is no national waiting list available. All that can be said with certainty, is that there are not enough organs being procured to meet the demand.

1.2 Research question

This dissertation aims to find a practical solution for the current shortage of transplantable human organs in South Africa.

It is submitted that the easiest way to enable the procurement of more organs, is to first identify the problems with the current organ procurement method, and consequently to propose an organ procurement method that has the potential to solve these problems, whilst retaining the positive aspects of the current organ procurement method. In addressing this issue the writer will critically discuss current South African legislation regulating organ transplantation, consider alternative organ procurement methods, as well as the impact that bioethics and the Constitution might have on the success of an organ procurement system.

1.3 Significance of the study

The shortage of transplantable human organs is a problem that has been around almost as long as organ transplants itself. Although legislation regulating organ transplantation has been enacted several times during the course of a few decades, no successful solution has been implemented to alleviate the constant organ shortage in South Africa. Even after the legislature saw it fit to replace the now outdated legislation,[8] it still failed to successfully address the issue.[9]

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[7] Health Systems Trust: 15 000 wait for donated organs http://www.hst.org.za/news/15-000-wait-donated-organs (accessed 1 September 2013).
[8] Namely the Human Tissue Act, 65 of 1983.
[9] The Human Tissue Act was replaced with Chapter 8 of the National Health Act, 61 of 2003.

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Solving the constant organ shortage will be advantageous in numerous ways: lives will be saved; it is more cost effective to pay for a kidney transplant than for long-term renal dialysis; as a result of more transplants more people will have access to dialysis; less stringent criteria in order to be considered for an organ transplant may be implemented, which will result in more people having access to donated organs; ethical issues with regards to the allocation of a limited resource will be reduced; as more transplants are performed the operations will become more affordable; more hospitals will procure the necessary equipment to perform the transplant; and it will benefit the economy, to name but a few. From this list, it is clear that the benefits of finding a solution to the organ shortage can't be understated.

It is submitted that the best way to solve the constant organ shortage is to regulate organ procurement and other aspects relevant thereto with properly drafted legislation. To merely state that the situation is currently regulated by legislation is not adequate, the legislation has to meet certain criteria. These criteria are: that the solution must be cost effective; it can't put unnecessary strain or burden on the health sector or any other organ of state; it must have at least the possibility of being successful in a multicultural country like South Africa; it must address the reasons for the current organ procurement methods failure to meet the demand for transplantable organs; and it must both be ethically and constitutionally acceptable.[10] Furthermore, in order to be successful, any solution must be practical. The Oxford dictionary defines practical as: "(of an idea, plan, or method) likely to succeed or be effective in real circumstances; feasible."[11] Any recommendations must therefore have the ability to succeed in practice.

1.4 Research methodology

The research methodology of this dissertation is fourfold. Firstly, the writer critically discusses new legislation regarding organ transplantation, namely the National Health Act.[12] An in depth look is taken at the current legislative framework for

[10] The Constitution of the Republic of South Africa, 1996, hereinafter "the Constitution".
[11] http://oxforddictionaries.com/definition/english/practical (accessed 1 September 2013).
[12] 61 of 2003.

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cadaveric donations, living donations, as well as other aspects pertaining to organ transplantation.

Secondly, the main organ procurement methods are discussed respectively, first in general, then in terms of its success or failure in other countries, and thereafter the prospect of its success if applied in South Africa. In doing this, the writer will look at both the strong and weak points of each organ procurement method. A comparative approach will therefore be followed in chapter three in order to consider the success or failure of each organ procurement method in a specific country where it has been applied. Each of the organ procurement methods is subsequently also discussed in light of their respective ethical defensibility. Thereafter, the influence of the Constitution on organ transplants is considered with specific focus on the development of relevant case law.

Lastly, based on the research done throughout this dissertation, the writer considers the success of each organ procurement method as a whole, taking into account all the relevant factors discussed throughout his dissertation. Finally, a practical solution for the current organ shortage is formulated.

1.5 Explanatory terminology

Before the writer continues any further into this dissertation, it is necessary to define certain key concepts applied throughout this dissertation, in order to give the reader a better comprehension of the complex field of human organ transplantation.

1.5.1 Organ

For the purpose of this study, the definition of "organ" as defined in section 1 of the National Health Act[13] will be used. Section 1 states:

[13] 61 of 2003.

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““organ” means any part of the human body adapted by its structure to perform any particular vital function, including the eye and its accessories, but does not include skin and appendages, flesh, bone, bone marrow, body fluid, blood or a gamete.”

1.5.2 Organ transplantation

The Oxford dictionary defines an organ transplant, to: “take (living tissue or an organ) and implant it in another part of the body or in another body.”[14] All organs can potentially be procured from cadavers, however only non-vital organs such as a kidney can be procured from living donors.

1.5.3 Organ procurement method

The Oxford dictionary defines procurement as: “the action of obtaining or procuring something.”[15] An organ procurement method is therefore a method to obtain or procure organs fit for transplantation.

1.5.4 Health care worker

Throughout this dissertation the term health care worker will be used to describe a medical professional such as a doctor, a nurse, a paramedic, a health care provider or any other person involved in the provision of health services. This term is thus used in a very wide sense throughout this dissertation and is not restricted to the definition in the National Health Act.[16]

[14] http://oxforddictionaries.com/definition/organtransplant?q=organtransplant (accessed 12 August 2013).
[15] http://oxforddictionaries.com/definition/english/procurement (accessed 12 August 2013).
[16] As found in section one of the National Health Act.

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1.5.5 Brain death

This is an irreversible and irreparable cessation of all cerebrum, cerebellum and brain stem functions; consequently there is a complete termination of the heartbeat, respiratory functions, blood circulation, as well as digestive functions.[17] Brain death is also known as brain stem death.[18]

1.5.6 Cadaveric donation

Cadaveric donation is by far the most common form of harvesting human organs. It involves the harvesting of organs from a cadaver, that is, the body of a person that has recently died. It is important to note that the harvesting time for organs differ from organ to organ.[19]

1.5.7 Living donation

Living organ donation takes place when organs are harvested from a living person, and mainly involves the kidneys or a part of the liver. Living donation is less common than cadaveric organ donation, partly because fewer organs are available for harvesting without causing the death of the donor, and partly because there is no gain, other than emotional gain, involved for the donor.[20] It thus follows that this kind of donation is often made to a close friend or relative.

1.5.8 References to gender

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[17] Black JM and Matassarin-Jacobs E. *Luckmann and Sorensen's medical surgical nursing: A psychophysiologic approach* 1993 4th ed Saunders WB 677.

[18] Black and Matassin-Jacobs 677. See also the definition of death in section 1 of the National Health Act.

[19] Slabbert M *Handeldryf met menslike organe en weefsel vir oorplantingsdoeleindes* (LLD thesis, University of the Free State 2002) 26.

[20] Section 60(4) and 60(5) of the National Health Act prohibit an organ donor from receiving any financial reward in exchange for the organ.

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Throughout this study, where reference is made to either the masculine or feminine form, it includes the other, unless the context of the discussion indicates otherwise.

1.6 Structure

This dissertation consists out of six chapters. The chapter division is as follows:

Chapter one: Introduction

The first chapter is an introduction to the research topic, the identification of the research question, the significance of the study, explaining or defining key concepts used throughout this dissertation, as well as a motivation of exclusions from this study.

Chapter two: An analysis of South African legislation and relevant factors

This chapter aims to set out the legislation currently governing organ transplantation, organ procurement and aspects relevant thereto.[21] This is done with reference to the now repealed Human Tissue Act,[22] in order to point out both the omissions from the new Act, as well as similarities between the two. It is important to note that although the Constitution is a legislative instrument, it is discussed separately in chapter 5. The reasons for this are twofold: Firstly, including both the National Health Act as well as the Constitution in one chapter would have made it too long, and secondly, the discussion of constitutional rights in chapter five is much easier done after chapters two to four, as it requires the readers foreknowledge of the various organ procurement methods.

Chapter three: Various organ procurement systems and aspects relevant thereto

In this chapter the main organ procurement methods are each discussed in general. Thereafter, each respective organ procurement method is discussed according to its

[21] Namely the National Health Act 61 of 2003.
[22] 65 of 1983.

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respective success or failure thereof as currently applied elsewhere in the world, therefore a partially comparative methodology was followed in this chapter. Finally, each organ procurement method is considered as a possible procurement method in South Africa.

Chapter four: The influence of bioethics

Chapter four considers the influence of bioethics in the context of the ethical defensibility of organ procurement methods, by testing each of the organ procurement methods against each of the four principles of bioethics. It is therefore important to discuss the ethical implications of each organ procurement method in the chapter following chapter 3 as the knowledge of each procurement method is still fresh in the readers mind.

Chapter five: The constitutional influence on organ transplants

Chapter five examines the influence of the Constitution on the legality of organ procurement methods, with specific reference to developments in case law. As the influence of the Constitution on current legislation, different organ procurement methods, as well as the relationship between ethical principles and constitutional rights are considered in this chapter, it is submitted that it is best to discuss this after chapters two to four.

Chapter six: Recommendations and conclusion

Chapter six will conclude the study by identifying organ procurement methods with a small or no chance of success in South Africa, as well as identifying the organ procurement method with the highest possibility of success in South Africa. After this organ procurement method is identified, the implementation thereof is discussed in detail, after which a general conclusion is given.

1.7 Exclusions

It is important to realise that this study is only a small part of a much larger picture in the context of organ transplantation. There are therefore several areas that deserve

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specific mention for being omitted in order to keep the research question from becoming too broad to discuss in this dissertation due to length constraints. First of all, this dissertation aims to address questions regarding organ procurement both for live, as well as cadaveric donations of transplantable human organs. Therefore, the possibility of xenografts,[23] is not discussed further in this dissertation.[24] Furthermore, as the purpose of this study is to find a practical solution to the organ shortage, the possibility of using regenerative medicine[25] is not considered further in this study due to the fact that it is still developing technology that is not yet affordable.

Much can also be said on the criminal sanctions involved in organ trafficking and other misdemeanours regarding organ transplantation. However, as there is enough information on the criminal aspect (or lack thereof) to conduct a whole, separate study, and in order not to lose track of the research question, this discussion has been entirely omitted from the study.[26]

As this study is based on possible solutions to the organ shortage in a South African context, the different cultures and religions in South Africa can potentially play a large role in the success or failure of an organ procurement system. However, this is a study that fit much better within a social sciences context than into a legal context. Therefore, these factors will be mentioned, although not discussed in detail. It is submitted that acknowledging the cultural and religious differences between South African citizens is adequate for the purpose of this study.[27]

Furthermore, the situation regarding minors or mentally ill persons is not dealt with in this dissertation.[28] This is because in doing so, focus on the main research question will be lost. The aim of this dissertation is not to identify and discuss all the possible

[23] Where an organ is transplanted from one species to another.
[24] For a discussion on xenografts, see Veatch RM *Transplantation ethics* 2000 chapter 17 259-273.
[25] Such as lab-grown organs. See for instance "Lab-grown human organs" http://www.euronews.com/2013/06/26/lab-grown-human-organs/ (accessed 1 September 2013).
[26] For more on the crime of organ trafficking and related matters, see Watson C *The organised crime of organ trafficking* 2006 (LLM dissertation University of the Free State).
[27] For more on different cultures and religions in South Africa, specifically in the context of organ transplantation, see Slabbert M *Handeldryf met menslike organe en weefsel vir oorplantingsdoeleindes* (2002) (LLD thesis, University of the Free State). See also Ebrahim AFM and Haffejee AA *The Shari'ah and organ transplants* 1989; Goolam NMI *Human organ transplantation- Multicultural ethical perspectives* 2002 (Unpublished paper presented at the 13th World Congress on Medical Law, Helsinki Finland); Veatch 2000 1-27; and Slabbert M, Mnyongani FD and Goolam N *Law religion and organ transplants* Koers 2011 76(2) 261.
[28] This would be regulated by, *inter alia,* the Children's Act 38 of 2005 and the Mental Health Act 17 of 2002. For a discussion on donation by minors, see Veatch 2000 236-244.

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problems or exceptions to the general law that could arise, but to identify a practical, workable solution for the organ shortage from a procurement perspective. It is therefore acknowledged that the situation regarding minors and mentally ill persons will have to be dealt with separately, as they are not in a position to give informed consent. However, it is submitted that it is not necessary to discuss for the purpose of this study.

1.8 Conclusion

This chapter has served as a general introduction to the research topic of organ transplants and organ procurement. In this study a practical solution to the constant organ shortage, specifically in a South African context, will be sought. This will be done by considering both current and previous South African legislation, various organ procurement methods, the influence of bioethics and the Constitution.

However, the aim of this study is not merely to make suggestions as to which organ procurement method should be applied, but also to identify those organ procurement methods that lack the ability to succeed in South Africa, thereby eliminating unsuitable organ procurement methods. In the quest to find a practical solution to the organ shortage, it must be borne in mind that if the solution was so obvious, the problem would have been solved many years ago already.

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CHAPTER 2

AN ANALYSIS OF SOUTH AFRICAN LEGISLATION AND RELEVANT FACTORS

2.1 Introduction

The South African position regarding organ transplantation has changed recently, due to the provisions in chapter 8[1] of the National Health Act[2] that came into force on the 1st of March 2012.[3] Before the promulgation of the relevant sections in the National Health Act, organ trade was regulated by the Human Tissue Act.[4] Throughout this chapter, reference will be made to the Human Tissue Act, pointing out the differences between the current and previous legislation. Potential problem areas, *lacunae* and oversights by the legislature, will also be identified and discussed. Furthermore, this chapter is written in the broader context of the research question, thus focusing on problem areas pertaining to organ procurement. This chapter therefore offers a comprehensive and all-inclusive discussion of the National Health Act in context.

It is important to note that even though the Constitution[5] is a form of legislation, it will be discussed later in this dissertation,[6] where most of the relevant case law will also be dealt with, as well as the relevant cases in light of its constitutional relevance.

2.2 The National Health Act[7]

Legislation governing organ trade in South Africa can be found in chapter 8 of the Act. The Act replaced the out-dated Human Tissue Act with a focus on addressing

[1] Sections 53- 68.
[2] 61 of 2003.
[3] South Africa (2012) Commencement of certain sections of the National Health Act (Act no 61 of 2003) *Government Gazette* 35081:3, 3 February 2012.
[4] 65 of 1983.
[5] The Constitution of the Republic of South Africa, 1996, hereinafter “the Constitution”.
[6] Chapter 5: The Constitutional influence on organ transplants.
[7] Hereinafter “the Act”.

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recent developments in the world of medicine. For the purpose of this discussion, the writer will focus on chapter 8 and the regulations to the Act.

It is worth noting at this point that there are mainly two sources of human organs for donation: live donations[8] and cadaveric donations.[9,10] The subsequent discussion will clearly distinguish between live donations and cadaveric donations, as there are several fundamental differences between them.[11]

2.2.1 Live donations

Live donations are donations where the donated organs, usually a kidney or a part of the liver, are harvested from a living person. It allows more time for preparations to be made prior to the transplant and generally the organs procured are of a higher quality than those procured from cadavers.

Organs from living donors are procured by obtaining the consent of the donor prior to the removal of the organ.[12] Guiding Principle 3 of the World Health Organisations'[13] *Guiding Principles on Human Cell, Tissue and Organ Transplantation* states that:

> "Donation from deceased persons should be developed to its maximum therapeutic potential, but adult living persons may donate organs as permitted by domestic regulations. In general living donors should be genetically, legally or emotionally related to their recipients. Live donations are acceptable when the donor's informed and voluntary consent is obtained, when professional care of donors is ensured and follow-up is well organized, and when selection criteria for donors are scrupulously applied and monitored. Live donors should be informed of the probable risks, benefits and consequences of donation in a complete and understandable fashion; they should be legally competent and

8 Where the organ is harvested from a living person, usually in the form of a kidney, a part of the liver or pancreas, or skin grafts.

9 In this case, the organs are harvested from recently deceased persons. Cadaveric donations are much more common than live donations, due to both physical as well as legislative constraints.

10 The other source, cloning, is not discussed in this thesis, as the availability of the required technology is very limited, as well as very advanced and costly, and at this time, it is thus not a good source of organ procurement in the Republic of South Africa.

11 For instance from whom the consent is required, when the consent should be given, the method of organ procurement, which organs can be harvested, the time the organs are procured, as well as time constraints for the removal of organs from cadavers.

12 See sections 55 and 56 of the National Health Act as well as guiding principle 3 of the World Health Organisations' *Guiding Principles on Human Cell, Tissue and Organ Transplantation* for the consent required from living donors.

13 Hereinafter the "WHO".

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> capable of weighing the information; and they should be acting willingly, free of any undue influence or coercion."[14]

Guiding Principle 3 thus sets out the requirements for live donations. Effect is given to Guiding Principle 3 in sections 55 and 56 of the Act. Section 55 states that:

> "A person may not remove tissue…from the body of a living person for the purpose referred to in section 56 unless it is done-
> *(a)* with the written consent of the person from whom the tissue…are removed granted in the prescribed manner; and
> *(b)* in accordance with prescribed conditions."

Section 56 continues to state that:

> (1) "A person may use tissue…removed…from a living person only for such medical or dental purposes as may be prescribed.
> (2) *(a)* Subject to paragraph *(b),* the following tissue…may not be removed or withdrawn from a living person for any purpose contemplated in section (1):
> (i) Tissue… from a person who is mentally ill within the meaning of the Mental Health Care Act, 2002 (Act No. 17 of 2002);
> (ii) tissue which is not replaceable by natural processes from a person younger than 18 years; …
> *(b)* The Minister may authorise the removal or withdrawal of tissue… contemplated in paragraph *(a)* and may impose any condition which may be necessary in respect of such removal or withdrawal."[15]

These sections must be read with section 1 containing the definitions. It is important to note that tissue is defined as: "…human tissue, and includes flesh, bone, a gland, an organ, skin, bone marrow or body fluid, but excludes blood or a gamete."[16]

When reading sections 55 and 56 together with the definitions in section 1 it is clear that tissue may not be removed from a living person without written consent.[17] The question arising here is twofold: (a) Who is regarded as a living person? and (b) What constitutes valid written consent? These questions are accordingly discussed separately.[18]

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[14] http://www.who.int/transplantation/TxGP08-en.pdf (accessed 9 October 2012).
[15] Section 56 gives effect to guiding principle 4 of the Guiding Principles on Human Cell, Tissue and Organ Transplantation, which states that: "No cells, tissues or organs should be removed from the body of a living minor for the purpose of transplantation other than narrow exceptions allowed under national law. Specific measures should be in place to protect the minor and, wherever possible the minor's assent should be obtained before donation. What is applicable to minors also applies to any legally incompetent person."
[16] Section 1 of the Act.
[17] According to section 55*(*a).
[18] Under paragraphs 2.2.1.1 and 2.2.1.2 respectively.

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2.2.1.1 Who is regarded as a living person?

To understand the concern at hand, one must first understand who is defined as a "living person". Common sense prescribes that one is alive until one is dead. However, it is not as simple as it may sound. In section 1 containing the definitions of the Act, death is defined as brain death for the first time,[19] without defining or explaining the concept of brain death any further. The only further aid given by the legislature can be found in regulation number 180, regulation 9.[20]

This regulation reaffirms the position as it was under the Human Tissue Act, namely that the death of a person must be determined by at least two medical practitioners, one of whom shall have been practising for at least five years after registration as such, and that none of these practitioners shall take part in the transplantation. As the regulation only mentions by whom death must be established, without mentioning the method of establishing death, there is still not a conclusive answer to be found as to a more comprehensive and workable definition of death.

However, in the recommended amendments to the current regulations[21] regarding the general control of human bodies, tissue and organs for transplantation, as published on the South African Transplant Society's[22] website,[23] the concept of brain death (also known as brain stem death) is explained further. It must be emphasized that these are only recommended amendments to the current regulations and at this stage, carries no legislative weight at all.[24] It states in chapter 4: Brain Stem Death, that:

1) "Brain stem death shall be diagnosed in the demonstration of the absence of reflexes of the brain stem in a person with a known cause of severe and irreversible brain damage

[19] McQuoid-Mason D and Dada M *Tissue transplantation and the National Health Act* CME : Your SA Journal of CPD : Forensics 2006 24(3) 129.
[20] GN R180 in *Government Gazette* 35099 of 2 March 2012.
[21] As drafted by the South African Transplant Society.
[22] Hereinafter "SATS".
[23] http://www.sats.org.za/Guidelines.asp (accessed 10 October 2012).
[24] It also needs to be kept in mind that the amendments were drafted by the SATS and not by the Department of Health.

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2) Diagnosis shall be made either by electrophysiological, radiological or other tests by simple, reliable bedside demonstrations of the absence of reflexes of the brain stem."

It then continues to list four clinical criteria for the diagnosis of brain stem death, as well as determining the minimum clinical signs of brain stem death in a very technical manner.[25]

Although these clinical criteria have the potential to clarify the situation, it won't be accepted as binding law until such a time as the Minister of Health deems fit to promulgate these regulations, and there is always the possibility of these draft regulations being amended once again, before being promulgated.

It is thus still necessary to define what exactly brain death means. When one takes a look at the different definitions of death, it is apparent that one can differentiate between a) whole brain death; b) brain death, also known as brain stem death; as well as c) neo- cortical death. A short distinction between these three forms of death is drawn:

a) Whole brain death: This looks at the brain at a cellular level and sets in when all the brain cells have in fact died. It is important to note that according to this definition of death, death is a process that doesn't happen instantly and that develops over time.[26]
b) Brain death:[27] This is an irreversible and irreparable cessation of all cerebrum, cerebellum and brain stem functions; consequently there is a complete termination of the heartbeat, respiratory functions, blood circulation, as well as digestive functions.[28,29]

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[25] Paragraphs (a)-(d) and (a)-(e) respectively. As these are recommended amendments to the current Regulations, the numbering is not what one would expect it to be.
[26] Veatch 2000 56-57. This definition of death is not suitable for determining death for means of organ transplantation, as whole brain death can take several hours to set in.
[27] Also known as brain stem death.
[28] Black JM and Matassarin-Jacobs E *Luckmann and Sorensen's medical surgical nursing: A psychophysiologic approach* 1993 4th ed Saunders WB 677.
[29] In recent years, however, it has been shown that the definition of brain death is flawed, Fost N *Reconsidering the dead donor rule: is it important that organ donors be dead?* Kennedy Institute of Ethics Journal 14(3) 249-251. See also McMahan J *An alternative to brain death* J.L. Med. & Ethics 2006 (34) 44 45-46.

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c) Neo- cortical death: In this instance the person has suffered damage to the cortex of the brain,[30] however, the brain stem functions are still intact and the person is in a so-called persistent vegetative state.[31] What is important here is that the person is still regarded as biologically alive, although being socially dead.[32,33]

From the discussion above, it is thus clear that neo-cortical death is not the same as brain death. The person is thus still alive and brain death has not set in yet. This means that anyone connected to lifesaving equipment such as a ventilator, whilst still having some brain stem functions, will be regarded as a living person for the purposes of section 55. This will be the case even if there is no chance of regaining consciousness or other forms of recovery.

The consequence of this is that if a neo-cortically dead person did not have a legally valid living will,[34] his/her organs will not be available to harvest until all the life-sustaining equipment is turned off and brain death has set in. When one looks at the different medical textbooks, one will realise that this might take a while.[35] The transplant team will thus be forced to wait, while the quality of the organs and the chances for a successful transplantation diminishes by the minute, due to the lack of oxygen.

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[30] The cortex, also known as the cerebral cortex, is the outer layers of the brain, and can clearly be seen to be the grey matter, as opposed to the white matter of the brain. It plays an important role in the ability to achieve consciousness. "cortex" Oxford Dictionaries 2010 Oxford University Press. http://oxforddictionaries.com/definition/english/cortex (accessed 26 July 2012).

[31] The term persistent vegetative state is used to describe the condition where a patient shows some brain stem activity, but there are no higher cerebral functions that can be detected. This is a severe form of brain damage. Although the patient thus breathes spontaneously, the patient remains unconscious. Macpherson G (ed) *Black's Medical Dictionary* 1999 39th ed 421.

[32] Under South African law, this means that a court order is needed to remove or stop administering artificial feeding. Succeeding with a court application will mean that passive euthanasia is applied. For more on this topic, especially in the context of the element of wrongfulness, see *Clarke v Hurst NO* 1992 (4) SA 630 (D) and Carstens PA and Pearmain D *Foundational principles of South African medical law* 2007 926- 937.

[33] Anencephaly is defined as "having part or all of the cerebral hemispheres and the rear of the skull congenitally absent." http://oxforddictionaries.com/definition/english/anencephalic (accessed 1 September 2013). This is a disorder that children are born with, rendering them biologically alive, yet socially dead- just as is the case with persons in a persistent vegetative state. For the remainder of this chapter, where reference is made to persons in a persistent vegetative state, anencephalic children are included, unless the context clearly indicates otherwise. For more on anencephalic children in the context of organ donation, see Veatch 2000 chapter 14 223-235.

[34] A living will is a document created with the intention of stating the testator's demands, should there come a time when the person is still alive, but unable to give these directives at the time. It thus mostly deals with the testator's wishes regarding end of life decisions.

[35] Although the time may vary, it will probably take too long for organ transplantation to still be a viable option.

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Another problem worth mentioning is that even if the person did indeed have a valid living will, stating that he/she does not wish to be kept alive artificially and that the person is indeed a willing organ donor, the transplant team might not be willing to do the operation, because even with this clear written consent, there might still be far-reaching consequences. If life-sustaining organs are removed before brain death sets in, it will result, at least factually, in the death of the donor. This is *prima facie* the wrongful[36] and intentional causation[37] of death, i.e. murder.[38]

What is important to note here, is that the legal issue is not the removal of the nasogastric tube, as this has already been resolved in *Clarke v Hurst*, where the court held that the removal of the nasogastric tube will not be wrongful conduct under the circumstances. By stating this, the court thus found that voluntary passive euthanasia is not wrongful, and thus it's not illegal.[39] It is thus permissible to stop administering medical care according to the patients' instructions or the instructions of an appointed *curator*, even if it results in the death of the patient. The problem is that with voluntary passive euthanasia, death might take a while to set in, rendering organs unfit for donation.

This seems like a waste of perfectly good organs. When a person is in a persistent vegetative state, the chances are good that this person will never regain consciousness again. For all practical purposes, one is a breathing vegetable, without any significant interaction to the outside world. This goes against the very reason many people choose to make use of a living will: to diminish suffering, relieve financial burdens and to do an altruistic deed: donating organs. In refusing to allow

[36] For more on the element of wrongfulness, see the discussion under paragraph 2.2.1.1(a) *Volenti non fit iniuria.*

[37] The element of causation stands on two legs: factual causation, as well as legal causation. For the determination of factual causation, the *conditio sine qua non*-test is applied, whereas for the determination of legal causation, there are several theories used and this can get very tricky. In the most difficult cases, the courts regularly fall back on policy considerations. For more on causation, see Neethling Potgieter Visser *Law of Delict 6th ed* 2010 Chapter 5. For more on causation in light of policy considerations, see *S v Daniels* 1983 3 SA 275 (A), *S v Mokgheti* 1990 1 SA 32 (A), and *S v Williams* 1986 4 SA 1188 (A).

[38] Snyman CR *Criminal Law* 2008 5th ed 447.

[39] The writer does not wish to enter into the euthanasia debate. The topic is not included for purposes of this study and reference to the *Clarke-case* is merely made to point out the relevance of the judgment to the current topic.

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the donation to take place, the donor's wishes and right to patient autonomy[40] is expressly defied.

Many people in a persistent vegetative state eventually die from hunger and dehydration after the nasogastric feeding tubes have been removed.[41] At this stage the organs will no longer be fit for transplantation. This means that a potentially perfect group of organ donors are completely disregarded for donation purposes. They are already in a hospital; there is time to find the best matches for the organs and do other preparations; and the quality of the organs should be very good, as there is blood supply to them until removal from the body for transplantation. However, these organs are currently being wasted.

It is troublesome that this issue still hasn't been dealt with specifically by the courts. One of the fundamental principles of medical law is that of patient autonomy, as set out in section 12(2)(b) of the Constitution. Patient autonomy, like every other right, has two sides, in this case the right to allow, as well as the right to refuse. This includes the fundamental right of a patient to refuse treatment, and should thus automatically include the right to refuse the continuation of artificial feeding, once the person is in a persistent vegetative state.

To this problem, the writer proposes two possible answers:

a) The application of *Volenti non fit iniuria*; and b) Modifying the definition of death for organ donors.

2.2.1.1(1) *Volenti non fit iniuria*

Volenti non fit iniuria is a defence that originates from the Roman and Roman-Dutch law and in its simplest form states that no harm can be done to a willing or consenting person.[42] The effect of this defence is that it negates the element of wrongfulness, whether it is applied in a delictual or a criminal context. The heart of this defence thus lies in consent. The requirements for this defence to succeed are:

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[40] In terms of section 12(2)(b) of the Constitution: "Everyone has the right to bodily and psychological integrity, which includes the right- to security in and control over their body."
[41] Unless further complications arise, this will most probably be the case.
[42] Neethling Potgieter Visser 103.

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the consent must be given voluntary or freely; the consenting person must be capable of volition; there must be full knowledge of the extent and nature of the harm; there must be full appreciation of the nature and extent of the harm; there must be actual, subjective consent given; as well as the consent not being *contra bonos mores.*[43,44] The consent given must thus be informed consent.

It is with this last requirement that further problems arise. As a general rule, consent to bodily harm is *contra bonos mores*, unless it is in cases of sport, medical intervention, or where the harm is insignificant.[45] To illustrate this, the court in *S v Grotjohn*[46] held that it is not a crime to commit or to attempt to commit suicide, however it is a crime to assist someone to commit suicide, and one can be found guilty of murder, attempted murder or culpable homicide.[47] This will be the case even if there was consent or an agreement present, the fact that the factual causation of death was a lawful suicide does not influence the unlawfulness of the assistants conduct.[48]

The writer argues that in the case of a person being in a persistent vegetative state, if life-sustaining organs are removed, a) there is no real harm; or b) any harm will be insignificant. The argument that no harm can be done in this case, is supported by Shah and Miller:[49]

> "More specifically, we contend that once a person has decided that she (1) retains no interest in remaining alive; (2) would like her therapy withdrawn; and (3) would like to donate her organs is not harmed by serving as an organ donor (sic)."[50]

The argument is thus, if a person states in a valid living will that she does not want to be kept alive, that no further treatment must be given, and that she is indeed a willing organ donor, no harm (or no significant harm) can be done to her in terms of *volenti non fit iniuria,* as she is a consenting person. No harm is done as her constitutionally

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[43] Neethling Potgieter Visser 106- 108.
[44] It is important to note that for consent to constitute valid consent, it must be informed consent. For a comprehensive discussion on informed consent, see Carstens and Pearmain 877- 906.
[45] Neethling Potgieter Visser 108.
[46] 1970 (2) SA 355 (A).
[47] *S v Grotjohn* 364.
[48] *S v Grotjohn* 265: "…is dit egter nodig om op die voorgrond te stel dat die blote feit dat die laaste handeling die selfmoordenaar se eie, vrywillige, nie-misdadige handeling is, nie sonder meer meebring dat bedoelde persoon aan geen misdaad skuldig kan wees nie."
[49] Shah SK, Miller FG *Can we handle the truth? Legal fictions in the determination of death* American Journal of Law and Medicine 2010 540.
[50] Shah and Miller 576.

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entrenched rights to patient autonomy and bodily integrity[51] are respected and with medication the most significant pain can be prevented. The loss of life in this case does not constitute harm as the patient is already "as good as dead"[52] and would most likely have died in her unconscious state at some point in the future.[53] Utilising *volenti non fit iniuria* has the consequence of the patient's death being an altruistic deed in itself.[54]

What is worth noting here is that the additional methods of obtaining consent from relatives that is available once the donor has died, is not available in the abovementioned situations. It is advisable that the legislature make provision for consent to organ donation by relatives in cases such as the above, where the person is "as good as dead"[55] but not dead in terms of brain death as set out in the regulations to the Act. This could save valuable time and allow for preparations to be made for the transplant before the donor dies and the organs start to deteriorate.

2.2.1.1(2) Modifying the definition of death for organ donors

The definitions of the various forms of death have already been stated above.[56] As had already been submitted, the organs of people in a persistent vegetative state are not transplantable before brain death sets in. By the time this happens, many of these organs are no longer in a transplantable condition. One possible solution to this dilemma is adapting the definition of death in determining the death of an organ donor.

Before recent advances in the world of medicine, determining death was mainly important for purposes of arranging the funeral, determining when certain legal relationships like marriage or partnerships ends, distributing the estate of the deceased, as well as in criminal law to be able to charge the accused of crimes such

[51] As set out in section 12(2)(b) of the Constitution.
[52] Shah and Miller 566.
[53] As O'Regan stated in *S v Makwanyane* 1995 (3) SA 391 (CC), the right to life includes much more than the mere right to existence, 325- 326.
[54] For more on this topic, specifically in the light of the Constitution, please refer to the discussion on whether a person can limit her Constitutional rights, and if so to what extent, chapter 5: The Constitutional Influence on Organ Transplants.
[55] Shah and Miller 566.
[56] See paragraph 2.2.1.1(a).

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as murder or manslaughter. Knowing only more or less when a person died was sufficient. However, the situation changed severely with the development of organ transplantations. Now, it is extremely important to know exactly when a patient dies, in order to harvest the organs in the best possible condition.

Shah and Miller rightly states:

> "[A]n important limitation on procuring organs for transplantation is the dead donor rule. The dead donor rule is a widely endorsed moral and legal constraint stipulating that the transplantation of vital organs can only occur after a donor's death because it cannot be the cause of the donor's death."[57]

The dead donor rule is found in section 62 of the Act, stating that any tissue may be donated after death.[58] *Prima facie*, this makes logical sense. If one removes vital organs from a living person, it will result in his/her death. Acting contrary to the dead donor rule is also forbidden by our common law, as murder is the unlawful, intentional causation of the death of a human being.[59] It thus seems as if removing the vital organs of a person for transplantation, resulting in her death, is illegal conduct as it falls under the definition of murder. The dead donor rule therefore serves to protect health care workers from committing murder and maintains public trust in the health care system.[60] The dead donor rule is well-known and followed as a moral standard around the world.[61]

So, if the dead donor rule makes sense, is followed worldwide and on the face of it seems right, what is the problem? The problem is this: during recent years, technology advanced at a tremendous speed, and with this came the ability to find out more and more about the human body. As a result of this, there are now many different definitions of death and neither one of them seems to be a perfect fit in all situations. One wants to be certain a person is dead, yet one doesn't want to waste any more valuable time than is absolutely necessary in the procurement of organs.

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[57] Shah and Miller 543. See also Veatch 2000 183-184 as well as Fost 249-260.
[58] S62(1)*(a):* "A person who is competent to make a will may- … donate his or her body or any specified tissue thereof to be used after his or her death."
[59] Snyman 447.
[60] Rodriguez-Arias, Maxwell D, Smith J and Lazar NM *Donation after circulatory death: Burying the dead donor rule* The American Journal of Bioethics 2011 11(8) 36.
[61] Rodriguez-Arias *et al* 36.

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In the widely known case of *S v Makwanyane,*[62] Justice Kate O'Regan made the following statement:

> *"The right to life is, in one sense, antecedent to all the other rights in the Constitution.* Without life in the sense of existence, it would not be possible to exercise rights or to be the bearer of them. But the right to life was included in the Constitution not simply to enshrine the right to existence. *It is not life as mere organic matter that the Constitution cherishes, but the right to human life: the right to live as a human being, to be part of a broader community, to share in the experience of humanity. This concept of human life is at the centre of our constitutional values.* The constitution seeks to establish a society where the individual value of each member of the community is recognised and treasured. The right to life is central to such a society. The right to life, thus understood, incorporates the right to dignity. *So the rights to human dignity and life are entwined. The right to life is more than existence, it is a right to be treated as a human being with dignity: without dignity, human life is substantially diminished*. Without life, there cannot be dignity. This was recognised by the Hungarian constitutional court in the case in which it considered the constitutionality of the death penalty:
>
> `It is the untouchability and equality contained in the right to human dignity that results in man's right to life being a specific right to human life (over and above animals' and artificial subjects' right to being); on the other hand, dignity as a fundamental right does not have meaning for the individual if he or she is dead. ... Human dignity is a naturally accompanying quality of human life.'… The importance of dignity as a founding value of the new Constitution cannot be overemphasised. *Recognising a right to dignity is an acknowledgement of the intrinsic worth of human beings: human beings are entitled to be treated as worthy of respect and concern."*[63]

From this quote, it is clear that the right to life, as enshrined in the Constitution, entails much more than merely the right to existence. Life, according to Justice O'Regan, must be *dignified* life. It is thus not life as mere organic matter (such as people in a persistent vegetative state) that the Constitution cherishes, but the right to live as a human being, being part of the community, able to share in the experience of humanity. Interaction with the world around us is thus the key to having a dignified life and the right to being treated with respect and concern is included in the right to human dignity.[64] This is in accordance with Jordaan's

[62] 1995 (3) SA 391 (CC).
[63] *S v Makwanyane* paragraphs 325- 326 and 328, writer's own emphasis.
[64] Section 10 of the Constitution.

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argument that "[a] new medical ethic has emerged which acknowledges that quality of life is more important than life as such."[65]

The argument can thus be made that because persons in a persistent vegetative state can have no meaningful interaction with their surroundings, both their dignity and life is reduced. As O'Regan rightly states: "without dignity, human life is *substantially* diminished."[66] If your dignity is automatically reduced when you are in a persistent vegetative state, how does one ensure that the right to dignity for these people are still respected? This can be done by treating them with respect and concern, specifically respect for bodily integrity, patient autonomy[67] and what the person would have wanted, had they been able to convey the message to others. It comes down to allowing a person in a persistent vegetative state the little freedom that is left over her life.

It is the submission of the writer that very few people would choose to die of dehydration and hunger after the nasogastric tube has been removed, regardless of the process being pain free, that most people would prefer a quick way to go. The only way to restore the diminished dignity of a person in a persistent vegetative state is thus to allow them to die with dignity. Jordaan agrees that an exception should be made to the total ban on assistance in the context of a doctor-patient relationship:

> "dat die algehele strafregtelike verbod op aktiewe hulpverlening by die sterwensproses ongrondwetlik is en dat 'n uitsondering erken behoort te word in die konteks van die geneesheer-pasiënt verhouding. Daar word aan die hand gedoen dat die wetgewer die geskikte instelling is om hervorming van die reg in hierdie verband teweeg te bring."[68]

Dying with dignity includes being allowed to die in a manner that is in line with the patients' values and beliefs. The writer finds it peculiar that one is allowed to commit suicide yet forbidden to die with dignity once in a persistent vegetative state and in the process also prevented from saving lives.

[65] Jordaan L *The right to die with dignity: A consideration of the constitutional arguments (2)* THRHR 2009 (72) 374 392.
[66] *S v Makwanyane* paragraph 325, own emphasis added.
[67] As enshrined in section 12(2)(b) of the Constitution.
[68] Jordaan L *The right to die with dignity: A consideration of the constitutional arguments (1)* THRHR 2009 (72) 192.

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In this regard, the writer makes two submissions. Firstly, that brain death is kept as the generally accepted definition of death. Secondly, as an exception or expansion to the general rule, neo-cortical death should be deemed to be the legally recognised definition of death for purposes of organ harvesting.[69] The dead donor rule is therefore disregarded in these cases, as it is not in the best interests of potential donors.[70] This should however be regulated very strictly to prevent abuse. It is submitted that it only be allowed where the person has given prior written consent, such as in a living will, to being an organ donor and also indicated that she doesn't want to be kept alive artificially.[71] Ideally, this should be addressed comprehensively by the legislature.

2.2.1.2 What constitutes valid written consent?

This brings one to the second question, namely what will be regarded as valid written consent? This question will be answered by first looking at the nature and scope of the required consent, and thereafter at the living will as a possible form of valid written consent.

2.2.1.2.1 The nature and scope of the consent

Now the question arises, what will qualify as valid written consent? The National Health Act only states that the "written consent" of the donor is required "in the prescribed manner" in chapter 8.[72] When one looks at the regulations to the Act, Regulation number 180 states in Regulation 2 that:

> "A person may not remove tissue… from the body of another living person for a purpose referred to in section 54 and regulation 3 unless written consent thereto has been granted as follows-
>
> (a) where such a person is older than 18 years, by that person;
> (b) where such person is younger than 18 years, by the parents or guardians of that person;

[69] This is supported in the case of the donor being in a persistent vegetative state or being an anencephalic infant, Fost 251.
[70] Rodriguez-Arias *et al* 41.
[71] This is in line with and founded on the new definition for death as proposed by Veatch RM *Transplantation ethics* 2000 138-139. He is however of the opinion that this is unsuitable for anencephalic children, Veatch 2000 228-229.
[72] Section 55*(a).*

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(c) paragraph (b) is not applicable to gamete donors who shall never be younger than 18 years; and (sic)"[73]

The regulations thus only list the person to give consent under certain circumstances, without mentioning the method of said consent."[74]

It is a shame that the legislature elected not to specifically define consent or informed consent in the Act or the regulations thereto, as it let a golden opportunity slip to create legal certainty. What is even more peculiar is the fact that informed consent is required in terms of section 6(1) of the Act without explicitly stating that informed consent (as described by the court in *Castell v De Greef*)[75] is the actual requirement. One would expect this situation to be rectified with an amendment to the Act.[76]

Section 6 of the Act states:

> "User to have full knowledge: 6(1) Every health care provider must inform a user of-
> (a) the user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interests of the user;
> (b) the range of diagnostic procedures and treatment options generally available to the user;
> (c) the benefits, risks, costs and consequences generally associated with each option; and
> (d) the user's right to refuse health services and explain the implications, risks, obligations of such refusal.
> (2) The health care provider concerned must, where possible, inform the user as contemplated in subsection (1) in a language that the user understands and in a manner which takes into account the user's level of literacy."

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[73] GN R180 in Government Gazette 35099 of 2 March 2012.

[74] The fact that there is no paragraph (d) present after the last 'and' makes one wonder whether it is the 'and' that shouldn't be there or if a subsection is in fact missing.

[75] *Castell v de Greef* 1994 (4) SA 408 (C) 425.

[76] The proposed draft regulations regarding the general control of human bodies, tissue and organs for transplantation, as published on the SATS website (http://www.sats.org.za/Guidelines.asp [accessed 10 October 2012]), states in paragraph 1(b) that:

1. A person may not remove tissue from the body of a living person for the purpose referred to in section 56 of the Act unless:
   (b) Written consent form (annexure A) completed in duplicate and signed by the live donor and recipient in the presence of the health care provider who is part of the transplant team, indicating that the procedure or proposed health intervention has been explained to the donor and recipient authorising the removal if the relevant tissue from the donors body and must also be signed by the health care provider who explained the procedure to the donor (sic).

This presupposes that consent must not only be obtained from the donor, but also from the recipient, and that both patients should sign the same document. Regrettably, informed consent is once again not mentioned and one will have to wait and see whether the Minister of Health will promulgate regulations similar to these.

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Section 6(1) clearly describes informed consent in a manner similar to the description of the court in *Castell v De Greef*.[77] The term 'informed consent' is used in sections 7(1), 7(3) and section 8. Section 7(3) determines that informed consent in section 7 shall mean consent as set out in section 6. It is silent about the use of the term in section 8, however. This illustrates the general poor drafting of the National Health Act. The situation would have been much simpler if the term 'informed consent' had been included in the definitions, or if section 6(1) had expressly stated that any mention in the Act of consent means informed consent as set out in section 6.

The only other mention of written consent made in the Act can be found in section 62.[78] From the heading it is already clear that we are dealing here with cadaveric donation and not living donation as in section 55. Section 62(2) also makes provision for a cadaveric donation if consent had not been given by the deceased.[79] This consent must be obtained from relatives and no description regarding the nature and scope of the required consent is given.

From the abovementioned sections, it is clear that the legislature made provision for various different methods of obtaining consent, both from the deceased during his lifetime, as well as from his relatives and those close to him after his death.[80] In light of this, it is strange that the same options have not been made available in the case of live donations. One explanation for this is that the legislature did not realise that people in a persistent vegetative state, thus being neo-cortically dead, will be regarded as living people. Another possibility is that the legislature didn't realise at the time that this will result in a loss of otherwise transplantable organs. These facts

[77] 425.
[78] Section 62(1)(a): "A person who is competent to make a will may-
(i) in the will;
(ii) in a document signed by him or her and at least two competent witnesses; or
(iii) in an oral statement made in the presence of at least two competent witnesses, donate his or her body or any specified tissue thereof to be used after his or her death, or give consent to the post mortem examination of his or her body, for any purpose provided for in this Act."
[79] In the absence of a donation under subsection (1)(a) or of a contradictory direction given by a person whilst still alive, the spouse, partner, major child, parent, guardian, major brother or major sister of that person, in the specific order mentioned, may, after that person's death, donate the body or any specific tissue of that person to an institution or a person contemplated in section 63. The addition of allowing a partner to give consent is an expansion from the Human Tissue Act. McQuoid-Mason and Dada 129.
[80] For a more detailed discussion of the requirements for cadaveric donations, please refer to paragraph 2.2.2 Cadaveric Donations.

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are similar to those in *Clarke v Hurst NO,*[81,82] where the court ruled in a declaratory order that it would not be wrongful if the nasogastric feeding tube is removed from the patient, resulting in hastening the patient's death. This would mean that persons under similar circumstances would literally have to starve to death and become brain dead before any organs can be harvested. This will indisputably have adverse effects on the quality of the organs and the possibility to harvest them. In addition thereto, muscle and other tissue might weaken and degenerate over time, resulting in a lower quality of organ procured.

If one gives effect to the ordinary meaning of these provisions in the Act, it would seem as if section 6(1) intends for all consent required by the Act to be informed consent. In terms of the Act and regulations alone, it does not seem that witnesses need to be present for valid written consent to be given. The writer contends that written informed consent, signed by the donor, should suffice. However, this is something that desperately requires clarification by the legislature or the courts.

2.2.1.2.2 The living will

Written consent came before the court for consideration in the *Clarke*-case, where the patient had a living will and was a member of the South African Voluntary Euthanasia Society. However, the court did not base its decision on the living will. It is currently not clear whether a living will is legally recognised. The South African Law Reform Commission recommended that the living will should be recognised to the extent that it requests a passive form of the termination of life.[83] The argument can also be made that a living will should be regarded as legally valid as it is merely the advance refusal of medical treatment and in essence no different than the forms patients routinely signs before undergoing any operations.

It is the submission of the writer that a living will should be deemed as valid written consent in terms of section 55(a) and regulation 2 of regulation 180,[84] as it is both written and signed by the testator. It seems *prima facie* that a living will complies with

[81] 1992 (4) SA 630 (D).
[82] For a more detailed discussion of this case in a constitutional context, please refer to chapter 5: The Constitutional influence on organ transplants.
[83] The South African Law Reform Commission *Report on Euthanasia and the Artificial Preservation of Life* 1998 RP186/1999 www.justice.gov.za/salrc/reports/r_prj86_euthen_1998nov.pdf (accessed 2 July 2013).
[84] GN R180 in Government Gazette 35099 of 2 March 2012.

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more requirements than those stated in the Act. If this is indeed the case, the transplant team can prepare and test for compatible recipients of the various organs, so that the transplant can proceed as soon as the artificial lifesaving equipment has been turned off.[85]

2.2.1.3 Further/ future requirements

Prima facie, it would seems that the above mentioned requirements (as found in the Act and the regulations thereto) are the only requirements that have to be complied with for a valid live donation to take place. However, the situation is more complicated than it seems.

Where there is inadequate legislation, legislation riddled with mistakes or material *lacunae,* a situation is created where the existing provisions become inoperable due to vagueness. It may even lead to people deciding to take the law into their own hands. In South Africa, this has happened in two ways: 1) self-regulation, or even worse, 2) the formation of black markets. For the purpose of this study, self-regulation as it is currently applied in South Africa will be discussed briefly.

2.2.1.3.1 Self-regulation

Self-regulation is when people decide that the law is inadequate, insufficient or just plain wrong, and then decides to supplement or replace the existing law with their own set of rules and guidelines.

There are currently transplant guidelines in existence, which is not legislation, but still needs to be taken into account. This is because various important role-players (including, but not limited to, medical insurance companies, hospitals, the Department of Health and the South African Transplantation Society[86]), have entered

[85] In the case of the team not relying on either *volenti non fit iniuria* or another definition of death being accepted in the context of organ transplants.
[86] For more information on SATS, see their website: http://www.sats.org.za/ (accessed 16 October 2012).

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into a contractual agreement with one another.[87] The content of this document is consistent with the draft regulations presented for discussion during May 2011 as can be found on the SATS website.[88] These regulations have not been promulgated and are from a legislative point of view of no effect as of yet. However, as the content of these draft regulations have been applied in practise both under the Human Tissue Act and the National Health Act, the writer deems it necessary to discuss the content of these regulations.[89]

What is of specific importance is Chapter 4: Donation of tissue:

> "REMOVAL OF TISSUE FROM LIVING OR DECEASED PERSONS (genetically related or unrelated for transplantation)
>
> 1. A person may not remove tissue from the body of a living person for the purpose referred to in section 56 of the Act unless:
>   (d) It has been reasonably established by the hospital or authorised institution and treating physician that the motive of the donor is not for profit and the donor and the recipient have provided affirmation to this effect."

At first glance this seems to differ from the previous set of draft regulations published by the Department of Health. Regulation 8 of the Draft Regulations Regarding the General Control of Human Bodies, Tissue and Organs for Transplantation[90] stated that:

> "Procedure for application for Ministerial approval of local and foreign unrelated donors
> 8. For transplants between persons not contemplated in regulation 7(2)(a),[91] the Minister may grant permission for the transplant, on receipt of a written application and documentation detailed in Annexure C of these regulations."

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[87] This is the position as far as the writer could establish after talking to various of the role-players, however nobody had been willing to confirm this in a formal statement.

[88] http://www.sats.org.za/Guidelines.asp (accessed 16 October 2012).

[89] It has also been confirmed by the Department of Health that the amended version of these regulations will soon be made available for public comment.

[90] Published in the Government Gazette, 30828 of 7 March 2008.

[91] Regulation 7(2)(a) states:
"No person may remove an organ or tissue from a living person for transplant into another person without the Minister's written approval, unless the person into whom the organ is to be transplanted is genetically related to the person from whom the organ is removed.
(a)For the purpose of this regulation, a person is genetically related to:
(i)His or her natural parents and children
(ii)His or her brother and sisters of whole or half blood
(iii)The brothers and sisters of the whole or half blood of either natural parents and,
(iv)The children of brothers and sisters of whole or half blood

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This requirement has been created for a very good reason: to prevent potential abuse. The idea behind it is that if the relationship between the donor and recipient is investigated prior to the transplant taking place, potential abuse can be prevented. The premise is that one would be able to ascertain whether there is a real emotional relationship between the donor and the recipient, or whether the donation is truly altruistic in nature. This is however, one of those instances where an idea that seems great on paper, miserably fails in practice. There just simply isn't enough manpower to ensure that after the transplant has been completed, financial gain isn't received in exchange for the organ.[92] It is thus very easy to sell an organ and only make the payment a few months later, or to make the payment in cash, or to buy the donor material things- the list can go on and on. However, this is the requirements that have to be adhered to.

Criteria to be considered in applications for an unrelated living donation were set out in Annexure B.[93] The criteria basically required the donation to be altruistic and in the best interest of the patient, that the necessary medical investigations and psychological examinations must be done, and that the application must be considered by the Ministerial Advisory Committee (MAC).

It appears that in the new set of draft regulations, things are much more simplified. No permission is needed from the Minister and now it needs to be reasonably established by the hospital or authorised institution as well as the treating physician that the motive of the donor is not for profit and that both the donor and the recipient

(v)The natural children of his brothers and sisters of the whole or half blood or of the brothers and sisters of the whole or half blood of either of natural parents."

92 In accordance with the prohibition in section 60 of the Act.

93 Annexure B states:

The motives of the donor should be assessed to be altruistic and in the best interest of the recipient,not self serving or for profit recipient,not self serving or for profit.
Unrelated donors may include but not be limited to spouses, friends and acquaintances
Medical investigations for both donor and recipient should conform to standard protocols
Donor and recipient should undergo psychological assessment by an independent and suitably qualified social worker or psychologist to ensure that no form of coercion exists and that both parties are fully informed and understand the implications of the procedures(sic)
Application to perform unrelated living donor transplant procedures must be forwarded to the relevant office at National Department of Health.
Applications must be approved by the Ministerial Advisory Committee (MAC) or another committee established for this purpose.

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have provided affirmation to this effect. The procedure is thus now the same for related and unrelated living donors.

However, this seems to contradict another provision in the draft regulations, stating:

> "PROCEDURE FOR APPLICATION FOR MINISTERIAL APPROVAL FOR UNRELATED DONORS, NON- SOUTH AFRICAN (BOTH RELATED AND UNRELATED RECIPIENTS) OR NEEDING CADAVERIC DONORS
>
> 1) Transplants between unrelated persons may only be performed with the written approval of the Minister
> 2) The Minister may grant permission for the transplant on receipt of a written application and documentation detailed in Annexure C of these regulations."

Read together, it seems as if the agreement had been drafted poorly and that the situation in fact remains unaltered from the first set of draft regulations.

Self-regulation may seem like a valiant effort to better the current situation, but it is a dangerous path to choose, fraught with numerous obstacles and problems. One of the main problems is that self- regulation is not legislation in any way. There is no legality present and the parties complying with the self-made rules are at the most parties to a contract. One might ask, if (such as in the current case), all the major role players in the health care services are indeed parties to this agreement, what the problem might be? The problem is that the most important persons' rights are being totally disregarded: the rights of the patients.

As the patient is not a party to the agreement, the terms of this agreement can't be forced on him/her. This has the consequence that in terms of legislation a non-related living donor does not need to comply with any more requirements than a related donor. However, in terms of the self-regulation agreement, a hospital can refuse to perform the transplant if not satisfied that the donation is not for profit. On the other hand, if the hospital does agree to perform the transplant without being satisfied that the donation is not for profit, it may be held liable for breach of contract. Likewise, the Minister may refuse to grant permission for an unrelated donation and the same problems arise.

Another issue that can arise is the available remedies to the donor and recipient, should the hospital or Minister decide the donation will be for profit and refuses to

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perform the transplantation. This situation may force the wronged party to utilise administrative law procedures.

Furthermore, one can be granted more rights than one is entitled to in terms of legislation, but these rights can't be taken away, as legislation sets the minimum requirements. Taking away these rights could render the contract void on the basis that it is not legally possible (thus the legality requirement has not been met) on ground of the contract being contrary to the public interest. This is so because the agreement has the potential to obstruct the administration of justice, or that it could be prejudicial to the public service.

In short, although self-regulation may seem like an inviting option, it is a road filled with potholes that should be avoided at all costs.

2.2.2 Cadaveric donations

Cadaveric donations are regulated by section 62 of the Act, as discussed above.[94] Section 62 is further supplemented by the regulations to the Act, specifically in regulation 4 of regulation 177.

Section 62 is in compliance with guiding principle 1 of the WHO guiding principles on human cell, tissue and organ transplantation.[95] Guiding principle 1 states that:

> "Cells, tissues and organs may be removed from the bodies of deceased persons for the purpose of transplantation if:
> (a) any consent required by law is obtained, and
> (b) there is no reason to believe that the deceased person objected to such removal."[96]

Cadaveric donations are of specific importance, due to the fact that most organs for transplantation are procured from cadavers. The reason for this is twofold: Firstly, both the vital and non-vital organs can now be procured and transplanted, as the removal thereof will no longer be regarded as potentially wrongful.[97] There is thus

[94] Under paragraph 2.2.1.2.1.
[95] http://www.who.int/transplantation/TxGP08-en.pdf (accessed 9 October 2012).
[96] http://www.who.int/transplantation/TxGP08-en.pdf (accessed 9 October 2012).
[97] See the discussion on wrongfulness above at paragraph 2.2.1.1(a).

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both a larger number, as well as a greater variety of organs available to harvest than would be the case in live donations.

The second reason is that it is much easier to donate after death than before death. This is due to the fact the requirements for consent as set out by the legislature are less strict in certain ways, for example the next of kin are allowed to donate organs and special permission is not needed from the Department of Health as in the case of an unrelated live donation.

Cadaveric donation has remained largely the same when one compares the National Health Act with the Human Tissue Act, without any major changes. Cadaveric donation is thus far less controversial than live donation, and as the legislation has basically remained the same, hence the usual problems that arise with new legislation are not present in this case.

Both live and cadaveric donations have been discussed individually. It is now necessary to compare the two with each other.

2.2.3 Differentiating through comparison between live and cadaveric donations

There are two main characteristics distinguishing cadaveric donations from live donations. Firstly, there are the respective individual constraints. With live donations, vital organs can't be harvested, whereas with cadaveric donations there are constraints to the harvesting time. This has a major influence on the method of organ procurement required.

Secondly, there is the difference in consent needed. With live donations, as indicated and discussed above, the written consent of the person herself is needed,[98] and in the case of unrelated live donations, additional consent is needed from the Department of Health.[99] With cadaveric donations the situation is very different. Here, consent can be either written or oral, given in the presence of at least two competent witnesses, prior to death. If this is not done, the next of kin (in a very

[98] According to section 55 of the Act.
[99] As discussed above under paragraph 2.2.1.3, currently on the grounds of a contractual agreement, this will possibly in the future to be addressed in the regulations to the Act.

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specific order)[100] can decide to donate the deceased's organs for the purpose of transplantation after her death.[101]

From the above a few things are very clear: that the chances of procuring organs from cadavers are much higher than procuring an organ from a living donor, that the form of consent differs greatly between live and cadaveric donations, and that the procurement of organs are undertaken in very different conditions.

Any proposal to increase the amount of procured organs for transplantation will thus have to distinguish clearly between live and cadaveric donations. The rest of this chapter will focus on areas of the National Health Act where no distinction needs to be made between live and cadaveric donations.

2.2.4 Allocation and use of human organs

The allocation and use of human organs is briefly addressed by section 61 of the Act. The section states that human organs "may only be used in the prescribed procedures"[102] and "must be allocated in accordance with the prescribed procedures."[103] The section itself gives no further clarification and neither does the regulations to the Act. The "prescribed procedures" mentioned are thus non-existent.

Guiding principle 9 of the WHO guiding principles on human cell, tissue and organ transplantation states that:

> "The allocation of organs, cells and tissues should be guided by clinical criteria and ethical norms, not financial or other considerations. Allocation rules, defined by appropriately constituted committees, should be equitable, externally justified, and transparent."[104]

[100] The order followed is first the spouse, then the partner, major child, parent, guardian, major brother or major sister of that person, in the specific order as mentioned.
[101] According to section 62(2) of the Act.
[102] Section 61(1) of the Act.
[103] Section 61(2) of the Act.
[104] http://www.who.int/transplantation/TxGP08-en.pdf (accessed 9 October 2012).

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The only other guidance can be found in the draft regulations that currently forms part of the self-regulation agreement as discussed above.[105]

Chapter 4 of this agreement states with regards to the allocation of harvested tissue:

1. "Harvested tissue shall be allocated in a fair and equitable manner
2. Access to harvested tissue shall be provided without regard to sex, age, religion, race, creed or colour of the recipient
3. The Chief Medical Officer shall establish a procedure for the recall of harvested tissue.
4. Tissue harvested from a cadaver shall be exported only in cases where local needs are satisfied."

From the discussion above it is clear that the current legislation regarding the allocation and use of human organs leaves much room for improvement. As it currently stands, it gives no direction whatsoever and there is a dire need for the legislature to intervene and correct the situation. Organ allocation will be discussed in more detail in chapter 3, in order to show the importance of both a successful organ procurement method and organ allocation method in procuring more organs for transplantation.

2.2.5 Purpose for removal

Section 64 *inter alia* deals with the purpose of removal of tissue from deceased persons. It reads as follows:

> "(1) A donation in terms of section 62 may only be made for-
> *(a)* the purposes of the training of students in health sciences;
> *(b)* the purposes of health research;
> *(c)* the purposes of the advancement of health sciences;
> *(d)* therapeutic purposes, including the use of tissue in any living person; or
> *(e)* the production of a therapeutic, diagnostic or prophylactic substance."

From this section it is clear that subsection 64(1)(d) will be applicable in organ transplantations.

With regard to the removal of organs from living persons, the Act merely states:

[105] Under paragraph 2.2.1.3.1 Self-regulation.

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"A person may only use tissue or gametes removed or blood or a blood product withdrawn from a living person only for such medical or dental purposes as may be prescribed."[106]

This is then followed in subsection (2) with a list of forbidden purposes, dealing with children and mentally ill persons. No further guidance is given either in the Act, or the regulations thereto regarding the prescribed purposes for removal.

This omission by the legislature is somewhat troublesome. Whether the legislature intended the purposes for removal as stated in section 64 to be applicable for live donations as well, or wanted them to be different, this omission shows a lack of attention to detail. The writer finds it difficult to understand how the legislature would refer to "purposes as may be prescribed" without actually listing them.

2.2.6 Payment

Receiving payment for the acquisition, supply, importation or export of any tissue is an offence as far as it is not provided for in section 60 of the Act. Section 60 states:

> "(1) No person, except-
> (a) a hospital or an institution contemplated in section 58(1)(a), a person or an institution contemplated in section 63 and an authorised institution or, in the case of tissue or gametes imported or exported in the manner provided for in the regulations, the importer or exporter concerned, may receive payment in respect of the acquisition, supply, importation or export of any tissue or gamete for or to another person for any of the purposes contemplated in section 56 or 64;
> (b) a person or an institution contemplated in section 63 or an authorised institution, may receive any payment in respect of the importation, export or acquisition for the supply to another person of blood or a blood product.
> (2) The amount of payment contemplated in subsection (1) may not exceed an amount which is reasonably required to cover the costs involved in the importation, export, acquisition or supply of the tissue, gamete, blood or blood product in question.
> (3) This section does not prevent a health care provider registered with a statutory health professional council from receiving remuneration for any professional service rendered by him or her.
> (4) It is an offence for a person-
> (a) who has donated tissue, a gamete, blood or a blood product to receive any form of financial or other reward for such donation, except for the

[106] Section 56(1) of the Act.

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> reimbursement of reasonable costs incurred by him or her to provide such donation; and
> (b) to sell or trade in tissue, gametes, blood or blood products, except as provided for in this Chapter.
> (5) Any person convicted of an offence in terms of subsection (4) is liable on conviction to a fine or to imprisonment for a period not exceeding five years or to both a fine and such imprisonment."[107]

From the above it is clear that the sale of organs for transplantation is currently an offence,[108] just as it was in terms of the Human Tissue Act.[109] One big difference from the Human Tissue Act, however, is the allowance of "reimbursement for reasonable costs incurred by him or her to provide [for the] donation…"[110] Neither the Act nor the regulations thereto gives any more guidance as to what these "reasonable costs" includes. The reason for this omission isn't clear, but one possibility is that the legislature didn't want to include a too narrow list. On the other hand, it might be because the legislature didn't want to include a too encompassing list. Once again, it is a question that will most likely have to be addressed by the courts. Hence it becomes a question of interpretation for the courts. By way of logical reasoning, the writer contends that it would seem as if costs for *inter alia* transportation; accommodation; hospital costs, aftercare, reimbursement for unpaid leave; as well as tests to determine whether the donor would be a suitable match should be included in "reasonable costs".[111]

This incentive by the legislature might just help convince prospective live donors to donate organs. It is questionable whether this section will be available to cadaveric donors, as they will have no costs in donating their organs.

So, although this incentive is a step in the right direction by the legislature, the writer contends that its effect will be minimal. Reimbursing donors for reasonable costs

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[107] Section 60 complies with guiding principle 5 of the WHO guiding principles on human cell, tissue and organ transplantation, which states that: "Cells, tissues and organs should only be donated freely, without any monetary payment or other reward of monetary value. Purchasing, or offering to purchase, cells, tissues or organs for transplantation, or their sale by living persons or by the next of kin for deceased persons, should be banned. The prohibition on sale or purchase of cells, tissues and organs does not preclude reimbursing reasonable and verifiable expenses incurred by the donor, including loss of income, or paying the costs of recovering, processing, preserving and supplying human cells, tissues or organs for transplantation."
[108] According to section 60(4)(a)-(b).
[109] According to section 28.
[110] Section 60(4)(a).
[111] McQuoid-Mason and Dada contend that "reasonable costs" will be *inter alia* travel costs and medical bills, McQuoid-Mason and Dada 129.

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might help convince friends, relatives or acquaintances to donate, but it is probably not a strong enough motivation for a stranger to donate an organ. It is submitted that the focus should be on how to increase cadaveric donations and to improve the allocation process, as this is where the greatest possibility of success lies to relieve the constant organ shortage.

2.3 Conclusion

In this chapter the implications of chapter 8 of the National Health Act that recently came into effect were discussed. It is clear that the most problem areas within the legislation can be found with regard to living donations, as opposed to cadaveric donations. This is also the part of Chapter 8 that underwent the most changes from the Human Tissue Act to its current form.

The first issue that arises is when exactly the moment of death is. Determining this is of extreme importance, as it is vital to harvest organs as soon as possible to ensure the best possible chance of a successful transplant. Furthermore, it is unclear what constitutes valid written consent from the donor with regard to live donations, whether one should go with the manner in which it was defined in the Human Tissue Act that has been repealed by the National Health Act, or whether one should assume that the omission means the requirements are now less strict than previously, and also less strict than in the case of cadaveric donations.

Another major question that arises is what will be regarded as "reasonable costs" for purposes of section 60 and how it will be defined remains another mystery until the courts cast some light on the subject.

Furthermore, section 61 dealing with the allocation and use of human organs is of absolutely no use as it refers the reader to "prescribed procedures" which were never prescribed. It is clear that the many *lacunae* in the Act are making it almost inoperable.

It is concluded that although the new provisions show an improvement of the mind-set from the now repealed Human Tissue Act in certain aspects, not enough has been done to regulate organ transplantation effectively, nor to ensure that the critical

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shortage in organs is substantially relieved. This seems strange in light of the fact that the legislature saw that the system under the Human Tissue Act was not working, and then attempted to correct the matter by making insufficient changes. Major changes needs to be made to the current legislation to ensure that people do not take the law into their own hands. The submission is made that a badly-regulated system can have severe adverse effects. Those limited by the lack of legislation will take the law into their own hands until such time as the Minister see fit to amend the current legislation properly, which is detrimental to the health industry. There still remains a dire need for a better organ procurement model. There is still work to be done.

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CHAPTER 3

VARIOUS ORGAN PROCUREMENT SYSTEMS AND ASPECTS RELEVANT THERETO

3.1 Introduction

It is widely agreed that "[f]rom the beginning of serious transplantation efforts, the problem has been trying to find ethically and morally acceptable ways to retrieve all usable organs, while at the same time respecting the cadaver donors, their families and other social values."[1]

The aim of this chapter is to discuss the main methods of organ procurement, both the positive aspects thereof, as well the shortcomings of each model. Firstly, each respective method is discussed in general. Thereafter a comparative approach will be followed in this chapter in order to consider the success or failure of each organ procurement method in a specific country where it has been applied. Where the country considered is the United States of America, a specific state will be reviewed as organ procurement is governed by each state individually and not by federal law. The writer will also consider the possible success of applying each respective method in South Africa. As Naylor states, a successful organ procurement method will have to be both ethically and morally acceptable, there must be the possibility to retrieve as much usable organs as possible, whilst respecting patient autonomy[2] and the impact on relatives.[3] A successful organ procurement method will also need to adhere to the Constitution and properly drafted legislation will need to regulate all aspects relevant thereto. It is important to note that procurement systems are usually aimed at either cadaveric or live donations, but are generally not suitable to be used for both. The reason for this is that there are fundamental differences in how these two forms of organ donation must be handled due to the inherent requirements of

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[1] Naylor CD *The role of the family in cadaveric organ procurement* Indiana Law Journal 1989-1990 65 167.
[2] As set out in section 12(2)(b) of the Constitution.
[3] Naylor 167.

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each.[4] At the very least, should one procurement system be used for both cadaveric and live donations, it will have to be adapted to suit the inherent requirements of both instances and there will inevitably be differences in the application thereof. As organ allocation procedures are closely related to organ procurement methods, it will also be discussed to determine the role allocation can play to alleviate the organ shortage. Finally, other aspects relevant to organ procurement will be pointed out and discussed, where after a conclusion will be drawn.

The various organ procurement methods will accordingly be discussed individually.

3.2 Opting-in

3.2.1 Opting-in in general

Opting-in is based on obtaining consent from the donor and is widely used as a method of organ procurement, including in South Africa. It is also the only method of organ procurement ever applied in South Africa.[5]

Opting-in is a very uncontroversial, yet also ineffective method of organ procurement.[6] It is uncontroversial as *prima facie,* it doesn't seem to infringe any fundamental rights, such as patient autonomy as set out in section 12(2)(b) of the Constitution. The choice is the donor's to make and the donor is not in any way required to make this decision at a certain stage. In certain instances where the donor is unable to give consent, provision is made for surrogate permission to be given, for example by a relative.[7] Opting-in also doesn't infringe the right to equality

[4] For live donations, the donor him- or herself can give consent and there is more time to prepare for the transplant. For cadaveric donations, the donor can no longer give consent and consent must be obtained from family members. Furthermore, there are very tight time constraints to harvest and transplant the organs before they become unusable. For more on the requirements of both live and cadaveric donations, see chapter 2.

[5] See section 2 of the Human Tissue Act 65 of 1983, as well as sections 55 and 56 read together with sections 6 and 7 of the National Health Act 61 of 2003.

[6] Opting-in is used as an organ procurement method in many countries. However, all these countries have a shortage of transplantable human organs.

[7] Veatch RM *Transplantation ethics* 2000 147.

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as set out in section 9 of the Constitution with regards to freedom of religion and culture.

Opting-in is based on the doctrine of informed consent. Consent is an essential requirement for any lawful medical intervention.[8] The doctor's duty to inform the patient was first discussed directly in South African law in *Lymbery v Jefferies*.[9] The requirement of consent by the patient has surfaced numerous times in case law[10] and was developed extensively to conclude that mere consent is not enough, to constitute valid consent the consent must also be informed consent.[11]

This means that the patient must be informed of material risks.[12] The risk will be material if:

(a) a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it;[13] 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.[14]

According to Van Oosten, knowledge and appreciation, obtained through information, are essential for informed consent to be present.[15] The requirements for informed consent are thus threefold: the patient needs to have knowledge of the risks, appreciation therefore, as well as actually consenting to the treatment.

As the doctrine of informed consent is a fundamental principle in South African medical law, it makes perfect sense that this is the first organ procurement method applied in South Africa.

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[8] Van Oosten FFW *The Doctrine of Informed Consent in Medical Law* 1989 33.
[9] 1925 AD 236. See Van Oosten 1989 39-41, as well as Carstens PA and Pearmain D *Foundational principles of South African medical law* 677, 696, 878, and 890- 891 for a discussion of this case.
[10] The most significant cases dealing with patient consent are *Stoffberg v Elliott* 1923 CPD 148 and *Castell v De Greef* 1994 (4) SA 408 (C).
[11] *Castell v De Greef* 426-427.
[12] *Castell v De Greef* 426.
[13] *Castell v De Greef* 426.
[14] *Castell v De Greef* 426.
[15] Van Oosten 447.

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3.2.2 Opting-in in South Africa[16]

Opting-in in South Africa is currently applied as a method of organ procurement in both living and cadaveric donations. Living donations must take place in terms of sections 55 and 56 of the National Health Act,[17] with the consent of the donor.[18] Cadaveric donations are regulated in terms of section 62 of the National Health Act and can take place in one of two ways: with the consent of the donor being obtained prior to death, which has the similar requirements as living donations,[19] or in the absence thereof, the spouse, partner, major child, parent, guardian, major brother or major sister of that person, in the specific order mentioned, may grant permission.[20] Although the family is only allowed to make a decision if the deceased omitted to do this him- or herself, health care workers do not easily act against the wishes of the family.[21] The role that relatives can play during the organ donation process is three-fold: the common law grants relatives certain rights to deceased relatives' remains; legislation requires the family's consent before removing any organs where the deceased omitted to give consent prior to death; and health care workers also request the family's consent even when not required to, due to emotional reasons.[22]

The reality is that most of the time health care workers have no way to confirm whether the family members are indeed acting according to the deceased's wishes or not. Spital states that "[t]he high rate of family refusal contrasts sharply with public opinion polls that show widespread support for organ donation."[23] This shows that even if a person supports organ donation in principle, he or she will rather refuse donation when unexpectedly asked to make a decision on the spot. It also indicates that family members might rather act according to their own views than the views of the deceased. The creation of an easily accessible national database will minimize

[16] For a more detailed and in depth discussion of current South African legislation regulating organ procurement, see chapter 2.
[17] 61 of 2003.
[18] Unfortunately, the Act does not directly define consent as informed consent in section 1. However, when looking at sections 6 and 7, as well as case law it is certain that the required consent form will indeed need to be informed consent.
[19] Section 62(1)(a).
[20] Section 62(2).
[21] Naylor 168.
[22] Naylor 168.
[23] Spital A *Mandated choice for organ donation: Time to give it a try* Ann Intern Med 1996 (125) 66.

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the role of relatives and thereby prevent the above from happening, resulting in less refusals from relatives and thereby supporting the donor's right to autonomy.[24]

As opting-in is already being applied in South Africa, it is easy to observe both its strong and weak points with a great amount of certainty, unlike other organ procurement systems for which determining the possible success or failure thereof in South Africa will, at least for the time being, rely on at least some degree of speculation.

3.2.2.1 The positive aspects of opting-in as a procurement system:

- It is uncontroversial in the sense that it is accepted very broadly and does not *prima facie* seem to be unconstitutional;[25]
- It does not require many resources like manpower or finance;
- It does not place a positive duty on the state to enable its application as this is done by health care workers;
- It is relatively simple and easily understandable; and
- It does not require nationwide educational campaigns.

3.2.2.2 The negative aspects of using opting-in as a method of organ procurement:

- Statistics show that it is ineffective;[26]
- It does not adequately motivate people to become organ donors;
- Allowing relatives to make the decision on behalf of the potential donor in cadaveric donations complicates the process and limits the chances of a donation; and
- Under current legislation,[27] no provision is made for a database containing a waiting list or a list of organ donors.[28]

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[24] This would eliminate the need to rely on relatives to determine the deceased's wishes. The database could be made easily accessible if the database is accessible through the internet with a username and password for each hospital or clinic.

[25] For more on the constitutionality of opting-in, see chapter 5, where the duty of the state to enact legislation on the basis of "… a right to reasonable action by the state in all circumstances and with particular regard to human dignity" is discussed in light of socio-economic rights. *Government of the Republic of South Africa & Others v Grootboom & Others* 2001 (1) SA 46 (CC) 83.

[26] As shown in chapter 1.1.

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So if there currently is an organ procurement method in place that complies with the Bill of Rights, that is uncontroversial and respects the fundamental right of patient autonomy, why search for an alternative? The reasons are simple: opting-in is an insufficient method to procure enough organs to provide for the high demand and has not been able to meet the demand for human organs over several years. *In casu*, the negatives also outweigh the positives by far. An organ procurement system that does not step on anybody's toes, but is inherently incapable of providing enough organs is bound to be a failure. Based on the failure of opting-in as an organ procurement method, it would seem that prospective donors require better motivation than altruism alone in order to consent to organ donation.

3.3 Presumed consent[29]

3.3.1 Presumed consent in general

It has been observed that "[p]roponents of 'presumed consent' to organ donation have always faced an uphill battle."[30] This method of organ procurement accepts or makes the rebuttable presumption that all the citizens have given informed consent to be organ donors upon their death. The consent is thus merely presumed and not in any way real, informed consent. If one does not want to be an organ donor, one must make this objection publicly known prior to death,[31] in accordance with the requirements set out by the legislature.

This method of organ procurement is very controversial and problematic in more ways than one. It goes against some of the most fundamental human rights in

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[27] Specifically chapter 8 of the National Health Act 61 of 2003.

[28] This has the consequence of valuable organs going to waste because it can't be determined in a quick and easy manner whether the deceased is indeed an organ donor or not, and therefore many potentially usable organs are never harvested.

[29] Presumed consent is also known as opting out. The hard form of presumed consent is also referred to as "routine salvaging," Veatch 2000 144-145.

[30] Orentlicher D *Presumed consent to organ donation: Its* rise and fall in the *United States* Rutgers Law Review 2008- 2009 62(2) 295 296.

[31] Fourie EJ *An analysis on the doctrine of presumed consent and the principles of required response and required request in organ procurement* (LLM dissertation, University of Pretoria 2005) 49.

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several aspects. Presumed consent "raises the specter of one of society's deepest fears" namely that organs may be obtained against someone's wishes, or that one's death might be hastened to obtain the organs.[32] As Fourie[33] correctly states:

> "One of the main characteristics of a legitimate and publicly accepted organ procurement system is the donor's degree of active participation in his/ her decision to either "opt in" or "opt out" of the organ donor pool. Procurement systems which do not provide an opportunity to give legally recognised consent by the person who is regarded as a donor, is not only illegal in terms of most legal systems based upon the principles of fundamental rights, but will also receive a great deal of public disapproval."[34]

It is important to note that this method of organ procurement can only be considered for cadaveric donations,[35] as applying it to live donations will be in direct conflict with several sections in the Constitution.[36]

Using this method of presumed consent has the effect that the donor's rights to autonomy and freedom, and in some cases even the right to choose a religion, are disregarded. Furthermore, the success of this organ procurement method heavily relies on the presence of sufficient resources to ensure that it is easy to withdraw consent; in order to easily establish whether a person has indeed "opted out";[37] and also, most importantly of all, there must be sufficient education regarding organ transplantation given to the public to be able to legitimately assume that all major citizens are in a position to give informed consent and to make an informed decision. Without these requirements being met, the public won't support this method of organ procurement. Public support for organ procurement is crucial as organs are obtained from the public.

Fourie identifies two degrees of application of presumed consent: strong application and weak application.[38] With a strong application of presumed consent a person is considered to have consented to organ donation unless an objection had been

[32] Orentlicher 296.
[33] Fourie 49.
[34] Fourie 94.
[35] Fourie 43.
[36] Such as sections 9, 10, 11, 12(2)(b) and 14.
[37] Slabbert M *Combat Organ Trafficking- reward the donor or regulate sales* Koers 2008 73(1) 75 79.
[38] Fourie 52.

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raised before death, without taking into account the input of relatives.[39] With the weak application of presumed consent, relatives have a bigger role in that the can override the decision of the deceased.[40] With the weak application, the decision thus ultimately lies with the relatives.

There are three possible reasons why presumed consent may result in a higher number of organs procured, as identified by Healy.[41] The first is that applying presumed consent may eliminate the problems with regard to relatives.[42] Although it sounds good on paper, Healy is of the opinion that this does not hold true in practice, as the wishes of relatives are still taken into account.[43] The second reason is that the question asked changes, shifting the focus away from asking permission, to rather asking if any objection against donation had existed.[44] The third reason is that when a new organ procurement system is adopted, it is likely that the state will invest in infrastructure, personnel and public campaigns to support it. In this case, it is possible that the success is due to better visibility, campaigning and resources, rather than the change in consent required.[45]

3.3.2 Presumed consent in the United States of America and Spain

Several countries have enacted legislation establishing presumed consent as an organ procurement method. These countries include Austria; Brazil; France; the United States of America and Singapore.[46] Another country that deserves mention here is Spain.[47] Presumed consent both in the United States of America[48] and Spain

[39] Fourie 52.
[40] Fourie 52.
[41] Healy K *Do presumed-consent laws raise organ procurement rates?* DePaul Law Review 2005-2006 55 1017.
[42] Healy 1028.
[43] Healy 1028.
[44] Healy 1028.
[45] Healy 1029-1030.
[46] Jacob MA *On silencing and slicing: Presumed consent to post-mortem organ "donation" in diversified societies* Tulsa Journal Comp. & International Law 2003- 2004 293 247, see also Ghods AJ and Sava S *Iranian model of paid and regulated living-unrelated kidney donation* CJASN 2006 1(6) 1136 1143.
[47] Healy 1040.
[48] Due to the fact that that presumed consent was enacted in the majority of states in the USA. Orentlicher 305- 308.

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will be discussed, in order to show respective failure and success of presumed consent as an organ procurement method in practice.

3.3.2.1 Presumed consent in the United States of America

In the United States of America, presumed consent laws have been enacted in several states and vary from a hard to a weak application of presumed consent.[49,50] The 1987 Uniform Anatomical Gift Act recommended the use of presumed consent under certain circumstances in section 4.[51] The use of presumed consent was however limited to cadavers under the custody of coroners and medical examiners.[52] After presumed consent featured numerous times before the courts[53] and the enactment of the 2006 Uniform Anatomical Gift Act which was enacted in 33 states as well as the District of Columbia, presumed consent was almost entirely abolished.[54]

3.3.2.2 Presumed consent in Spain

Unlike in the United States of America, it would seem that the Spanish model of presumed consent has been very successful.[55] More than merely successful, it has been identified as "the most successful deceased-donor organ donation program."[56] However, the success is mainly attributed to factors other than the use of presumed consent, like the training of heath care workers, proper delegation, as well as a strong hospital presence.[57] This indicate that the specific organ procurement method might have less to do with the amount of organs procured than the actual

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[49] Jacob 250.
[50] Presumed consent is currently practised in California, Florida, Hawaii, Kentucky, Louisiana, Maryland, Michigan, North Carolina, and Wisconsin, Jacob 250. See also Richards A *Don't take your organs to heaven....Heaven knows we need them here: Another look at the required response system* Northern Illinois University Law Review 2005- 2006 26 365 392.
[51] Orentlicher 300.
[52] 1987 Uniform Anatomical Gift Act section 4. See also Orentlicher 302.
[53] Orentlicher 305- 308.
[54] Orentlicher 308.
[55] Healy 1039.
[56] Ghods and Sava 1143.
[57] Healy 1039- 1041.

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implementation thereof, together with the available resources and the quality of the health care workers' training. It would thus seem that the logistics around organ procurement might have a bigger impact on the amount of organs procured than the method of procurement.[58]

3.3.3 Presumed consent in South Africa

As presumed consent is a statutory created organ procurement system, legislation would have to be enacted to make provision therefore.[59] "The fundamental idea behind presumed consent is that, in general, people are not strongly opposed to organ removal, and, given the opportunity to donate, most would choose to do so."[60] In South Africa, although this statement might hold true for the majority of the population, there is also a fundamental problem with this assumption. With the weak application, according to Orentlicher "…presumed consent did not address the major reason why people do not become organ donors after death- the refusal of family members to give consent."[61] It is submitted that the weak application of presumed consent will therefore not be successful, as it rests largely on the input of relatives, based on the same reasons as discussed above under opting-in. The rest of this discussion will therefore focus on the hard application of presumed consent.

For the hard application of presumed consent to be legitimately applied in South Africa, there has to be a rebuttable presumption that the majority of South Africans are in a position to make an informed decision regarding organ donation. This would enable people to "opt out" should they wish not to donate their organs upon death. However, in South Africa, a large part of the public are still exposed to very harsh living conditions and many South Africans have never even heard of organ transplantation. Therefore, many South Africans are in no position at all to make an informed decision regarding organ donation. Because many South Africans still live

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[58] Healy 1041.
[59] Fourie 49.
[60] Barnett AH and Kaserman DL *The shortage of organs for transplantation: Exploring the alternatives* Issues in Law & Medicine 1993 9(2) 117 122.
[61] Orentlicher 298.

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in remote, rural areas, it is difficult to imagine that an educational campaign would resolve this problem.

3.3.2.1 The positive aspects of presumed consent as a procurement system:

- The procurement of organs are faster and more effective than under an explicit consent system, such as opting-in;[62]
- Presumed consent, as the term indicates, creates a presumption of consent, therefore unless it is proven that the deceased has refused consent, the organs will be harvested for transplantation, resulting in more organs being harvested; and
- Applying presumed consent makes sense from a utilitarian perspective,[63] as utilitarianism only takes the consequences into account, in this case being more organs potentially being harvested and thus more lives saved.[64]

3.3.2.2 The negative aspects of using presumed consent as a method of organ procurement:

- In South Africa, the general public is not informed well enough in order to presume that they can give informed consent to organ donation;
- Presumed consent will almost certainly be viewed as an unjust infringement on the right to bodily integrity in terms of section 12(2)(b) of the Constitution, and will therefore be unconstitutional;
- Presumed consent will almost certainly be viewed as unfair discrimination based on ethnic or social origin, religion, conscience, beliefs or culture in terms of section 9(3) of the Constitution, as organ donation is not allowed in all cultures and religions;

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[62] Fourie 145.
[63] Orentlicher 308.
[64] Moodley 20- 21.

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- Section 12(2)(b) and the principle of autonomy is completely disregarded, rendering this organ procurement method both constitutionally and ethically indefensible;[65]
- The success of presumed consent relied on two presumptions, namely: "(a) people generally want to donate their organs, but (b) people's wishes to donate are frustrated because they do not get around to documenting their preferences while alive, and family members often are unreachable to give consent in the short time period in which organs must be removed for transplantation."[66] However, it did not take into account the negative role that relatives can play in the procurement process;[67] and
- The integrity of the organ transplant system might be compromised if organs may be procured without actual consent or the involvement of relatives, as health care workers might be more likely to cut corners in order to procure organs for transplantation.[68]

Whilst presumed consent is a potentially highly effective organ procurement method, is remains a controversial organ procurement method and it will likely never be universally accepted.[69] It is submitted that this organ procurement method does not have the ability to succeed in South Africa as it will not comply with the constitutional principles as set out in the Bill of Rights.[70]

3.4 Required request

3.4.1 Required request in general

[65] For an in depth discussion on the influence of ethics and the Constitution on presumed consent, see chapters 4 and 5 respectively.
[66] Orentlicher 309.
[67] Orentlicher 311- 313. For a more detailed discussion regarding the role of relatives, see the discussion on opting-in above.
[68] Orentlicher 320 and 322.
[69] Orentlicher 303.
[70] Such as the right to bodily integrity in section 12(2)(b); the right to privacy in section 14 and the right to equality in section 9 of the Constitution.

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Required request as a method of organ procurement places a duty on a certain group, usually employees of a specific state department, to request a person's donor status at certain specific events.[71] The duty is thus purely to ask the person whether she is interested in becoming an organ donor or not and only rests on the inquirer. The only duty therefore rests on the state employees to make an enquiry there is no corresponding duty on the prospective donor to give a binding response. This method of organ procurement is similar to required response, as it embodies the first step of required response.

The reasoning behind required request was that medical personnel did not approach patients or their relatives on a regular basis to discuss organ donation and that this contributed to the organ shortage.[72] If health care workers are required to request a persons' donor status, the presumption is that more organs would be procured. However, this organ procurement method "contain[s] an enormous logical flaw"[73] where relatives are approached for consent to donate at the time of death, as this will be both traumatic and morally suspect.[74]

3.4.2 Required request in the United States of America

Required request became part of American federal law through section 5 of the Uniform Anatomical Gift Act.[75] Section 5 makes provision for routine enquiry and required request as organ procurement method to be applied.[76] The idea was that medical personnel would approach patients or their next of kin in order to discuss the possibility of organ donation. The idea seems good on paper, as people often need

[71] These events can include when a person is admitted to a hospital or visiting a clinic, when applying for an identity document or driver's license, or when filling out tax return forms.
[72] Fourie 101.
[73] Veatch 2000 161.
[74] Veatch 2000 161.
[75] Of 1987.
[76] Section 5 states:
"(a) On or before admission to a hospital, or as soon as possible thereafter, a person designated by the hospital shall ask each patient who is at least 18 years of age: "Are you an organ or tissue donor?"…
(b) If, at or near the time of death of a patient, there is no medical record that the patient has made or refused to make an anatomical gift, the hospital [administrator] or a representative designated by the [administrator] shall discuss the option to make or refuse to make an anatomical gift and request the making of an anatomical gift…"

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an extra bit of motivation or raising awareness in order to make a decision. However, in practice it turned out that this organ procurement method "totally failed to achieve its objectives."[77] One of the factors that contributed to the failure of this procurement system is the fact that health care workers are generally reluctant to approach family members with such an emotionally charged decision. Another contributing factor is that grieving family members are often not in an emotional state to make these decisions in such a short time and therefore they rather refuse without giving any consideration to the matter. One of the key reasons for the failure of this organ procurement thus seems to be the timing of the request.

3.4.3 Required request in South Africa

It is submitted that required request as applied in the United States of America will likely yield the same results in South Africa. This is because the factors that caused required request to fail in the United States of America, namely the role of relatives and unfortunate timing of the request, are universal to all nations and there is no evidence to indicate that this organ procurement system might yield any different results.

For required request to be applied successfully as an organ procurement method in South Africa, certain preparations and amendments to the American model will have to be made. As one of the main obstacles is obtaining consent during emotionally difficult times from patients and relatives, a solution might be to request prospective donors at an earlier stage. This will potentially eliminate any unwillingness or uncertainty resulting from emotional stress. The request could be made upon visiting or being admitted to a clinic or hospital, without the need for the patient to be critically ill or already deceased. Also, an online database would have to be established to record all the data and to make it readily available to health care personnel.

[77] Fourie 102.

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3.4.3.1 The positive aspects of required request as a procurement system:

- A lot more people might be reached than with opting-in ;
- This method is less restrictive than presumed consent in terms of limiting constitutionally entrenched rights; and
- It could be amended to make the request upon admittance or the visitation of a hospital or clinic, or even at the application for an identity book or a driver's licence, when high levels of emotional distress are not necessarily present.

3.4.3.2 The negative aspects of using required request as a method of organ procurement:

- This method might still be too weak as people are not forced to make a decision for or against donation;
- It is not guaranteed that the majority of citizens will be reached;
- The timing of requesting a persons' donor status can negatively influence the response; and
- It requires resources such as trained personnel and funding, as well as a national database to record responses received.

3.5 Required response[78]

3.5.1 Required response in general

Is has been said that "the principle of required response is only an incentive used with an existing procurement system such as explicit consent."[79] Required response is therefore not an organ procurement method on its own, but rather used together with another organ procurement method, making it a combined organ procurement method. Required response, unlike opting-in or required request, places an active

[78] Required response is also known as mandated choice.
[79] Fourie 98.

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duty on the prospective donor to declare his or her donor status. It is thus a method that forces one to ponder the issue of organ donation and make a binding decision. This method of organ procurement acknowledges patient autonomy in that every individual has the right to determine what is to happen to his or her body upon death.[80] Required response is also a less intrusive organ procurement method than presumed consent in that it only requires the individual to make a choice at a certain event,[81] rather than making an assumption in the absence of a decision being made. Required response therefore aims to correct two of the major flaws causing the shortage in donated human organs: failure to ask, as well as the refusal to donate by relatives.[82] It takes the burden off relatives and health care workers, so that they don't need to make a difficult decision during a difficult time and at the same time it respects patient autonomy.[83] The biggest negatives of opting-in[84] and presumed consent[85] are thus not a problem if required request is used. Therefore, Spellman has identified required response as "the best alternative to increase organ donation in the United States."[86] Required response is also supported as a viable organ procurement method by Veatch, who stated that the time has come for an organ procurement method that expects people to consider their willingness to donate their organs upon death and requires a response.[87]

The key to the success of this method is to reach the optimum amount of people and to ensure that people are put in a situation where they can make an informed decision, as well as having a proper database to record and enable access to this information.

[80] This is in accordance with section 12(2)(b) of the Constitution, stating that: "[e]veryone has the right to bodily and psychological integrity, which includes the right to security in and control over their body."
[81] Such as applying for an identification document or driver's licence, or upon filing tax returns.
[82] Richards 402.
[83] Spellman *Encouragement is not enough: The benefits of instituting a mandated choice organ procurement system* Syracuse Law Review 56 353 372.
[84] The role of the family and the fact that people do not make a choice regarding organ donation whilst still alive.
[85] Patient autonomy not being respected.
[86] Spellman 370.
[87] Veatch 2000 178.

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3.5.2 Required response in the United States of America: Texas

The USA state of Texas requires citizens to either opt in or opt out of organ donation upon the renewal of a driver's licence.[88] However, the state has an 80% refusal rate.[89] Spellman makes the valid argument that the reason for the failure of required response in Texas is the situation under which the response is required. Expecting positive results from people who are not in great spirits from waiting in queues is futile. However, although Spellman suggests that better results may be achieved under different circumstances, these circumstances are not named. The failure of this organ procurement method, just as the failure of required request, can be attributed to the unfortunate timing of the request.

3.5.3 Required response in South Africa

It is submitted that required response should be used together with opting-in (explicit consent) as an incentive to increase the number of organs procured.[90] For required response to be successful in South Africa, an intensive information campaign on organ procurement, allocation and transplantation must be implemented in order to inform the public of all the relevant aspects regarding organ procurement, allocation and transplantation in order to be able to make an informed decision on the matter. This is in line with Spellman's opinion that citizen's need to be educated and that donation misconceptions need to be dispelled.[91] Thereafter people could be asked to confirm their donor status when voting, when applying for an ID document or driver's license or when admitted to a hospital or clinic as part of a routine procedure. It must be kept in mind that the timing of the request will be crucial to its success or failure. Failure to comply with the request can be deemed as an incomplete submission or application.

[88] Spellman 372.
[89] Spellman 372.
[90] See Fourie 99 for a partial agreement with this viewpoint.
[91] Spellman 373.

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3.5.2.1 The positive aspects of required response as a procurement system:

- The public will be educated regarding organ procurement, allocation and transplantation;
- Every person will be forced to make an informed decision regarding organ donation;
- A national database will exist documenting every person's decision, creating an easy, quick way to determine a deceased's donor status and simultaneously rendering the family's choice unnecessary in most instances;
- Jobs will be created; and
- Required response will be more effective than required request as prospective donors will consider the matter with ample time and without being at their own sickbed or at the sickbed of a relative.

3.5.2.2 The negative aspects of using required response as a method of organ procurement:

- Resources will be needed to implement this procurement method, including financial aid, advertising and educational materials, as well as support staff; and
- A preparation or transitional period will be needed before required response can be implemented as an organ procurement method.

Required response as an organ procurement system is not without its limits. All prospective donors will not be reached as all South African citizens do not have drivers' licences and all South African citizens do not apply for ID documents. Also, some citizens who apply for an ID document are still minors where the situation will be unclear until decided by the courts or regulated by legislation.

3.6 Sale of organs

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3.6.1 Sale of organs in general

The sale of organs is probably one of the organ procurement methods with the most ethical issues.[92] Therefore, it is also one of the most controversial incentives to increase both living and cadaveric donation.[93] Although it has been advocated for years as a possible organ procurement system by academics, Iran is currently the only country to apply it. However, during recent years, support for the sale of organs has grown.[94] The possible success of this organ procurement method is founded on the belief that the use of self-interest, such as monetary gain, to shape human behaviour will be more successful than the use of altruism.[95]

3.6.2 Sale of organs in Iran

The only country where the sale of organs is currently allowed is Iran. Iran has had a regulated government-funded renal transplantation programme for unrelated living donors since 1988.[96] There is no involvement from organ brokers and the government pays a fixed amount for organs received, therefore eliminating the possibility of being taken advantage of for financial reasons.[97] As the renal transplant waiting list in Iran has virtually been eradicated,[98] it seems as if this organ procurement method is successful in Iran.[99]

3.6.3 Sale of organs in South Africa

The sale of organs is currently prohibited in South Africa by section 60(4) of the National Health Act. The Act does, however, make provision for a donor to receive a "form of financial or other reward for such donation…for the reimbursement of

[92] See chapter 4 that deals with these ethical issues in much more detail.
[93] Kwitowski BT *Learning from each other: Combining strategies to end the organ shortage* J. Med. & L. 2005 141 148.
[94] Slabbert 265- 266.
[95] Ghods and Sava1136.
[96] Venter 117.
[97] Venter 118.
[98] Ghods and Sava 1139.
[99] Venter 119.

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reasonable costs incurred by him or her to provide such donation…" It is unfortunate that these costs were not further defined in the regulations to the Act, as it leaves the door open for illegal payment of organs.[100] No other financial reward is currently allowed.

To allow the sale of organs in South Africa will require extensive legislation regulating the matter.

Slabbert recommends the use of a futures contract to sell organs. A futures contract is a contract entered into by the donor whilst alive where the organs are to be harvested upon death.[101] This contract thus will be subject to a suspensive term as it will only become enforceable upon death, as well as a suspensive condition as it will depend on the organs being fit for transplantation. If the sale of organs in South Africa is based on the Iranian model, it has the benefit that many of the ethical concerns will already have been addressed successfully.[102] There are however, several ethical concerns still unsolved.[103]

3.6.2.1 The positive aspects of the sale of organs as a procurement system:

- Money, or self-interest,[104] makes the world go round, and is therefore a strong motivator to increase the amount of procurable organs;
- Allowing the sale of organs has the ability to eliminate illegal transplantations[105] and so-called black markets; and
- If there are enough organs available for donation to meet the demand, it might result in reduced costs, especially for kidney transplants, as the cost of months or years of dialysis is excluded.[106] However, this might be a positive regardless of the organ procurement method, as long as the offer of transplantable organs meets the demand.

[100] Slabbert Koers 2008 88.
[101] Slabbert M *Handeldryf met menslike organe en weefsel vir oorplantingsdoeleindes* (LLD thesis, University of the Free State 2002)150-151.
[102] Ghods and Sava 1140-1141.
[103] Ghods and Sava 1141-1142.
[104] Ghods and Sava 1136-1137.
[105] Ghods and Sava 1143.
[106] Barnett and Kaserman 125.

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3.6.2.2 The negative aspects of using the sale of organs as a method of organ procurement:

- The situation regarding the property rights of human organs is unclear and will require statutory regulation, which will require important policy decisions to be made;[107,108]
- Strong disapproval on various ethical grounds still exist;[109]
- Allowing the sale of organs will mainly have the ability to relieve the shortage of kidneys, and not all organs as this organ procurement method is mainly used in live donations;
- The normal contractual principles can't be applied easily to the sale of organs; and
- Allowing the sale of organs will have to be regulated properly by legislation to prevent abuse. However, it is clear from the National Health Act that the legislature has not yet been able to draft proper legislation regarding organ procurement.[110]

There are compelling arguments both for and against the sale of organs as an organ procurement method. The bottom line is that the sale of organs in South Africa will only be successful after various serious problems are properly addressed and well drafted legislation is enacted. This will require time and resources, something the government does not seem keen on providing when it comes to organ procurement. This is partially understandable as organ transplantation is not viewed as basic health care and therefore not a priority. Although this organ procurement method shows the potential to alleviate the organ shortage, it is submitted that this method of organ procurement will not be successful in South Africa as there are just too many

[107] For more regarding property rights of human organs, see Slabbert *"This is my kidney, i can do what i want with it" – Property rights and ownership of human organs* Obiter 2009 499.
[108] See Cloete R *Die grondwetlike erkenning en beskerming van welvaartsregte:* New property*, sosio-ekonomiese regte en ander onstoflike sake* THRHR 2003 531- 564 for a compelling argument that socio-economic rights, as incorporeal things, as well as public resources, may be included in the Constitutional concept of "property" as entrenched in section 25 and thereby enjoy even further protection.
[109] Ghods and Sava 1141-1142.
[110] For a detailed discussion on the shortcomings of the National Health Act with regard to organ transplantation and aspects relevant thereto, see chapter 2.

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problems that need to be sorted out, of which ethics are the least worrisome, before it will have the ability to be successful.

3.7 Organ donation from prisoners

3.7.1 Organ donation from prisoners in general

This method of organ procurement has provoked heavy debate and is one of the most controversial methods of organ procurement. There are basically two methods of harvesting organs from prisoners. The first is to procure organs from deceased prisoners before the bodies are released to family members. The second method involves rewarding prisoners who are also organ donors, thus reducing a prison sentence in response to donation.[111] There are numerous problems with this method of organ procurement. Rewarding a prisoner with a reduced sentence if the prisoner is prepared to donate upon death is impossible to enforce. It is unthinkable that a person might be prevented from changing his or her mind regarding donation at a later stage, yet this is the only way to ensure that prisoners won't be receiving reduced sentences for free, thus receiving the reduced sentence without actually donating any organs upon death.

3.7.2 Organ donation from prisoners in China

The first method is applied in China and has caused widespread criticism from both academics and human rights activists.[112] The reason for this method of organ procurement providing a large number of organs annually,[113] is the fact that the

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[111] Ryan CJ *The anatomical wealth of nations: A free market approach to organ procurement* MSU Journal Of Medicine And Law 2009 427 433.

[112] This practice was initially created by China's 1984 *Temporary Rules Concerning the Utilization of Corpses or Organs from the Corpses of Executed Criminals*. The Chinese Government then enacted the "Provisions on the Administration of Entry and Exit of Cadavers and Treatment of Cadavers" in 2006 in an attempt to prevent abuse. See Hemphill *China's practice of procuring organs from executed prisoners: Human rights groups must narrowly tailor their criticism and endorse the Chinese Constitution to end abuses* Pacific Rim Law & Policy Journal 2007 16(2) 431.

[113] Hemphill 436.

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death penalty can be awarded when found guilty of one of sixty-eight different crimes in China.[114] However, after strong criticism worldwide, China will phase out organ procurement from prisoners and launch a voluntary donation system by the end of 2013.[115]

3.7.3 Organ donation from prisoners in South Africa

If organs are procured from prisoners in South Africa, it will without a doubt meet fierce opposition. Procuring organs from prisoners will likely be an unjustifiable limitation of section 9 of the Constitution. It will also be very difficult to regulate, as the proposed award for prisoners is a lesser sentence. If a lesser sentence is awarded to a prisoner upon the agreement to become a cadaveric donor, there is nothing to guarantee that the organs will indeed be donated upon death, or even that the organs will be fit for transplantation. If prisoners regularly agree to be living donors and to donate their kidneys, it will put strain on already scarce available resources in prisons.

3.7.3.1 The positive aspects of organ donation from prisoners as a procurement system:

- The number of procured organs might increase.

3.7.3.2 The positive aspects of organ donation from prisoners as a procurement system:

- It will be difficult to enforce;

[114] Hemphill 437.
[115] *China to phase out use of prisoners' organs for transplants* http://www.reuters.com/article/2013/08/15/us-china-organs-idUSBRE97E09920130815 (accessed 16 September 2013).

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- It disregards section 12(2)(b) of the Constitution and the principle of autonomy, rendering this organ procurement method both constitutionally and ethically indefensible;[116]
- Both the transplant and aftercare will put strain on limited resources and be a possible security risk; and
- This organ procurement method will not have the same success in South Africa as in China as the death penalty is no longer legal in South Africa.

From the above it is clear that organ donation from prisoners does not have the ability to succeed in South Africa.

3.8 Organ allocation

Organ allocation needs to be distinguished from organ procurement. Organ procurement, as was shown above, deals with the collection or harvesting of organs from the donors- when it is done, how it is done, what the requirements are. Organ allocation, on the other hand, deals with the distribution of the organs after procurement to the recipients thereof. Successful organ procurement methods mean little if the procured organs isn't delivered to the right recipients in a timely manner. Organ allocation sets out rules and guidelines according to which the recipients for organs are chosen. Some of the most common criteria include general health, the chance of the transplant being a success and age. These rules and guidelines are necessary in order to manage the limited resources in such a way that has the possibility to yield the best results. Although the guidelines might vary from hospital to hospital, organ allocation must comply with the principles of distributive justice. Distributive justice is defined by Beauchamp and Childress as "fair, equitable and appropriate distribution in society determined by justified norms that structure the terms of social co-operation."[117] Moodley argues that "distributive justice is

[116] For an in depth discussion on the influence of ethics and the Constitution on presumed consent, see chapters 4 and 5 respectively.
[117] Beauchamp T and Childress J *Principles of Biomedical Ethics* 2009 6th ed 241.

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particularly relevant in South Africa… where, especially in the public health sector, limited resources exist."[118]

3.8.1 Current South African organ allocation methods

Organ allocation is not currently properly regulated by legislation.[119] This is one of the largest omissions by the legislature from the National Health Act.[120] Allocation guidelines are established by hospitals or hospital groups and may differ slightly. These guidelines aim to establish objective criteria to determine the best allocation for each organ. *The Additional Protocol to the Convention on Human Rights and Biomedicine concerning Transplantation of Organs and Tissues of Human Origin*,[121] determines that organs be allocated "only among patients on an official waiting list, in conformity with transparent, objective and duly justified rules according to medical criteria."[122]

The guidelines typically include the following criteria:

a. Age of the recipient[123]

   As the aim of the allocation procedure is to achieve the best possible chance of successful organ transplants, the age of the recipient is considered. Generally, the younger the recipient is, the better his or her general health and the better the chances of success. It makes logical sense that an organ would rather be allocated to a 30 year old than a 60 year old.

b. Age of the donor

   Donated organs can be seen as used tyres. The older the donor, the more mileage there is on the organs. If it is assumed that an organ generally has an 80 year lifespan, and the organ is donated by a 50 year old, the organ should have about 30 years left. If, however, the organ is donated by a 30 year old, it

[118] Moodley K ed 2011 *Medical Ethics Law and Human Rights* 74.
[119] Although section 61 of the National Health Act makes provision for allocation in accordance with the "prescribed procedures" these procedures are not prescribed further in the Act or the regulations thereto.
[120] 61 of 2003.
[121] http://conventions.coe.int/Treaty/en/Treaties/Word/186.doc. (accessed 20 March 2013).
[122] Article 3.
[123] Slabbert M *One heart, two patients: Who gets a donor organ?* Stell LR 2009 (1) 124 126.

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will have about 50 years left. Thus, the organs from a younger donor at the time of death, have the potential to last a lot longer.

c. Social Merit[124]

Social merit is a controversial organ allocation criterion. It involves concerning aspects of a potential recipient's social life or social worth, such as drinking habits in the case of a liver transplant or whether the potential recipient is an athlete or a minister, thus whether this person is well-known or has contributed to society. There are many who believe that it should not be considered at all during the allocation process and that the only criteria considered should be purely medical criteria.[125] Slabbert goes so far as to state that "[s]ocial merit should never be a determining factor in the allocation of scarce organs for transplantation as it is nearly always prejudicial and not based on fairness."[126] This view can't be fully supported, as social factors can have an influence on the medical success of the transplant. For example, whilst it might seem prejudicial to consider the drinking history of a liver recipient, if the recipient is an alcoholic, chances are that his or her lifestyle might diminish the chances of long term success and therefore have the consequence that medically, there might be a more worthy recipient based purely on the fact that in a non-alcoholic recipient, the organ might have a longer life span. From this it is clear that determining if a factor is social or medical might not always be black or white, there are factors that can be considered under both social and medical criteria.

d. Financial position

Although this is viewed by many as an undesirable criterion,[127] there is no escaping the fact the money makes the world go round and that organ transplants are costly procedures. Therefore, if one does not have medical insurance or the financial resources to afford the transplant and aftercare, one might not be viewed as a suitable candidate to receive an organ.

e. Geographical area

[124] Slabbert 2009 Stell LR 127.
[125] *The Additional Protocol to the Convention on Human Rights and Biomedicine concerning Transplantation of Organs and Tissues of Human Origin* in article 3.
[126] Slabbert 2009 Stell LR 128.
[127] Slabbert 2009 Stell LR 128.

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Organs are only transplantable for a short time after harvesting, ranging from five to 72 hours depending on the type of organ.[128] The organ thus needs to reach the recipient in a very short time span for the transplant to have the best possible chance of success. This logistical problem severely limits the potential recipient pool that donor organs can be matched to. This has the consequence that only recipients from geographical areas that are close enough to the donor will be considered seriously.

f. Urgency

Urgency requires priority to be awarded to the recipient most in immediate need. There is a fine line between being on top of the urgency list and being disqualified as a suitable recipient. This is because one goes from being the recipient most in need of an organ to a person that is not healthy enough to survive a transplant.

g. Medical benefit to the recipient

This criterion aims to ensure that the transplant will have an overall probable chance of success if properly executed.[129] "A common way of prioritising patients is in terms of their need for treatment, with the implication that the greater the capacity to benefit from treatment, the greater the need."[130] This criterion is also required by *The Additional Protocol to the Convention on Human Rights and Biomedicine concerning Transplantation of Organs and Tissues of Human Origin.*[131]

h. Biological characteristics of the donor organ and recipient

Biological characteristics include *inter alia* the size of the organ, blood type and tissue typing.[132] The aim of determining these characteristics is to find the best possible biological match between donor and recipient, in order to achieve the best possible medical outcome.

i. Quality of donated organs

In order for the transplant to be successful, the quality of the donated organ must be as good as possible. For this reason, organs from donors with certain illnesses or conditions are generally not considered as suitable organs for

[128] Slabbert 2002 26.
[129] Slabbert 2009 Stell LR 130.
[130] Moodley 76.
[131] Article 3.
[132] Fourie 118.

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donation. These conditions include *inter alia* HIV/AIDS,[133] Hepatitis, Tuberculosis and certain types of cancer.

j. Time on waiting list

Where there is a waiting list for prospective recipients, the length of time spent on the waiting list is an important factor to be considered.[134] In principle, the person that has been the longest on the list, whilst taking into account the degree of tissue matching, and urgency, should be the first to receive an organ.

From the above discussion it is clear that all of these factors must be taken into account when deciding to whom an organ should be allocated. It thus becomes a balancing act to achieve the best possible outcome by taking into account all of the above-mentioned factors. Moodley gives a comprehensive prioritisation policy to illustrate how these factors are applied in practice.[135] However, it remains a difficult decision to be made. South Africa is in desperate need of proper legislation regulating the allocation of human organs for transplantation in detail.

3.8.2 Proposed amendments and changes

It is important to keep in mind that although having effective allocation procedures in place is cardinal to the successful transplantation of organs, "…even the most efficient system of allocation could not cure the underlying problem: a vast shortage of organs."[136] Whilst effective allocation procedures thus ensure that all donated organs are placed with the best donor, it can never make up for the shortage that still exists. Therefore, the possibility of using other resources together with organ procurement and organ allocation methods needs to be considered.

[133] For proposed changes regarding donors and recipients with HIV, see paragraph 3.9.2 below.
[134] Moodley 287.
[135] Moodley 79-81.
[136] Ryan 428.

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3.8.2.1 Creation of a National waiting list

The creation of a national waiting list is crucial to reduce the organ shortage. It will enable health care workers to compare the information of transplantable organs to the prospective recipients in the country. This will also mean that the medical information of prospective organ recipients is easily available for comparison to donated organs. Furthermore, it is required in terms of article 3 of *The Additional Protocol to the Convention on Human Rights and Biomedicine concerning Transplantation of Organs and Tissues of Human* Origin, which determines that organs be allocated "only among patients on an official waiting list…" It is suggested that a national waiting list is required irrespective of the organ procurement or organ allocation methods applied.

3.8.2.2 Creation of a National donor list

The creation of a national donor list is just as important as the need for a national waiting list. Most importantly, a donor list will contain the donor status of prospective donors. This eliminates the need to establish the donor status through emotionally distraught relatives and also the chance of relatives refusing to give permission for the donation. A donor list will contain the basic medical information of prospective donors, such as age, weight, blood type *etc.* In the event of sudden or unexpected death, this information will be easily accessible by health care workers. Less time will therefore be wasted to determine if the donor's organs might be a suitable match for a specific recipient. Just as with the need for a national waiting list, it is suggested that a national donor list is required irrespective of the organ procurement or organ allocation methods applied.

3.8.2.3 Allowing HIV positive organs to be donated

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In a study undertaken by Gokool *et al*,[137] the "results suggest that both patients and health care workers find it acceptable to include HIV-positive cadaveric donors for transplantation into eligible HIV-positive recipients, despite the unknown risks."[138] Currently, all organs from donors that are HIV positive are discarded. Therefore, an estimated 30% of the donor pool is automatically deemed unfit to donate.[139] Allowing HIV-positive people to become organ donors will result in providing a whole new group of patients with the possibility of receiving a transplant for the first time. Although this does not have the potential to alleviate the organ shortage for HIV-negative patients, it is definitely a wonderful opportunity to better the lives of HIV-positive patients and to make progress towards the goal of being able to provide everyone in need of a transplant with a donor organ.

3.9 Other aspects relevant to organ procurement

Although the following matters are not organ procurement or allocation methods in own right, they play a pivotal role in organ procurement and allocation, and therefore require further discussion.

3.9.1 Education

The value of proper education can't be stressed enough. Education is crucial in obtaining informed consent, one of the essential requirements for a valid donation. Without having proper knowledge of what organ transplants entail, a prospective donor can't make a proper decision. Without having proper knowledge, most people would not even consider making a choice for or against donation, much less make an uninformed decision. It is thus clear that awareness regarding organ transplantation has to be raised. Although it has been argued that the role of

[137] Gokool S, Fabian J, Venter WDF, MacPhail C, Naicker S *HIV positive kidney transplants for HIV-positive individuals: Attitudes and concerns of South African patients and health care workers* SAMJ 2010 100(2) 96.
[138] Gokool *et al* 98.
[139] Gokool *et al* 96.

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education is limited in procuring more organ donors,[140] it is submitted that this does not hold true for South Africa. South Africa is a country that still struggles to provide all its citizens with basic needs like water, housing and sanitation. Relieving the organ shortage has not been a government priority,[141] as organ transplantation is not viewed as basic health care, and the only education thus far, has been done by non-government organizations such as the Organ Donor Foundation. Therefore national educational campaigns on the matter and raising awareness will likely yield positive results. The more people are confronted with the harsh reality of organ shortage, the better the chances are that they will be motivated to act in an altruistic manner.

3.9.2 HIV/AIDS

Many organs are viewed as not suitable for donation on the basis that the donor was HIV positive. Likewise, many prospective recipients are disqualified because of their positive HIV status. Of course, it would be totally unacceptable if a HIV negative patient received a HIV positive organ. However, this causes many organs that are otherwise in a good condition, to go to waste. A policy that favours HIV negative recipients over HIV positive recipients was bound to come under the spotlight at one time or another.[142] It has been suggested that organs from HIV positive donors should be allocated to HIV positive recipients.

> "In South Africa the number of patients with HIV who have chronic kidney disease is increasing and it has been shown that they may do well after kidney transplantation provided that they do not have AIDS and adhere to ARV treatment. It has therefore been accepted that patients living with HIV may be accepted for renal replacement treatment provided they fulfil certain criteria."[143]

[140] In a study undertaken by *inter alia* Kaserman, it was found that "[t]he results fail to support (indeed, strongly reject) the increased educational efforts argument…Thus, the empirical results strongly suggest that increased educational spending is unlikely to have a significant effect on the organ shortage." Kaserman DL *Fifty Years of Organ Transplants: The Successes and The Failures* Issues in Law & Medicine, 2007 23(1) 61-62. This study was undertaken in the USA, where much more has been done to promote organ transplantation than in South Africa.
[141] As can be seen in the lack of proper regulation thereof in the National Health Act 61 of 2003.
[142] Carstens and Pearmain 151.
[143] Moodley 82.

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This is a relatively new concept that promotes the values of human dignity, equality and freedom. It is a concept that stands the chance to gain widespread support from both the general public and health care workers.[144]

> "The key reasons given for providing transplants to HIV-positive individuals using HIV-positive kidneys were to afford them the opportunity for longer survival, to avoid discrimination because of their HIV status, and to allow them equal rights of health care access compared with HIV-negative patients."[145]

This is a new avenue that is still in the beginning stages of exploration, however, it seems well worth the resources needed to further investigate. Expanding the donor pool to HIV positive donors will enable previously unsuitable recipients to have access to a whole new group of potential donors. Also, it will not create a bigger organ shortage for HIV-negative patients, as only organs from HIV-positive donors will be transplanted into HIV-positive recipients. Therefore, South African health policy guidelines have already been revised to make provision for HIV-infected patients having access to dialysis and kidney transplantation, as long as they meet the eligibility criteria.[146] Although this change in allocation policy does not alleviate the shortage of organs for HIV negative patients, is opens up new hope and opportunities for HIV positive patients that was previously unavailable.

3.9.3 Tax incentives

Tax incentives generally grants an organ donor a tax credit for the year in which the donation takes place. If the donation is a cadaveric donation, the tax credit would be taken into account for the purpose of determining the estate duty. As the first R3 500 000 of a deceased estate is not taxable in South Africa, one wonders how much of a motivational factor this will be in practice. One could even argue that this will only benefit the rich and discriminate against the poor, as those with a estate worth R3 500 000 or less will not be able to enjoy this benefit.

[144] Gokool *et al* 98.
[145] Gokool *et al* 98.
[146] Gokool *et al* 96.

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3.9.4 Favourable consideration as a recipient

Another incentive to motivate potential donors is to guarantee them that should they ever need an organ, they will jump the queue and therefore receive the required organ quicker than others on the waiting list. This is clearly only available as motivation for live donations.

3.10 Conclusion

In an age of rapid technological improvement, the potential of organ transplantation to save lives is being severely constrained by the failure of public policy and the law to keep pace with technological advances. This technological development is the root of the urgent need to come up with better organ procurement systems.

From the wide range of possible organ procurement methods, it is clear that there are problems with each respective method, and that there is still much room for the improvement of organ procurement models. From the study of the literature available on organ procurement methods, "we are left with the uncomfortable feeling that something must be done, but we cannot be certain what that something is."[147]

Fourie makes the argument that both required response and required request as methods of organ procurement will increase public awareness of organ donation and will therefore also lead to an increase in the number of organ donors.[148] The premise here is that without knowledge, one can't consider the matter properly, but with the necessary knowledge, one has the ability to think the matter through and make an informed decision. This is of course subject to receiving enough information to have knowledge, appreciation and consent in the matter.[149] Nonetheless, proper education of the public on the matter is vital to expand the donor pool. The documentation of people's wishes regarding organ donation whilst they are still alive

[147] Barnett and Kaserman 118.
[148] Fourie 149.
[149] Neethling Potgieter Visser 106- 108.

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is crucial in order to procure the maximum amount of organs and to maintain the integrity of the chosen organ procurement system.[150]

"The pertinent question at present is not whether we should have a major policy change but, rather, which of the available policy alternatives should be chosen to replace the current policy."[151] This remains, after many years of speculation, a particularly difficult question to answer.

To summarize, it is concluded that the main changes needed in organ procurement and organ allocation, in order to alleviate the organ shortage, are:

- Proper education of the public on organ transplants and organ donation is needed;
- HIV positive donors and recipients need to be accepted if other relevant criteria are met;
- The current procurement system of opting-in should remain similar for live donations;
- The current procurement system of opting-in should be replaced with required response for cadaveric donations;
- There will thus be a dual organ procurement system in place with separate rules for live and cadaveric donations;[152]
- A national database must be created to record every person's donor status and basic medical information;
- A national waiting list must be created to record information of patients in need of an organ transplant, including basic medical information;
- The role of family members in cadaveric donations should be limited to instances where the donor did not give permission prior to death or when it can be proven that the donor had a change of mind regarding donation and did not register the latest decision; and
- An intensive information campaign on organ procurement, allocation and transplantation must be implemented in order to inform the public.[153]

[150] Orentlicher 329.
[151] Barnett and Kaserman 137.
[152] For a discussion of a dual system of procurement including explicit consent for live donations and presumed consent for cadaveric donations, see Fourie 148.
[153] Fourie 147.

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It is submitted that although there has been a constant and overwhelming organ shortage in the past, it is a problem that can be solved with the correct methods and resource allocation. When law and practice comes together as a functioning unit, the "law is beautiful- it has a certain elegance of logic, a certain rightness of reason, which when correctly understood an[d] applied, is no less entrancing than the constructs of higher mathematics. This is certainly also true for medical law."[154] However, when the law fails, it does so miserably, as can be seen in the current demand for transplantable human organs.

[154] Carstens and Pearmain 19.

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CHAPTER 4

THE INFLUENCE OF BIOETHICS

4.1 Introduction

Ethics in medical law is as old as the subject itself and originates from the doctor-patient relationship. The doctor-patient relationship is historically based on the Hippocratic Oath, which all doctors are obliged to take, and dates back to old Greek times around the 5th century BC. It is the oldest known written document regarding medicine and ethics and is based upon the principle of *primun non nocere*- meaning above all, do no harm, which is in line with the principle of non- maleficence.[1] It is an intertwined thread that surfaces throughout the areas where law and medicine cross paths.

Generally and nationally the Health Professions Council of South Africa[2] released modern guidelines on ethical rules. Internationally, there are various documents regarding medical ethics, of which the most prominent for the purposes of this discussion is *The Declaration of Istanbul on Organ Trafficking and Transplant Tourism.*[3] Ethics in relation to medical law and health care law is also the frequent subject of academic writings, both in South Africa[4] and abroad.[5]

Ethical questions regarding medical law in general, and more specifically organ transplantation, are usually extremely hard to answer and the debates around these

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[1] First, do no harm. See Moodley K (ed) *Medical ethics, law and human rights: A South African perspective* 2011 3.
[2] Hereinafter "the HPCSA".
[3] The Declaration of Istanbul on OrganTraffickingandTransplantTourismhttp://multivu.prnewswire.com/mnr/transplantationsociety/33914/docs/33914-Declaration_of_Istanbul-Lancet.pdf (accessed 13 September 2012).
[4] See Moodley K (ed) *Medical ethics, law and human rights: A South African perspective* 2011; see also Dhai A and McQuoid-Mason D *Bioethics, human rights and health law* 2011.
[5] Of the most recognised writings are those by Beauchamp TL and Childress JF in the respective editions of their work *Principles of biomedical ethics*, the most recent being the 2009 6th ed and from Oxford University Herrings J's *Medical law and ethics* 20103rd ed. See also Veatch RM *The basics of biomedical ethics* 2003 2nd *ed.*

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issues will most likely continue for many years to come.[6] Most of the ethical problems posed by these medical procedures are relatively new, as they are created and multiplied just as fast as new technology is developed and a wider variety of medical interventions are made available.

This is an emotionally charged field of practice, as one often deals with the creation and ending of life, morality issues and religious opposition. It can involve extremely sensitive bodily examinations with severe intrusions on a patient's rights to privacy and dignity. Where organ transplantation is involved, fierce opposition from religious groups as well as conservative groups can be expected. Regarding organ transplantation, the central questions have stayed mostly the same throughout the years: Is it ethical to sell organs? Is it ethical to use animal organs for humans? Is it ethical to interfere with nature in this way? Is it ethical to presume a deceased has given consent to donate organs?

Medical ethics involves a critical analysis of choice- making that are based on *inter alia* moral, religious and philosophical values and principles. Moodley states that "[b]ioethics deals with the moral issues raised by developments in the biological sciences at a more general level."[7] Many different doctrines of thought exist on how to approach an ethical problem, of which some of the most prominent ones are: consequentialism; Kantian deontological theory; virtue ethics; communitarianism; casuistry and principlism.[8] The latter is one of the most recent and modern developments of ethics. It was developed by the writers, Beauchamp and Childress[9] and is based on what they call the "four principles of bioethics". The four principles are: patient autonomy, non-maleficence (doing no harm); beneficence (doing only good); and finally justice. It is an approach that is widely followed, both locally[10] and

[6] See Slabbert M *Handeldryf met menslike organe en weefsel vir oorplantingsdoeleindes* (LLD thesis University of the Free State 2002).
[7] Moodley 4. Dhai and McQuid-Mason defines bioethics as: "an ethical reflection on a vast array of moral issues concerning all living things which arise from the application of biomedical science to human affairs and the whole biosphere." Dhai and McQuoid-Mason 3.
[8] Dhai and McQuoid-Mason 9-15; see also Moodley 19.
[9] The most recent edition of their work being the 6th edition of *Principles of biomedical ethics* 2009.
[10] For local support, see Venter B *A selection of constitutional perspectives on human kidney sales* (LLM dissertation University of South Africa 2012); Moodley (ed) *Medical ethics, law and human rights: A South African perspective* 2011; and see also Dhai A and McQuoid-Mason D *Bioethics, human rights and health law* 2011.

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internationally.[11] It can be argued that this is not a doctrine by itself, but rather four principles applicable under several of the various doctrines applied in ethics. However, as these four principles are applied in several of the ethical doctrines, using these principles is preferable over using the doctrines themselves in this chapter, as they can be applied to all the organ procurement methods and because they are merely principles, as opposed to doctrines, they enjoy a much wider scope of application. Much of the discussion that follows is therefore prognostic as this method of determining the ethical defensibility of organ procurement has not been applied before to this extent. These four principles will accordingly be discussed separately. This chapter will therefore first discuss the interaction between medical law and ethics, in order to show the need for considering ethics, where after the four principles of bioethics will be discussed separately. After this general discussion on principlism, the ethical defensibility of all the organ procurement methods already discussed in chapter three will be considered in light of these four principles of bioethics as identified by Beauchamp and Childress.[12]

4.2 The interaction between medical ethics and medical law

It has been observed that "[i]t would not be correct to say that every moral obligation involves a legal duty; but every legal duty is founded on a moral obligation."[13]

The relationship between medical ethics and medical law is fundamental to establish whether a specific organ procurement method should be accepted on both ethical and legal grounds.[14,15] To establish the interdependency or the relationship between medical ethics and medical law, the extent to which the medico-ethical framework informs the legal framework needs to be determined;[16] it needs to be established

[11] For international support, see Herring J *Medical law and ethics*, 3rd ed 2010; see also Mason JK, McCall-Smith RA and Laurie GT *Law and medical ethics* 6th ed 2002.
[12] Beauchamp and Childress chapters 4-7.
[13] *R v Instan* [1893] 1 QB 450, 453.
[14] Carstens P *Revisiting the infamous Pernkopf Anatomy Atlas: Historical lessons for medical law and ethics* Fundamina 2012 18(2) 36, as relativised on organ procurement.
[15] In this chapter, the focus will fall on whether a specific organ procurement method should be accepted on ethical grounds, where in the next chapter, (chapter 5) the focus will fall on whether a specific organ procurement method should be accepted on legal grounds.
[16] Carstens 36.

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whether a normative, ethical value can simultaneously be a legal right;[17] and finally it needs to be determined if unethical conduct is automatically regarded as unlawful conduct.[18]

Traditionally, the practice of medicine was viewed as a "natural science that deals with the body";[19] as opposed to the modern idea that medicine should be based on humanness.[20] There is therefore more and more a movement to include ethics, as a branch of philosophy, in the practice of medicine.[21] However, there is a clear difference between the law and ethics. Where the law stipulates the minimum standards or requirements, ethics is concerned with the ideal conduct or outcome.[22] Therefore, it is possible that conduct could be regarded as unethical, and yet still lawful.[23] Although the law and ethics are two separate fields, they are still inseparably linked.

It has been submitted that medical law is a tool for enforcing medical ethics.[24] Giesen contends that medical ethics and medical law are intrinsically interwoven and that medical ethics therefore do not stand separate from the law.[25] This is supported by other writers who state that it is pointless to separate the moral dispute from the legal dispute, as they are inevitably intertwined.[26] This is further supported by the fact that the HPCSA created a consolidated ethical code of conduct in terms of the Health Professions Act,[27,28] and that although courts are not bound by codes of conduct, it is unquestionably a significant factor to be considered.[29] The courts therefore acknowledge the important role medical ethics has to play in medical law.[30]

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17 Carstens 36.
18 Carstens 36.
19 Moodley 9.
20 Moodley 9.
21 Moodley 9; for more on the relationship between philosophy and ethics, see Moodley 7-10.
22 Herring 3.
23 Carstens 40; see also Herring 3.
24 Carstens 44.
25 Giesen D *International medical malpractice law: A Comparative Study of Civil Responsibility Arising from Medical Care* 1988 669.
26 Mason K and Laurie G *Mason & McCall Smith's law and medical ethics* 2006 7th ed 4.
27 56 of 1974.
28 Carstens and Pearmain 264.
29 Carstens and Pearmain 264.
30 Carstens 40; see also Herring 3 and Giesen 669: "Yet, it will often be necessary for the law and society, and, thus, for the courts if called upon, to take cognizance of established codes of medical ethics."

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From the above discussion, it is clear that the influence of bioethics on organ transplantation can't be ignored.

4.3 The four principles of bioethics

4.3.1 Patient autonomy

Patient autonomy is one of the foundational principles of medical law and entrenched both in the Constitution[31] and in the common law.[32]

The principle of autonomy is derived from the Greek words *autos* and *nomos*, which can be translated as "self" and "governance" respectively.[33] Autonomy thus means to govern oneself.[34] This principle is entrenched in section 12(2)(b) of the Constitution and in practice exercised by own decision-making and the usage of a living will. Autonomy has also been described as "the obligation to respect the decision making capacities of autonomous persons."[35]

Beauchamp and Childress provide the following explanation of patient autonomy:

> "To respect an autonomous agent, is at a minimum to acknowledge that person's right to hold views, to make choices, and to take actions based on personal values and beliefs. Such respect involves respectful action, not merely a respectful attitude… Respect, on this account involves acknowledging decision-making rights and enabling people to act autonomously, whereas disrespect for autonomy involves attitudes and actions that ignore, insult, or demean others' rights of autonomy."[36]

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[31] In section 12(2)(b).

[32] The *locus classicus* for patient autonomy in South Africa can be found in *Stoffberg v Elloitt* 1923 CPD 148. See also *Castell v de Greef* 1994 (4) SA 408 (C).

[33] Beauchamp and Childress 99.

[34] It has been said that "autonomy recognises the duty of healthcare professionals to respect the freedom of patients to make decisions for themselves." Dhai and McQuoid-Mason 38.

[35] Beauchamp TL *Methods and principles in biomedical ethics* Journal of Medical Ethics 2003 (29) 269. See also Veatch 2003 71- 73 and 84.

[36] Beauchamp and Childress 2003 63, also in Beauchamp and Childress 2009 103, quoted in Herring 2010 25. From this quote it is evident, as previously observed by Veatch, that patient autonomy is often referred to or discussed in 'rights language'. Veatch 2003 72- 74.

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Acknowledging patient autonomy can be beneficial.[37] Some of these benefits are that the constitutional rights to bodily integrity,[38] dignity,[39] and privacy[40] are respected, it ensures better doctor-patient communication and it promotes a healthy doctor-patient relationship as the patient has more time to interact with the health-care professional and has a greater degree of control, which can in turn result in respect toward the health care provider for acknowledging the patient's choice.

The case *Stoffberg v Elliott*[41] is the *locus classicus* of patient autonomy in South African law, where Watermeyer J stated that:

> "In the eyes of the law, every person has certain absolute rights… and one of those rights is the right of absolute security of the person… [A] man, by entering a hospital, does not submit himself to such surgical treatment as the doctors in attendance upon him may think necessary…By going into hospital, he does not waive or give up his right of absolute security of the person… and, unless his consent to an operation is expressly obtained, any operation performed upon him without his consent is an unlawful interference with his right of security and control of his own body…"[42]

From this judgment it is clear that the patients' right to choose is highly respected by the law. This right was even further developed in *Castell v De Greef,*[43] where patient autonomy is applied in a broad sense:

> "It is clearly for the patient to decide whether he or she wishes to undergo the operation, in the exercise of the patient's fundamental right to self-determination. … Even if the risk of breast-loss were insignificant, a life-saving operation which entailed such risk would be wrongful if the surgeon refrains from drawing the risk to his patient's attention, well knowing that she would refuse consent if informed of the risk. It is, in principle, wholly irrelevant that her attitude is, in the eyes of the entire medical profession, grossly unreasonable, because her rights of bodily integrity and autonomous moral agency entitle her to refuse medical treatment."[44,45]

The court in *Castell v De Greef* is thus clearly of the opinion that a patient has the right to refuse *any* medical treatment, regardless of the opinions of medical

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[37] Herring 206.
[38] As set out in section 12(2)(b) of the Constitution.
[39] As set out in section 10 of the Constitution.
[40] As set out in section 14 of the Constitution.
[41] 1923 CPD 148.
[42] *Stoffberg v Elliott* 148-149.
[43] 1994 (4) SA 408 (C).
[44] *Castell v De Greef* 420- 421. For a discussion on this case, see Carstens and Pearmain 711.
[45] Quoted and supported in Malherbe R and Venter R *Die reg op lewe, die waarde van menslike lewe en die eutanasie-vraagstuk* TSAR 2011 (3) 478.

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professionals. Even a life-saving procedure would be wrongful if informed consent was not obtained.[46] From this judgment it is evident that the right to patient autonomy and by implication, the right to bodily and psychological integrity, enjoys a broad scope and the implications thereof can be far-reaching.

The submission of Malherbe and Venter that the same principles applied in *Castell v De Greef* and *Stoffberg v Elliott* in the context of operations can be extended to the refusal of lifesaving or life prolonging treatment is supported in principle.[47] In the case where informed consent (or informed refusal) had been obtained, patient autonomy should thus be given effect to, and this seems to be the case even in extreme circumstances.[48]

Venter states: "A patient, if adequately informed, is usually the best judge of his own interest."[49] This makes logical sense in so far as the patient knows better than any other person, what his or her personal circumstances entail, and when enabled with the necessary information to make a decision after considering all the relevant factors, the patient is certainly in the best position to decide what would be and what would not be in his best interests.[50] Venter also states that: "If a patient agrees to undergo a medical procedure without the adequate information about the possible risks or alternatives he is not acting autonomously. This emphasises the importance of informed consent concerning respect for autonomy and the right to self-determination."[51]

If consent is not informed consent, it is thus not deemed to be a valid form of consent. The defence of informed consent is based on the principle of *volenti non fit iniuria*.[52] This principle states that no harm is done to a person who consents wilfully thereto. Any consent given by a patient will not *ipso facto* be sufficient, informed

[46] Strauss 4.
[47] Malherbe and Venter 478.
[48] For example, where the patient refuses potential lifesaving treatment. An autonomous persons' decisions should be valued unless in acting autonomously, the person is acting to the detriment of others, see Dhai and McQuoid-Mason 70.
[49] Venter 84.
[50] It is important to note that patients can view total well-being as more important than medical well-being and that this might be in conflict with achieving medical well-being. Veatch 2003 51- 53.
[51] Venter 84.
[52] For a more detailed discussion on this defence, see chapter 2.2.1.1.1.

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consent.[53] The qualification of consent as informed consent is acknowledged as an essential requirement for valid consent in medical treatment and procedures.

The landmark case in South African law regarding informed consent is *Castell v De Greef*.[54] In this case the court established the standard of the "reasonable patient" is applicable to cases of informed consent for medical interventions.[55,56] The court thus rejected the "reasonable doctor" standard on grounds of it being in contrast with the right to patient autonomy, self-determination and bodily integrity.[57,58] The court also set out the requirements for valid informed consent, which was then turned into a checklist of confirmation of informed consent protocol:[59]

1. The consent must be given freely or willingly. This implies that no force or threat may be used to procure the relevant consent;
2. The person consenting must have the legal capacity to comprehend the situation and its possible consequences;[60]
3. The consenting person must have knowledge of the scope of the consent given;[61]
4. The consenting person must have full appreciation of the nature and scope of the consequences of the consent (the possible benefits, harm or infringement of rights);[62]
5. The person must indeed subjectively consent to the full extent of the consequences to follow the consent;[63]
6. The consent can't be against the *boni mores* or in other words, against the legal opinions of the community;[64]

[53] Dhai and McQuoid-Mason 74.
[54] 1994 (4) SA 408 (C).
[55] By accepting the reasonable patient standard, the principle of paternalism was rejected. *Castell v De Greef* 426; see also Carstens and Pearmain 885- 887; Van Oosten FFW *Castell v de Greef and the doctrine of informed consent: Medical paternalism ousted in favour of patient autonomy* De Jure 1995 164; as well as Dhai and McQuoid-Mason 69.
[56] This rejection of paternalism shows a change in the approach to medical law and the distancing from the Hippocratic oath, which has been referred to as paternalistic. Veatch 2003 58.
[57] Carstens and Pearmain 886; see also Strauss SA *Doctor, patient and the law* 3rd ed 1991 4- 5; as well as Giesen D *From paternalism to self-determination to shared decision making* Law and Medicine 1988 107.
[58] As entrenched in section 12(2)(b) of the Constitution.
[59] Carstens and Pearmain Annexure H. The checklist can also be found at www.samls.co.za (accessed 29 July 2013).
[60] Carstens and Pearmain Annexure H.
[61] *Castell v De Greef* 425; see also Dhai and McQuoid-Mason 72; as well as Strauss 8.
[62] *Castell v De Greef* 425; see also Dhai and McQuoid-Mason 72; as well as Strauss 8.
[63] *Castell v De Greef* 425; see also Dhai and McQuoid-Mason 72; as well as Strauss 9.

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7. The health care provider must inform the health care user of *inter alia*:
   The diagnosis, benefits and risks of both receiving and refusing the proposed treatment, complications, disadvantages, procedure to be followed and possible prognosis of the treatment; as well as any and all alternatives with their respective benefits, risks, complications and disadvantages; in language understandable by laymen.[65] The patient also needs to be informed of the right to a second opinion and the right to refuse treatment. In essence, the patient has to have a general understanding of the proposed treatment in order to be able to make an informed decision.

The requirements set out in *Castell v de Greef* are the requirements in law for consent to be valid, informed consent and it also complies with the seven elements of informed consent as identified by Beauchamp and Childress.[66] The HPCSA[67] has published guidelines with regard to the ethical considerations to informed consent, setting out statutory requirements, how to handle emergency and other situations as well as how to make sure informed consent has indeed been given.[68] Informed consent was also adopted into legislation in section 6(1) and 6(2) of the National Health Act,[69] where the requirements for informed consent is set out, thereby reaffirming informed consent as a fundamental principle in South African medical law. Section 7(1) continues to state that "[s]ubject to section 8, a health service may not be provided to a user without the user's informed consent," save for a few exceptions listed in section 7(1)(a)- (e).[70] It can thus safely be said that informed consent is indeed a fundamental principle in South African medical law.

Information on informed consent can easily be obtained from a broad spectrum of sources, as was indicated above. From the above it is thus also clear that patient

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[64] For instance, consent to active physician-assisted suicide, better known as euthanasia, is unlawful based on the fact that it is regarded as against the boni mores.
[65] Carstens and Pearmain Annexure H, see also section 6 of the National Health Act 61 of 2003; as well as Strauss 9.
[66] Beauchamp and Childress 120-121. The seven elements identified are: competence; voluntariness; disclosure; recommendation; understanding; decision; as well as authorization.
[67] The Health Professions Council of South Africa.
[68] http://www.hpcsa.co.za/downloads/conduct_ethics/rules/seeking_patients_informed_consent_ethical_consideration.pdf (accessed 17 September 2012).
[69] 61 of 2003.
[70] The exceptions make provision for instances where the user's consent can't be obtained and is obtained from an agent, by law, by court order, or from relatives.

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autonomy is firmly embedded in South African law, and therefore a principle that requires proper consideration in determining whether conduct or a situation is ethically just, also in the context of organ donation.

4.3.2 Non-Maleficence

Non-maleficence is closely associated with the principle of *primun non nocere*: first, do no harm, or, "the obligation to avoid causing harm".[71,72] This principle is also often looked at in conjunction with the principle of beneficence, namely, to do only good. Beauchamp and Childress distinguishes between the two by pointing out that non-maleficence requires refraining from action, whereas beneficence requires one to take action and help another.[73]

In the context of organ transplantation, the principle of non-maleficence has a direct influence on the transplant procedure when a living donor is used.[74] Harm caused to both the recipient and the donor during the transplant procedure is unavoidable. Harm inflicted upon the recipient can be justified by the fact that the quality of life might be improved drastically by means of living donation. The situation with regard to the donor is however very different. The donor's kidney is removed during an operation, but he receives no medical benefit to justify this action.[75] The question thus now becomes how can one justify this infringement by means of a medical procedure if there are no medical benefits to be gained by the donor?

An argument made by Beauchamp and Childress,[76] and supported by Venter,[77] is that if you weigh up the harm done to the donor by means of the transplant (the possible pain, discomfort and the inability to work for a while) against the harm done to the recipient if he does not receive a kidney, it fails in comparison. A voluntary

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[71] Beauchamp 269.
[72] The principle of non-maleficence is supported by the Constitution in section 12(1)(e), which states that "Everyone has the right to freedom and security of the person, which includes the right- not to be treated or punished in a cruel, inhuman or degrading way." For a discussion on non-maleficence and human rights, see Dhai and McQuoid-Mason 43- 45.
[73] Beauchamp and Childress 151.
[74] Venter 88.
[75] Venter 88- 89.
[76] Beauchamp and Childress 152- 153. See also Moodley 63-64.
[77] Venter 89- 90.

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limitation of the right to bodily integrity can never outweigh the right to a dignified life[78] or the right of access to health care services.[79] According to Beauchamp and Childress, no absolute ethical rule exists that always favours avoiding harm over providing benefit, therefore prioritising one principle over the other is unsustainable.[80] This is in accordance with the doctrine of double effect, which states that when an act results both in being beneficial and causing harm at the same time, the act might still be regarded as ethically defensible.[81,82]

From the discussion above it is clear that the principle of non-maleficence is not absolute and that it can be justifiably limited.

4.3.3 Beneficence

The word "beneficence" originates from the words *bene* (well or good) and *facere* (to do).[83] However, beneficence does impose a number of moral rules. These include protecting and defending the rights of others, preventing harm to others, removing conditions that will cause harm to others, helping persons with disabilities, and rescuing persons in danger.[84] Beauchamp describes beneficence as "obligations to provide benefits and to balance benefits against risks."[85]

Generally it refers to doing good and the active promotion of goodness, kindness and charity. More specifically referred to in terms of medical law, it refers to the fact that all medical practitioners have a responsibility to provide beneficial treatment and

[78] Sections 10 and 11 of the Constitution, specifically in context of O'Regan's judgment in *S v Makwanyane* 1995 (3) SA 391 (CC).
[79] Section 27(1)(a) of the Constitution.
[80] Beauchamp and Childress 150, supported by Venter 88.
[81] Explained in Beauchamp and Childress 162 and Veatch 2003 97- 98, supported by Venter 93, and also mentioned within the context of the sale of kidneys in Slabbert M *Ethics, justice and the sale of kidneys for transplantation purposes* 2010 13(2) 93.
[82] Beauchamp and Childress lists 4 "necessary conditions" for the doctrine of double effect to result in acceptable action, namely: the nature of the act; the agent's intention; the distinction between means and effects; as well as the proportionality between the good and bad effect, see Beauchamp and Childress 162- 163.
[83] Oxford Dictionaries www.oxforddictionaries.com/definition/english/beneficent (accessed 23 July 2013).
[84] Moodley 57.
[85] Beauchamp 269.

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to avoid or to minimise harm.[86,87] As pointed out earlier, beneficence requires one to take action and help another.[88]

Therefore, it also places an active duty on the state to enable health care workers to do good. In other words, the state has a duty to put in place legislative and other measures necessary for the realisation and enabling of health care workers to do good, thereby enabling the realisation of constitutionally entrenched rights.[89] It is submitted that this duty on the state stems from two sources: the Constitution,[90] as well as ethics, insofar as the principle of beneficence requires action in order to do good.[91] Beneficence thus has an important role to fulfil in medical ethics, especially in the context of enactment of legislation, policies and guidelines.

4.3.4 Justice

The term justice is difficult to define without fault or flaw. Generally, it is defined with words such as fairness,[92] reasonableness, equality and what is right- thus with a sense of entitlement.[93,94] One definition of justice in the context of medical law is that justice is the "obligations of fairness in the distribution of benefits and risks."[95] Beauchamp and Childress differentiate between formal and material justice.[96] According to them formal justice is based on the principle that equals must be treated equally, whilst unequal's must be treated unequally.[97] Material justice is

[86] Moodley 57. See also Dhai and McQuoid-Mason 41.
[87] The principle of beneficence is also embodied in the Constitution, which states in section 27(1)(a) that: "Everyone has the right to have access to- health care services…" For a discussion on benficence and human rights, see Dhai and McQuoid-Mason 41- 43.
[88] Beauchamp and Childress 151.
[89] For an in depth discussion on the states' duty to provide adequate legislative measures in a constitutional context, see the discussion in chapter 5.5.6.
[90] As discussed in chapter 5.5.6.
[91] Beauchamp and Childress 151.
[92] Dhai and McQouid-Mason 45.
[93] Beauchamp and Childress 28.
[94] The principle of justice is also enshrined throughout the Constitution, as a specific right in section 10, as well as a democratic value in sections 7(1); 36(1) and 39(1)(a). For a discussion on justice and human rights, see Dhai and McQuoid-Mason 45- 47.
[95] Beauchamp 269.
[96] Beauchamp and Childress 242- 243.
[97] See also Veatch 2003 125.

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made up of six accepted principles, these being: to each person an equal share, according to need, effort, contribution, merit and free-market exchanges.[98]

One of the most difficult consequences of justice in one case is that it will prevent justice in another case. This is particularly true when it comes down to allocating, setting priorities and rationing available resources.[99] The decision to benefit one cause more often than not results in the detriment of another cause. It thus once again, becomes a balancing act to do the greatest good with limited resources.

Moodley states that a common way of solving this balancing problem is by implementing a method based on the needs of a patient.[100] According to this method, "the greater the capacity to benefit from treatment, the greater the need [is]."[101] This is determined by taking into consideration the approximate amount of years of good quality life the patient will gain from the treatment.[102] This method is supported by the distributive model of justice. However, there are also the implications of rights justice and legal justice to take into consideration. Rights-justice is concerned with human rights (as entrenched in the Constitution and other legislation), whereas legal-justice is concerned with the law and its requirements.[103] There is of course an overlap between these different models of justice. For the purpose of this discussion, however, the main focus will be on distributive justice. In *Soobramoney*[104] the court applied distributive justice to justify the application of guidelines to determine whether a patient will receive renal dialysis or not.[105] The court pointed out that the obligations imposed on the state by section 27 of the Constitution are "…dependent upon the resources available for such purposes, and that the corresponding rights themselves are limited by reason of the lack of resources."[106] It thus appears that the court is in support of distributive justice. However, distributive justice will not always be favoured above other forms of justice.

[98] Beauchamp and Childress 242- 243.
[99] Beauchamp and Childress 267.
[100] Moodley 76.
[101] Moodley 76. Another method that can be used is the application of social utility, where both beneficence and non-maleficence is applied socially and costs are compared to benefits received. This method does however pose quantification problems. Veatch 2003 123- 124.
[102] Moodley 76.
[103] Moodley chapter 8, and Moodley chapter 9 respectively.
[104] *Soobramoney v Minister of Health (Kwa-Zulu Natal)* 1998 (1) SA 765 (CC).
[105] *Soobramoney* 779.
[106] *Soobramoney* 771. Distributing, or allocating, a scarce resource such as transplantable organs is regarded as one of the "most dramatic and contested social ethical issues" today, Veatch 2003 137.

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In *Treatment Action Campaign*[107] relief was granted as the relief directly protected the right to life as entrenched in section 11,[108] thus supporting rights justice instead of relying only on the principles of distributive justice.

From the above it is clear that it is a difficult task to define justice, and therefore, also difficult to determine a just outcome, specifically with regards to organ transplantation.

4.4 Ethical defensibility of each organ procurement method

The four fundamental principles of bioethics, as identified and developed by Beauchamp and Childress[109] have been discussed above. Each of the organ procurement methods already discussed in chapter 3 of this dissertation will now be tested individually against each of these four principles in order to establish whether they are ethically defensible organ procurement methods. This will be determined by looking at the combined compliance with all four principles by each respective organ procurement method, rather than only concentrating on non-compliance with a single principle. It is important to take note that in some cases, the application of these principles may have conflicting results and that one therefore needs to look at the bigger picture in order to determine the ethical defensibility of each procurement method.[110] It is also important to take note that, as already stated earlier, these four principles of bioethics is not an ethical doctrine by itself. However, as these four principles are applied in several of the ethical doctrines, they are used rather than the doctrines themselves, as they can be applied to all the organ procurement methods and because they are merely principles, as opposed to doctrines, they enjoy a much wider scope of application. The discussion that follows is therefore

[107] *Minister of Health v Treatment Action Campaign* (2) 2002 (5) SA 721 (CC). For a more complete discussion on this case, see chapter 5.5.6.
[108] Of the Constitution.
[109] Beauchamp and Childress chapters 4-7.
[110] This bigger picture involves considering these principles together- for example, when looking at both beneficence and non-maleficence together, writers sometimes refer to this as the principle of utility. Veatch 2003 167.

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prognostic as this method of determining the ethical defensibility of organ procurement has not been applied before to this extent in this context.[111]

4.4.1 Opting-in

As pointed out previously,[112] opting-in is based on informed consent as a minimum requirement for organ procurement.[113] From the above discussion on patient autonomy, it was clear that informed consent is one of the cornerstones to achieving patient autonomy.[114] It can thus be concluded that opting-in complies with the principle of patient autonomy in the sense that organs can only be harvested after informed consent has been obtained.[115]

The principle of non-maleficence is being complied with in the sense that no harm is directly being done by using opting-in as an organ procurement method, as it does not *prima facia* limit any rights.

Beneficence requires doing good by taking action.[116] Therefore, knowing that opting-in as an organ procurement system is failing to supply the required number of organs, the principle of beneficence requires one to react to this by finding a better solution. As this has not been done by the state, it can be argued that opting-in does not satisfy the principle of beneficence.[117] However, it could also be argued that opting-in is at least partially complying with the principle of beneficence in that it does good by respecting autonomy, and it does not *prima facie* infringe on any other constitutionally entrenched rights.[118]

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[111] Kidney transplants have been discussed with regard to the four principles of bioethics in chapter 4 of Venter.
[112] In chapter 3.2.1.
[113] For an detailed discussion on opting-in as an organ procurement method, see chapter 3.2.
[114] In chapter 4.2.1.
[115] Unless the prospective donor refrained from expressing his or her wishes, in which case consent is obtained from the family.
[116] According to Beauchamp and Childress 151.
[117] In terms of the duty placed on the state in section 27(2) of the Constitution.
[118] Doing good by respecting autonomy is the result of an overlap of two principles and shows the inter-dependence between these two principles. For a more detailed discussion on whether keeping opting-in as an organ procurement system infringes any constitutional rights, see chapter 5.

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It is difficult to determine whether opting-in as an organ procurement method is just, as justice is very difficult to define. According to legal-justice and rights-justice, opting-in is probably just, as it does not *prima facie* disrespect any law or infringes any rights. However, when one looks at distributive justice the situation is more difficult. One can only distribute available resources, in this case being a very limited amount of transplantable organs. However, if there are ways to ensure that more resources are made available, is will be unjust to disregard this. Therefore, in the context of distributive justice, there is not only a duty to distribute available resources in a fair and just manner, but also to ensure that the optimum amount of resources is indeed procured. Keeping opting-in as organ procurement is therefore unjust, not because of the procurement form itself, but on the basis that it fails to deliver in practise.

From the above discussion it is clear that opting-in , although based of the approved method of requiring informed consent, in a South African context, has failed to successfully procure an adequate amount of transplantable organs and is therefore not ethically defensible, as it doesn't comply with the principles of beneficence and justice.

4.4.2 Presumed consent

Presumed consent as an organ procurement method accepts or makes the rebuttable presumption that all the citizens have given informed consent to be organ donors upon their death, unless proven otherwise.[119]

Presumed consent has been described as "the most outrageously unethical of all possible policies for organ procurement."[120] This is due to the fact that patient autonomy is disregarded when using presumed consent as an organ procurement

[119] For a detailed discussion on presumed consent as an organ procurement method, see chapter 3.3; see also Fourie EJ *An analysis on the doctrine of presumed consent and the principles of required response and required request in organ procurement* (LLM dissertation University of Pretoria 2005); Jacob MA *On silencing and slicing: Presumed consent to post-mortem organ "donation" in diversified societies* Tulsa Journal Comp. & International Law 2003- 2004 247; as well as Healy K *Do presumed-consent laws raise organ procurement rates?* DePaul Law Review 2005-2006 (55) 1017.

[120] Veatch 2000 160.

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method. This is because informed consent is a requirement to achieve true patient autonomy, and in this instance it is clear that no real informed consent was ever obtained.[121] It can be argued that patient autonomy can be realised as there is an opportunity to rebut the presumption of consent. However, this will then only constitute certainty for informed refusal, and the lack thereof can mean informed consent or a total lack of consent together with refraining from making this known. Furthermore, especially in South Africa with many rural areas, it cannot legitimately be presumed that all South Africans are in a position to give informed consent. To enforce an organ procurement method that doesn't require explicit consent can cause both "religious and cultural offence,"[122] which can have far-reaching consequences in a country as religiously and culturally diverse as South Africa.

Non-maleficence requires one to refrain from causing harm. It is evident that harm will be caused by presuming that all South Africans gave informed consent to being regarded as organ donors, unless an objection has been noted. Many South Africans may not even be aware of the possibility of organ transplantation and many more might not register objections as they might not have enough knowledge to be able to make an informed decision.

Presumed consent aims to do good by procuring more organs than can be procured under informed consent (thus seemingly complying with beneficence). However, as this disregards the principle of patient autonomy, the question now becomes whether this amounts to causing harm at the same time? In other words, is the principle of beneficence being complied with? The only reasonable conclusion, specifically in South African context, with due regard to the Constitution, is that presumed consent as an organ procurement method will do more harm than good. It will cause distrust amongst citizens and will lead to inequalities.[123]

Justice will also not be served by using presumed consent as a method of organ procurement in the South African context. Both in terms of rights justice and legal justice citizens will be treated unjustly. The right to freedom and security of the

[121] Supported by Herring J 435.
[122] Dhai and McQuoid-Mason 118, see also Herring 435.
[123] The idea of treating equals equally and unequals unequally an idea that was first introduced by Aristotle and is of significance here. To presume all citizens have given consent to organ donation whilst being fully aware that many citizens are not in a position to make an informed decision, will have the consequence of inequality because unequals were being treated equally.

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person as embodied in section 12(2)(b) of the Constitution, as well as the right to autonomy, will be severely limited. In order for presumed consent to be successful as an organ procurement system, it will need to be a justifiable infringement of the relevant Constitutional rights.[124]

From the discussion it is clear that there are several serious problems with presumed consent being ethically justifiable in the South African context. As these problems are inherent to the procurement method itself, it is therefore submitted that presumed consent is not ethically justifiable as an organ procurement method in South Africa.

4.4.3 Required request

Required request as an organ procurement method places a duty on a certain group, usually employees of a specific state department, to request a person's donor status at a specific event.[125] As required request doesn't place a duty to respond, patient autonomy is in no way infringed. Even if the person does decide to respond, it is out of own choice, and in the case of no choice being recorded, it doesn't lead to any presumption. This organ procurement method does therefore comply with the principle of autonomy.

Non-maleficence is the principle that states one should refrain from doing harm. Sadly, as good as required request seems on paper, this method of organ procurement often results in harm. This is caused by the often unfortunate timing that the request to donate is made: to the patient during his final hours, or to the family, upon death of the prospective donor, often resulting in either a lack of proper consideration, or an immediate negative response.

Required request complies with beneficence as it aims to increase the number of procured organs without diminishing the patients' right to autonomy. Therefore, it has at least the ability to achieve some good.

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[124] Such as the right to equality in s9; the right to human dignity in s10; the right to freedom and security of the person in s12(2)(b); and the right to privacy in s14 of the Constitution.

[125] For a detailed discussion on required request as an organ procurement method, see chapter 3.4.

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The principle of justice does not play a significant role in required request as organ procurement method. As there are not any insoluble injustices done, it might be concluded that this form of organ procurement therefore does comply with the principle of justice, and is therefore ethically justifiable. This submission is however qualified as a more opportune time for the request needs to be determined, in order to minimise harm.

4.4.4 Required response

Required response as an organ procurement method places an active duty on the prospective donor to declare his or her donor status at a predetermined event.[126]

Required response doesn't have a disregard for patient autonomy as it still leaves the choice of donation in the hands of the prospective donor. No presumption whatsoever is made regarding a person's donor status. However, for this organ procurement method to be ethically justifiable it will still need to be implemented in a proper manner. For example, before a person is allowed to become an organ donor, it must be determined whether the person is in a position to make an informed decision. It is submitted that this can be achieved through using a simple questionnaire, preventing the person form becoming an organ donor if informed consent can't be obtained.[127] This will eliminate the need for a medically trained professional to be present when the donor status is declared.

The principle of non-maleficence is being complied with insofar no harm is being done to prospective donors. However, allocating a large number of resources might have a detrimental effect on the society as a whole, and specifically on the health sector if resources are being distributed to other programs. Compliance with non-maleficence therefore relies on using the least possible amount of resources to achieve the goal.

[126] For a detailed discussion on required response as an organ procurement method, see chapter 3.5.
[127] This questionnaire will be discussed in more detail in the final chapter of this dissertation.

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Required response complies with beneficence as it aims to increase the amount of procured organs for transplantation without infringing on the rights of prospective donors.

As far as justice is concerned, this principle is complied with as long as distributive justice is being adhered to. Therefore, just as with non-maleficence, if resources are allocated correctly, justice will be complied with, but if too many resources need to be allocated in order for this organ procurement method to succeed, thereby causing detriment to other programs, the principle of justice will not be complied with.

Required response can be either ethically justifiable or ethically unjustifiable. If it is implemented in the proper manner, and therefore deemed ethically justifiable, it has the ability to address several of the shortcomings of the current organ procurement system.

4.4.5 Sale of organs

There are several academics worldwide advocating for the sale of human organs to be legalised.[128] There are also various proposals as to what may be the best organ sales model. However, all of them have two things in common: the sale of human organs, in exchange for money.[129] This organ procurement method is certainly one of the most fiercely opposed organ procurement incentives out there today. Since the 1980's, several countries enacted legislation prohibiting organ "donation" in exchange for monetary compensation, mainly based on ethical objections.[130]

In considering the ethical defensibility of the sale of organs as an organ procurement incentive, Beauchamp draws a distinction between the justification of policies and the justification of acts and concludes that the justifiability of acts is the more

[128] They include, but are not limited to Slabbert M *Ethics, justice and the sale of kidneys for transplantation purposes* PER 2010 13(2) 77; Kishore RR *Human organs, scarcities and sale: Morality revised* Journal of Medical Ethics 2005 31(6) 362; and Robinson SE *Organs for sale? An analysis of proposed systems for compensating organ providers* University of Colombia Law Review 1999 70 1019.

[129] For a detailed discussion on the sale of organs as an organ procurement method, see chapter 3.6.

[130] Ghods AJ and Sava S *Iranian model of paid and regulated living-unrelated kidney donation* CJASN 2006 1(6) 1136.

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pressing issue.[131] The biggest ethical problem with the sale of kidneys as organ procurement system involves the exploitation it may lead to, caused by either systemic injustice or constraining situations.[132] In the case of systemic injustice, the argument is that the poor or disadvantaged may be used to procure organs for the rich or more fortunate, where the poor themselves will not be able to buy organs and this procurement method does not create a sufficient incentive for the rich and more fortunate to sell organs themselves.[133] The mere fact that the poor might not be able to afford a transplantable organ in itself does not render the sale of organs unethical. This is after all the reality of a world that revolves around money. However, if legalising the sale of organs leads to abolishing organ donation or a decrease in cadaveric organ donation, it would mean that the poor would be even more disadvantaged than they are now. This will of course largely depend on the implementation of the sale of organs as a procurement system.

With regard to rights justice, the argument has been raised that the sale of organs will be an infringement on the right to human dignity. Venter contends that any infringement on dignity should not be considered on its own, but should be considered within perspective.[134] This is supported by section 36 of the Constitution, stating that any limitation of a right contained in the Bill of Rights, must be a justified limitation. It is therefore submitted that Venter's argument thus requires one to consider the factors as listed in section 36 of the Constitution. Venter makes a convincing submission that it is worse to allow a person to die due to a lack of available resources, than to limit dignity by allowing the sale of human kidneys.[135]

Other than systemic injustice, which may not comply with the principle of justice, constraining situations might result in the absence of true patient autonomy.[136] In this instance, the organ seller is "manipulated to the acceptance of offers because of the constraints of their impoverished condition."[137] Beauchamp rightly states that sellers do not need to be completely free from manipulation or other constraining influences

[131] Beauchamp 272.
[132] Beauchamp 272.
[133] Dhai and McQuoid-Mason 119.
[134] Venter 102.
[135] Venter 102.
[136] Dhai and McQuoid-Mason 119.
[137] Beauchamp 272.

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(such as debt), the seller only needs to be free enough to still be able to act in an autonomous manner.[138]

As far as compliance with non-maleficence and beneficence is concerned, it really depends on how this organ procurement method is implemented. If by aiming to do good, harm is caused instead, this procurement method will not be ethically defensible and this situation should thus be avoided at all costs. Should the sale of organs be implemented sufficiently, it may result in the shrinking of black markets and increase the number of transplants. However, if it is implemented in an incorrect manner, it may result in black markets flourishing under the banner of legitimate organ sales or even result in a smaller amount of procured organs, as there is a big possibility that very few people would be willing to donate if they can receive payment instead.

4.4.6 Organ procurement from prisoners

As with the sale of organs, organ procurement from prisoners has been largely condemned. Organs procurement from prisoners can be in the form of either live donation or cadaveric donation.[139]

In the case where organs from prisoners are automatically donated after death, the principle of patient autonomy is being completely disregarded. Here, neither the prisoner, nor his family has any say in determining whether his organs are donated or not.

This is one of the cases where trying to do good (by increasing the amount of procured organs for transplantation), results in doing bad (by rewarding prisoners with no guarantee that they will not change their minds regarding donation). In this case, neither beneficence (to do good), nor non-maleficence (to refrain from doing harm), is being complied with.

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[138] Beauchamp 273.
[139] For a detailed discussion on organ procurement from prisoners as an organ procurement method, see chapter 3.7.

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Using a reduced sentence as incentive for organ procurement, as far as the principle of justice is concerned, rewarding prisoners for donating organs seems inherently unjust for two reasons: firstly, prisoners are being rewarded whilst others who make the exact same donation aren't, thus giving prisoners preferential or unequal treatment; and secondly, these prisoners are in effect being rewarded for committing a crime, if the crime had not been committed they would not have been eligible for the reward.

From the discussion it is clear that organ donation from prisoners is not an ethically justifiable organ procurement method, regardless of which model is used. Should prisoners want to donate organs, they must do so in accordance with law that applies to all prospective donors.

4.5 Conclusion

It is clear that one cannot take a comprehensive look at medical law without taking into account the relevant principles of ethics. This also holds true specifically in the context of organ procurement methods. As medical ethics involve a critical analysis of choice- making that is based on *inter alia* legal, moral, religious and philosophical values and principles, it is a difficult balancing act to satisfy all these criteria. It is submitted that for an organ procurement method to succeed, it must *inter alia* be ethically defensible.

On the other hand, however, just because an organ procurement method is ethically defensible does not mean it will be a successful organ procurement method. This can clearly be derived from the lack of success of the current organ procurement method, opting-in. The key to finding the best organ procurement method seems to be the consideration of all the relevant factors to each procurement method, both positive and negative, and then identifying the method that complies best with all these factors. It must thus at the very least be a method that is not completely disqualified by any one of the relevant criteria, whilst keeping in mind the influence of all four principles of bioethics. The overall benefit must therefore be weighed against the possible harm done by not complying with each of the four principles of bioethics.

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It has been determined in this chapter that opting-in, even though overall ethically defensible, has failed as an organ procurement system and to continue using it will be ethically indefensible as it no longer complies with the principles of beneficence and justice. Presumed consent fails to comply completely with any of the four principles of bioethics and is therefore not ethically defensible as an organ procurement method. Required request is deemed ethically defensible as it complies, at least *prima facie,* with all four principles, with the qualification that it has to be implemented in the correct manner. Required response, is difficult to label as either ethically defensible or not. There are elements of this organ procurement system that might be problematic, however if implemented in a proper manner it will be ethically defensible and solves several of the shortcomings of the current organ procurement method. The sale of organs has traditionally met fierce opposition, mainly based on ethical grounds. Many of the criticisms have nevertheless been disproved over the years and although there are several areas that could be problematic, none of them seems insoluble. Organ procurement from prisoners is ethically indefensible, regardless of which of the four principles is considered.

It is submitted that finding the appropriate organ procurement method relies on much more than ethical consideration alone. Due regard needs to be given to all the relevant factors, which includes the chances of success in a South African context as discussed in chapter three, as well as the implications of the Constitution, which will be discussed in chapter five. However, at the very least this chapter enabled the writer to disqualify certain organ procurement methods as ethically defensible organ procurement methods, thereby narrowing the scope of possible organ procurement systems. At the end of this chapter, only required request, required response, and the sale of organs remain as viable options for an organ procurement method. It is however essential to bear in mind that the organ procurement method will still need to be based on informed consent.

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CHAPTER 5

THE CONSTITUTIONAL INFLUENCE ON ORGAN TRANSPLANTS

5.1 Introduction

According to section 2 of the Constitution of South Africa, 1996,[1] the Constitution is the supreme law in the Republic of South Africa, to the extent that any law or conduct inconsistent with the Constitution is invalid. It is therefore clear that no attempt to alter the existing law can be successful without giving due consideration to the rights and values entrenched in the Constitution.[2]

To determine whether a certain constitutional right is being adhered to in the context of medical law, it is necessary to follow a multi-layered approach where one first looks at the Constitution, then at relevant legislation, the common law, case law as well as the relevant principles of medical ethics.[3] It is thus essential to take into account all the different forms of law when dealing with any constitutionally entrenched right.

The Bill of Rights[4] lists all the rights entrenched in the Constitution. In addition, it deals with the application,[5] limitation[6] and interpretation[7] thereof. The aim of this chapter is to determine the influence that the Constitution has on the law pertaining to organ transplants. For purposes of this chapter, it is thus necessary to identify the following: the specific rights involved with the research topic; the scope of these rights; including the application of the Bill of Rights; the interpretation thereof; if these rights are justifiably limited under the current legislation; if these rights can be justifiably be limited in terms of proposed amendments to the current legislation as

[1] Hereinafter "the Constitution".
[2] Currie I and De Waal J *The Bill of Rights Handbook* 2005 7-8. Carstens PA and Pearmain D *Foundational principles of South African medical aw* 2007 10.
[3] For a more detailed explanation of the multi-layered approach, see Carstens and Pearmain 1- 2.
[4] Found in Chapter 2 of the Constitution.
[5] Section 8 of the Constitution.
[6] Section 36 of the Constitution.
[7] Section 39 of the Constitution.

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well as identifying any other aspects relevant thereto. In doing this; it is important to keep in mind that the provisions in the Constitution have in many cases deliberately been formulated very broadly,[8] thus leaving the interpretation thereof to the Constitutional Court and academics. The Constitution thus doesn't interpret itself and the interpretation of its provisions largely lies with the interpreter thereof.

The writer thus proceeds to deal with the application, limitation and interpretation of the rights in the Bill of Rights in general. Thereafter, each of the applicable rights is discussed separately with reference to legislation where applicable, considering the scope, interpretation and possible limitation of the specific right. A discussion of the development of relevant case law and its consequences is also included.

5.2 The application of the Bill of Rights

Before one can take a look at the different individual rights in the Bill of Rights, one must have an understanding of when the Bill of Rights can be applied to begin with. Section 8 of the Constitution states that:

> "(1) The Bill of Rights applies to all law, and binds the legislature, the executive, the judiciary and all organs of state.
> (2) A provision of the Bill of Rights binds a natural or a juristic person if, and to the extent that, it is applicable, taking into account the nature of the right and the nature of any duty imposed by the right.
> (3) When applying a provision of the Bill of Rights to a natural or juristic person in terms of subsection (2), a court-
> (a) in order to give effect to a right in the Bill, must apply, or if necessary develop, the common law to the extent that legislation does not give effect to that right; and
> (b) may develop rules of the common law to limit the right, provided that the limitation is in accordance with section 36 (1).
> (4) A juristic person is entitled to the rights in the Bill of Rights to the extent required by the nature of the rights and the nature of that juristic person."

It is important to note that the application of the Bill of Rights can be categorised into various groups: It can be applied either directly or indirectly,[9] vertically between the

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[8] For instance section 11, merely stating that: "Everyone has the right to life."

[9] Currie and De Waal 32. The Bill of Rights is applied directly, when the right of a beneficiary has been infringed by someone with a duty not to infringe the right. For more on the direct application

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state and an individual or horizontally between individuals.[10,11] The Bill of Rights is binding on the legislature, the executive, the judiciary, all organs of state,[12] natural persons as well as juristic persons[13] (to the extent required by the nature of the rights and the juristic person).[14,15] From this it is clear that the Bill of Rights enjoys wide application.

There are two facts mentioned above that are of particular importance for the purposes of this discussion. Firstly, the fact that the Bill of Rights binds the state deserves further discussion. "Section 8(1) binds all organs of state in all spheres of government to comply with the Bill of Rights."[16] Organs of state are expressly defined in section 213 and include:

> "(a) any department of state or administration in the national, provincial or local sphere of government; or
> (b) any other functionary or institution –
> (i)exercising a power or performing a function in terms of the Constitution or a provincial constitution; or
> (ii)exercising a public power or performing a public function in terms of any legislation…"[17]

The Department of Health, for example, would thus qualify as an organ of state, as would public hospitals. In the context of socio-economic rights, these are the organs of state involved with and influenced by medical law, together with the legislature. This brings us to the second fact that deserves further discussion: the fact that the

of the Bill of Rights, see Currie and De Waal 35-64. When the Bill of Rights is applied indirectly, it is applied during the interpretation, development or application of the common law or legislation. For more on the indirect application of the Bill of Rights, see Currie and De Waal 64-72.

[10] Currie and De Waal 43-55.

[11] The court explained the difference between the vertical and horizontal application of the Bill of Rights in *Du Plessis and Others v De Klerk and Another* 1996 (3) SA 850 (CC) 861: "The term "vertical application" is used to indicate that the rights conferred on persons by a bill of rights are intended only as a protection against the legislative and executive powers of the state in its various manifestations. The term "horizontal application" on the other and indicates that those rights also govern the relationships between individuals, and may be invoked by them in their private law disputes."

[12] Section 8(1) of the Constitution. Cheadle is of the opinion that 'all law' for the purposes of section 8(1) includes legislation, common law rules as well as customary law. Cheadle, Davis, Haysom (eds) *South African Constitutional Law: The Bill of Rights* 2005 2nd ed 3-10, 3-15.

[13] Section 8(2) of the Constitution.

[14] Section 8(4) of the Constitution.

[15] Cheadle states that the primary function of a constitution is to both empower and restrain the state in various aspects. Cheadle *et al* 3-2.

[16] Cheadle *et al* 3-15.

[17] Section 213 of the Constitution.

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Bill of Rights is binding on the legislature.[18] If any legislation does not comply with the Bill of Rights, it must be declared invalid, according to section 172(1) of the Constitution.[19] This has the consequence that legislation can be tested against the Bill of Rights, and if found inconsistent with the Constitution have the consequence of being declared invalid.

For the purposes of this study, as it deals primarily with the current legislation regarding organ transplantation, as well as the lack thereof, together with possible amendments that will have to be tested against the Constitution and enforced by the Department of Health and hospitals, the Bill of Rights will almost always be applicable.

5.3 The limitation clause[20]

The limitation clause makes provision for the rights in the Bill of Rights to be limited. However, to be a valid limitation, a list of requirements must be met. Section 36 of the Constitution states that:

> "1) The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including:
> a) the nature of the right;
> b) the importance of the purpose of the limitation;
> c) the nature and extent of the limitation;
> d) the relation between the limitation and its purpose; and
> e) less restrictive means to achieve the purpose.
> 2) Except as provided in subsection (1) or in any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights."

Prima facie, it is clear that the rights in the Bill of Rights can be limited and are thus not absolute.[21] However, to be a valid limitation the abovementioned requirements

[18] Section 8(1) of the Constitution.
[19] Section 172(1) states that: "When deciding a constitutional matter within its power, a court- (a) must declare that any law or conduct that is inconsistent with the Constitution is invalid to the extent of its inconsistency; and (b) may make any order that is just and equitable…"
[20] Section 36 of the Constitution.
[21] Section 36(1) of the Constitution.

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have to be met. The fact that rights in the Bill of Rights may only be limited in terms of law of general application can be both positive and negative. On the positive side, it eliminates the possibility of discrimination and inequality. On the negative side, it creates one very big question: What happens when an individual wants to limit his or her Constitutional rights? Does this constitute an unjustifiable limitation on the grounds that it is not in terms of law of general application, or are there now other rules at play?

The first requirement is that the limitation must be made in terms of law of general application. Although "law" itself hasn't been interpreted by the Constitutional Court, it seems that "law of general application" includes all forms of legislation, the common law,[22] as well as customary law.[23,24]

As mentioned above, if the limitation is not a limitation in terms of law of general application, the limitation clause will not be applicable. The question is thus: can a right in the Bill of Rights be limited by other means than the limitation clause, and if so, what are these means and to what extent can these rights then be limited? In other words, can an individual limit his or her own constitutional rights validly by choice, even if it is not under law of general application?

To find the answer to this question, one must look for law that either permits the action in question, or confirm the lack of a prohibition against the action. The answer to this is brilliant, yet simplistic. When legislation does not provide for certain situations, one must always return to the provisions of the common law. It is important to keep in mind that courts must apply or if necessary develop the common law to the extent that legislation does not give effect to the applicable right.[25]

It is however possible to make the argument that using a common law defence to justify the limitation of rights is in fact, law of general application, consequently this will in fact fall within the scope of the limitation clause. This is in line with the

[22] Currie and De Waal 169.
[23] *Du Plessis v De Klerk*.
[24] This view is shared by Cheadle *et al* 30-9.
[25] Section 8(3) of the Constitution.

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beginning of section 36(1), stating that: "The rights in the Bill of Rights may be limited *only* in terms of…"[26]

It thus seems that the only valid limitation of rights in the Bill of Rights will be in terms of law of general application, which includes legislation, the common law and customary law.[27]

Once it has been established that the limitation in question is in fact through law of general application, it must be shown that the limitation is both reasonable and justifiable in an open and democratic society that is based on the values of equality, human dignity and freedom, by taking into account the factors set out in section 36(1)(a)-(e). Currie and De Waal state that "[t]he reasons for limiting a right need to be exceptionally strong."[28] They contend that section 36 has the consequence of not only requiring an important purpose for the valid limitation of rights in the Bill of Rights, but that the restriction must also be able to achieve its purpose and that no other realistic solution exists that is able of achieving the same purpose without the limitation or by means of a lesser limitation.[29]

To determine whether the limitation of a right in the Bill of Rights is justifiable it needs to be determined in accordance with the provisions set out in section 36. This is done in two stages: firstly, it must be determined whether a constitutionally entrenched right has indeed been limited. Secondly, it has to be determined whether the infringement can be justified.[30] This is done by considering the factors listed in section 36(1)(a)-(e). These factors must rather be viewed as a balancing act than a check-list.[31] This balancing act requires an assessment that is based on proportionality.[32] In balancing conflicts between rights, the court uses dignity as a primary mechanism to resolve these conflicts.[33] It is therefore not non-compliancy with one of these factors that results in the limitation being unreasonable in terms of section 36 of the Constitution, but rather the collective effect of all these factors taken together. The limitation of each of the specific rights will be addressed later, in

[26] Writer's own emphasis.
[27] Currie and De Waal 169.
[28] Currie and De Waal 164.
[29] Currie and De Waal 164.
[30] Currie and De Waal 166.
[31] *S v Manamela* 2000 (3) SA 1 (CC) 19.
[32] Devenish GE *The South African Constitution* 2005 182.
[33] Botha H *Human dignity in comparative perspective* Stell LR 2009 2 215.

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paragraphs 5.5.1- 5.5.6, dealing with the applicable rights in the Bill of Rights on an individual basis.

5.4 The interpretation of the Bill of Rights

In order to ascertain the meaning of a provision in the Constitution, the provision needs to be interpreted according to the rules of interpretation.[34] Currie and De Waal identify two stages of interpretation: firstly, determining the meaning or the scope of a right, and secondly, whether the challenged law or conduct is in conflict with the right.[35] Section 39 of the Constitution regulates the interpretation of the Bill of Rights and states that:

> "(1) When interpreting the Bill of Rights, a court, tribunal or forum-
> (a) must promote the values that underlie an open and democratic society based on human dignity, equality and freedom;
> (b) must consider international law; and
> (c) may consider foreign law.
> (2) When interpreting any legislation, and when developing the common law or customary law, every court, tribunal or forum must promote the spirit, purport and objects of the Bill of Rights.
> (3) The Bill of Rights does not deny the existence of any other rights or freedoms that are recognised or conferred by common law, customary law or legislation, to the extent that they are consistent with the Bill."

Although interpreting the Constitution will be in many ways the same as interpreting any other text, it is still a unique document in many ways and there are additional factors that that need to be taken into account. These factors include the history leading to and resulting in the Constitution being drafted and the circumstances under which it was drafted. Also, the fact that there are core values entrenched in the Bill of Rights, namely equality, human dignity, and freedom, that needs to be promoted whenever the Bill of Rights is interpreted. This is also known as the so-called purposive interpretation and can help to give more content to broadly

[34] For general introductory rules on interpretation, see Botha CJ *Statutory interpretation: an introduction for students* 2012. For more on constitutional interpretation, see Currie and De Waal 145-162; see also De Ville JR *Constitutional and statutory interpretation* 2000.
[35] Currie and De Waal 145.

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formulated rights.[36] Further aid can also be found in previous judgments of the Constitutional Court as well as in both international and foreign law.

Care must be taken to adhere to the obligations created by section 39. They are, *inter alia,* that the three core values[37] *must* be promoted,[38] that international law *must* be considered when interpreting the Bill of Rights,[39] and that the spirit, purport and objects of the Bill of Rights *must* be promoted when dealing with legislation, the common law or customary law.[40] In the end, the interpretation of the provisions of the Constitution is the task of the judiciary, and more specifically the judges of the Constitutional Court.

5.5 Specific rights

There are various constitutionally entrenched rights that are specifically important in the context of organ transplants and more specifically, organ procurement methods. The writer thus proceeds to deal with each of these applicable rights separately, considering the scope, interpretation and possible limitation of each specific right. Relevant case law is also discussed and the significance thereof pointed out. Consequently the influence of the Constitution on organ transplantation is discussed under each paragraph respectively.

5.5.1 Equality[41]

Section 9 of the Constitution states that:

> "(1) Everyone is equal before the law and has the right to equal protection and benefit from the law.
> (2) Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures

[36] Currie and De Waal 148.
[37] Equality, human dignity and freedom.
[38] Section 39(1)(a) of the Constitution.
[39] Section 39(1)(b) of the Constitution.
[40] Section 39(2) of the Constitution.
[41] Section 9 of the Constitution.

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> designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination may be taken.
> (3) The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.
> (4) No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3). National legislation must be enacted to prevent or prohibit unfair discrimination.
> (5) Discrimination on one or more of the grounds listed in subsection (3) is unfair unless it is established that the discrimination is fair."

This section is extremely important, as it clearly states that the state may not discriminate directly or indirectly against anyone on *inter alia* grounds of religion, belief or culture.[42]

South Africa is known as a multi-cultural country with people from various religions, beliefs and cultures calling it home.[43] This can be very problematic for the legislature when enacting legislation that cannot discriminate on any of the grounds listed in section 9. Legislation has to accommodate all the various religions and cultures, enabling members to practise their choice of religion freely, without unreasonably limiting the rights of others or placing a burden on them.[44]

Furthermore, section 9(1) places everyone as equal before the law and gives everyone the right to equal protection and benefit from the law. Any legislation thus enacted by the legislature must allow for the equal benefit of the rights contained therein and make provision to achieve the realisation of these rights.[45] Even if legislation makes provision for organ donation without *prima facie* discriminating against a specific group, it might still not comply with section 9(1). This is indeed the case with the current organ procurement system, opting-in, as it is unsuccessful in obtaining enough organs to meet the required demand.[46] Therefore, although there is currently legislation making provision for organ donation,[47] as it does not have the

[42] Section 9(3) of the Constitution.
[43] The Preamble of the Constitution states that South Africans are "united in our diversity".
[44] To give effect to section 9, the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 was enacted.
[45] The right to equality thus protects the ethical principle of justice, and specifically rights justice. For more on the ethical principle of justice, see chapter 4.3.4.
[46] For more on organ procurement methods, and the shortcomings of opting-in as an organ procurement method, see chapter 3.
[47] Namely, the National Health Act 61 of 2003.

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ability to provide enough organs to meet the demand it cannot satisfy the requirements of equal protection and equal benefit as set out in section 9(1). Ackermann is of the opinion that there will be a violation of section 9(1) if the differentiation or *lacuna* (in this case) does not have a "rational connection to a legitimate government purpose".[48,49]

The importance of the interrelation between equality and human dignity must not be underestimated. "[H]uman dignity is the *criterion of reference* or the *criterion of attribution* essential to the understanding of equality."[50] With this statement, Ackermann argues that equality, as a legal concept, can't fully make sense when being applied to human beings unless a criterion of reference or attribution is used to determine *in respect of what* are human beings equal.[51] He strongly suggests that human dignity or human worth must be the criterion of reference or attribution.[52] Therefore the right to equality must be viewed together with the right to human dignity.[53,54]

5.5.2 Human dignity[55]

Section 10 of the Constitution states that:

"Everyone has inherent dignity and the right to have their dignity respected and protected."[56]

The idea of inherent dignity or intrinsic worth is the key to fully understand the concept of human dignity.[57] To Ackermann:

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48 *Prinsloo v Van der Linde and Another* 1997 (3) SA 1012 (CC) 1024-1025.
49 Ackermann *Human dignity: Lodestar for equality in South Africa* 2012 182.
50 Ackermann 30. 2 212- 214.
50 Section 10 of the Constitution.
51 Ackermann 85.
52 Ackermann 85.
53 In *Prinsloo v Van der Linde* the court held that any infringement on human dignity as a result of unequal treatment will be regarded as *prima facie* unfair discrimination in terms of section 9, *Prinsloo v Van der Linde* 1026. See also Devenish 62.
54 Botha 212- 214.
55 Section 10 of the Constitution.
56 Section 10 thus mentions dignity in two ways: firstly, as inherent to all human beings, and secondly, as an enforceable right. "However much the *right to dignity* may suffer infringement in an imperfect world, the inherent dignity that everyone *has* cannot be destroyed." Ackermann 95.

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> *"[t]he human worth (dignity) of each and every person is the capacity for and the right to respect as a human being… which in turn separate humans from the impersonality of nature, enables them to exercise their own judgment, to have self-awareness and a sense of self-worth, to exercise self-determination, to shape themselves and nature, to develop their personalities and to strive for self-fulfilment in their lives."*[58]

Human dignity thus needs to be viewed in the context of daily human life, where dignity is achieved by individuals in their individualism. In their daily life, thoughts, choices and actions humans live out their human dignity.[59]

When interpreting the Bill of Rights, one "must promote the values that underlie an open and democratic society based on human dignity, equality and freedom".[60] Dignity is further enshrined in section 7(1)[61] as well as being one of the founding values of the Republic of South Africa,[62] and thus enjoys ample protection under the Constitution. Throughout the Constitution, dignity is mentioned in a total of 8 different sections.[63] In these sections, it functions as a first order rule,[64] a second order rule,[65] a correlative right,[66] as well as a value.[67] The right to human dignity is thus one of the core values entrenched in the Constitution.[68]

This is in line with the dictum made by O'Regan in *Dawood*:[69]

> "Human dignity therefore informs constitutional adjudication and interpretation at a range of levels. It is a value that informs many, possibly all, other rights… Human dignity is also a constitutional value that is of central significance in

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[57] Botha 197.
[58] Ackermann 23-24.
[59] Dignity gives effect to the ethical principle of non-maleficence, meaning to refrain from causing harm, Dhai and McQuoid-Mason 44. Dignity further protects the ethical principle of justice, and more specifically rights justice, Dhai and McQuoid-Mason 46. For more on the ethical principle of justice, see chapter 4.3.4.
[60] Section 39(1)(a) of the Constitution.
[61] Section 7(1) reads: "This Bill of Rights is a cornerstone of democracy in South Africa. It enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom."
[62] Section 1 of the Constitution reads: "The Republic of South Africa is one, sovereign, democratic state founded on the following values: (a) Human dignity, the achievement of equality and the advancement of human rights and freedoms."
[63] Dignity is entrenched in sections 1; 7(1); 10; 36(1); 39(1); 165(4); 181(3) as well as section 196(3) of the Constitution.
[64] Woolman *et al Constitutional law of South Africa* 2012 2nd ed 36-19-20.
[65] Woolman 36-20-21.
[66] Woolman 36-21-22.
[67] Woolman 36-22-25; 36-19-25. See also Goolam N *Human dignity – our supreme Constitutional value* PER 2001 4(1) 43.
[68] Devenish 61.
[69] *Dawood & Another v Minister of Home Affairs and Others* 2000 (3) SA 936 (CC).

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> the limitations analysis. Section 10, however, makes it plain that dignity is not only a value fundamental to our Constitution, it is a justiciable and enforceable right that must be respected and protected. In many cases however, where the value of human dignity is offended, the primary constitutional breach occasioned may be of a more specific right…"[70]

Defining the term dignity is much harder than establishing its importance.[71] Currie and De Waal rightly state: "Though we can be certain of the pivotal importance of human dignity in the Constitution we can be less certain of the meaning of the concept."[72] Woolman attempts to define dignity by identifying five primary definitions of dignity.[73]

An important facet of dignity is the right to self-actualization.[74] Ackermann J describes how dignity and freedom is necessary to achieve self-actualization:

> "Human dignity cannot be fully valued or respected unless individuals are able to develop their humanity, their 'humanness' to the full extent of its potential… An individual's human dignity cannot be fully respected or valued unless the individual is permitted to develop his or her unique talents optimally. Human dignity has little value without freedom; for without freedom personal development and fulfilment are not possible. Without freedom, human dignity is little more than an abstraction. Freedom and dignity are inseparably linked. To deny people their freedom is to deny them their dignity."[75]

Another noteworthy aspect is the fact that the courts do not only view dignity on an individualistic basis, but also as a communal characteristic.[76] This approach is clearly voiced in *Port Elizabeth Municipality v Various Occupiers*:[77]

> "It is not only the dignity of the poor that is assailed when homeless people are driven from pillar to post in a desperate quest for a place where they and their families can rest their heads. Our society as a whole is demeaned when state action intensifies rather than mitigates their marginalisation."[78]

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[70] *Dawood* 961-962.
[71] Botha 200- 201.
[72] Currie and De Waal 273.
[73] The five primary definitions of dignity, as identified by Woolman, are: 1) Individual as an end-in-herself; 2) Equal concern and equal respect; 3) Self-actualization; 4) Self-governance and 5) Collective responsibility for the material condition of agency. Woolman 36-7; 36-10-12 and 36-14.
[74] Woolman 36-11. This facet of human dignity therefore allows the individual to act autonomously.
[75] *Ferreira v Levin* 1996 (1) SA 984 (CC) 1013-1014.
[76] Botha 204- 205.
[77] 2005 (1) SA 217.
[78] *Port Elizabeth* 227. See also *Khoza v Minister of Social Development* 2004 (6) SA 505 (CC) 538, where the court notes that the personal well-being of the wealthier members in a community is dependent on the on the minimum well-being of the poor.

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Dignity must thus be viewed as more than mere duties owed to individuals by the state, it also has to be seen as a form of collective good, where dignity arise from mutual recognition between individuals.[79,80]

In *S v Williams*[81] the Constitutional Court held that "It is therefore reasonable to expect that the State must be foremost in upholding those values which are the guiding light of civilised societies. Respect for human dignity is one such value…"[82] There is thus a duty on the state to ensure that dignity is not left behind when important decisions are made by the State or any organ of State.[83,84]

The Constitutional Court held in *Grootboom,* in the context of the right to housing in terms of section 26 of the Constitution that:

> "Section 26, read in the context of the Bill of Rights as a whole, must mean that the respondents have a right to reasonable action by the state in all circumstances and with particular regard to human dignity. In short, I emphasise that human beings are *required* to be treated as human beings."[85]

This judgment is in line with the judgment in *S v Williams.* Woolman contends that the "brief history of our new-found ability to recognize the inherent dignity[86] of our fellow South Africans is meant to suggest how the extension of this right progresses from mere duties of justice to duties of virtue that have as their aim the qualitative perfection of humanity."[87] This is an appealing thought in the sense that it establishes a movement back to one of the oldest forms of ethics in the Western world, namely virtue ethics.[88] The earliest writings on virtue ethics come from the well-known Greek Philosopher, Aristotle, and it was widely revived in the 20th

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[79] Woolman 36-15. Dignity can therefore be achieved by adhering to the principle of beneficence, in other words, by doing good. For more on beneficence, see chapter 4.4.3.
[80] This also illustrates the need of tolerance required by dignity, Goolam 48-49.
[81] 1995 (3) SA 632 (CC).
[82] *S v Williams* 655.
[83] Goolam 46, see also Devenish 63.
[84] Any reduction or limitation if individual liberty for the sake of the collective good must, however, be justified in terms of the limitation clause. Devenish 63.
[85] *Government of the Republic of South Africa & Others v Grootboom & Others* 2001 (1) SA 46 (CC) 83. Own emphasis added.
[86] The notion of inherent dignity is an important one, as it reaffirms that every human being has intrinsic worth, Liebenberg S *The value of human dignity in interpreting socio-economic rights* SAJHR 2005 21 1 6-7.
[87] Woolman 36-2.
[88] Moodley 20.

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century.[89] It requires one to consider the character and virtue that the doer acted with and thus looks at the subjective mind, intentions and attitude of the doer, rather than merely considering the act itself.

Dignity's relationship to the different substantive rights in the Bill of Rights will influence and shape our understanding thereof.[90] Even if the basic idea of what dignity entails stays the same, it will be examined by looking through a different coloured lens. As O'Regan observes in *Dawood:*

> "Section 10, however, makes it plain that dignity is not only a *value* fundamental to our Constitution, it is a justiciable and enforceable *right* that must be respected and protected. In many cases, however, where the value of human dignity is offended, the primary Constitutional breach occasioned may be of a more specific right such as the right to bodily integrity…"[91]

This indicates that both in general, and more specifically in the context of medical law, if the infringement could be addressed under another right, that is how it should be done and dignity will then only function as a value that informs the right, rather than a right on its own.[92] If, for instance, an infringement of a persons' right to dignity is also an infringement under section 12(2)(b) or section 27 of the Constitution, the case should be brought on one of the latter sections, and not on section 10.[93] This, however, does not lead to dignity being less important in the matter. Dignity remains a value that must be taken into consideration when dealing with the Bill of Rights.[94] The court in *Carmichele v Minister of Safety and Security*[95] stated that the courts obligation to develop the common law is not discretionary, and that the courts have a "general obligation" to develop the common law where necessary.[96] The court went so far to say that courts might in certain circumstances be obliged to raise this matter on its own.[97] Furthermore, the values in the Constitution must "guide the

[89] Moodley 29.
[90] Woolman 36-25.
[91] *Dawood* 962. See also Botha 198- 199 for a discussion on the different applications of dignity as a right and dignity as a value.
[92] Woolman 36-22.
[93] Botha 198.
[94] For this reason, more is said on dignity in the context of specific other rights in the Bill of Rights throughout this chapter.
[95] *Carmichele v Minister of Safety and Security* 2001 (4) SA 938 (CC).
[96] *Carmichele* 322.
[97] *Carmichele* 322.

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development of all areas of law."[98] The most significant finding of the court was that there rests a positive duty on the state to protect the rights in sections 10, 11 and 12 of the Constitution.[99, 100] Merely refraining from infringing these rights will therefore not always be sufficient.[101] The state must actively protect the rights to dignity, life and freedom and security of the person.

As can be seen from the discussion under the right to life in terms of section 11,[102] the rights to life and human dignity are intertwined and dependent on one another. Without life, there can't be dignity. However, without dignity, there can be no *human life* possible.[103] O'Regan J held that dignity "is the foundation of many of the other rights that are specifically entrenched…"[104] Chaskalson agrees in the same case by contending that:

> "The rights to life and dignity are the most important of all human rights, and the source of all other personal rights in [the Bill of Rights]. By committing ourselves to a society founded on the recognition of human rights we are required to value these two rights above all others. And this must be demonstrated by the state in everything it does…"[105]

Carstens and Pearmain state that: "Health is an essential for life and for human dignity… The capacity for the enjoyment of the rights to life and human dignity is obviously significantly diminished by poor health."[106] From this quotation it is thus clear that having good health, or at the very least access to health care, can promote the rights to life and human dignity. In the context of organ transplantation, human dignity is thus one of the most important rights to adhere to. It is important that the process of organ transplantation as a whole needs to be dignified, thus every step needs to respect the various role-player's right to dignity. This means that the method of organ procurement, the consent needed, the manner in which consent is obtained, the allocation procedures, the harvesting method, care and treatment after the transplant has been completed, as well as any other aspect relevant to organ

[98] *Carmichele* 227. See also Botha 200.
[99] Namely, the rights to to life, dignity, and freedom and security of the person.
[100] *Carmichele* 324. See also Botha 200.
[101] Botha 200.
[102] *S v Makwanyane and Another 1995* (3) SA 391 (CC) 506.
[103] *Makwanyane* 506.
[104] *Makwanyane* 440-441.
[105] *Makwanyane* 451.
[106] Carstens and Pearmain 29.

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transplants, need to be conducted in a manner as dignified as is possible. This is in line with one of the requirements for the valid limitation of any right in terms of section 36, namely that less restrictive means to achieve the purpose must at least have been considered in order for a Constitutionally entrenched right being justifiably limited.[107]

From the discussion above, it is clear that the influence of the Constitution is of paramount importance in any discussion on law relating to organ transplants. What is just as clear is that the different rights in the Bill of Rights can be in conflict with one another. The same is true for values such as human dignity, equality and freedom, to the extent that where these values inform specific rights, the content of one value can be very different in the context of different rights. One example is that dignity as a value, might require that one may not be refused life-saving treatment if it exists in the context of the right to life. Contrary to this, dignity might determine that the state should not save a few lives by granting everyone unqualified access to expensive medical procedures, which in turn could result in the collapse of the public health sector. It thus becomes a balancing act between the conflicting rights and the application of the limitation clause to find the best solution to the problem at hand.[108] This is no easy or clear-cut task and trying to predict how the courts will handle such an issue remains pure speculation.

However, the various rights in the Bill of Rights do not only stand in conflict with another. To the contrary, they usually support and enhance one another. This is particularly true for dignity when it functions as a value, as it informs almost all the other rights in the Bill of Rights to some extent.[109]

Venter asks two very important questions: “[C]an any human dignity exist in relation to renal dialysis? Can any human dignity be lost when a kidney donor receives a form of remuneration for the donation of his kidney?”[110]

It has been argued that a patient receiving renal dialysis is not leading a dignified and humane life.[111] However, even if the treatment might not be purely humane or

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[107] Section 36(1)(e) of the Constitution.
[108] *Manamela 19.*
[109] *Dawood* 961-962.
[110] Venter B *A selection of constitutional perspectives on human kidney sales* (LLM thesis, University of South Africa 2012) 38.

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dignified, receiving renal dialysis must certainly be more humane and dignified than not receiving treatment at all, especially when the purpose of the treatment is taken into account. On the other hand, the most dignified option would be to receive an organ as soon as possible and thus spend as little time as possible on dialysis. One proposed solution is to allow the sale of organs. From the above discussion, it can be derived that there are arguments based on the right to human dignity both in favour of and against allowing the sale of organs.

5.5.3 Life[112]

Section 11 of the Constitution grants everyone an unqualified right to life by simply stating that: "Everyone has the right to life."

This constitutionally entrenched right, although only six words in length, is perhaps the most important right of all. Without life, all other rights become almost instantly worthless, with very few exceptions to this general rule.[113] The right to life is comprehensively discussed by the Constitutional Court in *Makwanyane*. O'Regan J stated:

> *"The right to life is, in one sense, antecedent to all the other rights in the Constitution.* Without life in the sense of existence, it would not be possible to exercise rights or to be the bearer of them. But the right to life was included in the Constitution not simply to enshrine the right to existence. *It is not life as mere organic matter that the Constitution cherishes, but the right to human life: the right to live as a human being, to be part of a broader community, to share in the experience of humanity. This concept of human life is at the centre of our constitutional values.* The constitution seeks to establish a society where the individual value of each member of the community is recognised and treasured. The right to life is central to such a society. The right to life, thus understood, incorporates the right to dignity. *So the rights to human dignity and life are entwined. The right to life is more than existence, it is a right to be treated as a human being with dignity: without dignity, human life is substantially diminished*. Without life, there cannot be dignity. This was recognised by the Hungarian constitutional court in the case in which it considered the constitutionality of the death penalty:

[111] Venter 38.
[112] Section 11 of the Constitution.
[113] For instance, the rights to dignity and privacy are respected and protected even after death in the form of doctor-patient confidentiality.

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> `It is the untouchability and equality contained in the right to human dignity that results in man's right to life being a specific right to human life (over and above animals' and artificial subjects' right to being); on the other hand, dignity as a fundamental right does not have meaning for the individual if he or she is dead. ... Human dignity is a naturally accompanying quality of human life.'… The importance of dignity as a founding value of the new Constitution cannot be overemphasised. *Recognising a right to dignity is an acknowledgement of the intrinsic worth of human beings: human beings are entitled to be treated as worthy of respect and concern."*[114]

From this quote, it is clear that the right to life, as enshrined in the Constitution, entails much more than merely the right to existence. Life, according to Justice O'Regan, must be *dignified* life. It is thus not life as mere organic matter (such as people in a persistent vegetative state) that the Constitution cherishes, but the right to live as a human being, being part of the community, being able to share in the experience of humanity. Interaction with the world around us is thus the key to having a dignified life and the right to being treated with respect and concern is included in the right to human dignity.[115]

The argument can thus be made that because persons in a persistent vegetative state can have no meaningful interaction with their surroundings, both their dignity and life is significantly reduced. As O'Regan rightly states: "…without dignity, human life is substantially diminished."[116] If your dignity is automatically reduced when you are in a persistent vegetative state,[117] how does one ensure that the right to dignity for these people are still respected? This can be done by treating them with respect and concern, specifically respect for bodily integrity, patient autonomy[118] and what the person would have wanted, had they been able to convey the message to others. It comes down to allowing a person in a persistent vegetative state the little freedom that is left over her life.

Woolman contends that section 11 read with section 7(2) does not only provide a safeguard against killing or the diminution of life, but that it can also impose positive obligations on the state to protect life.[119] These positive obligations include, *inter alia*, the duty of the state to enact legislation to preserve life where possible. Changing

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[114] *Makwanyane* 506-507, writer's own emphasis.
[115] Section 10 of the Constitution.
[116] *S v Makwanyane* 506.
[117] Herein after "persistent vegetative state".
[118] As enshrined in section 12(2)(b) of the Constitution.
[119] Woolman 39-14.

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the current organ procurement system to a more effective one will promote and protect the right to life.

The right to life is *prima facie* in favour of preserving life whenever and wherever possible. It is one of the most important rights in the Bill of Rights, as life is a pre-requisite for the enjoyment of all the other rights in the Bill of Rights. Although dying is a part of life, and seen as the completion of life rather than the opposite thereof,[120] it is human nature to extend it and hold on to life as long as possible. Where there are life-saving treatments available, it is against human nature to let a person die due to a lack of resources. Yet this is the reality we currently live in.[121]

5.5.4 Freedom and security of the person[122]

Section 12 of the Constitution states that:

> "(1) Everyone has the right to freedom and security of the person, which includes the right—
> (*a*) not to be deprived of freedom arbitrarily or without just cause;
> (*b*) not to be detained without trial;
> (*c*) to be free from all forms of violence from either public or private sources;
> (*d*) not to be tortured in any way; and
> (*e*) not to be treated or punished in a cruel, inhuman or degrading way.
> (2) Everyone has the right to bodily and psychological integrity, which includes the right—
> (*a*) to make decisions concerning reproduction;
> (*b*) to security in and control over their body; and
> (*c*) not to be subjected to medical or scientific experiments without their informed consent."

Of specific importance for the current discussion is section 12(2) and more specifically section 12(2)(b). Having security in and control over one's body is a fundamental principle of medical law, with far reaching consequences.

[120] *Soobramoney* 784.
[121] *Soobramoney* 782. Sachs J contended that "the rationing of access to life-prolonging resources is regarded as integral to, rather than incompatible with, a human rights approach to health care."
[122] Section 12 of the Constitution.

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Section 12(2)(b) clearly gives everyone a constitutionally entrenched right to bodily integrity. In the context of medical law, section 12(2)(b) support and promote the principle of patient autonomy.[123] This is done in two ways, by granting a right to a) security in; and b) control over one's body. Currie and De Waal give the following concise explanation to point out the difference between a) and b):

> "'Security in' and 'control over' one's body are not synonyms. The former denotes the protection of bodily integrity against intrusions by the state and others. The latter denotes the protection of what could be called bodily autonomy against interference. The former is a component of the right to be left alone in the sense of being 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."[124]

In practice patient autonomy is achieved by obtaining informed consent from the patient before any action is taken.[125] Informed consent is thus in many ways inseparable from patient autonomy, and thus also from the right to freedom and security of the person. However, the right to freedom and security of the person is in no way a new concept in South African law.[126] Both patient autonomy and informed consent have developed considerably during the last century, as can clearly be seen in the relevant case law. A short discussion of the case law follows to show the progressive support for these two principles.

As early as 1923, in the case of *Stoffberg v Elliot,*[127] the court looked at the right to security of the person and patient autonomy. The facts of this case are as follows: Mr Stoffberg was a patient of Dr Elliott and scheduled to undergo treatment for cancer in his penis. During the operation it was discovered that the cancer was much more advanced than expected and Dr Elliott consequently amputated the penis. This constituted a clear deviation of the consent given by Mr Stoffberg prior to being anaesthetised.

[123] In addition to autonomy being protected in section 12(2)(b), autonomy is further protected in the Constitution by section 11 which embodies the right to life and by section 14 dealing with the right to privacy, Dhai and McQuoid-Mason 39.
[124] Currie and De Waal 308- 309.
[125] This is also required by section 6 and 7 of the National Health Act 61 of 2003.
[126] See *Stoffberg v Elliott* 1923 CPD 148.
[127] 1923 CPD 148.

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Watermeyer J stated that "… every person has certain absolute rights… and one of those rights is the right of absolute security of the person."[128] He went further and added: "… a man, by entering a hospital, does not submit himself to such surgical treatment as the doctors in attendance upon him may think necessary… By going into hospital, he does not waive or give up his right of absolute security of the person…"[129]

When analysing this, it is important to note that constitutional rights are not absolute and can be limited by the limitations clause.[130,131] Sadly, the Constitutional Court has not had the chance to interpret section 12(2)(b) directly as of yet.[132] Much of what is written about this section thus remains pure speculation or an educated guess at best. Determining for instance whether it is an unjustified limitation to not allow one to sell a bodily organ is thus no easy task.

Clearly, not allowing a person to sell an organ is a limitation of section 12(2)(b) as it limits one's 'control over' one's body. The Constitutional Court has stated by mouth of O'Regan J and Sachs J in a dissenting judgment that the human body is not something to be commodified and that the Constitution demands respect for the human body.[133] The reason for this, however, seems to be that "[t]he very character of [prostitution] devalues the respect that the Constitution regards as inherent in the human body."[134] It seems that the real problem they have is thus not the commodification of the human body, but rather treating it without the required respect.

Section 12(2)(b) specifically states that everyone has the right "to security in and control over their body." The question that now arises is when, in the context of organ transplants, is an organ still part of your body? Certainly, up until it is removed, it still forms part of your body. Is the fact that a removed organ was once a part of your body enough to keep regarding it as part of you? And when it is transplanted into another human being, at what point does it become part of their body? Is it once

[128] *Stoffberg v Elliott supra* 148.
[129] *Stoffberg v Elliott* 149.
[130] Section 36 of the Constitution.
[131] For a comprehensive discussion of the right of absolute security of the person in the context of the *Stoffberg*- case, see Carstens and Pearmain 879- 883.
[132] Woolman S 40- 89.
[133] *S v Jordan* 2002 (6) SA 642 (CC) 671.
[134] *Jordan* paragraph 671.

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you give permission to donate, when the organ is removed or after it has been transplanted? Basically, it comes down to how long after removal from the body, should one have control over one's body parts? This is also important to determine until when permission to donate can be revoked. This question has neither been addressed by the legislature, nor the courts. However, it is bound to surface within the foreseeable future.

Something that is noteworthy is a particular defence, *volenti non fit iniuria,* stating that no harm can be done to someone that consents thereto.[135] This ties in closely to the doctrine of informed consent. Informed consent in South African law dates back to the case of *Castell v De Greef,*[136] where the requirements of informed consent were introduced and imported into South African law.[137] *Castell v De Greef* is commonly regarded as the *locus classicus* in this regard.[138]

In this case the plaintiff underwent an unsuccessful subcutaneous mastectomy that resulted in *inter alia,* necrosis and deformation of the areolae of the plaintiff. The court rejected the reasonable-doctor approach and replaced it with the doctrine of informed consent, thereby moving away from medical paternalism and toward patient autonomy.[139] This is clearly in support of the rights to self-determination and freedom and security of the person as voiced in section 12 of the Constitution.

The right to freedom and security of the person is inextricably weaved together with patient autonomy and informed consent, and together they form the basis of medical law. It is therefore just logical that patient autonomy and informed consent must play a vital role in organ transplantation law. Based on the right to freedom and security of the person, any organ procurement method will therefore need to adhere to patient autonomy by utilising informed consent.

"Because to take away a man's freedom of choice, even his freedom to make the wrong choice, is to manipulate him as though he were a puppet and not a person."[140] Consequently, organ procurement by means of presumed consent or procurement

[135] For a more detailed discussion on *volenti non fit iniuria*, see chapter 2.
[136] 1994 (4) SA 408 (C).
[137] Carstens and Pearmain 891-892.
[138] Carstens and Pearmain 891.
[139] Carstens and Pearmain 892.
[140] Madeleine L'Engle http://www.goodreads.com/quotes/tag/human-rights (accessed 7 November 2012).

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from prisoners is irreconcilable with section 12(2)(b) of the Constitution. Organ procurement methods such as opting in or required response, however supports and promotes the right to freedom and security of the person.

5.5.5 Privacy[141]

The right to privacy enables an individual to live free from interference from others and is of specific importance in medical and health care law.[142] Section 14 of the Constitution states that:

> "Everyone has the right to privacy, which includes the right not to have—
> (*a*) their person or home searched;
> (*b*) their property searched;
> (*c*) their possessions seized; or
> (*d*) the privacy of their communications infringed."

The right to privacy contained in section 14 does not include an exhaustive list of all the instances where privacy will be protected, however, it does give four instances in subsections (a)-(d) that is definitely included in the right to privacy. Privacy has been interpreted numerous times by the Constitutional Court and from its various judgments it is clear that privacy must be respected and upheld wherever possible.

Langa DP states that "privacy is a right which becomes more intense the closer it moves to the personal sphere of the life of human beings, and less intense as it moves away from that core."[143] From this quote it is clear that when dealing with any privacy-issue related to healthcare, health and the life of a person, privacy must be given very high priority.[144]

O'Regan J and Sachs J summarise the *Bernstein*[145] judgment as follows in *Jordan*:

[141] Section 14 of the Constitution.
[142] Devenish goes as far as to state that privacy is a "basic human need," Devenish 79.
[143] *Investigating Directorate: Serious Economic Offences and Others v Hyundai Motor Distributors (Pty) Ltd and Others: In Re Hyundai Motor Distributors (Pty) Ltd and Others v Smit NO and Others* 2001 (1) SA 545 (CC) 557.
[144] Another cause of the importance of the right to privacy is the overlap between the rights to privacy and dignity, Devenish 80.
[145] *Bernstein and Others v Bester and Others NNO* 1996 (2) SA 751 (CC).

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> "In *Bernstein*, Ackermann J held that the right to privacy in the interim Constitution must be understood as recognising a continuum of privacy rights which may be regarded as starting with a wholly inviolable inner self, moving to a relatively impervious sanctum of the home and personal life, and ending in a public realm where privacy would only remotely be implicated, if at all… *There can be no doubt that autonomy to make decisions in relation to intensely significant aspects of one's personal life are encompassed by the term*."[146]

This tie in with the previous quote from *Hyundai Motor Distributors,* in the sense that the closer to the personal sphere, the more important privacy becomes and thus the harder it becomes to limit the right. Limiting privacy in the public sphere *versus* limiting privacy in the private sphere was considered extensively in *S v Jordan:*

> "Commercial sex involves the most intimate of activity taking place in the most impersonal and public of realms, the market place; it is simultaneously all about sex and all about money…A prohibition on commercial sex, therefore, will not ordinarily encroach upon intimate or meaningful human relationships. Yet it will intrude upon the intensely personal sphere of sexual intercourse, albeit intercourse for reward."[147]

From this quote it can be seen that there can be conflicting aspects when it comes to limiting privacy. It is submitted that the same will hold true for the argument to sell human kidneys. The sale of human kidneys can be seen as a purely commercial transaction: goods in exchange for money. On the other hand, however, the goods in this scenario are pieces of a person's body, an organ that only one person has autonomy over. As Currie and De Waal state: "This is a difficult opposition to mediate: the intimacy of the transaction would suggest that it is at the core of privacy while its mercantile aspects would put it in the public domain."[148]

With organ transplants there are a number of conflicting legislative instruments pertaining to privacy. There is the Promotion of Access to Information Act 2 of 2000 that grants the right to access to information and has the goal to "actively promote a society in which the people of South Africa have effective access to information to enable them to more fully exercise and protect all of their rights."[149] However, there are also sections 14-17 of the National Health Act 61 of 2003 dealing with

[146] *S v Jordan* 48-49. Own emphasis added.
[147] *S v Jordan* 53.
[148] Currie and De Waal 321.
[149] Promotion of Access to Information Act 2 of 2000, Preamble. Hereinafter referred to as "PAIA".

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confidentiality, access to and the protection of health records. From this it can be seen that although the State values the individuals' privacy, the right to privacy must be limited in certain instances in order to allow individuals to exercise their rights and for the health care industry to be able to function properly.

5.5.6 Health care[150]

Section 27 specifies the various rights pertaining to health care and embodies so-called socio-economic rights.[151] There are, however, also other socio-economic rights entrenched in the Bill of Rights, for instance section 26 of the Constitution relating to housing. As these rights themselves have inherent similarities, for the purpose of this discussion reference will also be made to judgments on other socio-economic rights where applicable under the current heading.

Section 27 of the Constitution states that:

> "(1) Everyone 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 realisation of each of these rights.
> (3) No one may be refused emergency medical treatment."

Section 27 is important as it gives effect to the ethical principle of beneficence.[152] In *Soobramoney* the Constitutional Court had to interpret section 27 of the Constitution. The facts of the case are briefly as follows: The Appellant in this case was a diabetic suffering from ischaemic heart disease and cerebro-vascular disease, as well as irreversible chronic renal failure. Due to the fact that the applicant was not free of significant vascular or cardiac disease, he was not eligible for a kidney transplant,

[150] Section 27 of the Constitution.
[151] Socio-economic rights are also known as second generation rights, that are based on the principle of social justice, Devenish 146.
[152] Beneficence means to do good. For more on beneficence, see chapter 4.4.3.

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and according to the Addington hospital policies and guidelines, therefore also not eligible for regular renal dialysis.[153]

The court pointed out that the obligations imposed on the state by section 27 are "…dependent upon the resources available for such purposes, and that the corresponding rights themselves are limited by reason of the lack of resources."[154]

The court also stated:

> "Some rights in the Constitution are the 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. However, the guarantees of the Constitution are not absolute but may be limited in one way or another. In some instances, the Constitution states in so many words that the state must take reasonable legislative and other measures, within its available resources "to achieve the progressive realisation of each of these rights."[155,156]

This clearly shows that in certain cases, the court will value the wellbeing of a collective group higher than that of an individual, due to the limitation of section 27(1) by section 27(2).[157] Carstens and Pearmain correctly point out that "[t]he individualistic approach must have limits if society is to function successfully as a whole."[158] In *Grootboom* the Court found that rather than granting a right to demand immediate relief, there exists a duty on the State to develop a comprehensive plan to meet the obligations imposed on it by the Constitution.[159] According to Yacoob J, establishing whether a socio-economic right has been complied with, requires one to establish whether the state has taken reasonable steps.[160] Woolman believes that reasonable measures demand that the State both establish and implement a

[153] It is important to note that the duty of the State regarding organ transplantation and the availability of resources for organ transplants was not discussed further in this case as the Appellant was not eligible for a transplant due to medical reasons.
[154] *Soobramoney* 771.
[155] Section 27(2).
[156] *Soobramoney* 779.
[157] Moellendorf D *Reasoning about resources: Soobramoney and the future of economic right claims* 1998 SAJHR 327 330.
[158] Carstens and Pearmain 47.
[159] *Grootboom* 67 and 86.
[160] *Grootboom* 66.

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coherent, well-co-ordinated and inclusive programme with the aim to progressively realise the content of the right.[161]

What is noteworthy is that the decision in the *Soobramoney*-case might be very different if decided after the proposed National Health Insurance has come into effect.[162] This is because a large part of the judgment was based on the provisions in section 27(2), which states that the state must take reasonable legislative and other measures, *within its available resources*.[163] Once National Health Insurance is in place, there might be a legal duty on the state to provide for social security in the form of access to dialysis or to make alternative treatment, such as organ transplants, available to all of those in need thereof.[164]

A fact well worth mentioning is that the Constitutional Court does not follow a uniform approach when it comes to different socio-economic rights. Throughout its judgments a development in the thought process can be observed. In its various judgments the Court considers the dignity interests of those parties seeking relief in terms of sections 26 or 27 in a progressively more serious manner.[165] In *Soobramoney* Sachs J states: "In all the open and democratic societies based on dignity, freedom and equality with which I am familiar, the rationing of access to life-prolonging resources is regarded as integral to, rather than incompatible with, a human rights approach to health care."[166] According to Sachs, it is thus perfectly justifiable to limit access to resources that merely have the ability to lengthen the recipients' life.[167] He goes even further by suggesting that not only is it justified, but also fundamental to an open and democratic society.[168]

Contrary to the judgment in *Soobramoney*, the Court in *Grootboom* stresses the need that state action must *in all circumstances* be reasonable action with particular

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[161] Woolman 56A-7.
[162] For more on National Health Insurance see the Government website at http://www.doh.gov.za/list.php?type=National%20Health%20Insurance (accessed 22 January 2013).
[163] This requirement is in line with the principle of justice, specifically distributive justice, as a social approach is preferred above an individualistic approach. Dhai and McQuoid-Mason 145.
[164] National Health Insurance is still in its first, preparatory phase and it will still be several years before it is fully functional.
[165] Woolman 36-59.
[166] *Soobramoney* 782.
[167] Although it is agreed that the rationing of resources is essential, it nonetheless remains a "tragedy for justice", especially in the case of rationing medical resources. Moellendorf 1998 SAJHR 332.
[168] *Soobramoney* 782.

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regard to human dignity.[169] In *Treatment Action Campaign*[170] further development of the Courts view on the importance of human dignity can be observed as the argument of inadequate resources *in casu* was rejected by the Court. This was justified by stating that the needs of the affected people outweighed the financial implications on the State. The court stated that refusing life-saving treatment *in* casu can in no way be consistent with respecting the right to human dignity. Here, the need to respect the dignity of those concerned thus outweighed the lack of adequate resources. Furthermore, it was found that the state failed to adopt reasonable measures to enable the progressive realisation of the rights embodied in section 27.[171]

What is noteworthy is that in *Soobramoney* life-lengthening treatment was denied on the grounds of inadequate resources, whereas in *Treatment Action Campaign* potential life-saving treatment was granted in spite of inadequate resources. From this it is clear that the effect of the treatment in question has an influence on the outcome of the court's decision. A clear distinction can thus be made between these two cases. In *Treatment Action Campaign* relief was granted as the relief directly protected the right to life as entrenched in section 11, of a group of people. Granting the requested relief in *Soobramoney* would not have had the same effect, as it could not have saved a life, but merely prolonged it. This is significant as the Court granted relief where the need was greater. The state is under the obligation to "provide care according to need rather than the ability to pay."[172] The *Treatment Action Campaign*-judgment is also in accordance with the judgment in *Grootboom*, as "… a right to reasonable action by the state in all circumstances and with particular regard to human dignity"[173] has been complied with. Socio-economic rights are seen as more than a mere key to bare survival, and comprises of "the development and exercise of the people's associational, intellectual and emotional capabilities."[174] It thus seems as if the courts are gradually giving more importance to both socio-economic rights

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[169] *Grootboom* 83.
[170] *Minister of Health v Treatment Action Campaign* (2) 2002 (5) SA 721 (CC).
[171] *Treatment Action Campaign* 750, see also Brand D and Heyns C (eds) *Socio-economic rights in South Arica 2005* 139.
[172] Brand and Heyns C 132.
[173] *Grootboom* 83.
[174] Liebenberg 8.

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and human dignity, both as a right as found in section 10, but also as a value informing other fundamental human rights.[175]

In considering socio-economic rights, the "reasonableness" standard is of great importance. Yacoob J states that "[r]easonableness must also be understood in the context of the Bill of Rights as a whole."[176] Some of the elements of a reasonable plan listed by the court in *Grootboom* include:

- Sufficient flexibility to be able to cope with emergency, short, medium and long-term needs;
- Allocating appropriate financial and human resources to execute the plan; and
- Adequate legislation, policies and programmes must be in place to achieve the plan. This is inclusive of proper allocation of tasks and monitoring programmes being implemented.[177,178]

The court in *Glenister v President of the RSA and Others: Helen Suzman Foundation as Amicus Curiae*[179] found that section 7(2) of the Constitution requires the state to take steps that are both reasonable and effective in order to fulfil constitutional rights.[180] The court goes further to state that this duty rests, *inter alia*, on the Executive and Parliament when initiating and enacting legislation.[181] There is thus a duty on the Executive and Parliament to actively ensure that legislation is enacted in order to make possible the fulfilment of constitutionally entrenched rights. In addition to this duty in terms of section 7(2), the court in *Carmichele* found that there is a duty on the state in terms of section 39(2) to develop the common law to protect the right to dignity, life and freedom and security of the person.[182]

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[175] As stated in sections 1, 7(1) and 39(1)(a) of the Constitution.
[176] *Grootboom* 69.
[177] *Grootboom* 68-69 For a more detailed discussion on *Grootboom*, see Hassim A Heywood M and Berger J (eds) *Health and Democracy: a guide to human rights, health law and policy in post-apartheid South Africa* 2007 37-39.
[178] These elements of a reasonable plan, as part of the reasonableness requirement have to be considered in light of human dignity, Liebenberg 3.
[179] 2011 (3) SA 347 (CC). Hereinafter the *Glenister* case.
[180] A court may require a "comprehensive explanation from the state on the measures elected to fulfil the socio-economic rights," Devenish 149. The state can therefore be held accountable by the courts and may be obliged to defend and explain its choices.
[181] *Glenister* paragraphs 189-190.
[182] *Carmichele* 322.

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With regard to the right to access to health care in terms of section 27, the court held in *Treatment Action Campaign* that there is a duty on the state to establish the "progressive realisation of each of [the socio-economic rights entrenched in the Constitution]."[183] Taking into account that this case was decided in 1997, it raises the question: What has been done since to realise the rights contained in section 27?

It is true that a new act with regard to health care has been promulgated since, namely the National Health Act,[184] that came into effect on the 1st of March 2012.[185] However, the question remains whether the Act has achieved the standard of a reasonable legislative measure as required by section 27(2). It is the writer's submission that the National Health Act does not meet the standard of a reasonable legislative measure with regards to organ transplantation law, as required by section 27(2). Venter raises the possibility that there might be a duty on the state to find alternative options if a specific resource has been limited for a number of years.[186] *In casu,* it is submitted that the state has a duty to find alternative measures to alleviate the constant organ shortage, by replacing the current organ procurement system of opting-in with a more suitable organ procurement method.[187] The court in *Port Elizabeth* held that that our entire society is demeaned when government action denies citizens basic needs.[188]

5.6 Conclusion

In this chapter the writer investigated the constitutional influences on organ transplantation law. One of the main factors that has to be kept in mind when considering legal development is that the law can take a long time to change, it is conservative and often a few years behind societies perspectives on morality and the law.

[183] *Treatment Action Campaign* 754.
[184] 61 of 2003.
[185] South Africa (2012) Commencement of certain sections of the National Health Act (Act no 61 of 2003) *Government Gazette* 35081 of 3 February 2012.
[186] Venter 58.
[187] For more on the different organ procurement methods, see chapter 3.
[188] *Port Elizabeth* 227.

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However, there is a duty whenever new law is enacted or when existing law is amended, interpreted or limited, to do so in a manner that protects and promotes the values underlying an open and democratic society based on human dignity, equality and freedom.

Each of the rights, applicable to this study, in the Bill of Rights was examined, specifically in the light of the research topic. The scope and application of the limitation clause were also examined to determine whether and to what extent an individual can limit his or her own rights. What is clear from the study is that many of the rights in the Bill of Rights are intertwined and cannot be read in isolation- they inform one another and must thus be looked at together to form an overall picture.

When considering any right in the Bill of Rights a comprehensive and complex study is required. There are many aspects that deserve proper consideration: The application of the right, the meaning or content of the right, the interpretation of the right, other existing law, whether it be in the form of legislation, common law, case law or ethics, the limitation of the right, in the case of dignity, equality or freedom whether it operates as a right or a fundamental value and so forth. Establishing what the court might find in a specific case is no easy task.

Section 7(2) is applicable to all the above rights and places a positive duty on the state to respect, protect, promote and fulfil these rights. In the context of organ transplants, this means that the state has a duty to allow people to exercise their respective rights, to prevent third parties from interfering with someone’s rights, as well as establishing a proper legislative framework to enable the progressive realisation of these rights.

It is submitted that the State has failed to provide a proper legislative framework to relieve the critical shortage of human organs available for transplantation and thus fails to uphold the applicable rights and values as discussed above.

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CHAPTER 6

RECOMMENDATIONS AND CONCLUSION

6.1 Introduction

The aim of this study was to find a practical solution to the constant shortage of transplantable human organs in South Africa, by examining various methods of organ procurement and aspects relevant thereto. In addressing this issue the writer critically discussed current South African legislation regulating organ transplantation, considered alternative organ procurement methods, and examined the impact that bioethics and the Constitution might have on the possible success of an organ procurement system.

6.2 Synopsis of findings

6.2.1 Chapter 1: Introduction

The aim of this dissertation was to find a practical solution for the current shortage of transplantable human organs in South Africa. The importance of solving the constant organ shortage was indicated: lives will be saved; it is more cost effective to pay for a kidney transplant than for renal dialysis; people previously precluded will be more likely to have access to dialysis; less stringent criteria to be considered for a transplant may be implemented; resulting in more people having access to donated organs; ethical issues with regards to the allocation of a limited resource will be reduced; as more transplants are performed the operations will become more affordable; more hospitals will procure the necessary equipment to perform the transplant; to name but a few. From this list, it is clear that the benefits of finding a solution to the organ shortage can't be understated.

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In short, this chapter served as an introduction to the research topic, and the identification of the research question. It indicated the significance of the study, explained or defined key concepts used throughout this dissertation. Lastly, it motivated the exclusion of certain areas from this study.

6.2.2 Chapter 2: An analysis of South African legislation and other relevant factors

This chapter examined the current legislation[1] governing organ transplants, and more specifically organ procurement in South Africa. It considered possible improvements from previous legislation[2] and also critically evaluated the shortcomings thereof. It was concluded that chapter 8 of the National Health Act is riddled with shortcomings. The main shortcomings are the uncertainties regarding the moment of death; what constitutes valid written consent; the omission of a definition of "reasonable costs"; as well as one of the most important *lacunae:* the complete omission of regulations regarding organ allocation. These *lacunae* have the consequence of rendering the National Health Act almost inoperable when it comes to organ transplants. It was therefore concluded that new legislation, or at least proper amendments to the current legislation are needed to rectify the numerous shortcomings.

6.2.3 Chapter 3: Various organ procurement systems and aspects relevant thereto

The aim of this chapter was to discuss both the positive aspects, as well the shortcomings of the main methods of organ procurement within a South African context, taking into account lessons learned from other countries that implemented the respective organ procurement method. From the wide range of possible organ procurement methods, it was clear that there are problems with each respective method, and that there is still plenty room for the improvement of organ procurement models. From the study of the literature available on organ procurement methods,

[1] The National Health Act 61 of 2003.
[2] The Human Tissue Act 65 of 1983.

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we are certain that something needs to be done, but determining what that something is, is a much harder task. This chapter focused on practical ways to improve organ procurement and organ allocation. The following nine-phase plan was subsequently formulated: proper education of the public on organ transplants and organ donation is needed; HIV positive donors and recipients need to be accepted if other relevant criteria are met; the current procurement system of opting-in should remain similar for live donations; the current procurement system of opting-in should be replaced with required response for cadaveric donations; there will thus be a dual organ procurement system in place with separate rules for live and cadaveric donations;[3] a national database must be created to record every person's donor status and basic medical information; a national waiting list must be created to record information of patients in need of an organ transplant, including basic medical information; the role of family members in cadaveric donations should be limited to instances where the donor did not give permission prior to death or when it can be proven that the donor had a change of mind regarding donation and did not register the latest decision; and an intensive information campaign on organ procurement, allocation and transplantation must be implemented in order to inform the public.

6.2.4 Chapter 4: The influence of bioethics

In this chapter the influence of bioethics on organ procurement was examined. The importance of the relationship or interaction between bioethics and the law was pointed out, where after the four principles of bioethics was explained. Thereafter, each of the organ procurement methods examined in chapter 3, was tested against the four principles of bioethics in order to determine the ethical defensibility (or lack thereof) of each organ procurement method.

Ultimately, it was determined in this chapter that opting-in, even though overall ethically defensible, has failed as an organ procurement system in practice and to continue using it will be ethically indefensible as it no longer complies with the

[3] For a discussion of a dual system of procurement including explicit consent for live donations and presumed consent for cadaveric donations, see Fourie EJ *An analysis on the doctrine of presumed consent and the principles of required response and required request in organ procurement* (LLM dissertation, University of Pretoria 2005) 148.

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principles of beneficence and justice. Presumed consent fails to comply completely with any of the four principles of bioethics and is therefore not ethically defensible as an organ procurement method. Required request is deemed ethically defensible as it complies, at least *prima facie,* with all four principles. Required response, on the other hand, is difficult to label as either ethically defensible or not. There are elements of this organ procurement system that might be problematic, however, if implemented in a proper manner it will be ethically defensible. The sale of organs has traditionally met fierce opposition, mainly based on ethical grounds. Many of the criticisms have however been disproved over the years and although there are several areas that could be problematic, none of the ethical concerns seems insoluble. Organ procurement from prisoners was found to be ethically indefensible, regardless of which of the four principles is considered.

6.2.5 Chapter 5: The Constitutional influence on organ transplants

As the Constitution is the supreme law of the Republic of South Africa,[4] no attempt to amend existing law can be successful without giving due consideration to the rights and values entrenched in the Constitution. In this chapter, the application, limitation and interpretation of the Constitution were explained. Thereafter the specific rights of equality; human dignity; life; freedom and security of the person; privacy and health care were examined in light of each right's influence on organ transplantation, and more specifically, organ procurement methods. It was shown that section 7(2)[5] is applicable to all the above rights and places a positive duty on the state to respect, protect, promote and fulfil these rights. In the context of organ transplants, this means that the state has a duty to allow people to exercise their respective rights and to prevent third parties from interfering with someone's rights. One of the most important realisations from this chapter was that in terms of section 27(2) of the Constitution, the state has a duty to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of certain rights.[6] It was furthermore submitted that the state has not complied with this duty in respect

[4] Section 2 of the Constitution of the Republic of South Africa, 1996, hereinafter "the Constitution".
[5] Of the Constitution.
[6] Section 27(2) of the Constitution.

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of taking reasonable legislative and other measures, within its available resources, to ensure the proper regulation of organ transplants.[7]

6.3 Recommendations: A practical solution

The need of finding a practical solution to the organ shortage is expressed by Barnett and Kaserman: "The pertinent question at present is not whether we should have a major policy change but, rather, which of the available policy alternatives should be chosen to replace the current policy."[8]

In chapter one the necessary characteristics of a successful organ procurement method were identified, namely: that the solution must be cost effective, it can't put unnecessary strain or burden on the health sector or any other organ of state, it must have at least the possibility of being successful in a multicultural country like South Africa; and it must address the reasons for the current organ procurement methods failure to meet the demand for transplantable organs. Furthermore, in order to be successful, any solution must be practical. The Oxford dictionary defines practical as: "(of an idea, plan, or method) likely to succeed or be effective in real circumstances; feasible."[9] Any recommendations must therefore have the ability to succeed in practise. Throughout the recommendations, these characteristics were kept in mind, in order to ensure that the recommendations comply with these basic requirements, assuring the success thereof.

The recommendations arising from this study are divided into three parts: Firstly, recommendations are made regarding which organ procurement methods are deemed unsuitable for use in a South African context, where after the remaining organ procurement method is discussed as the organ procurement best suited for South Africa. Finally, the important role that factors other than the organ procurement method can play in alleviating the constant organ shortage is considered.

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[7] For a detailed discussion on the duty of the state in terms of section 27 of the Constitution, see chapter 5.5.6.

[8] Barnett AH and Kaserman DL *The shortage of organs for transplantation: Exploring the alternatives* Issues in Law & Medicine 9(2) 1993 117 137.

[9] http://oxforddictionaries.com/definition/english/practical (accessed 1 September 2013).

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6.3.1 Organ procurement methods unsuitable for use in South Africa

After taking into consideration the combined findings of chapters three to five, it can safely said that most of the organ procurement methods considered in this study are unsuitable for successful use in a South African context. These main reasons for the unsuitability of each of these organ procurement methods will be discussed shortly.

6.3.1.1. Opting-in

Opting-in as it is currently applied in South Africa is unsuitable as an organ procurement method for various reasons. Throughout chapters one to five it was indicated that continued use of this organ procurement method will not result in procuring enough transplantable organs to meet the demand. In chapter one, this was shown with organ transplant statistics; in chapter two the problems with the legislation governing organ transplants was critically discussed; chapter three pointed out the failure of this organ procurement method in South Africa; and chapter four rejected opting-in as an ethically defensible organ procurement on the grounds that continued use will not comply with the principles of beneficence and justice. Finally, chapter five showed that the continued use of opting-in as it is currently being applied will not comply with the duty of the state to "take reasonable legislative measures, within its available resources, to achieve the progressive realisation [of access to health care]."[10]

6.3.1.2. Presumed consent

In this study, it has been shown in chapters three to five that presumed consent will not be successful as an organ procurement method in South Africa. As shown in

[10] Section 27(2) of the Constitution.

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chapter three, using this organ procurement method will result in distrust from the public and will therefore lack public support. In chapter four it was indicated that presumed consent as an organ procurement method is not ethically defensible in terms of rights justice. Furthermore, it was strongly indicated, both in chapters four and five, that presumed consent as an organ procurement method doesn't comply with patient autonomy[11] as achieved through informed consent. It is submitted that these problems are insoluble, specifically in light of our Constitution.

6.3.1.3. Required request

Required request has been eliminated as a possible organ procurement method in chapter three. From chapter three it can be seen that using required request as an organ procurement method is unlikely to succeed in South Africa, as family involvement still play a big role and that the unfortunate timing of required request leads to frequent refusals. Because of these obstacles this organ procurement method may also fail to satisfy the states duty in terms of section 27(2) to take reasonable legislative measures, as detailed in chapter five.[12]

6.3.1.4. Sale of organs

Reaching a decision on whether the sale of organs will be a viable option as an organ procurement method in South Africa was more difficult than making a decision regarding the other organ procurement methods. Ethical concerns regarding this organ procurement method have been largely invalidated.[13] The property rights or lack thereof regarding human organs needs to be clarified and as the normal contractual principles are hard to apply to the sale of human organs, this is also in need of a solution. Ultimately, it came down to the practicality of its implementation, should it be chosen. In a country like South Africa, where the corruption of

[11] Both as a principle of bioethics, as well as a constitutional right.
[12] In paragraph 5.5.6.
[13] For a discussion on the ethical defensibility of the sale of organs, see chapter 4.4.5.

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government officials frequent the news and where the legislature fails time and time again to properly draft even relatively simple legislation, finding solutions to all the hurdles seems highly unlikely. It is therefore submitted that using the sale of organs will not constitute a practical solution to the organ shortage.

6.3.1.5. Organ donation from prisoners

Chapters three to five have strongly indicated that organ donation from prisoners will not be successful as an organ procurement method in South Africa. In chapter three it was shown that this organ procurement method does not make practical sense, especially in South Africa with overcrowded jails, the high occurrence of HIV/AIDS, and a strained Department of Correctional Services. Organ procurement from prisoners was furthermore found to be ethically indefensible in chapter four.[14] Chapter five showed that implementing this organ procurement method will likely be an unjustified infringement of the right to bodily integrity, and will also very likely be an unjustifiable infringement on the right to equality.

6.3.2 Organ procurement method best suited for South Africa

From the above discussion of the organ procurement methods that were disqualified as suitable organ procurement methods, it is submitted that there is only one suitable organ procurement method left: required response.

Required response is founded on the constitutionally entrenched principle of autonomy and therefore enjoys both strong constitutional and ethical support. It also fully respects the individual's freedom of choice and creates no presumption at the lack thereof. Furthermore, although it is still somewhat dependant on the altruism of the donor, there is now the further motivation to consider donation as a requirement

[14] In paragraph 4.4.6.

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for the valid submission of certain applications.[15] If required response should be accepted as an organ procurement method, the following recommendations should be taken into account:[16]

- Proper education of the public on organ transplants and organ donation is needed prior to the change in organ procurement method;[17]
- The current procurement system of opting-in should remain similar for live donations;
- The current procurement system of opting-in should be replaced with required response for cadaveric donations;
- A national donor list must be established to record every response received;
- This donor list or database should be easily accessible to the necessary health care personnel for speedy determination of a deceased or critically ill patient's donor status;
- Every major citizen must be required to submit their donor status upon the application for an identity document, a passport, a driver licence, or at the submission of tax returns or a vote during elections;[18]
- Every response should be recorded on the electronic database containing the registered donor list;
- If a response is not given, it must be deemed an incomplete application or submission and must not be accepted until completion;
- The request must be made in the form of a simple questionnaire to ensure that informed consent is obtained and to eliminate the need for trained medical personnel to request the consent. The questionnaire should look similar to this example:[19]

[15] The success of this organ procurement method is therefore based on more than pure altruism, as the consideration of organ donation is now required to fulfil the self-interest of obtaining a driver's licence or submitting a tax-return, for example. The need for an organ procurement method founded on self-interest is based on the argument made by Ghods AJ and Sava S *Iranian model of paid and regulated living-unrelated kidney donation* CJASN 2006 1(6) 1136.
[16] These recommendations are based *inter alia* on those made in chapter 3.10.
[17] The success of education in South Africa is clearly visible from the number of donor registrations during August each year. http://odf.org.za/ (accessed 1 September 2013).
[18] As submitted by Fourie 150.
[19] This is a very basic example. There are of course many more questions that can be asked, however, it is submitted that its success will lie in its simplicity.

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REQUEST FOR ORGAN DONATION

Please indicate your answer with a cross in the appropriate box.

Do you know what organ donation is?	YES	NO
Do you know what the benefits and risks to organ donation are?	YES	NO
Do you understand the possible consequences of organ donation?	YES	NO
Do you want to register as an organ donor?	YES	NO
Specify any organs you don't want to donate, if any.		

- Answering no to any of the above questions will preclude the person from being registered as an organ donor;
- The request form should be accompanied by informative and educational posters or flyers to answer the most frequently asked questions that prospective donors might have; and
- The role of family members in cadaveric donations should be limited as far as possible to instances where the donor did not give a response prior to death or when it can be proven that the donor had a change of mind regarding donation and did not register the latest decision.

6.3.3 The role of factors other than organ procurement methods

In chapters two and three various factors were pointed out that are not organ procurement methods themselves, however they have the potential, when implemented together with the correct organ procurement method, to increase the amount of transplantable organs procured. It is therefore submitted that the above mentioned recommendations, together with the implementation of the factors below, will result in alleviating the current organ shortage. They will each be discussed shortly:

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6.3.3.1 Creation of a national waiting list

The creation of a national waiting list will serve a crucial function in reducing the organ shortage. It will enable health care workers to compare the information of transplantable organs to the prospective recipients in the country. This will also result in the medical information of prospective organ recipients being easily available for comparison to donated organs. It is submitted that a national waiting list is required irrespective of the organ procurement or organ allocation methods applied.

6.3.3.2 Creation of a national donor list

The creation of a national donor list is equally important to the need for a national waiting list. A donor list will contain the donor status of prospective donors. This eliminates the need to establish the donor status through emotionally distraught relatives and also excludes the chance of relatives refusing to give permission for the donation (based on their own reasons and not those of the deceased). A donor list will contain the basic medical information of prospective donors, such as age, weight, blood type, which will be easily accessible to health care workers, resulting in identifying possible matches quicker. Just as with the need for a national waiting list, it is suggested that a national donor list is required irrespective of the organ procurement or organ allocation methods applied.

6.3.3.3 Minimising the role of relatives

Minimising the role of relatives is a crucial factor in increasing the amount of procured transplantable organs. As was shown in chapters two to three, relatives will rather refuse to donate than to consider donation during difficult circumstances. Furthermore, minimising the role of relatives combined with the use of a national donor list, ensures that the deceased's true wishes are respected and thereby also respecting patient autonomy.

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6.3.3.4 Allowing HIV positive organs to be donated

HIV positive donors and recipients need to be accepted if other relevant criteria are met, insofar as was discussed in chapter 3.8.2.3. Consequently a whole group of people previously automatically disqualified based on their medical history, will be granted access to organ transplantation.

6.3.3.5 Education

The value of proper education can't be stressed enough. Education is crucial in obtaining informed consent, one of the essential requirements for a valid donation. Without having proper knowledge of what organ transplants entail, a prospective donor can't make a proper decision. Without having proper knowledge, most people would not even consider making a choice for or against donation, much less make an uninformed decision. It is thus clear that awareness regarding organ transplantation has to be raised. Although it has been argued that the role of education is limited in procuring more organ donors,[20] it is submitted that this does not hold true for South Africa. South Africa is a country that still struggles to provide all its citizens with basic needs like water, housing and sanitation. Relieving the organ shortage has not been a government priority,[21] as organ transplantation is not viewed as basic health care, and the only education thus far, has been done by non-government organisations such as the Organ Donor Foundation. The success of education in South Africa is clearly visible from the yearly increased number of donor registrations during August, organ donor month.[22] Therefore national educational campaigns on the matter and raising awareness will likely yield positive results. The more people are confronted with the harsh reality of organ shortage, the better the chances are that they will be motivated to act in an altruistic manner.

[20] Kaserman DL *Fifty Years of Organ Transplants: The Successes and The Failures* Issues in Law & Medicine, 23(1) 2007 61-62.

[21] As can be seen in the lack of proper regulation thereof in the National Health Act 61 of 2003, as dicussed in chapter 2.

[22] http://odf.org.za/ (accessed 1 September 2013).

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6.3.3.6 Tax incentives

Tax incentives generally grants an organ donor a tax credit for the year in which the donation takes place. If the donation is a cadaveric donation, the tax credit would be taken into account for the purpose of determining the estate duty. As the first R3 500 000 of a deceased estate is not taxable in South Africa, one wonders how much of a motivational factor this will be in practise. One could even argue that this will only benefit the rich and discriminate against the poor.

6.3.3.7 Favourable consideration as a recipient

Another incentive to motivate potential donors is to guarantee them that should they ever need an organ, they will jump the queue and therefore receive the required organ quicker than others on the waiting list. This is clearly only available as motivation for live donations.

6.3.3.8 Expanding the definition of death for the purpose of organ harvesting

Currently, death is defined as brain death.[23] In this regard, two submissions were made: Firstly, that brain death is kept as the generally accepted definition of death. Secondly, as an expansion of the general rule, neo-cortical death should be deemed to be the legally recognised definition of death for purposes of organ harvesting. However, this should be regulated very strictly by the legislature to prevent abuse. It is submitted that this only be allowed where the person has given written consent, either on a donor list or in a document such as a living will, to be an organ donor and *also* indicated that she doesn't want to be kept alive artificially. It is submitted that this will be necessary in order to prevent possible abuse.

[23] Section 1 of the National Health Act.

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6.4 Final conclusion

Organs can only be procured for the purpose of transplantation in a manner allowed by the law. Aristotle very rightly stated that: "Even when laws have been written down, they ought not always to remain unaltered."[24] This is certainly still the case today, even more so than a few years ago due to the rapid advances in modern technology and medicine.

From this study it is clear that solving the constant shortage of transplantable human organs in South Africa will require more than merely changing the organ procurement method. In order for the offer of transplantable human organs to meet the demand, a multi-layered solution is needed that involves education, legal reform, and due consideration of how things work in practice. As can be seen from the failure of the current organ procurement system, a pure academic approach is not enough to solve the problems at hand. Due regard needs to be given to factors like time constraints, human nature, human emotion and successful motivational factors. This is particularly important in the context of medical law, where the battle is one not merely between right and wrong, but between life and death.

Even though solving the constant shortage of transplantable human organs in South Africa will not be an easy task, it is certainly an achievable one. It is however stressed again that solving the organ shortage will not be achieved through one single step. It requires the consideration and implementation of several steps, of which changing the organ procurement method is merely the first step in reaching a practical solution that is likely to succeed in real circumstances.

[24] http://www.quotationspage.com/quote/24244.html (accessed 21 August 2013).

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