

Ethical issues in donation of organs or tissues by living donors

**Ethical issues in organ donation
Discussion paper No. 2**

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NHMRC

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- Donating organs after death: ethical issues
- Ethical issues in donation of organs or tissues by living donors
- Ethical issues raised by allocation of transplant resources
- Certifying death: the brain function criterion

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1. The purpose of this document

Donation of certain organs and tissues by living donors is well established in Australian medical practice and is legally authorised. This document examines some of the major ethical issues involved in this practice.¹

A decision or a problem involves ethical issues when, for instance, it deals with questions of human well-being; when there may be questions of balancing the needs and interests of different people; and when issues of great importance to how we live our lives are at stake, and when someone wants to do what is right. In this sense, the question of living donation is an ethical one, because it involves balancing the needs and interests of different people - chiefly here the potential recipient and the potential donor - and because it concerns important issues about the well-being of those involved.

The document sets out various views that can be held about living donation, and aims to provide as far as possible a balanced discussion of the ethical issues. The writers do not aim to tell readers what to decide, but rather suggest what they could take into account. By outlining some of the issues and complexities involved in the practice of living donation, the document may assist people in thinking through their own decision by helping to ensure that they have not overlooked important matters. As there are very complex issues involved in living donation, potential donors will need to give the decision careful thought, and seek counselling and discussion with a health professional.

Finally, since medicine is an evolving science and further developments in transplantation are likely, this document only discusses those transplantations currently being carried out in Australia.

¹ This is the second paper in a set of four discussion papers on transplantation ethics produced by the Australian Health Ethics Committee (AHEC). The first is entitled *Donating organs after death: ethical issues*; the third is entitled *Ethical issues raised by allocation of transplantation resources*; and the fourth is entitled *Certifying death: the brain function criterion*.

2. What organs and tissues are donated by living donors in Australia?

This section discusses which organs or tissues may be donated by living donors in Australia. Though currently in Australia living donors are most often considering kidney or bone marrow donation, it is important to distinguish all the different regenerative and non-regenerative tissues which may be donated.

a) **Regenerative tissue**

Regenerative tissue, which includes blood, bone marrow, bone and liver segments, grows back naturally after removal. The main risks to the donor are therefore immediate ones which derive from the removal procedure itself.

i) Blood

Donation of blood is well established in Australia, both from unrelated donors and from related donors. It is also possible for a person to 'donate' blood for his or her own use at a later date ('autologous' donation).²

ii) Bone marrow

The transplantation of this tissue is well established in Australia, and registers of potential bone marrow donors have been established. Donation may be from related or unrelated donors.

iii) Bone

Bone from living donors is almost always from joint surgery and therefore consists of femoral heads and tibial plateaus which have been replaced with prostheses. Recipients will usually be unrelated to the donors.

iv) Liver segment

The donation of part of a liver to a related person is undertaken in Australia (this is referred to as a split-liver transplant).

² Recently one Australian hospital has established a cord blood bank in which baby's blood from the placenta, taken from the cord after it has been cut and tied, is stored for later donation.

v) *Sperm and ova*

These may also be donated.³

b) **Non-regenerative tissue**

Non-regenerative tissue, such as a kidney, once removed, is not naturally restored in the donor. The donor will be permanently without that particular organ or tissue.⁴

Kidney donation is the most common form of such donation in Australia. Each person has two kidneys and, if one is donated, the remaining one (provided it is healthy) is capable of carrying out the function of cleansing the blood normally. On the other hand, having only one kidney means that the donor is more vulnerable to harm if the remaining kidney is injured or suffers disease at a later date.

The donation by living donors of one of their two kidneys to a related person is well established. In 1994, there were 102 recorded kidney donations by living donors (23% of all kidney transplantation in Australia). Most donors were sisters (28) and mothers (26), followed by brothers (19), fathers (14), unrelated donors (9), children (4) and other relatives (2).⁵

³ Because of their role in reproduction such donations involve unique ethical issues which are beyond the scope of this document. Some of these issues are discussed in the NHMRC *Ethical guidelines on assisted reproductive technology* (1996), available for sale through the Australian Government Publishing Service (AGPS) on phone: 132 446 (freecall).

⁴ An exception is where a person who receives a heart-lung transplant for chronic lung disease donates his or her heart to another person. This operation is sometimes called a 'domino operation'.

⁵ ANZDATA Eighteenth Report, 1995, pp 97.

3. Reasons why some people decide to become living donors

People choose to be living donors, or choose not to be, for different kinds of reasons or for a mixture of reasons. Some of these are outlined in the following two sections of this document. Again, remember that the aim of this document is not to say certain reasons are to be recommended or are better than others, but to explain some of the ways that different people think about the matter.

In many cases the desire to donate an organ may be based on the wish to save the life or improve the health of a relative with whom there are already bonds of affection and love. This may even be an overwhelming concern.

In other cases, a person may wish to do something to save the life or improve the health of an unknown person in the community, based on more impersonal ideas of helping others or giving to the community. For example, this may be a consideration for those who volunteer to be placed on a register of potential bone marrow donors (or who volunteer to donate blood).

Such donors may consider that the potential personal disadvantages or discomforts of donating are more than outweighed by the potential benefits to the person needing a transplant.

Various religious traditions may support living donation, although different traditions may of course think about it in their own particular way. For instance, living donation may be considered as an opportunity to give of one's self to another human being, even a stranger. On this view, organ donation can represent the highest capacity of human giving: the gift of life itself. Such giving benefits not only the receiver but also the giver and the society as a whole.

A word on donation for financial reasons

In some parts of the world, people may 'donate' organs for financial gain. Australian law in all States expressly prohibits and penalises any trade or commerce in human organs or tissues. The World Health Organisation has expressly argued against the practice. Guidelines issued by the Dialysis and Transplantation Sub-Committee of the Australian and New Zealand Society of

Nephrology and the Australian Kidney Foundation⁶ also require that it be clearly understood that there should be no financial gain to the donor.

Many consider that there are great moral objections to selling organs; others may disagree. However, since this discussion is concerned with decisions about current living donation practices in Australia, where donation for financial gain is illegal, this matter is not pursued further here.

⁶These guidelines, produced initially in 1992 and now under review, are well accepted and established in Australia and are referred to throughout this discussion paper.

4. Reasons why some people decide not to become living donors

a) Ethical considerations

Section 3 looked briefly at some reasons in favour of living donation. However, it should be noted that whilst a person may support living donation in principle, he or she may place certain limitations on their acceptance of the practice. Such limitations may include the following: it may be insisted that it is permissible only on the understanding that the donor's life is not put at risk; that the donation is genuinely voluntary and not coerced; that transplantation is the only medical means of treating the recipient; and that there are good prospects for the transplantation being a successful treatment.

b) Risk to donor

Someone may consider all the different factors involved, and decide that overall it is preferable or best not to donate. Remember that, in different cases, there will be different factors to be considered. For instance, someone may decide that the disadvantages involved in donation outweigh the potential for benefit to the recipient; or someone may decide in a particular case that the personal disadvantages and discomforts are too great, or it would be better if another person donated instead.

c) Different ways of serving the community and of helping others

There are many different ways of showing concern to the community and to others, and some people may consider that they would prefer to show such concern in other ways.

5. Some important ethical issues to be considered

a) Introduction

There are two principal reasons why decisions about living donation raise ethical considerations.⁷ First, these decisions are about using a donor in ways that may cause harm, risk of harm, pain or loss. This may be temporary (as in the case of blood donation) or permanent (as in the case of kidney donation). Second, they are decisions that are intended to benefit others. So, they are decisions that involve a balance between one person's interests (for instance, in being physically whole) and that of another (who is in need of medical help).

Deciding whether or not to be a living organ or tissue donor can be a relatively simple matter as it is, for instance, when deciding to donate blood. Here, if a person chooses to donate, he or she suffers no lasting harm, only a temporary inconvenience. Also, as a blood donor is acting for the benefit of strangers, the decision to donate is fairly free from pressure to choose one way or another.

However, being a living donor can be a complex matter. Where a person donates a kidney, he or she chooses to suffer permanent loss of part of the body for the benefit of someone else who will usually be a relative. Here, the choice can involve a difficult balance between the donor's interests and those of the recipient. The proposed donation might also affect others in the family and their opinions may put pressure on the potential donor. Because of these possible complexities, thinking through the decision carefully will be vitally important.

This paper has noted a number of the ways in which living donation might be ethically justified. Whatever justification a person accepts, there is one consideration which should inform all decisions about living donation. This is the principle of 'informed consent'. Important decisions that individuals make about their own lives - in particular, medical decisions - should be both free (voluntary) and uncoerced. They should also be based on a sound understanding of what is at stake. Ensuring that this is so is part of what is implied in the fundamental principle of respect for the dignity of every human being and sometimes requires that great care be taken.

⁷ The relevant legal considerations are set out in legislation in each State and Territory. Appendix 2 provides a summary of this legislation.

b) The decision to be a living donor should be genuinely free and uncoerced

A voluntary decision is one made without undue pressure, without coercion, force or persuasion against one's will. A person's decision may not be voluntary if people who are powerful or influential have put too much pressure on him or her, or if he or she has not had the opportunity to consider all the relevant aspects of the situation. The context of the decision will play a part in the decision-making process. This process may be facilitated by individual and/or family counselling, and consideration may be given to accessing social work and other counselling and support services provided in hospitals and in the community. Whatever the decision of an individual regarding whether or not to become a living donor, there still may be the need to talk things over with a counsellor or other independent adviser throughout the decision-making process and afterwards.

i) *Related donors*

Experience of organ donation by living donors indicates that the best outcomes are achieved when donors are parents, mature siblings or grandparents of the recipient. The genetic relationship usually leads to a donor being closely matched in tissue type so that risks of rejection are small; this is important for kidney and bone marrow donation. Some family members will be better matches than others, and some who may be good matches may be unable to donate for other medical reasons. Accordingly, the common context of deciding to be a living donor is that some members of the family of the recipient will be preferred donors because of their close tissue match to the recipient. There may be only one such medically-suitable donor or there may be more than one. This is also the case with bone marrow transplantation.

ii) *Unrelated donors*

In other cases, the donor may be unrelated to the recipient. It may help to distinguish between cases where the donor is unrelated genetically to the recipient, but is a known family member (eg a spouse) and cases where the donor is an unrelated stranger, as may happen of course with blood donation or bone marrow donation. The Australian and New Zealand Society of Nephrology/Australian Kidney Foundation guidelines provide that unrelated kidney donations may be considered where the transplant is offered to a specific individual, the reason for the donation is unmistakably a charitable act and the donor fulfils all requirements of the guidelines for related donors. Between 1983-1993, 18 such kidney transplantations took place in Australia, about 3.5% of all kidney donations from living donors.

For potential donors deciding outside of a family context, for example an individual deciding whether or not to donate bone marrow to an unrelated stranger, there are still many potentially complex issues to think through.

iii) Factors affecting the decision when donating within families

It follows that very many decisions to be living donors will be made within a family context - whether blood relations or less commonly, spouses, de factos or in-laws - and involve the needs of specific members of that family. Very often, in living donation, there will be a host of pressures and family complexities to take into account. These may affect the extent to which a decision to donate or not to donate is genuinely free. Understanding some of these complexities and family dynamics can assist greatly in reaching a decision that is genuinely voluntary.

It is important to distinguish between different kinds of pressure that a person faced with the decision about living donation may feel:

- **Unavoidable pressures**

There will be some influences that arise simply from the facts of the situation, and which cannot, even with the best will in the world, be changed. These may include the fact that the intended recipient will die without the transplantation, which of course makes any decision highly charged; that only one person in the family is a suitable donor and so the spot-light falls on him or her alone; and so on.

Some donors will be able to assess the effects of these sorts of facts and still arrive at their own decision. Such decisions will be, in ethical terms, voluntary. It may be said in such cases that the pressures arise from the nature and urgency of the situation, and although some people may feel in such circumstances they have 'no choice', they feel this not because they are being coerced, but because of the strength of the reasons behind their decision. They choose to donate for those reasons.

In other cases, there may be potential donors for whom the implications of such facts are so overwhelming that they will not be able to decide for themselves, but will give in to the strongest influence. This situation should be avoided. Careful counselling may be needed to assist a person to sort out the issues sufficiently so that he or she can come to a sound decision.

- **Avoidable pressures**

On the other hand, there may be pressures brought to bear on a potential donor that amount to undue pressure from others, whether conscious or not. These may arise from particular relationships in the family. For example, there may be pressure put on a family member to donate in exchange for certain favours - whether specified or left more vague - or there may be threats of disapproval, perhaps implied or unspoken, if a person refuses to donate. Sometimes, even when more than one person in a family would be a suitable donor from a medical point of view, there may be pressure brought to bear on one particular family member as the one who

should donate. That pressure may stem from how that person is viewed by other members of the family.

If a person is unable to make his or her own decision because of such pressures, these decisions whether or not to donate will not be sound, and there may be lasting harm to relationships in that family. Again, sensitive counselling may be able to assist in helping people to see a clear way through such problems.

The Australian and New Zealand Society of Nephrology/Australian Kidney Foundation guidelines recommend that adequate provision should be made for ensuring that a donor can withdraw from a donation or honourably withhold donation.

c) The decision to be a living donor should be based on adequate information and understanding

An informed decision is one based on information relevant to the making of that decision. Any information is relevant if it is important to the particular person making the decision. Potential donors need information and need to understand that information well enough to be able to weigh up all the factors. Hence, people will often need to have information explained and repeated, and will need sufficient time to consider their decision. The decision is not only rational, but involves attitudes and feelings and time is needed to reconcile these and perhaps for conversations with family, medical practitioners, counsellors or other advisers.

Of course, in assisting a potential donor to make his or her decision about donation, doctors have an ethical and legal duty to warn⁸ about material risks in a treatment. Material risks are those that most people would want to know and also those that would be significant for a particular individual. It follows that a donor, before deciding about donation, should ask the appropriate medical practitioner to disclose the risks of the intended procedure and of its short and long term effects.

The Australian and New Zealand Society of Nephrology/Australian Kidney Foundation guidelines provide for full medical assessment of the donor, including an assessment of the function of both kidneys and the person's fitness to undergo general anaesthetic, together with a psychological assessment. These guidelines require that the donor be interviewed in private on one or more occasion so that the nature and possible consequences of donation are properly explained.

The donor and recipient may or may not be treated by different doctors. In the case of living related donation however, it is probable and practical that the potential donor will first discuss donation with the recipient's doctor as it is likely that the family of the recipient will have an ongoing relationship with that doctor. Because

⁸ See Appendix 3 for more information about a doctor's 'duty to warn'.

the recipient's doctor usually has had a long term commitment to the recipient, it may be advantageous for the potential donor to have an independent medical advocate to protect his or her interests. All unrelated bone marrow donors will be treated by a doctor who is not involved in the treatment of the potential recipient, but there are no standard procedures for this in Australia for other types of donation.

A distinction can be made between predominantly medical considerations and predominantly psychological/social considerations that shape decision-making in the context of a particular family, or for a particular individual, and that may relate to the discussion of pressures in Section 5(b) above.

Medical considerations

Before making the choice to donate, potential donors should consider the following matters:

The exact nature of the donation procedure and follow up: This will of course vary with the type of donation, but should include all information that may affect the decision of a potential donor. For example, it should be known that, for bone marrow transplantation, there is a possibility of a request for a second donation of marrow.

Risks to the donor: Because donation usually involves both general anaesthesia and a major surgical procedure on a healthy individual, there must be careful assessment and consideration of the risks to the donor on a case-by-case basis. These include both operative risks (immediate risks of the operation) and long term risks. For example, the risks of kidney donation include surgical complications and hypertension. Information should be made available to potential donors about the risks and the medical treatment available should they experience medical problems, for example, renal failure. The wish to donate is a generous impulse, but individuals considering becoming live donors must also give careful consideration to their own health, and to the various possible outcomes for themselves.

The chances of success of the transplantation: These will vary according to the type of transplantation and the particular medical condition of the recipient. Information about the likely benefits for the recipient in terms of improved health and life expectancy will also be relevant. A potential donor may want this information when weighing up whether the risks to himself or herself are outweighed by the potential benefit for the recipient. Potential donors should understand that, whether or not they decide to donate, the patient may die.

Reasons for using a living donor: These may be a reduced risk of rejection, or lack of cadaveric organs. For example, it may be that it is likely that the potential recipient will die before a cadaveric organ becomes available, or it may be thought more desirable simply to by-pass the long wait for a cadaveric organ. So a

potential donor may wish to weigh up the benefits to the recipient of receiving one of his or her own organs immediately rather than waiting for the chance of a cadaveric organ. Sometimes the donor's decision may involve a compromise, for instance, to volunteer to donate if the recipient has not received a cadaveric organ within the next two years.

Psychological considerations

This includes information and understanding about possible emotional and psychological consequences of making a decision one way or the other, for the potential recipient, the potential donor, the relationship between these two people, and for other family members. Much of the following discussion focuses on donation within families (whether or not the family members involved are related genetically), but similar issues have to be thought through for unrelated donations to strangers, such as occurs in some bone marrow transplantations. These questions can only be answered within the context of understanding a particular family and/or the particular individuals involved. Individual and family counselling is likely to assist here and should be available to all concerned. Within hospitals, counselling services are provided by social workers, by pastoral care workers, and by other support staff. Ongoing counselling and support also may be necessary for some individuals and families as, whatever the outcome, certain issues may take some time to resolve.

Tissue typing and other medical checks may identify only one suitable donor in a family, which can lead to great pressure being put on that person. There may be more than one suitable donor and in these cases there can be complex pressures again as a choice is made between these people. As examples of such pressures, focus may fall on one of the suitable people for various reasons, perhaps without sufficient thought. In other cases there may be one person who is extremely eager to donate and so perhaps too willing to overlook possible difficulties that may be encountered. Often, such very willing people may need even more careful counselling to ensure that their decision is sound.

Living donation offers the recipient immediate hope. Because the results are generally favourable, the mood of the recipient, family and donor are usually optimistic. Against this background, other issues need to be considered:

Prospects of survival of recipient: It is argued by some that it is preferable to donate to recipients who are not critically ill, because choosing recipients with higher chances of survival better balances the risk to the donor. In addition, when such recipients are chosen, there is less need to make a decision under pressure and the additional time allows thorough medical and psychological evaluation of the proposed donor.

Changes in donor/recipient relationship: The exceptional nature of what has

happened and what both the donor and recipient have shared may be mutually enhancing. After a donation, there is often increased contact between a donor and the recipient where they are known to each other. Experience in bone marrow transplants suggests that reaction to being identified as a donor is very positive.

Feelings if the donation fails: The possibilities of the donation failing need to be assessed. If the donation does fail, the donor may have feelings of guilt or inadequacy or feelings of anger, sadness, or that the donated organs or tissues have been wasted, and that the discomforts he or she has suffered have been made for nothing. This has also been the experience of some bone marrow donors where the recipient later dies.

Feelings of 'ownership' towards the recipient: Living donors can feel closer to recipients and have expressed attitudes of ownership about the state of health and activities of the recipient. They may feel that they have a right to ensure that the recipient is taking good care of his or her health and therefore of the donated organ or tissue. Conversely, the recipient may identify with the donor and feel that part of the donor is living in them. Ultimately such feelings may not be in the best interest of either party.

Debt of gratitude felt by the recipient towards the donor: The recipient's feelings of gratitude and indebtedness are likely to be strong and may be accentuated by the increased contact that often happens between donor and recipient after the donation. In some cases, the recipient may feel locked into a creditor-debtor relationship and feel never able to pay back the debt. Some say that donation can involve what they call the 'tyranny of the gift'.

Feelings of recipient if the donation has harmful effects on the donor: This possibility also must be considered. A recipient may feel guilty and responsible if the donor suffers for his or her sake.

Consequences of not donating: A decision not to donate can have a major impact on relationships within a family. The recipient's illness is often life-threatening and death may occur before or after transplantation. It is therefore important that the family, including prospective donors, do not have unrealistic expectations for the recipient nor underestimate the difficulties for the donor. A decision not to donate might be entirely appropriate for the individual, but still have profound effects on family relationships if the proposed recipient dies. It is very important to consider whether such factors amount to undue pressure on a potential donor to agree to donate.

In summary it can be said that a potential donor has a number of rights, including:

- the right to medical information about the donation procedure and its short term risks as well as information about the possible long term risks of the donation;

- the right to information about the recipient's medical prospects following transplantation;
- the right to independent medical advice;
- the right to counselling to discuss the potential psychological and social consequences of the decision to donate and adequate time to consider this information; and
- the right to decide not to donate.

6. The decision made on behalf of a child donor

Living donation of regenerative tissue by children is legally permitted, under certain strict conditions, in all Australian States except the Northern Territory. In the ACT only, living donation by children of non-regenerative tissue is permitted, but only under the most exceptional circumstances. In all cases, child donation is only permissible for transplantation into close relatives of the child.

Donation by children is ethically complex. They will often be sought as a donor to a sister or brother, particularly for bone marrow donation. It is difficult and, in cases of very young children, impossible to ensure that children have a full understanding of what is involved. Because of their immaturity and dependence, children are very vulnerable and great care must be taken to protect their interests. In other words it may be said that donation by children should only occur when there are overwhelming arguments in favour of it.

Where parents make the decision, they will face the complex task of balancing the respective interests and welfare of their different children and their family. Some say that the death of a sister or brother can be such a serious threat to the well being of a potential donor that their overall interests would be more damaged by their sibling's death than by the discomforts of, say, a bone marrow transplant. A parental decision will therefore require a serious consideration of the interests of the donor, the recipient and the family as a whole.

As a child matures, he or she will be able to have a better understanding of such matters and a clearer appreciation of the significance of his or her own decisions. Hence, although legally still a minor, an older child may in practice take a more active part in such decision making than a younger child.

Some people see the family as an intimate group in which the interests of one member are strongly linked to the interests of all: they argue that the good of the family as a whole is more important than the interests of only one member. Other people would argue that more importance should be placed on the interests of individual family members. Reaching a balance between helping others and concern for oneself is typical of family relationships and is not unique to donation, although the seriousness of questions of living donation can make such questions especially difficult.

⁹ The assent of the child is mandatory where risks of donation are more than minimal (see Appendix 2).

Consistent with these views, decisions to permit a child to be a living donor will only be ethically sound where:

- the risks to the child donor are minimal;
- the donation is to a person - such as a sibling - with whom the child has an intimate relationship (the child donor may then benefit indirectly from the benefits to the recipient, for example, in having a brother or sister survive);
- the donation is a last resort in treatment for the recipient;
- the proposed transplant is of proven efficacy and expected benefit, and there is a good chance that the risks and discomforts involved for the donor child will be outweighed by the benefits of transplantation;
- the parents consent and the child (if she or he is able to do so) agrees or assents⁹. The child's understanding of the donation and transplantation may be incomplete, but efforts must be made to ensure that his or her understanding is as thorough as possible, consistent with his or her age; and
- to the best of the parent's (or family's) judgment, all the reasonably expected benefits (to recipient and donor) clearly outweigh all the reasonably expected risks and discomforts (to the donor and recipient).

7. Conclusion

This paper has set out some of the ethical matters involved in the donation of organs and tissues by living donors. It is the aim of the paper to provide information on both the medical aspects and the ethics of living donation, in order to assist people to reach sound, informed decisions about such donation and also to enhance community understanding of this area of health care.

Appendix 1

Transplantation Ethics Working Party

Terms of Reference

The aim of the Australian Health Ethics Committee's (AHEC's) work in this area is to address in a broad fashion social issues not dealt with in the guidelines for donation of cadaveric organs and tissues currently being developed by the National Health Advisory Committee of the National Health and Medical Research Council (NHMRC)¹.

The aim of the overall project is to produce information that:

- a) is both practical and informative;
- b) provides guidance to clinicians, policy makers and support services on ethical aspects of organ donation and transplantation; and
- c) provides a basis for informed community debate.

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¹ The NHMRC report *Recommendations for the donation of cadaveric organs and tissues* was finalised in June 1996 and is currently available for purchase through government bookshops

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Appendix 2

The present Australian legal position

Adults

All States permit living donor donation of regenerative tissue/organs provided that prescribed consent procedures are followed. For adults, these include written consent that states the purpose of the donation, the presence at the time of consent of the medical practitioner who provided the medical advice, in SA & WA, the absence of family and/or friends at that time, and a certificate by the designated officer or registered medical practitioner certifying:

- the terms of the consent;
- that requisite medical advice was given;
- that consent was given in the presence of the certifier;
- that the donor is an adult of sound mind; and
- that the consent was freely given.

All States permit the donation of non-regenerative tissue by adults provided the same procedures are followed as for regenerative tissue with the addition that the certificate must also state:

- that the purpose of the donation is the transplantation into the body of another living person;
- that tissue removal not take place less than twenty-four hours after the consent; and
- the time of the consent.

The respective legislation is:

ACT Transplantation and Anatomy Act 1978 ss. 6-10

NSW Human Tissue Act 1983 ss. 6-9

NT Human Tissue Transplant Act ss. 6-10

QLD Transplantation and Anatomy Act 1979 ss. 8-12

SA Transplantation and Anatomy Act 1983 s. 7-10

TAS Human Tissue Act 1985 ss. 5-9

VIC Human Tissue Act 1982 ss. 5-12

WA Human Tissue and Transplantation Act 1982 ss. 6-9

Children

All States except NT permit the donation of regenerative tissue by children for the purpose of transplantation into the body of a parent or sibling or, in WA, TAS & ACT a relative.

Consent is to be given by a parent and, in VIC, QLD, WA & ACT, “parent” does not include a guardian or other person in loco parentis. That consent must be on the basis of medical advice given to and understood by both the parent and the child.

In all States except SA and WA, the designated officer or medical practitioner must certify:

- the terms of the consent,
- that requisite medical advice was given,
- that consent was given in the presence of the certifier,
- that the parent is an adult of sound mind,
- that his or her consent was freely given,
- that the child understood the nature and effect of the procedure, and
- that the child was in agreement.

In QLD, a twenty-four hour waiting period must be observed before the tissue is removed and in SA consent must be approved by a Ministerial Committee.

In QLD and VIC, such donation can be given by a child who, due to age, cannot understand provided that the certifier certifies that she or he is of the opinion that the proposed recipient is in danger of dying without the transplant and, in QLD, that the risk to the child donor is minimal.

Only in ACT is it permitted to remove non-regenerative tissues from a child and then only when it is to be transplanted into a family member who is in danger of death and when both parents consent. A Ministerial Committee must agree.

Revocation

Consent to donation can be revoked and such revocation is conclusive. In NSW, VIC & NT there are additional provisions requiring inquiries to be made concerning the possibility of transplantation and informing appropriate people of the revocation. Consent to donate may be revoked up to the point of donation.

Appendix 3

‘Duty to warn’

The following information is drawn from the judgement in the case of *Rogers v Whitaker* (1992) 175 CLR 497:

‘The law should provide that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment: a risk is material if, in the circumstances of the particular case, a reasonable person in the patient’s position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should be reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it’ (at 502).

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