Editorial

A DEARTH OF DONORS

> To grunt and sweat under a weary life,
> But that the dread of something after death, -
> The undiscover'd country, from whose bourn
> No traveller returns, - and puzzles the will,
> And makes us fear those ills we have.
>
> *Hamlet Act III Scene 1*

Anthropologists would confirm that a social trait which has accompanied every human civilisation is a pervading interest in death, expressed in a profusion of peri-mortem lore and funereal rituals. This has been interpreted as signifying that the human race, in comparison with any other species, has always exhibited a higher intellectual plane of activity, has always appreciated a higher, non-materialistic moving force to human activities, and has perhaps an implicit belief in some form of afterlife.

The journey across to the 'other side' and the later sojourn of the corruptible body of the deceased had to be prepared for comprehensively. The deceased relative or friend had to be sent on his way with all due pomp and the ensurance of being adequately provided for in a measure commensurate with the status, rank and social profile that he enjoyed before death. Examples of this are the neolithic tombs scattered across the Western world, the catacombs in Rome and other Roman cites, and the vast acres of cemeteries with their mausoleums, memorial crypts and chapels, tombstones, impressive marmoreal monuments and cenotaphs. Indeed, in some cultures this notion of preparation during life for the hereafter may have been at the very hub of that civilisation, almost amounting to the *raison d'être* of that culture, the day-to-day driving force. This is perhaps best epitomised by the Pharaonic obsession with pyramid-building in Egypt and Nubia, and a protracted intricate preparation of the corpse prior to interment.

> ...May you grant power in the sky, might on earth and vindication in the realm of the dead, a journeying downstream to Busiris as a living soul and a journeying upstream to Abydos as a heron; to go in and out without hindrance at all the gates of the Netherworld.[1]

In the same general vein, demonstration of any disrespect towards the bodies of the dead, or any form of mutilation of cadavers, was considered abhorrent, barbaric and a serious, dehumanising and repulsive breach of morals. Dissection of the dead in the interest of science was punishable by excommunication from the Roman Catholic church, and worse, based on the doctrine that the 'Church abhors the shedding of blood'.[2] Mutilation of the corpse of a criminal was an ancient punishment, and was the ultimate disgrace inflicted by the conqueror in war over those who have been vanquished and fallen in battle.

To a greater or lesser extent this notion has been fuelled and further nurtured in all the major religions and cults. In a religious sense the human body is endowed with potential immortality and a hope of resurrection; that which is 'sown in corruption would rise again in incorruption'. The return of 'dust to dust and ashes to ashes' had to be controlled and elaborately ritualised. The toning down or withdrawal of funereal pomp and circumstance, such as the banning of burial in consecrated ground, was indeed a demonstration of publicly expressed disapproval of the life and manner of death of the deceased.

It is surprising that in this *fin de siècle* era of declining religious involvement and secularisation, and of a combined humanistic, amoral or agnostic approach to life and death, these highly emotionally-charged and deep-seated attitudes to death and dead bodies have lingered so strongly, both in those with and those without a definitive religious alliance and allegiance. In the early Sixties, transplantation of human kidneys was no longer an experimentally-practised technique but had became a reality. A feasible, economical, and successful operation had replaced the drudgery of peritoneal dialysis and haemodialysis, and rectified the unpleasant and limited existence of patients with chronic renal failure. A permanent and effective solution to a common medical problem had been achieved. However, there was a need for donors and it became necessary to partially dismantle the human cadaver, as quickly as was possible after life, was pronounced extinct to provide the kidneys required for this purpose. The stakes were elevated even higher when the 'most noble' of organs was also transplanted: in December of 1967 at the Groote Schuur Hospital in South Africa Professor Christian Barnard performed the first technically successful heart transplant on Louis Washkansky, and a second and more therapeutically effective operation on Philip Blaiberg in January of the following year.

Advances in surgery, in immunology particularly in overcoming the rejection of non-self tissue and the recognition of the phenomena of tolerance, in the management of multi-organ and metabolic derangement have together led to an increasing number of organs and tissues that can be harvested and used successfully for transplantation purposes. Liver transplantation is now as routine as cardiac and renal replacements; more is yet to come particularly in the field of bone marrow and stem cell transplantation. In September 1998, the Australian Chris Hallam who had just lost an arm following an industrial accident received a transplant upper limb in Lyon, in an operation that lasted thirteen and a half hours and involved a multinational team. No evidence of rejection was evident in mid-November and the fingers were moving.

This attitude to augmented feasibility and effectiveness of transplantation is perhaps further epitomised by the decision of Mr Justice Johnson, High Court judge in England, to overrule a 15-year-old girl's decision not to have a heart transplant. Doctors at the Freeman Hospital in Newcastle-upon-Tyne had given the patient no more than

a week to live. They believed that the girl was 'too overwhelmed' to make an informed decision of her own and that 'events have overtaken her so swiftly that she not been able to come to terms with her (medical) situation'. The cardiac transplant went ahead successfully.

Politicians, responding to the public's concern, have ensured that the law kept reasonable pace with these medical developments. In this country the Human Tissue Act of 1961 laid down fundamental safeguards which appropriately regulated and controlled the post-mortem removal of organs and tissues for therapeutic purposes. Parliament has placed the onus in terms of consent for the removal of human cadaveric organs on 'the person lawfully in possession of the body after…death' or 'lawfully in charge of the body of a deceased',[1] although the law does not define this person. It is solely this individual - usually taken to be the immediate next of kin - who *may* authorise and give consent for such removals either in compliance with the wishes which had been expressed during life by the deceased or, if such intent was not known to have been expressed, after having ascertained that there was no contrary objection expressed by the deceased, and there is no current objection expressed to such removals by a surviving spouse or any surviving relative. The law *de facto* did not accept, as an alienable and incontestable declaration of intent and one not capable of being overruled after death, any expression of a declared intent to donate organs for transplantation made during life, such as the carrying of a 'donor card' by the deceased. The extent of the harvesting, whether it is to be limited to the kidneys or is to include other organs and tissues, is also left to the discretion of the survivors of the deceased.

The law also ensured that if the deceased had died violently, for example through homicide, a vehicular or industrial accident or misadventure, the legal authorities, in the shape of H.M. Coroner or the Procurator Fiscal, have a right of veto if they believed that the removal of organs for transplantation would vitiate the completeness of any post-mortem investigation relating to a criminal event. However effective lobbying by transplant groups has ensured that even in these instances it is quite exceptional for this legal right to be exercised, and transplant donations are regularly obtained from beating heart brain [stem] dead donors injured in a vehicular accident or by homicide. Because of potential commercial dealings in human organs Parliament swiftly enacted The Human Organs Transplants Act in 1989 which deals with living and cadaveric organ donations.[4]

In 1984 Arthur Caplan[5] reviewed the transplant scene in the United States and Europe - particularly in France - and identified major differences of opinions and philosophy between the different nations as to how matters of consent to organ removal for transplantation should be dealt with legally. In 1987 a Working Party chaired by Sir Raymond Hoffenberg[6] was convened from the UK Conference of Medical Royal Colleges and their Faculties, and reported to Department of Health and Social Security. It highlighted the major shortfall between actual demand for organs and the available supply of organs. The suggestion was made for the system of 'opting in', in which the surviving relative has to be approached, and has to come to a decision within the limited time-frame available to permit viable organs to be removed.

During the British Medical Association's Annual Meeting of Representatives, recently held in Belfast, doctors yet again warned government that the status quo in relation to transplantation is not satisfactory. They voiced their wishes for the current system to be reviewed, and perhaps changed, providing the scope to enable more essential life-sparing donations to become available. The general mood inclined towards the adoption of a scheme of 'presumed consent', i.e. an 'opting out' system as being a sensible way of resolving this problem, the implication being that everyone who is otherwise deemed suitable could automatically be assumed to be a transplant organ donor unless they had specifically declared that they did not wish to be considered as donors after death. Dr Evan Harris further suggested in his motion that relatives should not be allowed to overrule the wishes of a deceased patient who carried a donor card.

Such a system already operates elsewhere in Europe. For example, introduction of this scheme in Belgium, a generally conservative nation, has resulted in a doubling of the organs available for transplantation. The experience in Spain is very similar: only about 2.0% of the population opted out.

Any hint of the potential infringement of currently-held rights often leads to the use of emotive language, and the views canvassed at the BMA meeting were no exception: 'thrusting a card under their noses with a scalpel in the other hand is not a way to approach (bereaved) relatives' - 'What is the next principle to be sacrificed on the altar of expediency?' A Department of Health spokesman later indicated that an independent popular survey hastily commissioned by the Department showed that about 50% of those interviewed were in favour of the opt-out position with only 28% supporting the opt-out policy. Statistics, perhaps once again, are used to give support rather than illumination.

A checklist of the current inescapable facts may perhaps assist in reaching appropriate conclusions. That there is a perennial and acute transplant donor shortage is a fact of life. That the donation of cadaveric organs and tissues to the chronically ill can often be a long-lasting life-saving measure makes scientific and fiscal sense. Surely few will deny or doubt that the posthumous donation of organs to more than one donor is perhaps the most dispassionate, magnanimous and altruistic act of kindness and charity that can be undertaken, changing the lives of several individuals and their families. Families who have allowed organs to be retrieved from their nearest and dearest have been able to cope better with a totally unexpected, heart-rending, acute bereavement. Because the death of a loved one has enabled others to live is a gratifying prop enabling the bereaved to cope slightly better than they might otherwise have done. The vast majority of bodies are being cremated.

It is therefore essential that a forward is explored through this moral and cultural maze, to enable many more to be saved rather than die unnecessarily. A wider debate is needed. This issue would provide a salutary and productive debate for churches and religious groups. '*Debate*, rightly understood, is an essential element in the making of rational decisions of consequence by intelligent people.'[7]

There are therefore strong medical and ethical reasons for deceased bodies, to be donated to help others in a way that is possible for only a very few selected persons to do during life, instead of being allowed to gradually decompose or to be acutely reduced to ashes. We, as medical practitioners, living up to our name of doctors, should teach

the community and engage in a more intense public education campaign. Perhaps, too, as has been demonstrated by other issues such as blood donation, driving and drinking, cigarette smoking, the medical profession should teach by example and when the occasion sadly arises in our own families, not wait to be asked but volunteer. Parliament will have to take cognisance yet again of this issue, and new legislation may have to be mooted. Further public consultation is essential and once again the Royal Colleges should lead the way both professionally and publicly. This could be part of the 'mission statement' for the dawn of the next millennium.

Law, then, wishes to be the discovery of what is.
Plato, Minos, 4th century BC

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3 Human Tissue Act, 1961.
4 Andrews L. *My body, my property* Hastings Center Report (October), 1986; 16.
5 Caplan A. *Organ procurement; it's not in the cards* Hastings Centre Report 9 (No. 5), 1984; 14.
6 Report of the Working Party on the 'Supply of Donor Organs for Transplantation', 1987.
7 Robert HM in *Robert's Rule of Order,* 1915.

Dr Reginald Passmore

TO REG - A PERSONAL TRIBUTE

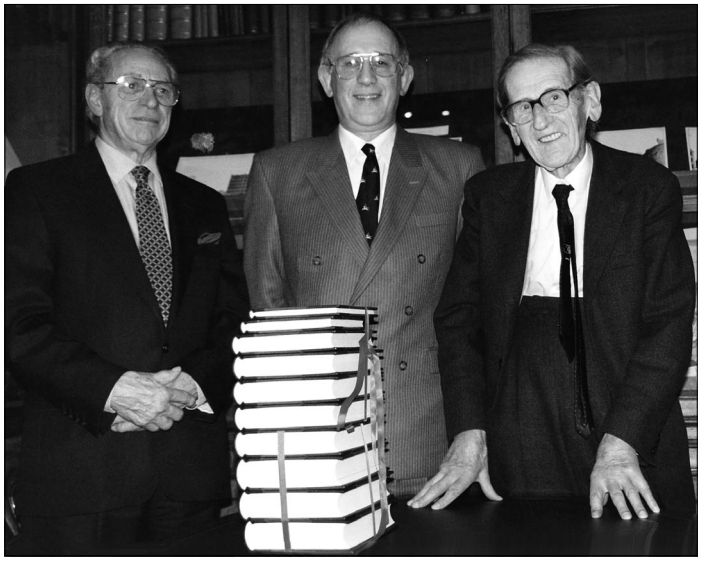
Quite recently Reg passed on peacefully in his sleep, almost 20 years beyond the 'three score and ten'. He was a great pillar of strength in his continuous association with the College, which spanned over many years, especially during his association with *Proceedings*. His encyclopaedic knowledge of literature and of the classics; of anyone over the age of 60 who was anybody in medicine in Britain and in the Commonwealth, whom he had either taught, corresponded with or considered a personal friend; made him an indomitable figure and a great sounding-board. He was also a debater of ideas, a man with tightly held and argued opinions which were well worth considering and, on many occasions, acceptable.

I had the pleasure of speaking with him at some length over the telephone a day or so before he died. What impressed me was that he was so very happy and contented because he had been spared so long; because he had retained the closeness and proximity of his family and of his many friends; because, although frail in body and, Reg grudgingly admitted, 'a trifle forgetful', he still had his full mental faculties; because he had been looked after so well by his medical colleagues in general practice and in hospital; because of his continued close association with the College. Indeed, he had new projects that he was still working on.

I am greatly privileged and the better off to have known Reggie over the last few years as 'my friend, faithful and just to me'.

You should be a father to my youth:
My voice shall sound as you do prompt mine ear;
And I will stoop and humble my intents
To your well-practis'd wise directions.

The Editor



Dr Bill Sircus, ex-President Professor John Cash and Dr Reg Passmore in the New Library.