A SELECTION OF CONSTITUTIONAL PERSPECTIVES ON HUMAN KIDNEY SALES

by

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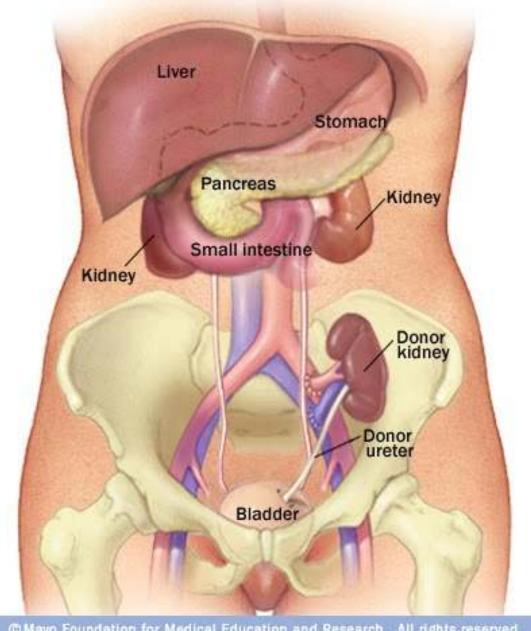
CO-PROMOTER: PROF M SWANEPOEL

JUNE 2012

PLEASE NOTE

GENDER REFERENCE

All references made to him or his in the masculine sense also applies mutates mutandis to she or her in the feminine sense.



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STATEMENT

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I, Bonnie Venter declare that: A Selection of Constitutional Perspectives on Human Kidney Sales is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references.

<u>15-06-2012</u>

BONNIE VENTER DATE

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I AM CERTAINLY NOT AN ADVOCATE FOR FREQUENT AND UNTRIED CHANGES IN LAWS AND CONSTITUTIONS. I THINK MODERATE IMPERFECTIONS HAD BETTER BE BORNE WITH: BECAUSE, WHEN ONCE KNOWN, WE ACCOMMODATE OURSELVES TO THEM, AND FIND PRACTICAL MEANS OF CORRECTING THEIR ILL EFFECTS, BUT I KNOW ALSO. THAT LAWS AND INSTITUTIONS MUST GO HAND IN HAND WITH THE PROGRESS OF THE HUMAN MIND, AS THAT BECOMES MORE DEVELOPED, MORE ENLIGHTENED, AS NEW DISCOVERIES ARE MADE, NEW TRUTHS DISCLOSED, AND - A MANNERS AND OPINIONS CHANGE WITH THE CHANGE OF CIRCUMSTANCES, INSTITUTIONS MUST ADVANCE ALSO. AND KEEP PACE WITH THE TIMES. WE MIGHT AS WELL REQUIRE A MAN TO WEAR STILL THE COAT WHICH FITTED HIM WHEN A BOY. AS CIVILIZED SOCIETY TO REMAIN EVER UNDER THE REGIMEN OF THEIR BARBAROUS ANCESTORS.

~ THOMAS JEFFERSON~

SUMMARY

There are thousands of desperate people globally who need a kidney for transplantation. The number of people who require a kidney transplant continues to escalate faster than the number of kidneys available for a transplant. The aim of this dissertation is to examine and analyse the judicial framework pertaining to kidney transplants in South Africa. The examination is conducted within the framework of the South African Constitution and the National Health Act 61 of 2003. The specific focus of this dissertation is to determine whether the payment of kidney donors could be regarded as constitutionally acceptable. A comparative study is undertaken, with Singapore and Iran as a background against which recommendations for the South African regulatory framework are made. The most important finding is that people should at least be granted the choice whether they would prefer to receive payment for their kidney donations or not.

Key terms: kidney donation; organ sales; Constitution; human life; human dignity; self-determination; privacy; healthcare; living donor; autonomy.

TABLE OF CONTENTS

STATEMENT			
ACKNOWLEDGEMENTSSUMMARY			
СНАРТ	ER 1 – INTRODUCTION	1	
1.1	BACKGROUND		
1.1.1	Introductory remarks		
1.1.2	The history of kidney transplants		
1.1.2.1			
1.1.2.2	South African kidney transplant history and transplant legislation time		
		4	
1.1.3	Current regulation of kidney transplants in South Africa	7	
1.1.4	Medical law and kidney transplants		
1.1.4.1	The link between the law and kidney transplants	9	
1.1.4.2	The public and private healthcare sector in South Africa	1′	
1.2	PURPOSE AND PROBLEM STATEMENT	14	
1.3	CHOICE OF LEGAL SYSTEMS	16	
1.4	RESEARCH APPROACH AND METHODOLOGY	16	
1.4.1	Explanatory notes on source referencing and bibliography	17	
1.5	OVERVIEW OF CHAPTERS	18	
1.6	POINT OF DEPATURE, ASSUMPTIONS AND HYPOTHESIS	20	
1.7	VALUE CONTRIBUTION	20	
1.8	MOTIVATION	20	
СНАРТ	ER 2 – HUMAN RIGHTS AND KIDNEY TRANSPLANTS	23	
2.1	INTRODUCTION	23	
2.2	SECTION 36 OF THE CONSTITUTION: LIMITATION OF RIGTHS	26	
2 3	THE DIGHT TO LIFE	27	

2.3.1	International and regional human rights instruments	27
2.3.2	The Constitution	29
2.3.3	The right to life and kidney transplants	30
2.4	THE RIGHT TO HUMAN DIGNITY	34
2.4.1	International and regional human rights instruments	34
2.4.2	The Constitution	36
2.4.3	The right to human dignity and kidney transplants	37
2.5	THE RIGHT TO SELF-DETERMINATION	41
2.5.1	International and regional human rights instruments	41
2.5.2	The Constitution	43
2.5.3	The right to self-determination and kidney transplants	44
2.6	THE RIGHT TO PRIVACY	47
2.6.1	International and regional human rights instruments	47
2.6.2	The Constitution	48
2.6.3	The right to privacy and kidney transplants	49
2.7	THE RIGHT TO HEALTHCARE	51
2.7.1	International and regional human rights instruments	51
2.7.2	The Constitution	53
2.7.3	The right to health and kidney transplants	58
2.8	CONCLUSION	62
CHAPT	ER 3 – SOUTH AFRICAN TRANSPLANT LEGISLATION	64
3.1	INTRODUCTION	64
3.2	THE REQUIREMENTS FOR A LAWFUL KIDNEY TRANSPLANT	64
3.2.1	The Human Tissue Act	64
3.2.1.1	Deceased kidney donors	65
3.2.1.2	Living kidney donors	66
3.2.2	The National Health Act	67
3.2.2.1	Deceased kidney donors	67
3.2.2.2	Living kidney donors	71
2 2	THE ASSESSMENT PROCESS REGARDING KIDNEY DONATIONS	. 73

3.3.1	The criteria for deceased-donor kidney transplantation	74
3.3.2	The criteria for living-donor kidney transplantation	75
3.3.2.1	The assessment of related living kidney donors	75
3.3.2.2	The assessment of unrelated living kidney donors	75
3.4	SHORTCOMINGS IN SOUTH AFRICAN TRANSPLANT LEGISLAT	ION.
		77
3.5	CONCLUSION	79
СНАРТ	ER 4 – BIOETHICAL PERSPECTIVES ON KIDNEY TRANSPLANTS	3 81
4.1	AN INTRODUCTION TO BIOETHICS	81
4.2	AUTONOMY AND THE DOCTRINE OF INFORMED CONSENT	82
4.3	NON-MALEFICENCE AND BENEFICENCE	87
4.3.1	Non-Maleficence	88
4.3.2	Beneficence	90
4.3.3	The Doctrine of double effect	93
4.4	JUSTICE	94
4.5	CONCLUSON	98
CHAPT	ER 5 – TO SELL A KIDNEY OR NOT: ARGUMENTS FOR AND	
	AGAINST THE SELLING OF HUMAN KIDNEYS	99
5.1	INTRODUCTION	99
5.2	ARGUMENTS THAT OPPOSE THE SELLING OF DONOR KIDNEY	S
		. 100
5.2.1	Exploitation of the poor by the rich would occur	
5.2.2	Informed consent cannot exist where payment is an undue	
	inducement	101
5.2.3	Selling a kidney is an affront to human dignity	. 102
5.2.4	Poor people will undergo risky procedures out of financial desperation	n 103
5.2.5	Public opinion	. 103
5.3	ARGUMENTS IN FAVOUR OF SELLING KIDNEYS	104

5.3.1	A competent person has the right to make informed decisions about t	
	body parts	104
5.3.2	Permitting the selling of kidneys has a number of benefits	105
5.3.3	Society allows persons to make informed decisions about other	risky
	activities	106
5.3.4	The demand for a black market will be diminished	107
5.4	CONCLUSION	107
СНАРТ	ER 6 – A MICRO-COMPARISON WITH THE TRANSPLANT	
	LEGISLATION OF SINGAPORE AND IRAN	109
6.1	INTRODUCTION	109
6.2	SINGAPORE AND KIDNEY DONATIONS	110
6.2.1	The HOTA and presumed consent	111
6.2.2	The HOTA and the reimbursement of living donors	112
6.3	IRAN AND KIDNEY DONATIONS	116
6.3.1	The Iranian model of paid kidney donations	117
6.3.2.	Ethical issues pertaining to the Iranian model	119
6.3.2.1	Arguments supporting the Iranian model	119
6.3.2.2	Arguments against the Iranian model	120
6.4	CONCLUSION	121
СНАРТ	ER 7 – CONCLUSION	123
REFER	ENCES	127
BOOK	5	127
JOURN	IAL ARTICLES	129
CASE	_AW	132
LEGISI	_ATION	133
INTERI	NATIONAL AND REGIONAL INSTRUMENTS	133
INTERI	NET	134



CHAPTER 1 – INTRODUCTION

"Every man must decide whether he will walk in the light of creative altruism or in the darkness of destructive selfishness."

1.1 BACKGROUND

1.1.1 Introductory remarks

At the back of the abdominal cavity, just above the waist of the human body, two extremely vital organs are located. These organs are approximately 10 to 13 cm long and about 5 to 8 cm wide. They represent only 0,5% of the body's total weight, but together these two organs contain about 160 km of blood vessels that receive 20 to 25% of all the blood pumped by the heart.² The body's total blood supply circulates through these organs about 12 times per day, and every hour they filter about 7,5 litres of blood.³ These organs have the life-sustaining task of removing waste products and excess fluids from the body, and they will continue performing until they have lost 75 to 80% of their function. These organs are known as the kidneys, and although most of us are born with two kidneys, life with only one kidney is possible. If a person's kidney does not perform its required function any more, he will have to undergo dialysis treatment until a kidney becomes available for transplantation. Haemodialysis is a treatment that removes the waste products and excess fluid gathered in the blood and body tissue as a result of kidney failure.⁵ The blood is filtered outside the body by means of a dialyser during two or three treatment sessions that can last between three and five hours each week.

¹ Martin Luther King, as quoted in his letter from Birmingham Jail. Dinar http://www.africa.upenn.edu/Articles_Gen/Letter_Birmingham.html (Date of use: 25 April 2011).

² Kidney Health Australia (KHA) "Kidney Facts" http://www.kidney.org.au (Date of use: 25 April 2011).

³ KHA http://www.kidney.org.au (Date of use: 25 April 2011).

⁴ KHA http://www.kidney.org.au (Date of use: 25 April 2011).

Harillall B and Kasiram M "Exploring the bio-psychosocial effect of renal replacement therapy amongst patients in a state hospital in South Africa" 2011 (16) *Health SA Gesondheid* 5.

State facilities only offer dialysis to patients who are eligible for a kidney transplant. The state facilities follow medical exclusion criteria, stating that a patient has to be eligible for a kidney transplant. Furthermore, the patient may not have an active, uncontrollable malignancy or short life expectancy or suffer from an advanced irreversible progressive disease of the vital organs such as cardiac, liver or lung disease. There are also psychological exclusion criteria: a person with any form of mental illness that has diminished capacity to take responsibility for his actions is excluded, as well as substance abusers (including tobacco users) and people who suffer from obesity. If one is accepted into a dialysis program, it is a time consuming and expensive experience. Dialysis also has physical and psychological disadvantages – patients complain of fatigue, headaches, pain, nausea, cramps, weight loss, depression, anxiety and loss of eyesight.

It is thus clear that a healthier option is a kidney transplant, since it reduces the dependence on dialysis treatment and allows a general improvement in a patients' well-being. Sadly, only 18% per million of the population in South Africa receive kidney transplants due to the acute shortage of available kidneys. ¹² In the end, most patients waiting for a kidney transplant lose hope; they stop the dialysis programme and rather go home to die.

Organ transplantation refers to a surgical operation where an organ is taken from one patient's body (also known as the "organ donor") and is placed into another patient's body (known as the "organ recipient"). The objective of organ transplantation is to restore a happy and useful life to a patient who was doomed to a premature death

⁶ Soobramoney v Minister of Health (Kwazula-Natal) 1997(1) SA 765 CC (hereinafter the Soobramoney case).

⁷ Department of Health South Africa (DOH) "Guidelines for chronic renal dialysis" http://www.doh.gov.za (Date of use: 16 August 2011).

It should be noted that patients that have mental handicaps are excluded, but HIV and AIDS are not a medical exclusion criteria if the patient has access to a comprehensive AIDS treatment plan, including antiretroviral treatment for at least six months. DOH http://www.doh.gov.za (Date of use: 16 August 2011).

⁹ DOH http://www.doh.gov.za (Date of use: 16 August 2011).

Dialysis can cost up to R200 000 per annum per patient in the private sector. Discovery http://www.discovery.co.za (Date of use 16 August 2011).

¹¹ Harillall and Kasiram 2011 Health SA Gesondheid 5.

¹² Harillall and Kasiram2011 Health SA Gesondheid 2.

due to a fatal disease of a vital organ. ¹³ Four classes of organ transplants exist. First there is an *autograft*. In this case, the donor and the recipient are the same individual, ¹⁴ and one part of the body is transplanted to a different part of the same body, for instance a skin graft or tissue graft. ¹⁵ Second there is an *isograft* – the donor and the recipient are genetically identical individuals of the same species, ¹⁶ such as with the first successful kidney transplant between twin brothers Ronald and Richard Herrick. Third and mostly done is an *allograft*, where the donor and the recipient are genetically dissimilar individuals of the same species, ¹⁷ thus both are human but they are two different bodies (as is the case with most kidney transplants). The last class is a *xenograft*, where the donor and the recipient are individuals of different species, ¹⁸ for example tissue transplanted from a pig to a human. The organ donor can be a person who has recently been declared brain dead ¹⁹ or a living donor, as is the case with most kidney transplants. ²⁰ Other life-extending measures substantially lower the quality of life, while a successful organ transplant dramatically restores one's health.

1.1.2 The history of kidney transplants

1.1.2.1 International history of kidney transplants

Organ transplantation is probably one of the twentieth century's most miraculous medical breakthroughs. Decades ago the thought of removing one patient's kidney and placing it into another patients' body, while keeping both patients alive, seemed

Hakim NS (ed) Introduction to organ transplantation 2.

¹⁴ Hakim (ed) Introduction to organ transplantation 1.

A tissue graft can be a grafting of any of the following: bone, nerves, tendons, blood vessels or eye materials. Hakim (ed) *Introduction to organ transplantation* 1.

Hakim (ed) Introduction to organ transplantation 1.

¹⁷ Hakim (ed) Introduction to organ transplantation 1.

Hakim (ed) Introduction to organ transplantation 1.

For the purpose of this research, the criteria that a person has to be declared brain dead will not be discussed. It is worth mentioning, though, that in the National Health Act definitions "death" is defined as "brain death".

Most solid organs, such as the heart, lungs, liver, pancreas and kidneys, can be transplanted. For the purposes of this research I will only refer to kidney transplants, because kidney transplants are the only transplants that can take place between living people. Liver transplants from a living donor are still in a developing phase. Slabbert M and Oosthuizen H "Establishing a market for human organs in South Africa Part 2: Shortcomings in legislation and the current system of organ procurement 2007 (28) (2) Obiter 305.

almost impossible. In the early 1950s there were several experiments with organ transplants in Paris, France and Boston in the United States of America, but all of these experiments failed miserably due to the fact that no immunosuppressant²¹ was available.²² Yet, in 1954 a report by Dr Joseph Murray and Dr John Merrill at the Bent Brigham Hospital in Boston shocked the world when it documented the first successful kidney transplant between living identical twin brothers – Ronald and Richard Herrick.²³ After countless failures, this procedure was a great success. The recipient of the kidney survived for eight years with no evidence of rejection. A clear lesson was learned: if surgeons could overcome the immunogenic barrier, a transplanted kidney could give new life to a dying patient. Today, kidney transplants have transformed from what was initially a clinical experiment to a routine and reliable practice that has saved thousands of lives.

1.1.2.2 South African kidney transplant history and transplant legislation timeline

While kidney transplants were already being done successfully in the United States of America and the United Kingdom, in the 1960s South Africa was not there yet. The first successful kidney transplant that took place in South Africa was performed by Dr Christiaan Barnard in October 1967, and two months later he performed the first heart transplant in the Groote Schuur Hospital in Cape Town. These transplants did not catch South African legislators totally unaware. Since 1952 the country has been legally prepared for transplants. In that year, the Post Mortem Examinations and Removal of Tissue Act 30 of 1952 saw the light. It was an advanced measure at the time, since the Act laid down a basis for all transplant procedures. In this regard South Africa was more advanced than some of more developed countries such as

Immunosuppressant therapy works by curbing the production and activity of lymphocytes. It has been used since the middle of the previous century to prevent the human body from rejecting transplanted organs. Anti-immune drugs may raise the chances of survival of a transplanted organ, but they also render a patient more vulnerable to other infections. An organ can still be rejected in spite of immunosuppressive therapy. Norval S *Defining moments:* Marius Barnard – an autobiography 177.

²² Norval Defining moments 177.

²³ Linden PK "History of solid organ transplantation and organ donation" 2009 (25) *Critical Care Clinics* 167.

²⁴ Cape Gateway "Chris Barnard performs world's first heart transplant" http://www.westerncape.gov.za/eng/pubs/public_info/C/99478 (Date of use: 10 January 2012).

Belgium, Holland, Austria, Western Germany, Japan and Switzerland, which had no transplant legislation.²⁵ South Africa, together with some of the American enactments and Italy, enjoyed the most sophisticated transplant legislation.²⁶

Since the first Act dealing with organ transplants (the Post Mortem and Removal of Tissue Act of 1952), South Africa has had three more major enacted statutes that specifically deal with the regulation of the anatomical removal of tissues.²⁷ These statutes are the Anatomical Donations and Post Mortem Examinations Act 24 of 1970, the Human Tissue Act 65 of 1983²⁸ and the National Health Act 61 of 2003.²⁹ Although not dealing directly with organ donation, there is also the Health Act 63 of 1977. This Act was promulgated to provide *inter alia* for measures for the promotion of the health of the South African public. This Act mainly focuses on the preservation of tissue through protection against the spread of infectious diseases such as HIV and AIDS.³⁰ The whole Health Act has been repealed by section 93 of the National Health Act. The healthiness of the donated tissue is of great importance, because if the recipient receives diseased tissue it could be useless.

All the previous Acts had more or less the same purpose regarding organ transplants. The Anatomical Donations and Post Mortem Examinations Act came into force on 9 March 1970 and repealed all previous legislation. This Act was the result of intensive study of legislation in other leading countries and it also considered South African practices and attitudes.³¹ The Act settled a number of issues at the time and had a broader scope, allowing for the donation of eye tissue (whereas the 1952 Act had strict provisions regarding this matter). The Act mainly provided for the donation of human bodies and tissue for therapeutic or scientific purposes, and for the removal of

²⁵ Strauss SA "The new legislation on tissue and organ transplantation" 1970 *South African Medical Journal* 803.

²⁶ Strauss 1970 South African Medical Journal 803.

Fourie EJ *An analysis of the doctrine of presumed consent and the principles of required response and required request in organ procurement* (unpublished LLM Thesis University of Pretoria 2006) 111.

²⁸ Hereinafter referred to as the Human Tissue Act.

²⁹ Hereinafter referred to as the National Health Act.

³⁰ Fourie Organ procurement 111.

³¹ Strauss 1970 South African Medical Journal 807.

such tissues and their use in living persons.³² The Act was framed to facilitate the acquisition and use of tissue, at the same time ensuring that the interests of the public are safeguarded. The Anatomical Donations and Post Mortem Examinations Act was later replaced by the Human Tissue Act 65 of 1983. The Human Tissue Act provided a long-standing regulatory framework regarding organ transplants in the country. The National Health Act of 2003 repealed the Human Tissue Act and all other previous health-related legislation, and established a single framework for the regulation of organ procurement and transplantation.³³

The statutory provisions of the National Health Act relating to the removal and use of tissue of both living and cadaveric donors are almost identical to those of the Human Tissue Act. It should be noted, however, that all previous legislation only dealt with the removal and transplantation of tissue; no legislation provided for the allocation of organs harvested for a transplant.³⁴ The National Health Act takes the extra step and explicitly facilitates allocation and use of human organs.³⁵

A few decades ago, South African transplant legislation could have been compared with other leading countries. Strauss even states that the Anatomical Donations and Post Mortem Examinations Act was rated as one of the most progressive measures of its kind in the world in 1970.³⁶ This is no longer the case. After all these years, South African transplant legislation is still in a developing phase; the legislation has lost track of trends and the needs of the majority of the people.

Cooper DKC *et al.* "Medical, legal and administrative aspects of cadaveric organ donations in the RSA" 1982 (62) *South African Medical Journal* 936.

Chapter 8 of the National Health Act contains sections 53 to 68, which deal with the control of the use of blood, blood products, tissues and gametes in humans. Proclamation R11 *Government Gazette* 35081.

Fourie Organ procurement 139.

Section 61(1) states that human organs obtained in terms of subsection (1) must be allocated in accordance with the prescribed procedures. This section looks promising at first glance. But these <u>prescribed procedures</u> only refer to section 68, which stipulates that the Minister of Health may make regulations pertaining to tissue, cells, organs, blood products and gametes.

³⁶ Strauss 1970 South African Medical Journal 803.

1.1.3 Current regulation of kidney transplants in South Africa

Kidney transplants in South Africa are currently controlled by the following legislation: the Constitution of the Republic of South Africa ,1996³⁷ and the National Health Act of 2003, as well as the Regulations in terms thereof.³⁸ The system of organ procurement, as prescribed by these two Acts, could also play a role.

Section 2 of the Constitution states: "The Constitution is the supreme law of the Republic; law or conduct inconsistent with it is invalid, and the obligations imposed by it must be fulfilled." Section 27(1) of the Constitution stipulates that everyone has the right to have access to healthcare services. Although this sounds very plausible, it should be noted that the abovementioned right to healthcare is internally limited by section 27(2), which stipulates that the state only has to take reasonable legislative and other measures within its available resources to achieve the progressive realisation of this right.³⁹ Other constitutional rights that also affect kidney transplants are the right to life (section 11), the right to human dignity (section 10), the right to privacy (section 14) and the right to self-determination (section 12).

The National Health Act currently regulates kidney transplants in South Africa. This Act replaced the Human Tissue Act, which had its origin in the first successful heart transplant operation performed by Dr Barnard in 1967. The Act governs the removal of tissue, blood or gametes from the bodies of living and dead persons for therapeutic and other uses, as well as the donation of human bodies. The National Health Act's draft regulations on organ transplants set out the approval criteria selecting donors for transplantation. A clear distinction is made between deceased and living donors, as well as related and unrelated living donors. The proposed assessment of donors will

³⁷ Hereinafter referred to as the Constitution.

Currently, there are no specific regulations for transplants published, yet these regulations are still under discussion between role players such as the government and the South African Transplant Society.

³⁹ Soobramoney v Minister of Health (Kwazula-Natal) 1997(1) SA 765 CC

Strauss SA Doctor, patient and the law: A selection of practical issues 147.

Draft Regulations of the National Health Act 61 of 2003 in Government Gazette 30828 of 7 March 2008.

in future be to treat all donors equally. This is a very problematic area, due to the fact that it is very difficult to value one person's life above another.⁴²

Internationally, two main organ procurement systems are acknowledged: an "opting-in" system and an "opting-out" system. The opting-in system is a voluntary and altruistic system. According to this system a person has to give explicit informed consent before his death, confirming that he wants to donate his organs. ⁴³ Countries that follow the opting-in system include South Africa, ⁴⁴ Iran, the United Kingdom and the United States of America. ⁴⁵ In contrast with the opting-in procurement system is the opting-out system. According to this system everyone is a potential organ donor unless the person has registered before death that he does not want to be an organ donor. ⁴⁶ Countries that follow the opting-out system generally have a higher success rate. These countries include Singapore, Spain, Belgium and France. ⁴⁷

The procurement system that is followed in a country plays a very vital role in that country's success rate in acquiring organs for donation. Singapore has about nine deceased donors per million of the population,⁴⁸ while Iran has 2.4 deceased⁴⁹ donors per million of the population.⁵⁰ The method of acquiring donated organs could also be the reason why a country like Spain has approximately 34 deceased donors

42 Slabbert M "One heart, two patients: Who gets a donor organ?" 2009 (1) Stellenbosch Law Review 136.

⁴³ Schicktanz S, Wiesermann C and Wöhlke S *Teaching ethics in organ transplantation and tissue donation* 6.

If a person decides to become an organ donor in South Africa he is not placed on any list. A person can indicate his wish to become an organ donor to the Organ Donor Foundation. Once this is done, the donor will receive a card and two stickers for his identification document and driver's licence, to indicate that he is a donor. Organ Donor Foundation http://www.odf.org.za (Date of use: 17 August 2011).

⁴⁵ Hartwell L "Global organ donation policies around the world" www.lorihartwell.com?GlobalOrganDonationPolices (Date of use: 18 August 2011).

Schicktanz, Wiesermann and Wöhlke Organ transplantation and tissue donation 7.

⁴⁷ Hartwell www.lorihartwell.com?GlobalOrganDOantionPolices (Date of use: 18 August 2011).

⁴⁸ Kwek *et al* "The transplantable organ shortage in Singapore – Has implementation of presumed consent to organ donation made a difference?" 2009 (38) *PubMed* 346.

It should be mentioned that even though Iran has a low deceased donor rate, they have a success rate of 26 per million of the population regarding renal transplants, and in 2009 approximately 1 615 renal transplants took place. Horvat LD, Salimah SZ and Garg AX "Global trends in the rates of living kidney donation rates in living kidney donation" 2009 (75) *Kidney International* 1088.

Thomas M and Klapdor M "The future of organ donation in Australia: Moving beyond the 'gift of life'" http://aph.gov.au/library/pubs/rp/2008-09/09rp11.htm (Date of use: 19 August 2011).

per million population,⁵¹ compared to South Africa with a disappointing 45 000 registered organ donors, which is less than 0,1% of the population.⁵² It should be noted, though, that the South African statistics are estimates, since there is no national register where people indicate their willingness to donate organs. The registered donors referred to are only those people who have contacted the Organ Donor Foundation indicating that they are willing to donate their organs. There are no records of those who have indicated a willingness to donate and those who eventually do donate their organs.

1.1.4 Medical law and kidney transplants

1.1.4.1 The link between the law and kidney transplants

Medical law truly exploded in the last few years. It is almost impossible to open any newspaper, magazine or web browser that does not have relevance to medical law. Medical law today is not only about medical negligence anymore; it has grown to include almost any issue that can constitute an interface between law and medicine. Examples of medical law in the media recently are cases like: "Prof charged after euthanasia of mom":⁵³ This article refers to Prof. Sean Davidson who was charged with attempted murder after giving his mother, who suffered from terminal cancer, a lethal dose of morphine. "R600m lawsuits against KZN Health Department":⁵⁴ This article focuses on the fact that the KwaZulu-Natal Health Department faces medical negligence claims totalling R600 million arising from obstetrics and gynaecology, paediatrics, orthopaedics, pharmacy, surgery and ophthalmology in the last 7 years.

Wong G "Spain leads the way in organ donation" articles.cnn.com/2009-06-17/health/organ.donation_1_organ-donation-donation-rates-number-of-organdonors?_s=PM: HEALTH (Date of use: 19 August 2011).

Organ Donor Foundation www.odf.org.za (Date of use: 15 August 2011).

Schoeman A "Prof. charged after euthanasia of mom" http://www.news24.com/SouthAfrica/News/Prof-charged-after-euthanasia-of-mom-20101010 (Date of use: 20 September 2011).

Regchand S "R600m lawsuits against KZN Health Dpt" http://www.iol.co.za/news/south-africa/kwazulu-natal/r600m-lawsuits-against-kzn-health-dpt-1.1146300 (Date of use: 20 September 2011).

And of course, the groundbreaking news of "SA first with HIV kidney transplant":⁵⁵ This article relates to how Dr Elmi Muller and her team pioneered a technique to transplant kidneys between HIV-positive donors and recipients.

Except for the medicinal and law interface in these articles, it is also clear from the last article that technology regarding medicine keeps on developing, whereas legislation regarding medicine has almost stagnated.

For the ordinary man on the street it would be difficult to understand how kidney transplants and the law have anything in common. Yet, in every aspect of our daily life we have to abide by certain laws; whether these regulate the manner in which we drive on the road or whether it regulates our daily conduct toward other human beings and their rights. Regulations also apply to everyone in the medical practice. The whole medical profession is regulated by the law.⁵⁶ The main purpose of medical regulations is to protect the rights of patients and medical professionals, and to place an obligation on medical professionals.

As everything in the medical world is regulated by laws, the same goes for kidney transplants. Kidney transplants are mainly regulated by chapter 8 of the National Heath Act. The law definitely plays a big role in the regulation of kidney transplants; and without regulations it will not be possible, as Crespi states:

... (M)any deaths from organ failure are no longer the result of an inexorable fate that we must accept, but occur in the modern world only as the unintended consequence of a flawed regime that can be changed.⁵⁷

Only the law can help with the dire need concerning the availability of kidneys for transplants. Taking this a step further, the law can develop and make the accessibility of kidneys easier by allowing the buying and selling of kidneys in a regulated

Erasmus J "SA first with HIV kidney transplant" http://www.mediaclubsouthafrica. com/index.php?option=com_content&view=artic le&id=1846:kidney-transplant-070710&catid =42:la nd news&Itemid=110 (Date of use: 20 September 2011).

The Health Professions Act 56 of 1974.

⁵⁷ Slabbert M Handeldryf met menslike organs en weefsel vir oorplantingsdoeleindes (unpublished LLD Thesis University of the Free State 2002).

environment. If you can sell your own sperm,⁵⁸ eggs⁵⁹ and even breast milk,⁶⁰ why not your kidneys? How can it be that one can sell the part of yourself that creates life but not a part that can maintain life?

1.1.4.2 The public and private healthcare sector in South Africa

The South African healthcare sector is divided into two sections – a public and private sector. The public sector is the largest and offers the most basic primary healthcare by the state.⁶¹ The public sector is mostly under-resourced and over-used. This sector is under pressure to deliver services to approximately 80% of the population.⁶² A recent definition of public health defined it as follows:

Public health is the science and art of preventing disease, prolonging life, promoting health through the organised efforts of society. Public health medicine is that branch of medicine which specialises in public health. Its chief responsibilities are the surveillance of the health of the population, the identification of its health needs, the fostering of policies which promote health and the evolution of health services.⁶³

The private sector is the complete opposite of the public sector. The reality of this difference is that only the employed and financially independent can afford access to private healthcare. This sector is much smaller than the public sector and can offer more specialised health services. The private sector includes all private health service providers (such as doctors and nurses), the institutions that represent health professionals, private health facilities and the funding mechanisms of private health services (medical schemes). ⁶⁴

Spath A "(Sperm) Banking for life" http://www.yourparenting.co.za/fertility/treatment-options/sperm-banking-for-life (Date of use: 24 October 2011).

⁵⁹ Egg Donation SA http://www.eggdonationsouthafrica.co.za (Date of use: 24 October 2011).

South African Breastmilk Reserve http://www.sabr.org.za/members.html (Date of use: 24 October 2011).

The public health system is funded through taxation. Thom A "Is NHI feasible" http://www.health-e.org.za/news/articl.php?uid=20032957 (Date of use: 25 January 2012).

⁶² SAinfo Reporter "Health care in South Africa" www.safrica.info/about/health/health.htm (Date of use: 11 January 2012).

Nadasen S Public health law in South Africa 16.

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* 164.

The separation of the healthcare services is very problematic for the allocation of deceased-donor kidneys. Currently, South Africa has no specific legislation regarding the allocation of donor kidneys. In the National Health Act there are only two sections that mention allocation: section 61(2) states that "human organs obtained in terms of subsection (1) must be allocated in accordance with the prescribed procedures";⁶⁵ and chapter 5 of the draft regulations⁶⁶ mentions that the allocation of organs must be based solely on the clinical needs of the intended patient and that other factors may not be taken into account.⁶⁷ These regulations envisage national control of a transplant database, but at this stage no national waiting list or controls exist.⁶⁸

At present, the process of organ allocation is based on an "agreement" between the public and private sector. According to this agreement, one available deceased kidney will go to the public sector and one to the private sector, according to the urgency of recipients. The relevant people working with kidney donations in these two sectors often consult each other to determine who has a patient with a more urgent need. There are private facilities that offer help to the public sector. For instance, the Netcare Transplant Division financially supports organ transplantation in the public sector by covering donor costs for all organs allocated to the public sector from the private sector.

The "prescribed procedures" fall within the discretion of the Minister of Health.

These regulations will form a part of the new Act, which is not yet promulgated.

Regulation 14: "Allocation of organs obtained from the body of a deceased person must be based purely on the clinical needs of the intended recipient and may not take into account the race, religious beliefs and political affiliation, culture, language or any aspect of the deceased person's life that has no bearing on the physical state or quality of the tissue in question".

⁶⁸ Slabbert 2009 Stellenbosch Law Review 136.

According to Prof. RS Britz, the allocation system of 50:50 between the public and private sector was scrapped in 2010, and a point-based allocation system has taken its place. There is no clarity if this is only applicable to kidney transplant recipients in Johannesburg. According to Anette Otto, kidney allocation in Pretoria, Limpopo, North West and Mpumalanga is sill based on a 50:50 split, and an additional point-based system. It is mentioned that the public and private system have an integrated list. Information supplied by Prof. RS Britz (rsbritz@gmail.com) (12-15/01/2012).

⁷⁰ Slabbert 2009 Stellenbosch Law Review 136.

⁷¹ Slabbert 2009 Stellenbosch Law Review 136.

Netcare "Corporate social investment programmes" http://www.csi.netcare.co.za/live/index_wider.php?cookie=k (Date of use: 12 January 2012).

It should be noted that the allocation process also occurs differently in the public and private sector. Kidney transplants in the public sector are more restricted because only a number of these transplants are performed per annum.⁷³ A patient can only be referred based on the opinion of his doctor and the following factors⁷⁴ are taken into account:

- The patient should have the prospect of living at least another two years with the transplanted organ.
- The patient must be younger than 60 years.
- The patient should not suffer from cardiac, liver or lung disease or unresponsive infections like Hepatitis B and C.⁷⁵

In the private sector the process is more complicated. It can be summarised as follows:⁷⁶ After being diagnosed, a patient is referred to the transplant consultancy of a transplant unit for assistance with the transplant preparatory process. At this point, the patient's condition should have been stabilised.⁷⁷ The patient is prepared mentally and also has to have the adequate support structures in place before and after the proposed transplant. This is only the preliminary screening process. Thereafter, the patient's case is reviewed monthly by a transplant panel, during which the transplant surgeons, physicians and counsellors will consider whether to put or keep the patient on the transplant list.⁷⁸

⁷³ Slabbert 2009 Stellenbosch Law Review 138.

⁷⁴ DOH http://www.doh.gov.za (Date of use: 12 January 2012).

HIV and AIDS are no longer a medical exclusion criteria provided the patient has access to a comprehensive AIDS treatment plan and is stable for at least six months and other exclusion factors are absent. DOH http://www.doh.gov.za (Date of use: 2 September 2011).

This process is only summarised, because there is no need to discuss the whole process in this dissertation.

⁷⁷ Slabbert 2009 Stellenbosch Law Review 135.

⁷⁸ Slabbert 2009 Stellenbosch Law Review 136.

1.2 PURPOSE AND PROBLEM STATEMENT

There are thousands of desperate people globally who need a kidney for transplantation. The number of people who require a kidney transplant continues to escalate faster than the number of kidneys available for a transplant. Approximately 5 000 people are waiting for organs in South Africa, and according to statistics only 400 organ transplants occur each year. According to the Organ Donor Foundation, at least 1 000 kidney transplants should take place each year. Sadly, not even a quarter of kidney transplants realise. In 2010, only 266 kidney transplants were performed in South Africa, and only 119 of these kidneys were donated by living donors.

The acute shortage of available kidneys can be ascribed to various social, political and moral factors; leading to a question whether allowing the buying and selling of human kidneys is not the right way to go. The National Health Act is a step in the right direction. Section $60(4)(a)^{83}$ of the National Health Act stipulates that a donor may be reimbursed for any reasonable costs that occurred during the organ donation, but neither the Act nor the draft regulations of the National Health Act stipulate who will be liable for the payment of these costs and what exactly "reasonable costs" entail.

The question can therefore be asked whether the legislator should not go the whole way and legalise the buying and selling of kidneys. The solution is simple, affordable, respects personal autonomy and cuts out the organ broker in the current black

There is no national waiting list in South Africa regarding organ donations; thus the amount referred to is only an estimate. Slabbert M and Oosthuizen H "Establishing a market for human organs in South Africa Part 1: A proposal" 2007 (28) (1) *Obiter* 53.

The Organ Donor Foundation is a non-governmental organisation in South Africa. They have a number of objectives, namely to educate the public about organ donation, to significantly increase the number of organs donated in South Africa, to increase awareness about organ donation among medical and paramedical professions, and to improve the donor identification and organ procurement programmes. Organ Donor Foundation http://www.odf.org.za (Date of use: 6 May 2011).

Organ Donor Foundation http://www.odf.org.za (Date of use: 25 April 2011).

Organ Donor Foundation http://www.odf.org.za (Date of use: 25 April 2011).

Section 60(4)(a) reads: It is an offence for a person who has donated tissue, a gamete, blood or blood product to receive any form of financial or other reward for such donation except for the reimbursement of <u>reasonable costs incurred</u> by him or her to provide such donation (own emphasis).

markets. Yet the question arises: will it be constitutionally acceptable in a country under the rule of law?

This dissertation focuses on the obligations that the government has in terms of the Constitution, as well as the basic human rights each individual has and how the government must protect these rights in a transplant context. These obligations are analysed in terms of the right to life, 84 the right to human dignity, 85 the right to self-determination, 86 the right to privacy, 87 as well as the right of access to healthcare services. 88 These rights will be evaluated against the proposal of buying and selling kidneys. Section 7(2) of the Constitution stipulates that "the state must respect, protect, promote and fulfil the rights in the Bill of Rights". Thus, if the government cannot fulfil these rights, it should be able to supply an alternative to improve the current kidney shortage. In addition to being constitutionally acceptable, the selling of kidneys must be bio-ethically justifiable as well. Therefore, kidney sales must also be tested against the four pillars of bio-ethics: respect for patient autonomy, beneficence, non-maleficence and justice. 89

In 2010, kidneys were illegally bought from Brazilian and Romanian sellers and transplanted into Israeli patients at a Netcare facility in South Africa.⁹⁰ These incidents made it clear once again that the trade of organs is happening; it is a reality. Where there is a demand there will always be a supply, whether legal or not. To legalise organ sales will decrease the success of the current black market regarding the trade of organs.⁹¹

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⁸⁴ Section 11 of the Constitution.

⁸⁵ Section 10 of the Constitution.

⁸⁶ Section 12(2)(b) of the Constitution.

⁸⁷ Section 14 of the Constitution.

⁸⁸ Section 27(1)(a) of the Constitution.

⁸⁹ Moodley K "Respect for patient autonomy" in Moodley K (ed) *Medical ethics, law and human rights: A South African Perspective* 41.

⁹⁰ Barnard M "Kidney transplant scandal spreads" http://www.news24.com/SouthAfrica/News/Kidney-transplant-scandal-spreads-20110228 (Date of use: 9 May 2011)

⁹¹ Slabbert M "Combat organ trafficking – reward the donor or regulate sales?" 2008 (73) KOERS 79.

1.3 CHOICE OF LEGAL SYSTEMS

The main focus of this dissertation will be South African legislation with regard to organ transplants. Special attention will be given to certain sections of the Constitution. Section 39(1) of the Constitution states that, when interpreting the Bill of Rights, international law must be considered and foreign law may be considered. Making comparisons can also broaden the horizons for law reformers and legislators: it helps a person to see how legislation can make a difference in another country. Organ transplant legislation in Singapore and Iran will thus be analysed. Singapore's Human Organ Transplant Act was chosen because of recent changes to this Act, which now allows the reimbursement of costs incurred by living donors in accordance with international and local ethical practices. ⁹² Iran is the second choice, because this country has been following a system of paid and regulated living unrelated kidney donation since 1988. ⁹³

Relevant South African legislation that governs organ transplantation is also discussed, namely the National Health Act. Mention will also be made of the recently repealed Human Tissue Act, since this Act established the system of organ procurement.

Lastly, reference is made to a number of international documents in order to provide insight on an international level concerning kidney transplants, for example the Declaration of Istanbul on Organ Trafficking and Transplant Tourism and the International Bill of Rights.

1.4 RESEARCH APPROACH AND METHODOLOGY

The envisaged research is not of an empirical nature, but involves a literature study of books, journal articles, legislation, case law and interviews with experts in the field of organ transplants. The study is primarily a critical analysis of the relevant South

⁹² Chew V "Human Organ Transplant Act (HOTA) http://infopedia.nl.sg/articles/SIP_1401_2009-01-08.html (Date of use: 2 August 2011).

Ghods AJ and Savaj S "Iranian model of paid and regulated living-unrelated kidney donation" 2006 (6) Clinical Journal of the American Society of Nephrology 1136.

African literature and legislation. A brief comparative study on kidney transplants in Singapore and Iran will also be undertaken.

1.4.1 Explanatory notes on source referencing and bibliography

- The date of publication of textbooks is either referred to with reference the actual year of publication or to the number of the edition of the book.
- Where a passage from a judgment or textbook is quoted and the quote itself
 contains references to other materials, the format of these references will not
 be altered to follow the format in the text of the thesis (on the basis that it is a
 quote and as such must remain unaltered).
- References to case names appears in the main body of the text in italics, except when they are intended as references to the people themselves, in which case they will appear as regular text, for example Soobramoney means the case of Soobramoney v the Minister of Health, KwaZulu-Natal while Soobramoney means the applicant in that case.
- With reference to sources, the citations are given as follows:
- Journal article citation for the first time: Bagheri A "Compensated kidney donation: An ethical review of the Iranian model" 2006 (16) Kennedy Institute of Ethics Journal 270. The second citation: Bagheri 2006 Kennedy Institute of Ethics Journal 270.
- Textbook citation for the first time: Dugard J International law: A South African Perspective 114. The second citation Dugard International law: A South African Perspective 114.
- Academic theses and dissertations citation for the first time: Fourie EJ An analysis of the doctrine of presumed consent and the principles of required response and required request in organ procurement (unpublished LLM Thesis University of Pretoria 2006) 132. The second citation Fourie Organ procurement 132. Theses and dissertations are referenced to in the same manner as a book.
- Publications / contributions in an edited book citation for the first time:
 Moodley K "Respect for patient autonomy" in Moodley K (ed) Medical ethics,

law and human rights: A South African perspective 41. The second citation: Moodley in Moodley (ed) Medical ethics, law and human rights 41.

- South African court cases citation: Soobramoney v Minister of Health (Kwazula-Natal) 1997(1) SA 765 CC.
- Websites citation for the first time: Burger K "Netcare apologises again for organ scandal" http://www.mg.co.za?article/2010-11-15-netcare-apologisesagain-for-organ-scandal (Date of use: 23 August 2011). The second citation: Burger http://www.mg.co.za?articale/2010-11-15-netcare-apologises-again-forscandal (Date of use: 23 August 2011).
- The style further does not cite pages with reference to the letter "p" but simply refers to the page number, for example 35.
- Paragraphs in footnotes are cited as follows: para 26.

OVERVIEW OF CHAPTERS 1.5

The dissertation will consist of seven chapters divided into various topics in the following manner:

Chapter one is an introductory chapter wherein the nature, history and current shortages regarding kidney transplants are discussed. There is also a brief discussion of the current unsuccessful organ procurement system in South Africa, and on how selling and buying kidneys legally could be a practical solution. There is also a short discussion regarding the law and medical issues. Nys⁹⁴ regards medical law as follows:

Medical law is an area of law, medical law does not respect traditional compartments with which lawyers have become familiar, such as torts, contracts, criminal law, family law and public law. Instead, medical law cuts across these subjects and today must be regarded as a subject in its own right. We maintain that it is a discrete area concerned with the law governing the interactions between doctors and patients and the organisation of health care.

⁹⁴ Carstens PA and Pearmain DL Foundational principles of South African medical law 3.

Chapter two is a discussion of the Constitution and kidney transplants. The following rights are analysed in the context of kidney transplants: the right to life, the right to human dignity, the right to self-determination, the right to privacy, as well as the right of access to healthcare services. Case law regarding the above is also included.

Chapter three of the dissertation looks at other South African legislation regarding kidney transplants. The Human Tissue Act (recently repealed) and the National Health Act are discussed, as well as the shortcomings of both these Acts. There is also a short discussion regarding the assessment of potential kidney donors and recipients.

Bioethical perspectives on kidney transplants are discussed in *Chapter four*. Because the selling of kidneys could be a moral problem, it is of great importance that the proposal of selling kidneys should be tested against the four basic principles of bioethics, namely autonomy, beneficence, non-maleficence and justice.

Chapter five focuses on the arguments in favour of and against the selling of kidneys.

Chapter six is a micro-comparison of legislation and organ transplants in South Africa with other countries such as Singapore and Iran. In Singapore residents are not yet allowed to sell their kidneys, but reimbursement for kidney-donation-related expenses are allowed.⁹⁵ However, in Iran, a regulated system of payment for kidneys was instituted in 1988, which eliminated the renal transplantation waiting list.⁹⁶

Chapter seven is a concluding section wherein the conclusion is drawn that the best possible solution regarding the current acute shortage of available kidneys, which will be constitutionally acceptable, is to legalise the buying and selling of kidneys.

96 Kleinsmidt A and Moosa MR "Organ transplant ethics" in Moodley K (ed) *Medical ethics, law and human rights* 282.

Leong S "10 apply to kidney live donor fund in first year" www.nuh.com.sg/news (Date of use: 11 May 2011).

1.6 POINT OF DEPATURE, ASSUMPTIONS AND HYPOTHESIS

The point of departure of this dissertation is that there is a huge demand for transplantable kidneys in South Africa and the current system of procuring these desperately needed kidneys is failing the patients who are waiting for a kidney transplant.

The state has a number of obligations that it should attend to in terms of the Bill of Rights. Yet, due to the lack of resources, among others, it cannot realise these rights for everyone in need. The state cannot even help all the patients in need of dialysis – not to mention help them with a transplant. An alternative, where the patient could help himself by buying a healthy kidney legally, is proposed as a solution. Such a proposal could withstand constitutional muster.

1.7 VALUE CONTRIBUTION

This dissertation focuses mainly on the acute shortage of available kidneys for transplantation and how ineffectively these transplants are regulated due to legislative shortcomings. It also focuses on the fact that there are available kidneys, but people are prohibited from selling their kidneys due to various limitations and penalties regarding payment of the kidney donor. Due to this fact, the research will focus on the Constitution and the obligations enforced therein on the government. Thus, if the government cannot fulfil these obligations they should be able to supply an alternative to improve the current kidney shortage. It is trusted that this dissertation will help propose a solution to the kidney shortage that will be constitutionally acceptable.

1.8 MOTIVATION

Almost every day there are various kinds of articles relating to organ transplants – in every newspaper, magazine and web page. For example, there is the article praising the miracle of organ donation and some organ recipients' gratefulness for the

received organ: "I'm alive because of someone's kindness". The article speaks of a 64-year old lady, Joan Bell, whose life was changed after she received a donated kidney. Then there is always the opposite: a shocking article ranting and raving about illegal organ trades: "Netcare apologises again for organ scandal". This article articulates how Netcare was fined R7,8 million after they pleaded guilty to unlawful surgeries where illegal kidneys were acquired and transplanted. All of these articles shine a light on the dire need for available organs for transplant purposes.

The problem here certainly is not that there are no kidneys available. At present, there are about 49 004 031 residents⁹⁹ in South Africa, which means that more or less the same amount of kidneys are available. The problem is more related to the ineffectiveness of the present legislation. It is no secret that most people do not grasp the idea of altruism. In the world of today, few people would give something away without receiving something in return – much less so undergoing an operation (the organ donor has to pay all costs incurred himself) and giving away a part of oneself to a complete stranger for free. The previous Human Tissue Act made no provision for the reimbursement of an organ donor and clearly stated in section 28 that a payment in connection with the supply of tissue, blood, blood products or gametes is prohibited. The National Health Act stipulates in section 60(4)(a) that a donor may be reimbursed for any reasonable costs that occurred during the organ donation; however, there still is no clarity as to how this reimbursement may occur.

This dissertation attempts to conduct a detailed and wide-ranging study of South African legislation regarding kidney transplants and to provide a manner in which more kidneys can be procured in a constitutionally acceptable way to the advantage of both the kidney donor and recipient. If more kidneys can be donated, less people would have to undergo the painful, often excruciating, process of dialysis. A kidney

⁹⁷ Hills M "I'm alive because of someone's kindness" http://www.echonews.co.uk/news/local_news/92059551.I_m_alive_because_of_ someone's_ kindness (Date of use: 22 August 2011).

Burger K "Netcare apologises again for organ scandal" http://www.mg.co.za?article/2010-11-15-netcare-apologises-again-for-organ-scandal (Date of use: 23 August 2011).

⁹⁹ South African Demographics http://www.indexmundi.com/south_africa/demographics profile.html (Date of use: 23 August 2011).

transplant is a more efficient life-extending measure, and research has shown that a living kidney transplant will probably be functioning at 95% two years after the transplant. 100

The more organs that are donated, the more lives are saved. One organ donor alone can save up to eight lives by donation all his organs. If kidney sales are regulated, even more lives can be saved because the donor is also "saved" in a way. The donor can be the provider of a family who needs the money to support his family, or a young aspiring intellectual who needs the funds for tertiary studies. Pope John Paul II recently remarked that the commercialisation of organs violates "the dignity of the human person". How does leaving a person to die when the needed organs are available not violate not only human dignity but the right to life as well?

¹⁰⁰ The University of Texas Medical Branch "Kidney transplant success rate" http://www.utmb.edu/renaltx/srate.htm (Date of use: 23 August 2011).

¹⁰¹ Finkel M "This little kidney went to market" http://www.nytimes.com/2010/05/27/magazine/27ORGAN.html (Date of use: 23 August 2011).

CHAPTER 2 – HUMAN RIGHTS AND KIDNEY TRANSPLANTS

"A bill of rights is what the people are entitled to against every government on earth, and what no just government should refuse, or rest on interference." 102

2.1 INTRODUCTION

Imagine a world where human rights are seen as inconsequential. Everybody, including the government, would be free to do as they please and to treat other people as they like. In this world it would not be frowned upon if people were discriminated against on grounds of their race, religion or sexuality. Treating human beings with complete disdain and utter disregard for humanity would be commonplace. Concentration camps, genocide – these horrific acts would be seen as justifiable based on prejudicial rhetoric. Furthermore, in this world it would not be regarded as unacceptable if non-consensual experiments were performed on human beings, such as having their bones broken and their wounds infected until they had seizures and suffered cardiac arrest. 103

If this all sounds familiar, it is because this world without human rights once existed before 1947. The horrific scene described above is known as the Holocaust. During this era, human rights were not regarded as important, and many atrocities were committed by the Germans against the Jewish. The Holocaust led to the Nuremberg Trails, 104 and these trails led to the Nuremberg Declaration, which was promulgated in 1947. 105 The Nuremberg Declaration has limited applicability, as it only deals specifically with human research and experimentation. Nonetheless, it was the first step in the direction of the modern era of human rights. 106 In 1948 – one year later – that the most significant development in human rights took place: the adoption of the

¹⁰² Bernstein RB Jefferson 72.

Newman B "The doctors of the Holocaust" http://www.remember.org/imagine/doctors.html (Date of use: 17 May 2012).

The Nuremberg Trials were a series of military tribunals held by the victorious allies of World War II. The best-known of these trials was the trial of the major war criminals where German officials were tried for crimes against peace, war crimes and crimes against humanity. Schmidt U Justice at the Nuremberg: Leo Alexander and the Nazi doctors' trail 4.

McLean SAM "Human rights and bioethics" http://www.unesco.org (Date of use: 17 May 2012).

¹⁰⁶ McLean http://www.unesco.org (Date of use: 17 May 2012).

Universal Declaration of Human Rights by the United Nations.¹⁰⁷ The Universal Declaration of Human Rights was adopted to set international standards for human rights: firstly, to defend individuals against the abusive powers of organs of state, and secondly, to promote the opportunity for individuals to develop through measures such education, healthcare and a safe living environment.¹⁰⁸

It is clear that the relationship between human rights and medical ethics is undeniable. 109 Human rights can be defined as the rights that we have, as humans, from birth until death, which are comprehensively defined in various documents and codes. 110 In South Africa, human rights have been codified into international, regional and national human rights law. Human rights are protected by the International Bill of Rights, which consists of the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights. 111 and the International Covenant on Economic, Social and Cultural Rights. 112 As can be seen from the last mentioned, human rights are broadly divided into categories. The three categories are civil and political rights, economic, social and cultural rights and lastly environmental rights. This chapter will mainly focus on the first two categories of human rights.

Civil and political rights, also known as "first-generation rights", were introduced to protect people from oppression by the state. First-generation rights ensure that everyone is entitled to participation in the political process and are free from interference by the government – as long as their actions are not harmful to others. An example of a first-generation right would be the right not to be subjected to medical or scientific experimentation without consent.

Hereinafter referred to as the UDHR. McLean http://www.unesco.org (Date of use: 17 May 2012).

Dhai A and McQuoid-Mason D Bioethics, human rights and health law 36.

In this chapter, the main focus is on human rights, whereas in chapter 4 there will a focus on medical ethics.

¹¹⁰ Dhai and McQuoid-Mason Human rights and health law 36.

The International Covenant on Civil and Political Rights of 1966, hereinafter referred to as the ICCPR.

¹¹² The International Covenant on Economic, Social and Cultural Rights of 1966, hereinafter referred to as the ICESCR.

Dhai and McQuoid-Mason Human rights and health law 37.

Dhai and McQuoid-Mason Human rights and health law 37.

Economic, social and cultural rights, also known as "second-generation rights", were introduced because people needed more than freedom from interference from the state to survive, for instance access to economic and other resources like food and shelter – thus, an adequate standard of living.¹¹⁵ An example of a second-generation right would be the right of access to healthcare. Section 231 of the Constitution clearly states the importance of international agreements. The section reads:

(A)ny international agreement becomes law in the Republic when it is enacted into law by national legislation; but a self-executing provision of an agreement that has been approved by Parliament is law in the Republic unless it is inconsistent with the Constitution or an Act of Parliament. 116

At regional level, South African human rights are protected by the African Charter of Human and People's Rights.¹¹⁷ In this chapter, both the international and regional human rights instruments are mentioned briefly in relation to the specific human rights pertaining to kidney transplants.

The most important national document protecting South African human rights is the Constitution or, more specifically, the Bill of Rights. The Constitution has a general impact on kidney transplants in three sections. First and foremost in section 2 it is stipulated that the Constitution is the supreme law and that any law or conduct inconsistent with it is invalid, and the obligations imposed by it must be fulfilled. Secondly, it is stated that the Bill of Rights must be respected, protected and fulfilled by the state. Thirdly, in section 39(1) it is stipulated that when interpreting the Bill of Rights, a court, tribunal or forum must promote the values such as human dignity, equality and freedom. Furthermore, international law must be considered and foreign law may be considered. In the Constitution there is also more specific fundamental human rights relating to kidney transplants – such as the right to life, the right to human dignity, the right to self-determination, the right to privacy and the right of

Dhai and McQuoid-Mason Human rights and health law 37.

¹¹⁶ Section 231(4) of the Constitution.

Hereinafter referred to as the African Charter.

¹¹⁸ Section 7(2) of the Constitution.

Section 39(1)(a) is of great importance in terms of chapter 6 of this dissertation. In chapter 6 there is a micro-comparison of transplantation legislation in Singapore and Iran.

access to healthcare services. These rights are discussed below. However, all these fundamental human rights are not absolute and may be limited or restricted by section 36 of the Constitution.

2.2 SECTION 36 OF THE CONSTITUTION: LIMITATION OF RIGHTS

None of the human rights guaranteed by the Bill of Rights are absolute. The general limitation section of the Constitution sets out specific criteria for the justification of restrictions on the rights in the Bill of Rights. Section 36 is referred to as a general limitation section because it applies to all the rights in the Bill of Rights, and limits all rights according to the same criteria. It should be borne in mind that a right cannot be limited for any reason. A law may legitimately limit a right in the Bill of Rights if it is a 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. The law of general application requirement can be summarised as follows: law for the purposes of this requirement is all forms of legislation, including common law and customary law. The general application requirement requires that the law must be sufficiently clear, accessible and precise so that the persons who are affected by it can ascertain the extent of their rights and obligations.

Consequently, the law must apply equally to all. For the second part of the requirement – that the limitation must be reasonable and justifiable in an open and democratic society – a number of relevant factors must be taken into account. These factors are: 128

the nature of the right;

¹²⁰ Currie I and De Waal J *The Bill of Rights handbook* 163.
121 Currie and De Waal *Bill of Rights handbook* 165.

¹²² Section 36(1) of the Constitution.

All forms of legislation include delegated and original legislation.

¹²⁴ Common law includes both the private law and the public law rules, such as criminal law.

Du Plessis v De Klerk 1996 (3) SA 850 (CC). See also Currie and De Waal Bill of Rights handbook 169.

¹²⁶ Dawood v Minister of Home Affairs 2000 (3) SA 936 (CC).

¹²⁷ Currie and De Waal Bill of Rights handbook 169.

¹²⁸ Section 36(1)(a)-(e) of the Constitution.

- the importance of the purpose of the limitation;
- the nature and extent of the limitation;
- the relation between the limitation and its purpose; and
- less restrictive means to achieve the purpose.

Thus, it is clear that fundamental human rights in the Bill of Rights may be limited; but only after a number of requirements have been fulfilled and if the limitations are for legitimate reasons. The human rights and their limitations in the Bill of Rights applicable to kidney donations will be discussed below.

2.3 THE RIGHT TO LIFE

The right to life is regarded as the most fundamental of all human rights.¹²⁹ This is because it gives rise to all other rights. If a person is not alive, he cannot be the bearer of other rights or exercise any of his rights, as observed by O'Regan in *Makwanyane*:¹³⁰

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.

The importance of the right to life is reflected by the fact that the right is protected by all international and regional human rights instruments.¹³¹

2.3.1 International and regional human rights instruments

The right to life is firstly and most importantly protected by the UDHR. In article 3 it clearly states that "everyone has the right to life, liberty and security of person". The right to life contained in the UDHR has become so established in international law

¹²⁹ Carstens and Pearmain Foundational principles of South African medical law 27.

¹³⁰ S v Makwanyane and Another 1995 (3) SA 391 (CC) (hereinafter referred to as the Makwanyane case) para 326.

¹³¹ Rehman J International human rights: A practical approach 68.

that it is described as having a *jus cogens*¹³² character; thus meaning that no derogation of this right is permitted.¹³³ The right to life is furthermore protected by article 6(1) of the ICCPR, which reads, "Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of life". States such as South Africa, which has ratified the ICCPR, must at all time take positive steps to effectively protect the right of life.¹³⁴

At regional level, the right to life is protected by article 4 of the ACHPR, which reads, "Human beings are inviolable. Every human being shall be entitled to respect for his life and the integrity of his person. No one may be arbitrarily deprived of this right". In most cases, the African Commission has followed the jurisprudence of the United Nations Human Rights Committee regarding the right to life. However, in some cases, the African Commission has interpreted the right to life in a wider context. For instance, in the ground-breaking case of *Social and Economic Rights Action Centre v Nigeria*, 136 the African Commission stated that the right to life implied a right to food as well. Even though the various international and regional human rights instruments may vary regarding the right to life, all the instruments have one thing in common, and that is that everyone has a right to life and that the state has an

The notion of *jus cogens* has its origin in the Vienna Convention on the Law of Treaties of 1969, which, in article 53 provides: "A treaty is void, if at the time of its conclusion, it conflicts with a peremptory norm of general international law. For the purposes of the present Convention, a peremptory norm of general international law is a norm accepted and recognized by the international community of states as a whole as a norm from which no derogation is permitted and which can be modified only by a subsequent norm of general internal law having the same character." Dugard J *International law: A South African perspective* 43.

¹³³ Dugard International law: A South African perspective 43.

Joseph R "The right to life is the most important of all" http://www.arha.org.au (Date of use: 19 May 2012).

Manby B "Civil and Political rights in the African Charter on human and Peoples' Rights: Articles 1-7" in Evans M and Murray R (eds) *The African Charter on Human and Peoples' Rights* 184.

Social and Economic Rights Action Centre and the Centre for Economic and Social Rights v Nigeria Communication No.155/96.

This case was about the environmental pollution of the Ogoni territory. The African Commission was of opinion that that the Nigerian Government was obliged to protect existing food sources from (among other things) environmental pollution. The Commission stated in this case that the destruction of land and farms was a violation of the right to life. Social and Economic Rights Action Centre and the Centre for Economic and Social Rights v Nigeria Communication No.155/96.

obligation to protect this right. In South Africa, the right to life is ensconced in the Bill of Rights.

2.3.2 The Constitution

The year 1996 ushered in the dawn of a new era, known as constitutionalism, which changed the entire legal landscape in South Africa. Suddenly the doctrine of parliamentary sovereignty was replaced by the doctrine of constitutional supremacy. Constitutionalism now meant that the government could only derive its power from a written constitution and that its powers would be limited to those as set out in the Constitution. The Constitution, as described in *Makwanyane*,

... provides a historic bridge between the past of a deeply divided society characterised by strife, conflict, untold suffering and injustice, and a future founded on the recognition of human rights, democracy and peaceful coexistence and development opportunities for all South Africans, irrespective of colour, race, class, belief or sex.

The Constitution contains a Bill of Rights that protects the rights of each South African citizen. One of the most fundamental rights provided by the Constitution is found in section 11 and reads that everyone has the right to life. The right to life, along with the right to human dignity, must be valued above all other rights. The absoluteness of the right to life has also been mentioned in a decision by the Hungarian Constitutional Court. In this decision it was mentioned that other rights may be limited, and may even be withdrawn and then granted again, but the right to life is absolute and must be preserved at all times. The South African Constitution differs from most other constitutions, as well as the ICCPR, due to the fact that the right to life is unqualified.

142 S v Makwanyane and Another 1995 (3) SA 391 (CC) para 83-85. See also Currie and De Waal Bill of Rights handbook 281.

¹³⁸ Currie and De Waal Bill of Rights handbook 2.

¹³⁹ Currie and De Waal Bill of Rights handbook 8.

¹⁴⁰ S v Makwanyane and Another 1995 (3) SA 391 (CC) para 214.

¹⁴¹ Decision 23/1990 (X31) AB.

¹⁴³ It differs from other constitutions of jurisdictions such as the United States, Canada, Hungary and India. Currie and De Waal *Bill of Rights handbook* 281.

¹⁴⁴ Currie and De Waal Bill of Rights handbook 281.

to the fact that the right to life may not be deprived arbitrarily. Chaskalson P remarks in the *Makwanyane* case that the right to life is given greater protection in the South African Constitution due to the fact that it is unqualified. According to section 7(2) of the Constitution, the state has obligations to respect, protect, promote and fulfil the right to life. Due to these obligations, negative and positive duties are imposed on the state. The negative duty implies that the right to life must be protected to the extent that no one else can take it away. For instance, one's right to life cannot be taken away by imposing the death penalty and one also has a right to defend your life by means of self-defence. The positive duty obligates the state to protect the lives of its citizens. The question can however be raised whether the state's duty to protect and promote life could be extended to include prolonging an end-stage renal-failure patient's life where it is within the state's capabilities to do so.

2.3.3 The right to life and kidney transplants

In all the international and regional human rights instruments that were mentioned above it is obvious that everyone has a right to life and that this right may not be deprived arbitrarily. The South African Constitution even entails an unqualified right to life; thus it is not limited in any way, except by section 36 of the Constitution. Yet, none of these human rights instruments discuss what exactly the right to life entails. In South Africa, the right to life was intentionally left unqualified and the Constitutional Court was given the authority to develop the right to life. That is exactly what the court did in the *Makwanyane* case. Although this case mainly focuses on the invalidation of the death sentence, a number of important remarks are made regarding the right to life. In this section, the author would like to focus on how the right to life can be interpreted in such a manner that the scope is extended to include the prolonging of an end-stage renal-failure patient's life by means of a kidney transplant.

¹⁴⁵ Currie and De Waal Bill of Rights handbook 281.

S v Makwanyane and Another 1995 (3) SA 391 (CC) para 85: "Our Constitution does not contain the qualification found in section 54(1) of the Hungarian Constitution, which prohibits only the arbitrary deprivation of life. To that extent, therefore, the right to life in section 9 of our Constitution is given greater protection than it is by the Hungarian Constitution".

¹⁴⁷ Cartens and Pearmain Foundational principles of South African medical law 27.

Thus far it has been argued that the right to life definitely entails a physical existence. Nonetheless, what is the use of a right to life as a physical being if it is not a life worth living? In *Makwanyane*, O'Regan J commented as follows:

... 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. 148

Sachs J enhances the idea of a life worth living by adding that the right to life could possibly impose a duty on the state to create conditions that will enable all persons to enjoy a life worth living. ¹⁴⁹ It could be argued that a patient with end-stage renal failure does not live a life worth living. Studies have shown that patients on dialysis have a noteworthy decrease in their quality of life. A patient on dialysis has to receive dialysis treatment for three to four hours at a time three to four times a week. ¹⁵⁰ Renal dialysis has a number of side effects, which can be divided into physical and psychological effects.

The physical side effects include a decrease in energy levels and endurance, fatigue, headaches, pain, itchiness, loss of sight, nausea, cramps, infections and weight loss. ¹⁵¹ It is obvious that all these symptoms will seriously affect the performance of a person's simple daily activities. The psychological effects include depression, aggression, fear, mental anguish, sadness and stress. ¹⁵² Consequently, it is obvious that a patient on renal dialysis has to make long-term health and lifestyle adjustments. Except for physical and psychological side effects, renal dialysis also places a tremendous financial burden on either the state or the private-sector patient. If the renal dialysis is supplied by the state, it costs the state more or less R200 000

¹⁴⁸ S v Makwanyane and Another 1995 (3) SA 391 (CC) para 326 (own emphasis added).

¹⁴⁹ S v Makwanyane and Another 1995 (3) SA 391 (CC) para 353.

¹⁵⁰ Canadian Institute for Health "Renal transplantation saving millions in dialysis costs" http://www.cihi.ca (Date of use: 20 May 2012).

¹⁵¹ Harillall and Kasiram 2011 Health SA Gesondheid 5.

¹⁵² Harillall and Kasiram 2011 Health SA Gesondheid 5.

per patient per annum.¹⁵³ The patient in the private sector can look at a financial setback of more or less R40 000 to R60 000 per month.¹⁵⁴ To make matters worse, the majority of patients are not healthy enough to attend work each day, or their occupation does not allow them to be absent during the hours required for renal dialysis; thus, they are retrenched and as such they also suffer a loss of income. Above all, it should be borne in mind that renal dialysis is only a life-prolonging treatment – it is not a cure for renal failure.¹⁵⁵

The ideal treatment for end-stage renal failure is a kidney transplant. After careful consideration of all the facts mentioned above, it is clear that life on renal dialysis is not a life worth living. This is possibly the reason why so many patients decide to stop their dialysis treatment and rather go home to die. However, a renal transplant has a number of benefits and can clearly increase one's quality of life. In our Bill of Rights the state's positive obligations to make life liveable is mostly codified by our socio-economic rights – such as the right to access to adequate housing and the right to access to healthcare, food, water and social security. This approach was confirmed in the *Khosa v Minister of Social Development* case, where it is cited that the socio-economic rights in the Constitution are implicated with the right to life, human dignity and equality. In socio-economic rights cases, the availability of human and financial resources also has to be taken into account to determine whether the state had complied with the constitutional standard of reasonableness.

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De Klerk A "A simple answer to kidney disease" http://www.mg.co.za/article/2011-04-04 (Date of use: 20 May 2012).

¹⁵⁴ Information supplied by Nurse R du Toit at Medi-Clinic Upington.

Davidson SN and Rosielle DA "Withdrawl of dialysis: decision making" http://www.eperc.mcw.edu (Date of use: 21 May 2012).

Harillall and Kasiram 2011 Health SA Gesondheid 2.

National Kidney Foundation "When stopping dialysis treatment is your choice" http://www.kidney.org (Date of use: 21 May 2012).

Harillal and Kasiram 2011 Health SA Gesondheid 2.

¹⁵⁹ Section 26 of the Constitution.

¹⁶⁰ Section 27 of the Constitution.

¹⁶¹ Khosa v Minister of Social Development 2004 (6) SA 505 (CC) (hereinafter referred to as the Khosa case).

¹⁶² Currie and De Waal Bill of Rights handbook 290.

¹⁶³ Khosa v Minister of Social Development 2004 (6) SA 505 (CC) para 44.

In Soobramoney v Minister of Health (KwaZulu-Natal)¹⁶⁴ the court dealt with an application for life-saving medical treatment in the context of the socio-economic right to healthcare instead of the right to life. Soobramoney brought a constitutional application, seeking an order for the hospital to provide him with access to dialysis treatment on grounds of emergency medical treatment. However, the court dismissed this application because Soobramoney's health could not be seen as emergency medical treatment, but rather as an "ongoing state of affairs". 165 This case is discussed in more detail in section 2.7.2. Nonetheless, one is left to wonder if the court's decision would not have been different if Soobramoney was a 25-year-old healthy man with renal failure, instead of a 41-year-old man who was extremely sick. 166 One can also wonder if the decision would not have been different if the application was brought on the grounds of a right to life and a right to access to healthcare and not based on emergency treatment. 167 Surely the results would have been different? In the author's opinion it could be argued that, as mentioned above, there is a duty on the state to provide end-stage renal-failure patients with conditions that constitute an enjoyable human existence. Chaskalson P comments in Makwanyane that the right to life is one of the most important rights and the source of all other rights. These rights must be valued and the state must demonstrate this in everything that it does. 168 Thus, the state could supply these patients with an alternative that is within their available resources. If these patients could be allowed to obtain a kidney for transplant purposes by buying it in a constitutionally acceptable manner they will be able to enjoy their human existence, instead of having a right to life that entails constant pain and suffering.

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¹⁶⁴ Soobramoney v Minister of Health (Kwazula-Natal) 1997(1) SA 765 CC

Soobramoney v Minister of Health (Kwazula-Natal) 1997(1) SA 765 CC para 21.

As mentioned in the *Soobramoney* case, Soobramoney was very ill. He was a diabetic who suffered from ischemic heart disease and cerebro-vascular disease. He had suffered a stroke and was in the final stages of chronic renal failure. *Soobramoney v Minister of Health* (*Kwazula-Natal*) 1997(1) SA 765 CC para 1.

In this case, the court suggested that the application of sections 27(1) and 27(2) of the Constitution were more appropriate to the facts of the case than sections 11 or 27(3) of the Constitution.

¹⁶⁸ S v Makwanyane and Another 1995 (3) SA 391 (CC) para 144.

2.4 THE RIGHT TO HUMAN DIGNITY

The right to human dignity entails the acknowledgement of the intrinsic worth of human beings.¹⁶⁹ Human dignity is regarded as one of the supreme human rights. The reason for this is because the right to life and the right to human dignity are joined at the hip, as stated in *Makwanyane* by Ackermann J:¹⁷⁰

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.

Everyone has the right to be treated in a dignified and humane manner.¹⁷¹ The importance of human dignity is incorporated in various international human rights instruments, as well as national constitutions. Human dignity is thus regarded as a universal duty and a universal responsibility.¹⁷²

2.4.1 International and regional human rights instruments

The main purpose of the right to human dignity is to try and correct substantial past human dignity violations and to prevent the reoccurrence of such violations in the future. The UDHR emphasises the importance of human dignity in its preamble, which states that the recognition of inherent dignity of all members of the human family is the foundation of freedom, justice and peace in the world. The right to human dignity is furthermore protected in article 1 of the UDHR, which reads, "All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood."

¹⁶⁹ S v Makwanyane and Another 1995 (3) SA 391 (CC) para 328.

¹⁷⁰ S v Makwanyane and Another 1995 (3) SA 391 (CC) para 327.

¹⁷¹ Goolam NMI "Human dignity – our supreme constitutional value" 2001 (4) *Potchefstroom Electronic Law Journal* 46.

¹⁷² Goolam 2001 Potchefstroom Electronic Law Journal 46.

Botha H "Human dignity in comparative perspective" 2009 (20) Stellenbosch Law Review 174.

Additionally, both the ICCPR and the ICESCR proclaim in their preambles that human rights are derived from the inherent dignity of the human person. Furthermore, the Universal Declaration of Human Responsibilities¹⁷⁴ explicitly expresses the importance of human dignity in article 1 and 2, which are categorised under the heading "Fundamental Principles for Humanity". Article 1 reads, "Every person regardless of gender, ethnic origin, social status, political opinion, language, age, nationality or religion has a responsibility to treat all people in a humane way"; while article 2 takes the responsibility even further: "No person shall lend support to any form of inhumane behaviour, but all people have a responsibility to strive for dignity and the self-esteem of all others.

At regional level, the right to human dignity is directly protected by article 5 of the ACHPR, which reads, "Every individual shall have the right to the respect of the dignity in a human being and to the recognition of his legal status". Human dignity is also protected in relation with the right to life in article 4 of the ACHPR, which reads, "Every human being shall be entitled to respect for his life and the integrity of his person". In comparison with Western philosophies, African traditions place great emphasis on the responsibilities of an individual regarding his rights. In a Western sense, the main focus is on individual rights; whereas in an African sense the focus is community responsibility and loyalty. A perfect example of this African community sense is *ubuntu*. According to *ubuntu*, the life of another person is at least as valuable as one's own; thus respect for the dignity of every person is integral to it. Ubuntu is comprehensively explained by Mokgoro J in *Makwanyane*:

Generally, *ubuntu* translates as *humaneness*. In its most fundamental sense, it translates as *personhood* and *morality*. Metaphorically, it expresses itself in *umuntu ngumuntu ngabantu*, describing the significance of group solidarity on survival issues so central to the survival of communities. While it envelops the key values of group solidarity, compassion, respect, human dignity, conformity to basic norms and collective unity, in its fundamental sense it denotes humanity and morality.

¹⁷⁴ The Universal Declaration of Human Responsibilities of 1997.

¹⁷⁵ Goolam 2001 Potchefstroom Electronic Law Journal 47.

Goolam 2001 *Potchefstroom Electronic Law Journal* 47. An ethic of community responsibility and loyalty can also be described as *dharma*.

¹⁷⁷ S v Makwanyane and Another 1995 (3) SA 391 (CC) para 225.

Its spirit emphasises respect for human dignity, marking a shift from confrontation to conciliation.

It can easily be deduced that the right to human dignity plays a very important role in the South African Constitution since, as stated in section 1, South Africa is a sovereign democratic state founded on human dignity, freedom and equality.

2.4.2 The Constitution

In South Africa, human dignity is regarded as the focal point of the Constitution due to the country's horrendous past of racial segregation. As mentioned in *Makwanyane* by O'Regan J:¹⁷⁸

Respect for the dignity of all human beings is particularly important in South Africa. For apartheid was a denial of a common humanity. Black people were refused respect and dignity and thereby the dignity of all South Africans was diminished. The new constitution rejects this past and affirms the equal worth of all South Africans. Thus recognition and protection of human dignity is the touchstone of the new political order and is fundamental to the new constitution.

Among the trinity of human rights that the South African society is based on, the right to human dignity is the most important. Human dignity is entrenched in section 1,¹⁷⁹ 7,¹⁸⁰ 36¹⁸¹ and 39¹⁸² of the Constitution. Section 10 of the Constitution explicitly proclaims that "everyone has inherent dignity and the right to have their dignity respected and protected". As established by Chaskalson J in *Carmichle v Minister of Safety and Security*,¹⁸³ human dignity is a central value of the objective, normative value system that must guide the development of all areas of law.¹⁸⁴ South Africa is

¹⁷⁸ S v Makwanyane and Another 1995 (3) SA 391 (CC) para 329.

Section 1 of the Constitution reads, "The Republic of South Africa is one, sovereign, democratic state founded on the following values: (1) human dignity, the achievement of equality and the advancement of human rights and freedoms".

Section 7 of the Constitution 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".

Section 36 is the limitation clause that was discussed earlier.

Section 39 is the interpretation clause that was discussed earlier.

¹⁸³ Carmichele v Minister of Safety and Security 2001 (4) SA 398 (CC) para 56.

¹⁸⁴ Currie and De Waal Bill of Rights handbook 272.

regarded as one of the world's most developed bodies of dignity jurisprudence. The only country that can compare with South Africa in this regard is Germany. Human dignity is not only a justifiable and enforceable right that must be respected and protected; it is also a value that is essential for the interpretation of all other fundamental rights, and it is of central significance regarding the limitation of other fundamental rights. In order to respect the right to inherent dignity, everyone must be able to enjoy their civil and political liberties and also have access to the social and economic means essential to their development. It can thus be concluded that a person's dignity is denigrated if he lives in degrading living conditions and is deprived of his basic needs. Social Regarding Inverse or the social and economic means essential to their development. The social deprived of his basic needs. Social Regarding Inving conditions and is deprived of his basic needs. Regarding Inving conditions and is deprived of his basic needs. Regarding Inving conditions and is deprived of his basic needs.

2.4.3 The right to human dignity and kidney transplants

The Constitution of South Africa specifically guarantees the right to human dignity in section 10.¹⁸⁹ It is clear from the discussion above that the right to human dignity – similar to the right to life – is the fountain from which all other fundamental human rights flow. Both these supreme rights have an absolute nature and must be preserved at all times.¹⁹⁰ If either of these rights is taken away, all other rights cease.¹⁹¹ It should be borne in mind that human dignity demands a humane existence, as emphasised by Ackermann J in *Makwanyane*:¹⁹²

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.

Woolman S "The architecture of dignity" in Cornell D et al (eds) The dignity jurisprudence of the Constitutional Court 1.

¹⁸⁶ Currie and De Waal *Bill of Rights handbook* 275.

Liebenberg S "The value of human dignity in interpreting socio-economic rights" 2005 (21) South African Journal on Human Rights 155.

¹⁸⁸ Liebenberg 2005 South African Journal on Human Rights 156.

¹⁸⁹ S v Makwanyane and Another 1995 (3) SA 391 (CC) para 58.

¹⁹⁰ S v Makwanyane and Another 1995 (3) SA 391 (CC) para 84.

¹⁹¹ S v Makwanyane and Another 1995 (3) SA 391 (CC) para 84.

¹⁹² S v Makwanyane and Another 1995 (3) SA 391 (CC) para 327.

From the above it can be deduced that life and human dignity are inseparable. Furthermore, health is an essential for both life and human dignity. It goes without saying that the capacity for enjoyment of the right to life, as well as human dignity, is significantly diminished by poor health. According to the Constitution of the WHO, dignity is a prerequisite of health.

The question then is, can 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? Lastly, the author would like to compare the mental anguish of a person on death row with that of a patient with end-stage renal failure.

Up until now it could easily be summarised that the right to human dignity entails that everyone has the right to be treated in a dignified and humane manner. The question can now be raised whether a patient with end-stage renal failure that is dependent on renal dialysis leads a dignified and humane life.

It could be argued that, if a patient has to attend his renal dialysis therapy three to four times a week for three to four hours per session, ¹⁹⁴ he is not living a dignified and humane life. The fact that this patient will have to make significant adjustments to his lifestyle instantly impairs his human dignity. Furthermore, it could be argued that if a patient has to suffer all the various physical and psychological side-effects described in section 2.3.3, his human dignity would be impaired. It is evident that a person's human dignity is harmed when he experiences a decrease in energy levels, fatigue, pain, loss of sight, infection, nausea and cramps. The patient's human dignity is impaired even more by psychological effects such as depression, aggression, fear and mental anguish. ¹⁹⁵

On the contrary, it could be debated that neither the kidney recipient nor the donor's human dignity would be impaired in any way by means of a kidney transplant. It would be more sensible to supply patients with viable donor kidneys and remove

¹⁹³ Cartens and Pearmain Foundational principles of South African medical law 29.

¹⁹⁴ Canadian Institute for Health http://www.ciha.ca (Date of use: 23 May 2012).

¹⁹⁵ Harillall and Kasiram 2011 Health SA Gesondheid 5.

them from renal dialysis treatment. Kidney transplants would also be more cost-effective¹⁹⁶ for society as a whole and would increase the recipient's human dignity and life expectancy.¹⁹⁷ This argument can also be extended to the constitutional acceptability of regulated sales of donor kidneys. One of the main arguments against a regulated market of kidney sales is that the selling of human kidneys constitutes a commodification of the body and consequently results in a decrease of human dignity. In this regard, the question can be raised why sperm donors, egg donors, milk donors and surrogate mothers do not suffer a loss of dignity but a kidney donor does? The words of Gill and Sade could be used to emphasise the position that human dignity is not decreased if a kidney donor receives remuneration:¹⁹⁸

(M)y kidney is not my humanity. In part, dignity is something that we convey by our behaviour and attitudes. If we establish a regulated system of sales, then it is our responsibility to create a culture of dignity for the paid donor. Many have suggested that the term "paid donation" or "rewarded gifting" be used to confer dignity to the procedure.

The fact that a sum or value is placed on a person's kidney does not lead to a decrease of a person's dignity. The court presently establishes the value on the loss of or damage to a person's body parts by means of damage claims – this does not lead to a decrease in the value of a person's dignity. As stated by Slabbert, monetary values are already attached to body parts: a diva is allowed to insure her voice and a tennis player to insure his arm, yet this does not make them any less human or impairs their dignity. Description

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The costs related to renal dialysis in comparison with a kidney transplant was discussed in section 2.3.3 of this chapter.

¹⁹⁷ Clark PA "Financial incentives for cadaveric organ donation: An ethical analysis" http://www.ispub.com (Date of use: 23 May 2012).

¹⁹⁸ Gill MB and Sade RM "Paying for kidneys: The case against prohibition" 2002 (12) *Kennedy Institute of Ethics Journal* 20. See also Matas AJ "Why we should develop a regulated system of kidney sales: A call for action!" 2006 (1) *Journal of the American Society of Nephrology* 1131.

¹⁹⁹ Matas 2006 Journal of the American Society of Nephrology 1131.

²⁰⁰ Slabbert M "Ethics, justice and the sale of kidneys for transplantation purposes" 2010 (13) Potchefstroom Electronic Law Journal 86.

The author would like to extend the scope of the right to human dignity to the right not to be treated or punished in a cruel, inhuman or degrading way.²⁰¹ In *Makwanyane* it was proclaimed that one of the reasons for the abolishment of the death penalty was because it was found to be a cruel, inhuman and degrading punishment.²⁰² In this case it was stated:²⁰³

Once sentenced, the prisoner waits on death row in the company of other prisoners under sentence of death, for the processes of their appeals and the procedures for clemency to be carried out. Throughout this period, those who remain on death row are uncertain of their fate, not knowing whether they will ultimately be reprieved or taken to the gallows.

How does the situation of the prisoner on death row differ from that of the patient with end-stage renal failure? The patient who receives renal dialysis is basically on "death row" – he receives his dialysis treatment along with other patients that are in the same position. Similar to the prisoner on death row, the patient is also uncertain of his fate. He does not know whether he will receive a donor kidney or eventually be left to die when renal dialysis is no longer a viable option. In *Makwanyane*, reference is made to the mental anguish that a convicted prisoner suffers while awaiting his death sentence.²⁰⁴ Does a renal-failure patient not suffer this exact same mental anguish while awaiting his "death sentence"? Furthermore, the prisoner on death row does not have the burden of financial implications that the renal dialysis patient has. Yet it is regarded as constitutionally unacceptable to treat a convicted criminal in this manner but constitutionally acceptable in the case of an end-stage renal failure patient.

Section 7(2) of the Constitution maintains that the state must respect, protect, promote and fulfil the right to human dignity. From the above discussion it is evident that renal dialysis causes a decrease of a person's human dignity. However, it is also evident that a renal transplant has the opposite effect and increases a person's dignity. Additionally in this section it was emphasised that the sale of human kidneys would not lead to a decrease of human dignity. Thus, the sales of human kidneys

²⁰¹ Section 12(1)(e) of the Constitution.

²⁰² S v Makwanyane and Another 1995 (3) SA 391 (CC) para 95.

²⁰³ S v Makwanyane and Another 1995 (3) SA 391 (CC) para 26.

²⁰⁴ S v Makwanyane and Another 1995 (3) SA 391 (CC) para 6.

should be considered by the state as a viable and constitutionally acceptable manner to save thousands of lives while protecting a person's right to dignity.

2.5 THE RIGHT TO SELF-DETERMINATION

The right to self-determination entails that a person has a right to make decisions regarding his own body. Self-determination is closely associated with the bioethical perspective of respect for autonomy that incorporates the doctrine of informed consent.²⁰⁵ The idea of control over one's own body can be illustrated by the following:²⁰⁶

I wish my life and decisions depend on myself, not on external forces of whatever kind. I wish to be the instrument of my own, not of other men's, acts of will. I wish to be a subject, not an object; to be moved by reasons, by conscious purposes, which are my own, not by causes which affect me, as it were, from outside. I wish to be somebody, not nobody: a doer – deciding, not being decided for, self-directed and not acted upon by external nature or by other men as if I were a thing, or an animal or a slave ... I wish, above all, to be conscious of myself as a thinking, willing, active being, bearing responsibility for my choices and able to explain them by references to my own ideas and purposes.

The idea of control of our own bodies is something that we as humans practise every day by the various decisions that we are entitled to make. The importance of this right is clearly reflected in various international and regional human rights instruments.

2.5.1 International and regional human rights instruments

As all other fundamental human rights, the right to self-determination is firstly and most importantly protected by the UDHR. Article 3 stipulates that every individual has a right to life, liberty and security of person. Three different rights are encompassed by article 3: firstly, the right to life, which entails the right to a humane existence (as discussed above); secondly, the right to personal freedom; and lastly, the right to security. The right to security entails the right to be protected against interferences

In this chapter, the discussion is only focused on the right to self-determination. The bioethical perspective of respect for autonomy is discussed in detail in section 4.2 of this dissertation.

²⁰⁶ Slabbert 2010 Potchefstroom Electronic Law Journal 96.

from the state, as well as protection of integrity rights.²⁰⁷ The fact that the right to security of persons is listed along with the right to life could mean that this right should be regarded just as important as the right to life and human dignity. At international level, the right to self-determination has been described as "one of the essential principles of contemporary International Law" and it has been mentioned that this right enjoys an *erga omnes*²⁰⁸ character.²⁰⁹ Additionally, the right to self-determination is protected by the identical provisions of the ICCPR and the ICESCR. Article 1 of these human rights instruments provides that "all peoples have the right of self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development". Self-determination is very broadly defined in International Law and thus leads to every state deciding individually what the exact parameters of this right entails.²¹⁰

At regional level, the right to self-determination is even less precise. The ACHPR protects this right in article 20, which reads, "All peoples shall have the right to existence. They shall have the unquestionable and inalienable right to self-determination. They shall freely determine that political status and shall pursue their economic and social development according to the policy they have freely chosen". The right to self-determination represents one of the most important roots of modern international human rights protection. Because this right is broadly defined, the African Commission has made numerous attempts to determine what exactly the right to self-determination entails. 212

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²⁰⁷ Rehman International Bill of Rights 89.

²⁰⁸ Erga omnes can be described as obligations that a state owes to the international community as a whole and in the enforcement of which all states have interest. Dugard International law: A South African perspective 43.

²⁰⁹ Dugard International law: A South African perspective 104.

²¹⁰ Rehman International Bill of Rights 66.

²¹¹ Killander M "African human rights law in theory and practice" in Joseph S and McBeth A (eds) Research handbook on international human rights law 401.

The African Commission has attempted to determine the exact parameters of the right to self-determination in various law cases, such as *Katangese People's Congress v Zaire* Communication 75/92.

2.5.2 The Constitution

The right to self-determination is even guaranteed by the Constitution in section 12(2)(b), which reads: "(E)veryone has the right to bodily and psychological integrity which includes the right to security and control over their body". As noted by Ackermann J in *Ferreira v Levin*, ²¹³ the purpose of this section is to protect aspects of bodily self-determination. In *Phillips v De Klerk*²¹⁴ the right to control one's own body in so far as that right is not in conflict with the overriding social interest was recognised:

The mentally competent individual's right to control his own destiny in accordance with his own value system, his "selfbeskikkingsreg", must be rated even higher than his health and life.

The right to self-determination basically entails the right to be left alone, and in relation to one's body, the right creates a sphere of individual inviolability. Section 12(2)(b) explicitly illustrates that this inviolability has two components, namely "security in" and "control over" one's body. The former entails the protection of bodily integrity against intrusions by the state and others; consequently, the right to be left alone in the sense of being left unmolested by others. The latter entails the protection of what is described as bodily autonomy or self-determination against interference; consequently, the right to be left alone in the sense of being allowed to live the life one chooses. In this section the focus will be on the latter right.

The fact that self-determination is an essential right is clearly illustrated by the capacity it protects – the capacity to express one's own character. ²¹⁸ By recognising an individual right of self-determination, the Constitution makes self-creation possible. It allows each one of us to be responsible for shaping our lives according to our own distinctive personalities. Kriegler J observed in *Ex Parte Minister of Safety and*

²¹³ Ferreira v Levin NO 1996 (1) SA 984 (CC).

²¹⁴ Phillips v De Klerk 1983 TPD (unreported).

²¹⁵ Currie and De Waal Bill of Rights handbook 308.

²¹⁶ Currie and De Waal Bill of Rights handbook 309.

²¹⁷ Currie and De Waal *Bill of Rights handbook* 309.

²¹⁸ South African Law Commission "Assisted decision-making: Adults with impaired decision-making capacity" 2004 23.

Security: In re S v Walters²¹⁹ that if the right to life, to human dignity or bodily integrity, are compromised, then the society to which we aspire becomes illusory. Kriegler J further emphasised the fact that any significant limitation to any of these rights would for its justification demand a very compelling countervailing public interest.²²⁰ The question can be raised: could the scope of the right to self-determination possibly be extended to the extent where a person has the right to be remunerated for a kidney donation, seeing that a person is allowed to decide upon the fate of his own body?

2.5.3 The right to self-determination and kidney transplants

A person's typical day consists of making various decisions. Every waking moment is filled with decisions and choices; choices such as what to wear, what to eat and what a typical day will involve. Except for these minor, mundane daily choices that one makes one also makes major decisions that has an influence on one's life. Decisions are made such as what religion, lifestyle or career to follow. From the above it can easily be deduced that everyone has the right to make decisions regarding control over their own bodies. It is obvious that people are entitled to this right. After all, it is guaranteed in various international human rights instruments and even explicitly in the Constitution. Yet, these same autonomous persons are not granted the opportunity to choose to be remunerated for a kidney donation.

Presently in modern South Africa people are more aware of the fact that they have a right to self-determination than they were 18 years ago. Since 1994 South Africans have been allowed to become more and more autonomous – even to the extent that since 1 February 1997 mothers are allowed to legally terminate their pregnancy. In the landmark case *Christian Lawyers Association of South Africa v Minister of Health* it was noted by Mojapelo J that if the state was to prohibit termination, that the state's interference would clearly constitute an impairment of women's right "to

²¹⁹ Ex Parte Minister of Safety and Security: In re S v Walters 2002 (4) SA 613 (CC) para 28.

²²⁰ Ex Parte Minister of Safety and Security: In re S v Walters 2002 (4) SA 613 (CC) para 28.

The Choice on Termination of Pregnancy Act 92 of 1996.

²²² Christian Lawyers Association of South Africa v Minister of Health 1998 (4) SA 1113 (T) (hereinafter the Christian Lawyers case).

bodily and psychological integrity" and more particular their right "to make decisions concerning reproduction" and "to security in and control over their body". ²²³

The question could be raised why the termination of a pregnancy is constitutionally acceptable, yet a kidney donor is not granted the choice to be remunerated for the donation of his kidney. The Constitution clearly states that "everyone" has the right of control over their body; thus the kidney donor should be allowed to receive remuneration for his kidney if he wishes; or at the very least be given the choice of being remunerated. Presently, a person only has the choice to donate a kidney altruistically. The pregnant mother is allowed to end the life of her unborn child because she firstly has the right to bodily and physically integrity and secondly the right to control over her body. As stated in the *Christian Lawyers* case:²²⁴

The fundamental right to self determination itself lies at the very heart and base of the constitutional right to termination of pregnancy.

Consequently, on the grounds of section 12(2)(b) of the Constitution, a kidney donor has a right to control over his body and thus he has the right to do with his body as he pleases. If one is allowed to end a life due to one's fundamental right to self-determination, then surely one should be allowed to save a life based on this exact same right? To make matters even worse, according to section 5(3) of the Choice on Termination of Pregnancy Act, any woman of any age is allowed to consent to an abortion. The implication of this section is that a minor as young as 12 years old is allowed to legally terminate her pregnancy without the consent of a parent. Thus, if a minor is allowed to make vital decisions regarding her body, it could be argued that a competent adult kidney donor should be allowed to decide to donate a kidney and benefit financially in return.

²²³ Christian Lawyers Association of South Africa v Minister of Health. See also Carstens and Pearmain Foundational principles of South African medical law 98.

²²⁴ Christian Lawyers Association of South Africa v Minister of Health. See also Carstens and Pearmain Foundational principles of South African medical law 92.

Section 5(3) of the Choice on Termination of Pregnancy Act reads, "In the case of a pregnant minor, a medical practitioner or registered midwife, as the case may be, shall advise such a minor to consult with her parents, guardian, family members or friends before the pregnancy is terminated: <a href="Provided that the termination of the pregnancy shall not be denied because such a minor chooses not to consult them" (own emphasis added).

Because of a person's strong right to self-determination, a person even has the right to refuse medical treatment.²²⁶ In most cases the refusal of medical treatment usually results in death. It could be argued that if a patient is allowed to make decisions that could result in his death, then a kidney donor should surely be allowed to make the decision to donate his kidney and receive remuneration for the donation? Donating a kidney does not result in death – as the case is with abortion or refusal of medical treatment. In fact, it results in quite the opposite: it saves the life of another person.

Section 7(2) of the Constitution entails that the state must respect, protect, promote and fulfil the right to self-determination. From the above discussion it is clear that the right to self-determination has already been developed to a certain extent. It is regarded as constitutionally acceptable for women to terminate their pregnancies due to this right, and for patients to refuse essential medical treatment. Both of these practices result in death. The author is of opinion that if a person is allowed to make such a decision on the grounds of the constitutional right to self-determination, a kidney donor should be allowed to receive remuneration for his kidney donation. The kidney donor is also entitled to the right to make decisions regarding control over his body. It should be borne in mind that a person is already legally allowed to donate his kidney; it is the remuneration of a kidney donation that is regarded as illegal. The question, however, could be raised what difference would the added benefit of remuneration make to the kidney donor's right to self-determination? In the author's opinion it would make no negative difference. The donor chooses to sell his kidney; it is but a mere part of his body. After his kidney is removed, he still has his whole body to have control over. If the remuneration of a kidney donor is regarded as constitutionally acceptable it will pose no disadvantage to the donor's right to selfdetermination. It would rather develop his right into a more developed right – the right to be allowed to choose to receive remuneration or not. The donor would then be allowed to make his own decisions regarding his body while prolonging the life of another person in need of a kidney transplant.

226 Section 6(d) of the National Health Act states, "Every health care provider must inform a user of – (d) the user's right to refuse health services".

2.6 THE RIGHT TO PRIVACY

The right to privacy can broadly be defined as the fundamental right of an individual to isolate his private life from the interference of the state or other persons. This right includes that the individual should be able to control what he wants to share or withhold from others. Privacy is regarded as a very important aspect of a person's personality; thus a person has an interest in the protection of his privacy.²²⁷ In the last few decades, the right to privacy has developed and become widely recognised in various human rights instruments.

2.6.1 International and regional human rights instruments

The protection of territorial and communications privacy is explicitly guaranteed in the UDHR. Article 12 reads that "no one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks". The right to privacy is also dealt with in article 17 of the ICCPR. The phrasing of this article is identical to the words stipulated in article of the UDHR. This article has been elaborated further by the Committee's general comment, and also by its case law under the optional protocol. 228 In the general comment to this article, the Committee noted that the obligations imposed by this article require the state to adopt legislative and other measures to give effect to the prohibition of such interferences and attacks, as well as to the protection of this right. 229

The right to privacy is not explicitly guaranteed in the ACHPR, but it is found in most domestic bills of rights, such as the South African Bill of Rights.

²²⁷ Neethling et al Neethling's law of personality 29.

²²⁸ Rehman International Bill of Rights 78.

Human Rights Committee General Comment No 16 para 1 and 8. See also Rehman International Bill of Rights 78.

2.6.2 The Constitution

In South Africa, an individual's right to privacy is protected by both the common law and the Constitution. According to the common law, every person has an independent personality right to privacy. For this section, however, the author will only focus on a person's constitutional right to privacy.

Section 14 of the Constitution reads that "everyone has the right to privacy, which includes the right not to have their person or home or property searched, their possessions seized or the privacy of their communications infringed. The right to privacy has two parts the first guarantees a general right to privacy and the second protects people against specific infringements of privacy such as searches, seizures and the infringement of communication". ²³⁰ It should be noted that, unlike the three fundamental human rights discussed earlier, the right to privacy is not absolute. This right can be limited in accordance with section 36 (the limitation clause) of the Constitution. The purpose of this limitation is because the courts have to find a balance between the public's right to know and the individual's right to privacy. ²³¹

The right to privacy aims to protect three categories of an individual's life. The first category protects a person against intrusions and interferences in his private life. 232 With regard to this right, a person is entitled to be left alone. The purpose of this right is to establish that the state and other people have nothing to do with a person's intimate affairs. The second category protects a person's privacy against infringement of his autonomy and allows every individual to choose the kind of lifestyle that he wants to lead. 233 The third category protects a person against the infringement of private facts. This right grants every individual control over his private information. This right is closely related to the right to human dignity, since the publication of false information that reflects negatively on a person can damage a person's dignity. 235 In

²³⁰ Currie and De Waal Bill of Rights handbook 315.

²³¹ Devenish GE A commentary on the South African Bill of Rights 157.

²³² Currie and De Waal *Bill of Rights handbook* 324.

Jordaan Y South African consumer's information privacy (LLD Thesis University of Pretoria 2003) 25.

²³⁴ Currie and De Waal Bill of Rights handbook 323.

²³⁵ Currie and De Waal Bill of Rights handbook 323.

this section, the focus will mainly be on the third category of informational privacy. In the medical context, the right to privacy is further protected by section 14 of the National Health Act.²³⁶ Also, the Promotion of Access to Information Act²³⁷ stipulates that no person may disclose any information about a patient unless the patient gives his written consent, or a court order requires the disclosure, or the non-disclosure represents a serious threat to public health.²³⁸ The question could be raised: would the remuneration of kidney donors constitute a breach of the donor's right to privacy?

2.6.3 The right to privacy and kidney transplants

Information pertaining to a person's health is regarded as highly confidential and, as mentioned above, is protected by the Constitution, National Health Act and Promotion of Access to Information Act. In *Hyundai Motor Manufactures*²³⁹ it was noted as follows:

Privacy is a right which becomes more intense the closer it moves to the intimate personal sphere of the life of human beings, and less intense as it moves away from that core ...

It could easily be said that a kidney transplant is part of one's intimate personal sphere of life. The right to privacy pertaining to a kidney transplant could easily be breached if a kidney donor's identity is revealed to the kidney recipient. In this section, the author would like to illustrate that by allowing a kidney donor to be remunerated for his donation would not infringe his right to privacy.

Presently in South Africa, all cases of kidney donations are regarded as confidential, except of course in the case of living donors where transplants are done within the same family.²⁴⁰ The implication of this confidentiality is that the identity of the kidney donor is protected and is not revealed to the kidney recipient. The reason for this is

Section 14 reads, "All information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment, is confidential.

The Promotion of Access to Information Act 2 of 2000.

Dhai and McQuoid-Mason Bioethics, human rights and health law 88.

²³⁹ Investigating Directorate: Serious Economic Offences v Hyundai Motor Distributors (Pty) Ltd: In re Hyundai Motor Distributors (Pty) Ltd v Smit NO 2001 (1) SA 545 (CC).

Organ Donor Foundation http://www.odf.org.za (Date of use: 28 May 2012).

that the kidney donor's right to privacy is regarded as stronger than the kidney recipient's right to information.

In the United States of America, a case study was done regarding whether the donor's right to information would outweigh the recipient's right to privacy if the kidney recipient was HIV positive.²⁴¹ In this case study it was concluded that the recipient's right to privacy was dominant – the reason being that a kidney donation is completely voluntary and the donor should not base his choice on the transplant outcome.²⁴² The author is of opinion that if the case study was to be done in South Africa, the results would be the same; mainly because the right to privacy is so strongly protected by the Constitution. The author further feels that the above case study emphasises the importance of the right to privacy. In South Africa, especially, the importance of the right to privacy is clearly illustrated by the fact that minors are allowed to obtain condoms, abortions and HIV tests without the knowledge of their parents.²⁴³

In consideration of the above, the author is of opinion that by allowing a kidney donor to be remunerated for his donation would not infringe his privacy. In Singapore, the remuneration of kidney donors has had no effect on the privacy of the kidney donors. According to the Minister of Health of Singapore, the identity of the kidney donor is confidential information.²⁴⁴ The kidney donor's privacy could only be infringed if his identity is revealed to the kidney recipient. If remuneration is allowed it would not change the current position. The mere fact that the kidney donor would receive an added benefit does not force him to reveal his identity.

Formica RN *et al* "Kidney transplantation and HIV: Does recipient privacy outweigh the donor's right to information?" 2010 (5) *Clinical Journal of the American Society of Nephrology* 925.

Formica et al 2010 Clinical Journal of the American Society of Nephrology 925.

²⁴³ Dhai and McQuoid-Mason Bioethics, human rights and health law 89.

²⁴⁴ Minister of Health Singapore "HOTA" http://www.pqms.moh.gov.sg (Date of use: 29 May 2012). The remuneration of Singapore citizens will be discussed in more detail in chapter 6 of this dissertation.

2.7 THE RIGHT TO HEALTHCARE

In all parts of the world, a person's health is vital to all other aspects of his life, such as his personal and social development. A person needs to be healthy to live his life to the fullest. Without health a person cannot do his work, care for his family or enjoy his life. Enjoyment of the right to life is interlinked and crucial to the realisation of many other fundamental human rights such as the right to life, human dignity, self-determination and privacy.

The right to health did not officially emerge from an international human rights instrument as other fundamental rights, but rather from an international health authority. In the preamble of the WHO, which was written in 1946, it was proclaimed that "the enjoyment of the highest attainable standard of living is one of the fundamental rights of every human being". According to the WHO, health can be defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". However, unfortunately for the majority of the world and especially South Africa, the reality of their definition of health does not meet the standard set by the WHO definition.

The right to health is further protected by international and regional human rights instruments.

2.7.1 International and regional human rights instruments

The right to health is foremost protected by Article 25 of the UDHR, which reads, "everyone has the right to standard of living adequate for the health and well-being of himself and of his family including food, clothing, housing and medical care ..." The UDHR aims to achieve "a common standard of achievement for all peoples and all

Ngwena C and Cook R "Rights concerning Health" in Brand D and Heyns C (eds) Socioeconomic rights in South Africa 108.

The article further states that everyone has the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. The author regards only the first part of this definition as important relating to the discussing of the right to healthcare.

nations". 247 Unfortunately, the UDHR has one missing component with regard to the right to health. It does not impose an obligation on the state to take positive measures toward the realisation of this right. This lacuna was addressed and corrected by the ICESCR. Article 12(1) of the ICESCR reads, "The State Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". The steps required for the realisation of these rights are stipulated in Article 12(2) of the ICESCR. 248 The obligation to take steps toward the realisation of this right is mandatory; however, every state has a margin of discretion in the choice of appropriate means for satisfying the right to health.²⁴⁹ The Committee on the ICESCR has established that there must be a maximum deployment of available resources towards the realisation of the right to health.²⁵⁰ If a state cannot meet the full realisation of a right due to lack of resources. it must at least endeavour to meet a certain minimum-level content of the right.²⁵¹ Consequently, it can be deduced that the state must demonstrate that it has deployed its available resources to the maximum extent. The Committee also emphasised that the availability and accessibility of healthcare for all individuals is a provision that should be sensitive to medical ethics and distinct cultures.²⁵²

As a result of the influence of international human rights instruments, the right to health is also protected at regional level by the ACHPR. Article 16(1) reads, "Every individual shall have the right to enjoy the best attainable state of physical and mental health". Article 16(2) provides for the realisation of the right by stating that "State parties to the present Charter shall take necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick". It

Ngwena and Cook in Brand and Heyns (eds) Socio-economic rights in South Africa 111.

Article 12(2) reads, "The steps to be taken by the State Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (a) the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) the improvement of all aspects of environmental and industrial hygiene; (c) the prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) the creation of conditions which would assure to all medical service and medical attention in the event of sickness".

²⁴⁹ Ngwena and Cook in Brand and Heyns (eds) Socio-Economic Rights in South Africa 113.

Ngwena and Cook in Brand and Heyns (eds) Socio-Economic Rights in South Africa 114.

Ngwena and Cook in Brand and Heyns (eds) Socio-Economic Rights in South Africa 114.

²⁵² ICESCR General Comment 14 para 12. See also Rehman International Bill of Rights 119.

is clear that the right to health is an important right, although compliance with its obligation remains rather problematic.

In South Africa, the right to health is explicitly recognised as a fundamental right in the Constitution.

2.7.2 The Constitution

During the era of apartheid,²⁵³ South Africa inflicted a number of violations against the human right to health. The racial segregation of white and black people affected people's health in a number of ways. Health was affected due to poor social conditions that caused ill health, the segregation of health services and unequal spending on health services.²⁵⁴ Since 1994, health in South Africa has been recognised as a fundamental human right.

The right to health is guaranteed explicitly by the Constitution in section 27(1)(a), which reads that "everyone has the right to have access to health care services, including reproductive health care". 255 It should be emphasised that the Constitution does not guarantee a right to health, but only the right of access to healthcare services. Section 27 does not only allow a person to have access to healthcare; it furthermore follows the international example of the ICESCR by developing the right even further – by stating that the government has a duty to steadily improve people's healthcare. Section 27(2) reads that "the state must take reasonable legislative measures, within its available resources, to achieve the progressive realisation of each of these rights". Section 27 imposes both positive and negative obligations on the state. The positive obligation pertaining to section 27(1) is discussed above. Section 27(3), however, imposes a negative obligation on the state by stipulating that no person may be refused emergency care. As with all other rights in the Bill of Rights, the state's general positive duties regarding these rights are set out in section

²⁵³ From 1948 to 1994.

Heywood M "A background to health law and human rights in South Africa" in Hassim, Heywood and Berger (eds) *Health and democracy* 11.

Section 27(1) of the Constitution further states that everyone has the right to have access to sufficient food, water and social security. These rights will however not be discussed in this section.

7(2) of the Constitution. The state is required to respect, protect, promote and fulfil the right to health. Section 27 is not an absolute right and is subjected to the limitation clause.

It should, however, be borne in mind that section 27 is not the only constitutional provision dealing with a right concerning health. As discussed earlier in this chapter, the right to bodily and psychological integrity also directly protects a person's health. Furthermore, the health of children and prisoners are also directly protected – respectively by section $28(1)(c)^{256}$ and section $35(2)(e)^{257}$ of the Constitution. There are additional rights that have an indirect bearing on the right to health, such as the right to life, human dignity, equality and housing. 258

As a socio-economic right the right to healthcare poses a challenge to the courts due to the fact that the development of socio-economic rights jurisprudence in South Africa is still in its infancy.²⁵⁹ The Constitutional Court, however, has affirmed that socio-economic rights are justiciable and that the principle of separation of powers does not have the effect of depriving courts of competence over such rights.²⁶⁰ There have been four Constitutional Court decisions that have a direct impact on the development and understanding of the right to healthcare. In this section, three of these cases and the direct influence they have had on the right to health will be discussed briefly.²⁶¹ The relevance of these cases pertaining to kidney transplants will be discussed in section 2.7.3 of this dissertation.

The first and most important case is the *Soobramoney* case. Soobramoney, a 41-year-old unemployed man, was a diabetic who suffered from ischemic heart disease

Section 28(1)(c) of the Constitution reads, "Every child has the right to basic nutrition, shelter, basic health care services and social services".

Section 35(2)(e) of the Constitution reads, "Everyone who is detained, including every sentenced prisoner, has the right to conditions of detention that are consistent with human dignity, including at least exercise and the provision, at state expense, of adequate accommodation, nutrition, reading material and medical treatment".

²⁵⁸ Ngwena and Cook in Brand and Heyns (eds) Socio-economic rights in South Africa 130.

Ngwena C "Substantive equality in South Africa health care: The limits of the law" 2000 (4) Medical Law International 2.

²⁶⁰ Ngwena and Cook in Brand and Heyns (eds) Socio-economic rights in South Africa 132.

The fourth case, *Van Biljon v Minister of Correctional Services* 1997 (4) SA 441, will be omitted due to the fact that it has limited value as a precedent and it does not contribute to the argument of this dissertation.

and cerebro-vascular disease, which caused him to have a stroke in 1996. In that same year his kidneys also failed. His condition was regarded as irreversible and by the time of the court case he was in the final stages of renal failure. His life could have been prolonged by means of renal dialysis; however, due to limited facilities at the Addington State Hospital, dialysis was denied. His request was also denied due to the fact that he did not meet the medical criteria for providing dialysis at state expenses. It should be noted that prior to the application Soobramoney had been receiving dialysis via private care, but his funds had run out and that is why he sought dialysis from a state hospital.

Soobramoney then decided to make an urgent application to the High Court for an order directing Addington Hospital to provide him with renal dialysis, and interdicting the respondent from refusing him admission to the renal unit of the hospital. In his application, he relied on sections 27(3) and 11 of the Constitution. The application was dismissed, and Soobramoney appealed to the Constitutional Court. The Court was of view that the right-to-life argument was inappropriate, as the Constitution provided explicitly for the right to health. Regarding section 27(3), the Court was of view that "emergency medical treatment" was capable of a broader meaning to include ongoing treatment for chronic conditions but it had a narrower meaning. This section was, however, not intended for conditions such as chronic renal failure but rather for sudden catastrophe or unexpected trauma. Soobramoney's condition

Soobramoney sought renal dialysis therapy from the Addington State Hospital in Durban. The hospital only provided treatment to a limited number of patients due to the fact that their renal unit only had 20 dialysis machines. Some of the machines were already in a poor condition. The hospital further noted that each treatment takes four hours and a further two hours for the cleaning of the machine before it can be used again.

Renal dialysis can only be provided to patients who are candidates for renal transplantation. Thus, dialysis is only provided to patients who need it as short-term therapy. Due to the fact that Mr Soobramoney had suffered from other diseases he was not a fit candidate for transplantation.

²⁶⁴ Section 11 of the Constitution was discussed in section 2.3.2 of this dissertation.

[&]quot;In our Constitution the right to medical treatment does not have to be inferred from the nature of the state established by the Constitution or from the right to life which it guarantees. It is dealt with directly in section 27." Soobramoney v Minister of Health (Kwazula-Natal) 1997(1) SA 765 para 19.

The purpose of the right seems to be to ensure that treatment be given in an emergency, and is not frustrated by reason of bureaucratic requirements or other formalities. What the section requires is that remedial treatment that is necessary and available be given immediately to avert harm. Soobramoney v Minister of Health (Kwazula-Natal) 1997(1) SA 765 para 20.

was described as an ongoing state of affairs and not an emergency that required immediate remedial treatment.²⁶⁷ The Court decided that section 27(3) did not apply to the facts of this case. The Court also emphasised that, even if chronic renal failure could be regarded as an emergency, the state was not violating its obligation as its resources were scarce. If section 27(3) was to have been interpreted in favour of Soobramoney, the state's obligation to ensure access to healthcare services would have been severely jeopardised. The state would have been constantly forced to provide immediate access to healthcare services, wherever and whenever it was demanded.²⁶⁸ Although the state has a constitutional duty to comply with the obligations imposed on it by section 27 of the Constitution, it was held in *Soobramoney* that the state did not breach their constitutional obligation by refusing Soobramoney renal dialysis.

The second case pertaining to the enforcement of socio-economic rights concerning health is *Minister of Health and Others v Treatment Action Campaign and Others*²⁶⁹. This case was an appeal by the government against the decision of the High Court. The applicants had challenged the decision of the government to confine the dispensation of Nevirapine to 18 pilot sites for the purpose of prevention of mother-to-child transmission of HIV. The main argument of the applicants was that the government's failure to provide access to all anti-retroviral therapy to prevent mother-to-child transmission constituted a number of breaches of the provisions of the Constitution. The provisions that were breached were section 7(2), 10, 12(2)(a), 27, 28(1)(c), 195²⁷⁰ and 237.²⁷¹ The applicants were successful before the High Court, but the case especially focused on the interpretation and application of section 27(1) and (2) of the Constitution. Botha J stated that the government did not take

²⁶⁷ Soobramoney v Minister of Health (Kwazula-Natal) 1997(1) SA 765 para 21.

Berger J "The Constitution and Public Health Policy" in Hassim, Heywood and Berger Health and democracy 36.

²⁶⁹ Minister of Health and Others v Treatment Action Campaign and Others 2002 10 BCLR 1033 (CC) (hereinafter referred to as the TAC case).

²⁷⁰ Section 195 of the Constitution requires that public administration must be governed by democratic values enshrined in the Constitution and that a high standard of professional ethics must be promoted and maintained.

²⁷¹ Section 237 of the Constitution stipulates that all constitutional obligations must be performed diligently and without delay.

reasonable measures to realise the right of access to healthcare. The judge granted an order to make Nevirapine available to all pregnant women who gave birth in the public sector and to their babies if a doctor was of the opinion that the Nevirapine is needed. The government appealed to the Constitutional Court against the decision. The Constitutional Court upheld the decision of the High Court and the appeal was determined by the application of section 27. In the *TAC* case the following was stated regarding rights such as access to education, land, housing, healthcare, food and water:²⁷²

These are the socio-economic rights entrenched in the Constitution, and the state is obliged to take reasonable legislative and other measures within it available resources to achieve the progressive realisation of each of them. In the light of our history this is an extraordinarily difficult task. Nonetheless it is an obligation imposed on the state by the Constitution.

In this case it was held that the decision to confine Nevirapine to only 18 pilot sites was unreasonable and thus constituted a breach of the state's obligations under sections 27(1) and (2) to the extent that it was rigid and inflexible.²⁷³ The mothers and their newborn babies outside the pilot sites were denied a potentially life-saving drug that could have been administered within the available resources of the state. The judgement of this case illustrates that the Constitutional Court regards the state as a servant of the Constitution and that it will be held to its constitutional duties.²⁷⁴

The relevance of the last constitutional case of importance, *Khosa v Minisiter of Social Development; Mahlaule v Minister of Social Development*, ²⁷⁵ lays in section 27(2) of the Constitution. This decision deals with the costs of extending social security to all. This case considered the reasonableness of the statutory limitation on access to an existing social assistance programme, and how this affects the state's positive obligation stated in section 27(2) of the Constitution. The Court rejected the state's allegation that the extension of benefits in question to all eligible permanent

²⁷² Minister of Health and Others v Treatment Action Campaign and Others para 94.

²⁷³ Minister of Health and Others v Treatment Action Campaign and Others para 80.

Swanepoel M Embryonic stem cell research and cloning: A proposed legislative framework in the context of legal status and personhood (LLM Thesis University of Pretoria 2006) 154.

²⁷⁵ Khosa v Minister of Social Development; Mahlaule v Minister of Social Development 2004 (6) SA 505 (CC) (hereinafter referred to as the Khosa and Mahlaule case).

residents would impose an extensive financial burden on the state.²⁷⁶ In doing this, the Court emphasised that the state had failed to provide clear evidence to show what the additional cost of providing social grants to aged and disabled residents would be.²⁷⁷ From this case it can be deduced that the state cannot simply plead poverty when it comes to realising a socio-economic right; instead it has to make out a case that is indeed limited by resources.²⁷⁸

The question could be raised that if a certain resource has been limited for a number of years, is the state not under an obligation to provide an alternative option that could relieve the need?

2.7.3 The right to health and kidney transplants

In 1946 the WHO proclaimed that the highest attainable state of health is an objective to aspire to. It is conspicuous that this objective has not been met in South Africa and will not be met in the near future. With the support of the relevant case law, in this section the author would like to challenge whether the state does fulfil its obligation in relation with the right to health. Thus, does the state really attempt to take reasonable legislative and other measures within its available resources to achieve the progressive realisation towards the availability of donor kidneys for transplant purposes? The author also questions whether it cannot be expected of the state to do something more and as such provide an alternative, like the remuneration of kidney donors in the case where they lack available resources to make more donor kidneys available.

Firstly, the author would like to focus on the general obligations imposed on the state by section 7(2) of the Constitution. This section requires the state to respect, protect, promote and fulfil the right to health. Each of these obligations can be analysed individually. *Respect* means that the government must respect the right of access to healthcare services by not unfairly or unreasonably getting in the way of people

²⁷⁶ Khosa v Minister of Social Development; Mahlaule v Minister of Social Development 2004 (6) SA 505 (CC) para 60.

²⁷⁷ Berger in Hassim, Heywood and Berger Health and democracy 44.

²⁷⁸ Berger in Hassim, Heywood and Berger Health and democracy 45.

accessing healthcare services.²⁷⁹ In a way it could be argued that, if the state does not grant persons the option of receiving remuneration for their kidney donation, the state is unreasonably getting in the way of kidney recipients' access to available donor kidneys; thus their healthcare services. *Promote* entails that the state must create a legal framework so that individuals are able to realise their rights on their own.²⁸⁰ This obligation has a direct relevance to the remuneration of kidney donors. It could be argued that the state could create a legal framework that allows for the remuneration of a kidney donor and therefore individuals will be able to realise their right to health on their own. The obligation to *fulfil* entails that the government must create necessary conditions for people to access healthcare by providing positive assistance, benefits and actual healthcare services.²⁸¹ Once again, the remuneration argument is of relevance to the obligation to fulfil. By allowing kidney donors to be remunerated, the state is creating the necessary conditions for kidney recipients to access healthcare.

Secondly, the author would like to focus on the case law discussed above and how it contributes to the argument in favour of remuneration for kidney donors. Even though the Court arrived at the correct conclusion in *Soobramoney* with relevance to the case's specific set of facts, there were nonetheless a number of shortcomings. This case was about renal dialysis and because of this it is also relevant to kidney transplants and the state's available resources. The Court held that the right-to-life argument was inappropriate to this case. Yet, the right to health and life should be seen as interconnected – without the right to life no other rights are able to exist. By adopting this approach the Court unduly minimised the relevance of the right to life. ²⁸² The Court also seemed to suggest that they had a limited role regarding the decisions about the allocation of healthcare resources and the protection of socio-economic rights. ²⁸³ The Court suggested that once it is asserted by a provincial or national healthcare provider that resources are unavailable, that *per se* limits the realisation of

²⁷⁹ Berger in Hassim, Heywood and Berger Health and democracy 33.

²⁸⁰ Berger in Hassim, Heywood and Berger Health and democracy 33.

²⁸¹ Berger in Hassim, Heywood and Berger Health and democracy 34.

Ngwena and Cook in Brand and Heyns (eds) Socio-economic rights in South Africa 136.

²⁸³ Moellendorf D "Reasoning about resources: Soobramoney and the future of economic right claims" 1998 (14) South African Journal on Human Rights 328.

a right of access to the service sought.²⁸⁴ From this it can be deduced that there is no promise in the judgement that the Court would actually ascertain whether the state and the provinces were in fact attempting to realise rights by making resources available that ought to have been available and utilising such resources effectively.²⁸⁵

In the *Soobramoney* case it was held that the state did not have to provide access to renal dialysis for people with Soobramoney's medical condition. The author would like to contest this. What would the judgement of this case have been if the facts were somewhat different? What if Soobramoney was a patient that was an eligible candidate for a kidney transplant? Surely the Court would then have granted him access to renal dialysis, and as soon as a viable kidney became available, access to a kidney transplant. According to the proper reading of this case, the state cannot spend vast amounts of money on non-priority areas if the effect is to limit access to essential services.²⁸⁶

If kidney donors are remunerated it will have quite the opposite effect. In the first place, the state will not have to spend vast amounts because the amount they will be paying for a kidney transplant will be less than that of renal dialysis.²⁸⁷ The state would actually save money. Secondly, renal failure cannot be regarded as a non-priority area in South Africa, seeing that the major health problems are regarded as AIDS, tuberculosis, malaria, gastroenteritis and hypertension.²⁸⁸ It should be noted that hypertension leads to renal failure and affects about 20% of the adult population.²⁸⁹ Thirdly, if the state is to spend funds on the remuneration of kidney donor patients, it will not limit access to essential services (renal dialysis); it would rather lighten the burden on the renal dialysis machines and thus more patients would

²⁸⁴ Moellendorf 1998 South African Journal on Human Rights 330.

Ngwena and Cook in Brand and Heyns (eds) Socio-economic rights in South Africa 137.

²⁸⁶ Berger in Hassim, Heywood and Berger Health and democracy 37.

For the costs of renal dialysis in both the private and public sector, see section 2.3.3. The cost of a kidney transplantation is R250 000, including the ImmunoPro Rx medication that must be taken for the first three months. After the procedure, the costs of a kidney transplant is about R10 000 per annum, as opposed to renal dialysis of R200 000 per annum. Information supplied by Prof. Britz (rsbritz@gmail.com) (29/04/2012).

Naicker S "End-stage renal disease in sub-Saharan and South Africa" 2003 (63) *Kidney International* 119.

²⁸⁹ Naicker 2003 Kidney International 119.

have access to this life-prolonging treatment while they wait for a viable kidney match.

Another point the author would like to raise is that the case was heard 15 years ago in 1997. Surely after such a period of time circumstances have changed. At the time of this case the state could only meet 30% of the demand of renal dialysis.²⁹⁰ Is this still the case today? Chaskalson P noted that²⁹¹

(t)he state has to manage its limited resources in order to address all these claims. There will be times when this requires it to adopt a holistic approach to the larger needs of society rather than to focus on the specific needs of a particular individual within society.

If the Constitution allows for the remuneration of kidney donors, then the state will be attending to the larger needs of society, seeing that there is a dire need for viable donor kidneys in South Africa.

The approach of the Court in the *TAC* case clearly illustrates that the idea of the minimum core should be seen as integral to rather than independent from the question whether the state has taken reasonable legislative and other measures to discharge its duty.²⁹² Ngwena and Cook are of opinion that²⁹³

Treatment Action Campaign itself is an instance where the state lost sight of its obligation concerning protecting health and the notion of providing a minimum floor or protection that was easily within its reach.

It could be asked: has the state not lost sight concerning the right to health of patients with end-stage renal failure? The demand for kidneys exceeds the supply extensively. There are not enough renal dialysis machines to keep patients alive while they await a viable kidney, neither are there enough viable kidneys available to relief the stress of the dialysis treatment. It could be argued that kidney patients, similar to the mothers and children in the *TAC* case, also have a right to life-saving treatment. A "floor of minimum protection", as mentioned above, is easily within the state's reach

²⁹⁰ Soobramoney v Minister of Health (Kwazula-Natal) 1997(1) SA 765 CC para 26.

²⁹¹ Soobramoney v Minister of Health (Kwazula-Natal) 1997(1) SA 765 CC para 31.

²⁹² Ngwena and Cook in Brand and Heyns (eds) Socio-economic rights in South Africa 143.

²⁹³ Ngwena and Cook in Brand and Heyns (eds) Socio-economic rights in South Africa 143.

concerning kidney recipients. If the remuneration of kidney donors is allowed, more kidneys will be available and there will not be a lack of available resources.

As mentioned in the *Khosa and Mahlaule* case, the state cannot merely plead poverty; it has to make a case that it is indeed limited by resources. If remuneration is allowed, the state cannot be limited by resources – in the first place because enough kidneys will be made available for transplant purposes, and secondly if there are funds available for dialysis, then surely the same funds could be used for life-saving treatment rather than life-prolonging treatment.

Consequently, in the author's opinion, the state is not fulfilling its obligation under sections 7(2) or 27(2) of the Constitution. The state does not respect, promote, protect or fulfil the kidney recipients' right to healthcare. Furthermore, the state does not take reasonable, legislative and other measures within its available resources to achieve the progressive realisation of the right to health pertaining to kidney recipients. The dire need for available kidneys has been a problem for a number of decades. Therefore, the state should provide the kidney recipients with an alternative option: they should be allowed to obtain a kidney in a constitutionally acceptable manner by having the state remunerate the kidney donor.

2.8 CONCLUSION

This chapter sought to examine whether the remuneration of kidney donors could be regarded as constitutionally acceptable. In the author's opinion, all of the constitutional rights that were examined proved that they could be used in favour of the remuneration of the kidney donor.

The right to life is regarded as the most important right of all the fundamental human rights because it is the foundation of all other rights. Without life, no other right can exist. It was held in *Makwanyane* that the right to life entails a life worth living. The author contested that the pain and suffering of renal dialysis does not constitute a life worth living, but that a kidney transplant would. The right to human dignity is regarded as interconnected with the right to life. According to Ackermann J, the right to life

incorporates the right to dignity. According to the author, human dignity and renal dialysis cannot exist in one space. The worldwide argument that a kidney donor's human dignity will be infringed if he receives remuneration for his kidney donation was also seen as far-fetched, seeing that a person's dignity is not infringed if he receives compensation for a body part lost in a car accident.

Furthermore, the issue was also raised why the cruel and inhumane treatment of a criminal could be regarded as constitutionally unacceptable, but the same treatment is regarded as constitutionally acceptable regarding an end-stage renal failure patient. All persons are allowed to make decisions regarding their own bodies – as guaranteed by the right to self-determination in the Constitution. Thus, if one is not allowed the option to decide whether or not to be remunerated for a kidney donation, then this right to self-determination is infringed. The remuneration of a kidney donor will have absolutely no effect whatsoever on the kidney donor's right to privacy. The kidney donor would still be allowed to remain anonymous.

Lastly, the author is of opinion that due to everyone's right to healthcare within the state's available resources, the state should allow persons to be remunerated for their kidney donation. Consequently, more end-stage renal failure patients will have access to renal dialysis until a viable kidney becomes available, and available kidneys will always be within the state's available resources. If the state does not allow the remuneration of a kidney donor but merely leaves the matters as it is (meaning that kidney donation is the only acceptable way to obtain a kidney), it could be argued that the state infringes on the rights that a person is entitled to by the Constitution.

After careful consideration of the above it should be regarded as constitutionally acceptable to remunerate a kidney donor for his kidney. However, it should be borne in mind that the sale of human kidneys is currently legally prohibited. The transplantation legislation pertaining to kidney transplants are discussed in the following chapter.

CHAPTER 3 – SOUTH AFRICAN TRANSPLANT LEGISLATION

"Written laws are like spiders' webs, and will, like them, only entangle and hold the poor and weak, while the rich and powerful will easily break though them" 294

3.1 INTRODUCTION

In South Africa, the Constitution is the supreme law of the land; any law or conduct inconsistent with it is invalid and the obligations imposed by it must be fulfilled.²⁹⁵ Section 27(1)(a) of the Constitution grants everybody the right to have access to healthcare services. Section 27(2) takes it one step further and states that the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. The requirements for a lawful kidney transplant are to the utmost extent regulated by legislation. Presently the regulatory framework in South Africa that is in force is the National Health Act. This chapter is a discussion of the requirements for a lawful kidney transplant of a living and deceased donor. Although this dissertation focuses only on the buying and selling of kidneys from living donors it is relevant to discuss the complete organ donation process in South Africa which includes deceased donors. Although the Human Tissue Act was repealed on 1 March 2012, it will be discussed, since it was the law for the past 29 years. A discussion of the current National Health Act and the draft regulations will then follow. Furthermore, shortcoming in the current Act will be highlighted.

3.2 THE REQUIREMENTS FOR A LAWFUL KIDNEY TRANSPLANT

3.2.1 The Human Tissue Act

The Human Tissue Act was repealed on 1 March 2012, but it was the only Act regulating organ transplants for the past 29 years and thus could be responsible for the acute kidney shortage.

Anarchis (600 BC), Scythian philosopher, quoted in Plutarch *Lives of the Nobel Grecians and Romans*.

²⁹⁵ Section 2 of the Constitution.

3.2.1.1 Deceased kidney donors

3.2.1.1.1 Consent regarding donation

A donor could be any person who has testamentary capacity (above the age of 16). Section 2 of the Act stipulated that a person could become a prospective donor in two different ways. Firstly, he could either state his wishes to become a donor in his will or in a document signed by him and attested to by at least two competent witnesses. Secondly, the prospective donor could express his wishes in an oral statement made by him in the presence of at least two competent witnesses. According to section 2(1)(b) the prospective donor could nominate a institution or person as a donee however this could be done by the donor's own discretion it was not a requirement. A prospective donor could also apply for an organ donor card, which includes two stickers for the prospective donor's identity document and driver's licence. Although this was not a requirement according to the Act, it could be done out of free will. 298

When the deceased's wishes were unknown, the Act stipulated that there were two ways to obtain permission for the donation. The most common way was for the deceased's spouse, major child, parent, guardian, major brother or major sister to grant permission for the donation.²⁹⁹ If the abovementioned persons were not available, the Director-General³⁰⁰ could grant permission for the usage of the organs after he had taken all reasonable steps to trace the deceased's family.³⁰¹

A decision to donate could be revoked at any time before the prospective donor's death. A donation that was made under section 2(1) of the Act could have been revoked in the same way in which it was made; in the case of a will or other document, another will or document could be drawn up or the original will or document could be intentionally destroyed.³⁰² Since the whole donation process was

²⁹⁶ Section 2(1) of the Human Tissue Act.

²⁹⁷ Section 2(1) of the Human Tissue Act.

Organ Donor Foundation http://www.odf.org.za (Date of use: 20 January 2012).

²⁹⁹ Section 2(2)(a) of the Human Tissue Act.

³⁰⁰ Director-General means the head of the national Department of Health.

³⁰¹ Section 2(2)(b) of the Human Tissue Act.

³⁰² Section 5 of the Human Tissue Act.

linked to a time limit, a prospective donor needed to inform his family or those close to him about his decision to donate.³⁰³

3.2.1.2 Living kidney donors

3.2.1.2.1 Consent regarding kidney donation

Section 18 of the Act stipulated that only a major person (18 years or older) could be a prospective donor after he granted written informed consent thereto. If a person wanted to be a donor but was a minor, he could become a prospective donor if his parents or guardians granted written consent thereto. The parents could only grant consent in the case of the removal of tissue that was replaceable by a natural process (for instance blood or hair). The minor could also in this instance grant written or oral consent in his own capacity as long as he was older than 14 years. A minor was not allowed to be a kidney donor, since a kidney is not replaceable by a natural process.

There were a number of restrictions regarding the transplantation of tissue.³⁰⁵ Under no circumstance could the following be used for transplantation:

- Any tissue of a person who was mentally ill within the meaning of the Mental Health Act 18 of 1973 (now replaced by the Mental Health Care Act 17 of 2003).³⁰⁶ Thus, it was prohibited to use a kidney for transplantation that was removed from a person who had been defined as mentally ill.
- Any tissue of a person who was a minor and that was not replaceable by natural processes. As mentioned previously, a kidney is not replaceable by a natural process and could therefore not be donated by a minor.

From the prospective donor's time of death, the practitioners have only limited time to transplant the organs, for instance heart and lungs must be transplanted within five hours, lungs within six hours, liver within 34 hours and kidneys within 72 hours. Slabbert 2009 Stellenbosch Law Review 129.

³⁰⁴ Section 18(b)(ii) of the Human Tissue Act.

In this section, there will only be a discussion of the prohibition regarding kidney transplants.

³⁰⁶ Section 19(i) of the Human Tissue Act.

In South Africa, most living kidney donations are between persons that share a family relationship or by spouses. If any other person, for instance a friend, wants to donate a kidney there is one more step regarding the consent. An application for consent must be sent to the Department of Health to ensure that the donation is completely altruistic.

3.2.1.2.2 Place of removal

There were specific requirements regarding the removal of a kidney from a living kidney donor for transplanting into the body of a living kidney recipient. The transplant could not occur in any place other than a hospital or authorised institution.³⁰⁷ Furthermore, the transplant could not take place without the written authority of the medical practitioner in charge of the hospital or institution. The abovementioned medical practitioner should not have been involved in the transplant concerned.³⁰⁸

3.2.1.2.3 Persons authorised to perform the kidney transplant

Section 23 of the Act firmly stipulated that no person except a medical practitioner or a person acting under his supervision could remove a kidney from the body of a living person or use or transplant a kidney so removed in the body of another living person.

3.2.2 The National Health Act

3.2.2.1 Deceased kidney donors

The donation of human bodies and tissue of deceased persons is controlled by sections 62 to 68 of the National Health Act. Kidneys obtained from a deceased person may only be transplanted according to the prescribed procedures. It is also of importance that a kidney may not be transplanted into any person who is not a South African citizen or a permanent resident of the Republic without the written consent of the Minister of Health. The prescribed requirements for a lawful kidney transplant are described below.

³⁰⁷ Section 20(a) of the Human Tissue Act.

³⁰⁸ Section 20(b) of the Human Tissue Act.

3.2.2.1.1 Consent regarding kidney donation

Consent is probably one of the most important requirements that should be adhered to regarding kidney transplants. There are a number of manners in which consent can be granted. These manners are all stipulated in section 62(a)(i)-(iii) and are the same as in the repealed Human Tissue Act.

The manners in which consent can be granted may be the same, but according to section 62(1)(b) of the Act, if a deceased granted consent in accordance with the abovementioned methods,³⁰⁹ he also had to nominate an institution or person as a donee. If he did not nominate an institution or a person, the donation will be considered as null and void.³¹⁰

If the deceased did not express his wishes during the duration of his lifetime, consent can also be granted by the deceased's spouse, partner, major child, parent, guardian, major brother or sister. Consent is only acceptable in this manner if the deceased did not express his unwillingness to donate when he was alive. The abovementioned persons also need to nominate an institution or person as a donee. If none of the mentioned family members can be located, the Director-General may grant consent to have the kidney of the deceased donated to a nominated institution or person. There are a number of requirements connected to consent given by the Director-General: the deceased should not have shown any inconsistency regarding the donation, and the Director-General must be convinced that all reasonable steps had been taken to trace the relevant persons to grant consent. The position regarding an unidentified deceased person is still uncertain.

According to section 65 of the Act, a prospective donor may revoke his consent to donate a kidney at any time. The consent must be revoked in the same way in which

A prospective donor does not need to nominate an institution or person when applying for a donor card. Organ Donor Foundation http://www.odf.org.za (Date of use: 20 January 2012).

³¹⁰ Section 62(1)(c) of the National Health Act.

³¹¹ In the specific order mentioned.

³¹² Section 62(2) of the National Health Act.

³¹³ Section 62(3)(b) of the National Health Act.

it was obtained. In the case of a will or a document, another will or document can be drawn up or the original will or document can be intentionally destroyed.

3.2.2.1.2 The kidney donor must be "dead"

Although this requirement seems very obvious, it is not. The most important part of this requirement is what exactly is meant by the term "dead". This requirement is of great importance because from the time of death there is only a limited time that most organs can still be considered as viable. For instance, the skin or corneas of a donor do not need to be transplanted immediately, but in the case of a heart the transplant must take place within five hours and a kidney transplant within 72 hours. It is evident that most transplant processes need to take place immediately after the donor's time of death; while there is still sufficient blood circulation for the transplant to be the successful.

In previous years, the decisive factor for "death" was the absence of any heart activity. This test was applied by Dr Barnard and his medical team and it entailed the following: a practitioner could certify a potential donor as dead as soon as the electrocardiogram showed no activity for five minutes and there was an absence of any spontaneous respiratory movement and reflexes. Medical science has developed a lot over the years and this test is no longer applied. Modern health practitioners are of opinion that there is not one single moment that can be accepted as a time of death, but that the determination of death can be described as a process. In process.

The brain, heart and lungs are considered as the organs that are needed for the continuation of life. Any disturbance or damage to any of these organs has almost an automatic effect on the other organs. Death was not previously defined and this led to huge complications in the legal world. In the Anatomical Donations and Post Mortem Examinations Act there were no definitions regarding "death" or "corpse"; however, in

³¹⁴ Barnard CN "The operation" 1967 South African Medical Journal 1271.

³¹⁵ Strauss SA Aspekte van wetgewing vir gesondheidspersoneel 39.

the National Health Act "death" can now be accepted as brain death. The majority of practitioners support the definition of death as the cessation of any brain activity. Most patients that have an absence of brain activity exist in a vegetative condition and can be regarded as merely "living corpses." It is not only medical practitioners that share this opinion; philosophers like McMahan and Singer are also of opinion that humans are merely "embodied minds", and that once a person has lost his higher cerebral functions he can be regarded as a non-person. Practitioners are of opinion that organs that are harvested before the donor's blood circulation stops will be more advantageous for the organ recipient. Thus, the new definition is more beneficial for kidney recipients because it will now be possible to harvest kidneys from a donor that still has a heartbeat, even though the heartbeat is supplied by a life-support device.

3.2.2.1.3 The allocation and use of deceased-donor kidneys

Kidneys obtained from a deceased donor for the purpose of transplantation may only be used in the prescribed manner and need to be allocated³²⁰ in accordance with the prescribed procedures.³²¹ The Minister³²² needs to prescribe a criterion for the approval of organ transplant facilities³²³ and procedural measures to be applied for

Brain death must be established by at least two medical practitioners, of whom one must have been practicing as a medical practitioner for at least five years, and neither of these medical practitioners may participate directly or indirectly in the transplantation. Section 11 of the Regulations to the National Health Act 61 of 2003 in GG 30828 of 7 March 2008 20 (hereinafter referred to as the Regulations to the Act).

³¹⁷ Strauss Aspekte van wetgewing vir gesondheidspersoneel 40.

Clarke DL and Egan A "Euthanasia – is there a case?" 2008 (1) South African Journal of Bioethics and Law 26. Also see McMahan J The ethics of killing: Problems at the margin of

³¹⁹ Strauss Aspekte van wetgewing vir gesondheidspersoneel 40.

The assessment process regarding donations will be discussed in section 3.3.

³²¹ Section 61 of the National Health Act.

³²² Defined as the Cabinet member responsible for health.

The approved kidney transplant facilities in South Africa are the following (divided into state and private facilities: 1.State facilities: Universitas Hospital (Bloemfontein). Groote Schuur Hospital, Red Cross War Memorial Children's Hospital and Tygerberg Hospital (Cape Town). Inkosi Albert Luthuli Hospital (Durban). Charlotte Maxeke Johannesburg Academic Hospital (Johannesburg). George Mukhaki Hospital and Steve Biko Academic Hospital (Pretoria). 2. Private facilities: Netcare Universitas Hospital (Bloemfontein). Christiaan Barnard Memorial Hospital Netcare (Cape Town). Entabeni Hospital and St Augustine Hospital Netcare (Durban). Garden City Clinic Netcare, Milpark Hospital Netcare and Wits Donald Gordon Medical Centre

such approval.³²⁴ The allocation of organs in South Africa is rather a troublesome concept, as previously mentioned.

3.2.2.1.4 Purposes of donation of body and tissue of deceased persons

The body and tissue of a deceased person may only be donated for the following purposes:

- The training of students in health sciences.
- Health research.
- The advancement of health sciences.
- Therapeutic purposes, including the use of tissue in any living person.
- The production of a therapeutic, diagnostic or prophylactic substance.

3.2.2.2 Living kidney donors

Section 56 of the National Health Act mainly regulates the position regarding the use of tissue harvested from living persons. "Tissue" is described in the Act as "human tissue, and includes flesh, bone, a gland, an organ, skin, bone marrow or body fluid, but excludes blood or a gamete". The donation of tissue that is not replaceable by natural processes is more strictly controlled than tissues that are replaceable by natural processes. Section 56(1) of the Act stipulates that tissue may only be withdrawn from a living person for medical or dental purposes, as prescribed. The other requirements for a lawful transplant are described below.

⁽Johannesburg). Jakaranda Hospital Netcare (Pretoria). Organ Donor Foundation http://www.odf.org.za (Date of use: 25 January 2012).

³²⁴ Section 59(4) of the National Health Act.

³²⁵ A gamete is defined as either of the two generative cells essential for human reproduction.

3.2.2.2.1 Consent regarding kidney donation

One of the most important requirements for a lawful kidney transplant is that the potential kidney donor must have given written informed consent. Tissue that is not replaceable by natural processes, such as kidneys, may not be harvested from a person younger than 18 years old even if there is consent from the parents. The donation of replaceable tissue is much more straightforward; there is no need for written consent from a major and a minor's parents can give permission regarding this donation.

A practitioner may only use tissue from a living person for the medical purposes that are prescribed in the Act. Even though these conditions exist, there are a number of restrictions on tissue donations. Under no circumstances may tissue be removed from the following persons:

- A person who is mentally ill within the meaning of the Mental Health Care
 Act. Thus, a kidney may not be removed from the living body of a person
 that can be defined as mentally ill by the abovementioned Act.³²⁸
- A person younger than 18 years, if the tissue is not replaceable by natural processes. A kidney is not replaceable by a natural process and may therefore not be removed from a minor.³²⁹

It should be mentioned that the Minister may authorise the removal or withdrawal of tissue and he may also impose any condition that may be necessary in respect of such removal or withdrawal.³³⁰

Section 60 of the Act imposes a strict limitation: remuneration may not be received for any donation. All donations are regarded as a "gift of life" and it will be an offence if a person who has donated a kidney receives any form of financial or other reward for

³²⁶ Section 55(1)(a) of the National Health Act.

³²⁷ Section 56 (2)(a)(ii) of the National Health Act.

³²⁸ Section 56(2)(a)(i) of the National Health Act.

³²⁹ Section 56(2)(a)(ii) of the National Health Act.

³³⁰ Section 56(2)(b) of the National Health Act.

such a donation.³³¹ However, section 60(4)(a) of the Act stipulates that a donor may receive reimbursement of reasonable costs incurred by him to provide such a donation, but neither the Act nor the Regulations³³² or the draft regulations determine who will be liable for these costs or what exactly "reasonable costs" entail. Any person who violates the Act is liable on conviction to a fine or to imprisonment for a period not exceeding five years or to both a fine and imprisonment.³³³

3.2.2.2.2 Place of removal

Section 58 of the Act regulates the position regarding the place of removal of the kidney from the living donor for the transplantation. The Act stipulates that the removal may only take place in a hospital or an authorised institution. The Act stipulates that the removal may only take place in a hospital or an authorised institution. The Act stipulates that the removal may only take place in a hospital or an authorised institution. The Act stipulates that the removal may only take place in a hospital or an authorised institution. The Act stipulates that the removal of the kidney further more, the written authority of the medical practitioner in charge of the clinical services at the hospital or institution is required. The medical practitioner in charge is unavailable, any other medical practitioner authorised by him can grant authority. Neither practitioner is allowed to participate in a transplant that he authorised.

3.2.2.2.3 Authorised persons that may perform the kidney transplant

The removal of the donor kidney may only be done by a registered practitioner, or a person acting under the supervision or on the instructions of the medical practitioner.³³⁸

3.3 THE ASSESSMENT PROCESS REGARDING KIDNEY DONATIONS

Fairness is the most important and vital concept regarding the assessment process. However, fairness is not easily achieved. Creating fair procedures is problematic: how can we, as human beings, decide whose life is more important regarding two

³³¹ Section 60(4)(a) of the National Health Act.

³³² Regulations of the National Health Act.

³³³ Section 60(5) of the National Health Act.

³³⁴ Section 58(1)(a) of the National Health Act.

³³⁵ Section 58(1)(b)(i) of the National Health Act.

³³⁶ Section 58(1)(b)(ii) of the National Health Act.

³³⁷ Section 58(2) of the National Health Act.

³³⁸ Section 59 of the National Health Act

patients? A system of fairness is partially created by legislation, but the final decision rests in the hands of the practitioners.

Annexure B of the draft regulations issued by the National Health Act must still be approved by Parliament. As soon as this takes place, the assessment of potential kidney donors will take place.

3.3.1 The criteria for deceased-donor kidney transplantation³³⁹

When organs are harvested from a deceased, there are a number of requirements that the donation must comply with. All these requirements need to be met according to the standard protocol. The requirements are as follows:

- Establishment and confirmation of brain death of the donor.
- The potential kidney(s) need to be declared as suitable and viable.
- Consent needs to be obtained from the family (even if the donor did previously give consent).
- The exclusion of any communicable diseases, malignancy or any other serious health issues regarding the kidney(s).
- The ability to maintain circulation or kidney viability until the kidney can be removed for transplantation.

The potential kidney donor will also be evaluated according to a number of other factors. These factors will differ, depending on the type of transplant and the needs of the patients on the recipient waiting list. There is also further evaluation on the following criteria:³⁴⁰ suitable ABO (blood-type) matching, suitable cytotoxic antibody screening, suitable HLA (human leukocyte antigen) matching, suitability of size and age of the kidney recipient, medical condition and degree of urgency, and the time that the kidney recipient has been on the waiting list.

³³⁹ Draft regulations of the Act 27.

³⁴⁰ Draft regulations of the Act 27.

3.3.2 The criteria for living-donor kidney transplantation

Encouraging the public to become potential living kidney donors is of great importance. As mentioned previously, it is more medically advantageous and can help with the dire need of available kidneys. Living kidney donors need to comply with a pre-criterion to qualify as donors. In the first place, the potential donor must be aged 18 years or older. Secondly, fully informed consent should be obtained from both the potential donor and the potential recipient concerning the risks and benefits of the procedures. Lastly, particulars of both the donor and recipient should be recorded in a transplant database and a lifetime follow-up must be established. If the kidney donor is not related to the kidney recipient, ministerial permission must be obtained for the transplantation. There is also a difference regarding the assessment of a related and an unrelated potential kidney donor.

3.3.2.1 The assessment of related living kidney donors

Regarding the assessment of relatives, the potential donor and potential recipient only need to prove that they share a genetic relationship within the third degree. The genetic relationship can be any person that falls into the following categories: parents, children, siblings, aunts and uncles, nieces and nephews or cousins.³⁴⁴ The abovementioned person can be a full or half blood relative. A potential donor needs to satisfy the medical, ethical and psychiatric criteria, and the donor as well as the recipient must be assessed and found suitable by a multi-disciplinary transplant selection panel.³⁴⁵

3.3.2.2 The assessment of unrelated living kidney donors

Regarding the assessment of unrelated donors the requirements are stricter. The reason for this is that a donation is supposed to be a "gift of life". When an unrelated person decides to become a donor, it can be questioned whether there is a financial

³⁴¹ Draft regulations of the Act 27.

³⁴² Draft regulations of the Act 27.

³⁴³ Draft regulations of the Act 27.

³⁴⁴ Draft regulations of the Act 28.

³⁴⁵ Draft regulations of the Act 28.

gain or any other type of benefit for him. Regarding this category, a potential donor can be a spouse, friend or acquaintance, but it is not limited to these. The potential unrelated kidney donors need to meet the following requirements:³⁴⁶

- The motives of the donor should be assessed; his motive should be altruistic and in the best interest of the recipient. There should be no profit involved.
- Both the potential donor and recipient should conform to all medical investigations.
- There must be a psychological assessment done by an independent qualified social worker or psychologist to ensure that both parties are fully informed and there is no form of coercion.
- An application for the unrelated donation needs to be forwarded to the relevant office of the national Department of Health.
- The abovementioned application needs to be approved by the Ministerial Advisory Committee or another committee established for this purpose.

All potential kidney donors and recipients are further evaluated in terms of the guidelines set by the various transplant centres.³⁴⁷ The main purpose of the discussed draft regulations is to try and establish a system of allocation regarding the donation of organs in South Africa. As mentioned earlier, currently the allocation of donor kidneys is simply done by an agreement between the various transplant centres and the private and public sector. This system could be regarded as unfair and unjust. The allocation of donor organs should be done according to the needs of the potential kidney recipients. The process needs to be more just, fair and controlled.

76

³⁴⁶ Draft regulations of the Act 28.

³⁴⁷ Draft regulations of the Act 28.

3.4 SHORTCOMINGS IN SOUTH AFRICAN TRANSPLANT LEGISLATION

In the 1950s, South Africa was a pioneer regarding transplant legislation. However, after a closer look at the current transplant legislation in force today this is no longer the case. There are a number of obvious shortcomings in the legislation.³⁴⁸

The author is of opinion that the consent requirement in the National Health Act is a very problematic area. The first problem regarding consent is the fact that a potential deceased kidney donor can meet all the requirements for becoming a donor and have a will, document or organ donor card to show his willingness to donate; however, at his time of death his family has the choice whether they want to donate his kidney(s) or not. This power position of the family is unfair and unjust and could even be unconstitutional – a donor's family should only be allowed to interfere if the donor showed unwillingness to donate before his death. The second problem regarding consent is the prohibitions regarding the mentally ill and minors previously discussed in both Acts. The mentally ill prohibition should be regulated on a case-to-case basis: if a person has sufficient intellectual capacity he should be allowed to make his own decisions. In *Pienaar v Pienaar's Curator*³⁴⁹ the court stated:

The mere fact that such a person has been declared insane or incapable of managing his affairs, and that a curator is appointed to such a person, does not deprive him of the right of administrating his own property and entering into contracts and other legal dispositions to the extent to which he may *de facto* be capable, mentally and physically, of doing so.

Section 2(1) of the Human Tissue Act and section 62 of the National Health Act states that any person who is competent to make a will or document that contains his wishes to donate a kidney can become a donor. If a mentally ill person is capable to enter into a legal contract without any influence, he should be allowed to become a potential donor.

In both Acts there is a prohibition that states that a kidney may not be harvested from a minor (18 years and younger) because it is not replaceable by a natural

³⁴⁸ There is only a short discussion concerning the shortcomings of the relevant legislation in this section, as this is not the main focus of the dissertation.

³⁴⁹ Pienaar v Pienaar's Curator 1930 OPD 171 para 174. Also see: Fourie Organ procurement 59.

process. This prohibition seems to be a bit contradictory, since section 129 of the Children's Act³⁵⁰ states that any child from the age 12 and older is allowed to give consent for any medical treatment or surgical operation if the child is of "sufficient maturity" and has the mental capacity to understand the benefits, risks, social and other implications of the treatment. Thus, these children are allowed to consent to surgical operations such as abortions but are not allowed to donate a kidney. Regarding this prohibition, section 2(1) of the Human Tissue Act and section 62 of the National Health Act plays a role again: a person only needs to be 16 years of age to make a will or document; thus a minor of the age 16 and above should be allowed to consent to transplantation.

Another problem area regarding both the Acts is the whole concept of "altruism". In both Acts³⁵¹ it is considered as a major offence to receive any payment for a donation. A donation is supposed to be a "gift of life" and it is commonly known that something cannot be perceived as a gift if a payment took place. However, the author regards this prohibition as one of the main reasons for the lack of available donor kidneys. The kidney donor makes a big sacrifice, in comparison with the kidney recipient. He has the larger scar after the surgery and he is not covered by the recipient's medical scheme, nor will his own medical aid pay for the costs as it not a required procedure. Section 60(4)(a) of the National Health Act creates the possibility of remuneration; yet it is not defined what exactly this remuneration entails. The cruel reality is that there will be more kidney donors if there is some kind of financial gain for the donor. And why should this not be allowed? Both donor and recipient will receive some form of benefit - the recipient will receive a kidney that will increase his life expectancy and quality, and the donor will receive a reimbursement that will improve his life in one way or another.

To substantiate this view, a reference is made to Radcliffe-Richards, who discusses the case of a Turkish father who wanted to sell his kidney with the

350 Children's Act 38 of 2005.

³⁵¹ Section 28 of the Human Tissue Act and section 60 of the National Health Act.

purpose of paying for urgent hospital treatment for his daughter. The father did not have any valuables or money that he could use to cover the costs of his daughter's treatment. Yet, he was prohibited from selling his kidney. This prohibited the father from saving his daughter's life and that of the potential kidney recipient. However, if the case was somewhat different and the sick daughter needed a kidney and her father had acted as her kidney donor, he would have been regarded as a hero. 352 It is difficult to understand why selling his kidney to pay for his daughters medical treatment should be regarded as a crime. A form of financial reward could help to improve the current shortage of available kidneys. As discussed earlier in chapter 2 the state cannot provide end-stage renal failure patient due to lack of resources thus they could provide the patients with an alternative – the choice to receive a donor kidney by means of compensation. However, to encourage the public, their perception regarding the payment of kidney donors should change, and this can only be done by educating the community regarding the need for more kidneys to be transplanted.

There are also a few serious shortcomings regarding the administration process of kidney donations. As previously mentioned, there is no national list of recipients waiting for kidneys or of people who are registered as potential donors. These lists could make a huge difference: they could give more clarity regarding the situation. Once there is more clarity it will be easier to find a solution for the shortage.

3.5 CONCLUSION

The transplant legislation in South Africa plays a major role in the procurement of donor kidneys. This chapter sought to examine the statutory framework and its shortcomings pertaining to kidney transplants in South Africa. The transplant legislation in South Africa plays a major role in the procurement of donor kidneys. Chapter 8 of the National Health Act could be a step in the right direction because

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³⁵² Radcliffe-Richards *et al* "The case for allowing kidney sales" 1998 (351) *The Lancet* 1951. Also see Slabbert and Oosthuizen 2007 *Obiter* 313.

section 60(4)(a) of the Act attempts to improve the current shortage of kidneys by providing the kidney donor with a reimbursement for the reasonable costs incurred by him. Yet, in the Act there is no indication what exactly is meant by reasonable costs and who will determine these reasonable costs. The legislator should have taken section 60(4)(a) one step further and legalised kidney sales in a regulated and constitutionally acceptable manner.

In the previous chapter of this dissertation it was concluded that kidney sales could be regarded as constitutionally acceptable. In the following chapter there will be a discussion whether kidney sales is acceptable if measured against bioethical principles.

CHAPTER 4 – BIOETHICAL PERSPECTIVES ON KIDNEY TRANSPLANTS

"Protection of the integrity of medical ethics is important for all of society. If medicine becomes, as Nazi medicine did, the handmaiden of economics, politics, or any force other than one that promotes the good of the patient, it loses its soul and becomes an instrument that justifies oppression and the violation of human rights." ³⁵³

4.1 AN INTRODUCTION TO BIOETHICS

The doctor-patient relationship forms one of the most important foundations of contemporary bioethics. This relationship is based on mutual trust between a patient and his healthcare practitioners. The term "profession" means "a dedication, promise or commitment publicly made". 354 But it is not always as easy as it sounds for the healthcare practitioner to uphold this promise. The foundations of this promise is based on the Hippocratic Oath, which is regarded as the first written document pertaining to the ethical practice of medicine. The core concept of this oath is primum non nocere or "above all, do no harm". 355 Since the times of the Hippocratic Oath up to the middle of the twentieth century, medical ethics stagnated to some degree, given that there was not much development in biological or health sciences. However, as the years went by, things started to change: technology advanced, practitioners became more experienced and discovered better ways of practising medicine and the general community's view of medical advantages changed. Practices that were once regarded as contra bones mores seemed to become more and more acceptable as the years went by. For example, medical advances such as organ transplants, legal abortions, in vitro fertilisation and life-sustaining treatment of terminally ill patients became an everyday occurrence. These medical advances changed most people's lives, as well as the role of the medical practitioner. Previously, the practitioner's world of decision-making was mostly black and white;

³⁵³ Quoted from Pellegrino Annals of Internal Medicine 307.

Pellegrino ED "Medical professionalism: Can it, should it survive?" 2000 (13) *The Journal of the American Board of Family Medicine* 148.

Moodley K "A place for ethics, law and human rights in healthcare" in Moodley K (ed) *Medical ethics, law and human rights* 3.

grey areas almost never occurred. A practitioner could follow basic rules and codes and all would be fine. However, as the medicine advanced the practitioner's role changed and the concept of bioethics was born.

Since its birth in the early 1970s, bioethics has grown immensely and now applies to all medical practitioners. Bioethics can be regarded as the part of ethics that deal with the moral issues raised by developments in the biological sciences at a more general level.³⁵⁶ Since bioethics is part of ethics it is also of importance to look at the general definition of ethics. According to the World Medical Association, ethics can be defined as follows: "Ethics is the study of morality - careful and systematic reflection on and analysis of moral decisions and behaviour, whether past, present or future". 357 Thus, ethics is a matter of knowing what the right thing is to do, while morality is a matter of doing the right thing.³⁵⁸ Because of bioethics, present practitioners follow a patientcentred holistic approach to healthcare instead of the more traditional approach of doing good and avoiding harm. Bioethics is based on four principles that provide practitioners with a framework to consult when they encounter any ethical problems. The four-principle approach developed in the United States of America and is based on four common basic moral principles, namely respect for autonomy, beneficence, non-maleficence and justice. 359 Although these four principles do not provide ordered rules, they can help doctors and other healthcare workers to make decisions when reflecting on moral issues that might arise from kidney transplants. In this chapter there will be a discussion of the four principles and how they relate to kidney transplants.

4.2 AUTONOMY AND THE DOCTRINE OF INFORMED CONSENT

Every day in life – from the moment we wake up until we go to sleep – we make our own choices regarding everything we pursue on that specific day. The act of making our own choices and often saying "it is my life, I'll do as I like", can be described as acting autonomously.

³⁵⁶ Moodley in Moodley (ed) Medical ethics, law and human rights 4.

Moodley in Moodley (ed) *Medical ethics, law and human rights* 3.

³⁵⁸ Moodley in Moodley (ed) *Medical ethics, law and human rights* 3.

³⁵⁹ Moodley in Moodley (ed) Medical ethics, law and human rights 5.

The word "autonomy" is derived from the Greek word autos, which means "self", and the word nomos, which means "rule"; thus literally meaning self-rule. According to Beauchamp and Childress,³⁶⁰ personal autonomy at a minimum can be defined as self-rule that is free from both controlling interference by others and from certain limitations that prevent meaningful choice. Autonomy is of great importance regarding kidney transplants because a kidney transplant can only be seen as morally legitimate if the kidney donor's autonomy can be guaranteed.³⁶¹ This resonates with the right to self-determination discussed earlier in chapter 2 is interlinked. A kidney donor can only be regarded as autonomous if he decided to proceed with his donation after being informed of the associated risks and if there was no pressure or force from others when the decision was made. It should be borne in mind that a financial gain should not be regarded as a measure of pressure – lacking wealth does not prevent a person from making a rational decision. 362 Respect for autonomy entails both a negative and positive obligation. As a negative obligation, autonomous actions should not be subjected to controlling constraints by others.³⁶³ As a positive obligation, respect for autonomy requires both respectful treatment in disclosing information and actions that foster autonomous decision-making.³⁶⁴ However, it should be noted that autonomy is not merely about someone making their own decisions: the concept of autonomy also has a number of implications and limitations.

In healthcare, respecting someone's autonomy has a number of *prima facie*³⁶⁵ implications. These implications will now be discussed. The medical practitioner needs to consult with his patient and obtain his agreement before he performs any procedures on him – hence, the vital obligation of informed consent.³⁶⁶ Patients wants to actively participate in decisions about their medical care and it is their right to make

360 Beauchamp TL and Childress JF Principles of biomedical ethics 99.

³⁶¹ Munson R "Organ transplantation" in Steinbock B (ed) Oxford handbook of bioethics 217.

Friedman EA and Friedman AL "Payment for donor kidneys: Pros and cons" 2006 (69) *Kidney International* 961.

³⁶³ Beauchamp and Childress Principles of biomedical ethics 104.

³⁶⁴ Beauchamp and Childress *Principles of biomedical ethics* 104.

A *prima facie* rule refers to one that must be fulfilled unless it conflicts on a particular occasion with an equal or stronger rule. Moodley in Moodley K (ed) *Medical ethics, law and human rights*.

³⁶⁶ Gillon R "Medical ethics: four principles plus attention to scope" 1994 (309) *British Medical Journal* 185.

decisions regarding treatment according to their own belief system, cultural and personal values and life plan.³⁶⁷ If one wants to respect a patient's wishes, one has to facilitate and encourage their input into the decision-making. All these implications are important regarding kidney transplants: a medical practitioner must obtain a kidney donor's informed consent after proper consultation, and during this consultation the practitioner should have made the kidney donor aware of all the risks associated with a kidney transplant (thus he may not deceive the patient).

As previously mentioned, autonomy is not without its limitations. One of the most problematic limitations is if a patient is unable to contribute fully to the discussion between him and his medical practitioner. Capacity is the term used to denote a patient's ability to make healthcare decisions. Capacity requires four elements of a patient's ability: to comprehend information about the condition and the choices available, to make judgements about the information consistent with personal values, to understand the potential outcomes and possible adverse consequences of the choices, and to possess the facility to freely communicate one's wishes. Regarding a kidney transplant, only the first two limitations can occur, namely a communication barrier or a patient rejecting his opportunity to exercise his right. Mental incompetence is not relevant to a kidney transplant because, as stated in the previous chapter, a kidney may not be removed from a person that can be regarded as mentally ill according to the Mental Health Care Act.

A patient, if adequately informed, is usually the best judge of his own interest. 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.

³⁶⁷ Karnani N "Bioethics: Applying the basic principles to resolve an ethical dilemma" 2008 (59) Northeast Florida Medicine Supplement 3.

Porter KK and Rai GS "Principles of medical ethics" in Rai GS (ed) *Medical ethics and the elderly* 3.

³⁶⁹ Karnani 2008 Northeast Medicine Supplement 3.

³⁷⁰ Karnani 2008 Northeast Medicine Supplement 3.

Informed consent has been part of South African law since the 1920s, but it was the landmark decision in *Castell v De Greet*³⁷¹ that emphasised its importance. A number of important decisions regarding informed consent were made in this case. One of the most important was the requirements that must *inter alia* be satisfied for consent to be regarded as a defence. These requirements include that the consenting party must have had knowledge and been aware of the nature of the harm or risk; the consenting party must have appreciated and understood the nature and extent of the harm and risk; the consenting party must have consented to the harm and assumed risk; and the consent must be comprehensive.³⁷² Consent to treatment will only be regarded as informed if it is based on substantial knowledge concerning the nature and the effect of the act consented to.³⁷³ The main purpose of the doctrine of informed consent is to protect autonomy. To protect a patient's autonomy, a medical practitioner is obliged to warn the patient consenting to a medical treatment of the material risk inherent to the proposed treatment.³⁷⁴

A risk is regarded as material in the following circumstances: if a reasonable person in the patient's position is warned of the risk, would be likely to attach significance to it or if 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. It should be emphasised that, in more recent case law it was decided that if there is only a very small chance of a risk occurring, the risk is regarded as negligible and the omission will not constitute negligence. The risk must be regarded as a greater than usual risk. The obligation to warn the patient of any inherent risk to the medical treatment is also subjected to the therapeutic privilege. In terms of the therapeutic privilege, a

³⁷¹ Castell v De Greef 1994 4 SA 408 (C).

The consent must be comprehensive in that it extends to the entire transaction, inclusive of its consequences.

³⁷³ Olwage v Louwrens 2004 1 SA 532 (C).

³⁷⁴ Castell v De Greef 1994 4 SA 408 (C) para 426.

³⁷⁵ Castell v De Greef 1994 4 SA 408 (C) para 426.

Louwrens v Oldwage 2006 (2) SA 161 (SCA) para 87. After the plaintiff had an iliac bi-femoral bypass he experienced a claudication in his left leg. The medical practitioners refer to this as "steal syndrome". In this appeal it was decided that there was only a 2% chance of a steal occurring; thus, no duty arose to inform the plaintiff, and the defendant was not regarded as unreasonable for not mentioning it.

medical practitioner may withhold information from a patient that in his view could be detrimental to the patient.³⁷⁷

When it comes to decision-making, informed consent can prevent patients from being deceived, exploited, tricked, misled, duped, manipulated or pressured so that their autonomy is violated.³⁷⁸ Informed consent is both an ethical and legal requirement. The National Health Act makes provision for the requirement of informed consent. In section 7 it stipulates that a health service may not be provided to a user without the user's informed consent.³⁷⁹ Section 8 stipulates that a user has the right to participate in any decision affecting his personal health and treatment. Informed consent is not something that should be taken up lightly. It does not take just a few minutes to obtain - it is a process. This process starts by first making sure that the patient is competent to make $decisions^{380}$ (the requirements for a competent person was discussed earlier). Next, the competent patient must be provided with information relevant to his decision; and the information must be understandable and sufficient.³⁸¹ The last step is to ensure that the patient's autonomy is not infringed by means of coercive forces, deception or situational pressures.³⁸² The last step is extremely important for a transplant programme that permits living kidney transplants, because it protects the kidney donor from familial and situational pressures.³⁸³ In some cases, the pressure the kidney donor receives from his family can be far worse than the so-called pressure that is caused by a financial gain. If a kidney donor makes the choice to sell it has no influence whatsoever on his right to privacy as discussed in chapter 2. As previously mentioned, a person's financial status has no direct link to his decisionmaking skills.

³⁷⁷ Blackbeard M "Consent to organ transplantation" 2003 (66) *Tydskrif vir Hedendaagse Romeins-Hollandse Reg* 53.

³⁷⁸ Munson in Steinbock (ed) Oxford Handbook of bioethics 217.

There are a number of exceptions to this rule. For example, informed consent does not have to be provided when failure to treat the patient could lead to serious risk or if the provision of a health service without informed consent is authorised in terms of any law or a court order.

³⁸⁰ Munson in Steinbock (ed) Oxford Handbook of bioethics 217.

³⁸¹ Munson in Steinbock (ed) Oxford Handbook of bioethics 217.

³⁸² Munson in Steinbock (ed) Oxford Handbook of bioethics 217.

³⁸³ Munson in Steinbock (ed) Oxford Handbook of bioethics 218.

Informed consent has an integral role to play with regard to kidney transplants. A kidney donor and recipient must be informed of all the consequences of the transplant. They must also be aware of the nature and extent of the transplant and must lastly appreciate and understand the nature and extent of the transplant. All this must be explained to the kidney donor and recipient in a sufficient and understandable manner. If a transplant is performed and there was no proper informed consent (meaning that the patient did not know in broad terms the nature of the transplant procedure), it could constitute criminal assault. Also, the failure to inform the kidney recipient sufficiently of alternative treatment available and the risks and consequences of the kidney transplant could lead to an action in delict. 385

4.3 NON-MALEFICENCE AND BENEFICENCE

In any medical intervention where a medical practitioner tries to help a patient there is always the unavoidable risk of harming the patient. An example would be when a patient is operated to remove a cancerous tumour: there is the chance that the cancer may be cured; however, during the surgery the patient is also harmed – his body is cut open in order to perform the surgery and in some cases an organ may be removed to prevent the cancer from spreading. In this case, a medical practitioner is confronted with the two principles of "beneficence" and "non-maleficence". The Hippocratic Oath imposes an obligation of non-maleficence and an obligation of beneficence: "I will use treatment to help the sick according to my ability and judgement, but I will never use it to injure or wrong them." Together, these two principles aim at producing net benefit over harm.

Although these two principles are inseparable in most cases, they are discussed separately in this chapter. The reason for this separation is because there are certain circumstances that exist where there is no obligation of beneficence towards others, but there is always an obligation not to do harm to others.

³⁸⁴ Blackbeard 2003 Tydskrif vir Hedendaagse Romeins-Hollandse Reg 53.

³⁸⁵ Blackbeard 2003 Tydskrif vir Hedendaagse Romeins-Hollandse Reg 53.

³⁸⁶ Beauchamp and Childress Principles of biomedical ethics 149.

³⁸⁷ Gillon 1994 British Medical Journal 185.

4.3.1 Non-Maleficence

Medical practice has been firmly rooted in the principle of *primum non nocere* (above all [or first] do no harm) since the times of the Hippocratic Oath. The majority of authors agree that it is the most fundamental principle of the Hippocratic Oath. 388 Non-maleficence implies that medical practitioners may not inflict harm on others. Thus, a surgical intervention may in no way harm the patient. 389 The obligation not to harm others is sometimes more inflexible than the obligation to help them. Nonmaleficence is regarded as a constant duty, whereas beneficence is regarded as a limited duty. 390 In some situations non-maleficence will overpower beneficence, even if the best outcome can be achieved by acting beneficently. 391 Non-maleficence will always overpower beneficence when the benefit involves committing a moral crime. When harm exceeds benefit it is best to assess whether this harm is unavoidable or intentional.³⁹² Yet, the principle of non-maleficence is not absolute and a beneficial action will not always take second place to an act of causing harm. According to Beauchamp and Childress, 393 no rules in ethics favour avoiding harm over providing benefit in all circumstances - the authors claim that an order of priority existing among the principles is unsustainable. A medical practitioner who acts in accordance with this principle needs to follow a number of rules. These five prima facie rules include the following: do not kill; do not cause pain or suffering; do not incapacitate; do not cause offense; and do not deprive others of the goods of life. 394

The principle of non-maleficence has a direct influence on the kidney transplant procedure when a living donor is used. When a kidney transplant is performed, harm to the recipient and donor is unavoidable. However, in the case of the recipient his harm is justified by the fact that he receives a more functional and beneficial kidney by means of living donation. The situation is however somewhat different for the

³⁸⁸ Beauchamp and Childress *Principles of biomedical ethics* 149.

³⁸⁹ Beauchamp and Childress *Principles of biomedical ethics* 149.

³⁹⁰ Karnani 2008 Northeast Medicine Supplement 4.

³⁹¹ Beauchamp and Childress *Principles of biomedical ethics* 150.

Moodley K "Non-Maleficence" in Moodley K (ed) Medical ethics, law and human rights 63.

³⁹³ Beauchamp and Childress *Principles of biomedical ethics* 150.

Beauchamp and Childress *Principles of biomedical ethics* 153. See also Moodley in Moodley (ed) *Medical ethics, law and human rights* 63.

donor – he donates his kidney and by this action is harmed, but he receives no medical benefit to justify this action. The question here is, is the donor really "harmed"? According to studies done by Dr Thomas Peters, director of the Transplant Centre in Jacksonville, Florida, the estimated mortality rate from living kidney donation is 3 out of 10 000, and more than 90% of those who have donated a kidney and been given proper medical care³⁹⁵ have confirmed that they would go through the process again.³⁹⁶

In the world of modern medicine, harm is sometimes acceptable in order to avoid harm. Beauchamp and Childress³⁹⁷ are of opinion that sometimes we have to do harm to the body in order to prevent harm. The author supports this argument by saying if you weigh up the harm done to the donor by means of the transplant (i.e. pain and discomfort for a few weeks) it cannot relate to the harm done to the recipient if he does not receive a kidney. One should remember the argument concerning the right to human dignity and the question whether a patient that receives renal dialysis is living in a dignified manner. If the recipient is in end-stage renal failure he will be subjected to the painful and exhausting process of dialysis. The dialysis can only do so much for the patient. Eventually, if the patient does not receive a kidney it can lead to his death (see the arguments on the right to life). It would be considered narrowminded to just focus on the donor. The medical practitioner has two patients – the donor and the recipient – and both should be considered. 398 Furthermore, this argument can be substantiated by referring to the fifth rule of non-maleficence: others should not be deprived of the goods of life. If a patient may not receive a kidney because the donor has to be harmed during the kidney transplant, both the recipient and the donor are harmed (in comparison with only the donor being harmed by the

The risk of harm is increased when dealing with a kidney transplant related to the black market. This can be avoided if legalised imbursement procedures are in place. Both the donor and recipient will receive better medical care. The benefit to the donor as well as recipient and society could be very significant. Berman E *et al* "The bioethics and utility of selling kidneys for renal transplantation" 2008 (40) *Transplant Proceedings* 1268.

³⁹⁶ Berman et al 2008 Transplant Proceedings 1269.

³⁹⁷ Kanniyakonil S "Living organ donation and transplantation: principilism or charity?" www.lifeissues.net (Date of use: 5 April 2012).

³⁹⁸ Schreiber HL "Legal implications of the principle Primum Nihil Nocere as it applies to live donors" in Land W and Dossetor JB (eds) *Organ replacement therapy: Ethics, justice and commerce* 13. See also Slabbert 2010 *Potchefstroom Electronic Law Journal* 96.

procedure).³⁹⁹ Is it not better to accept a limited amount of harm to the donor, as long as it takes place in the interest of the life and health of the recipient?⁴⁰⁰

According to Schreiber⁴⁰¹ there are four essential preconditions for the permissibility of live donors, which represent the maxim of no-harm principles. The following must be insured: the risk to the donor must be compared with the need of the recipient, the donor must be extensively informed before consenting to the operation, the agreement must be made willingly with no form of pressure, and the donation may not be made in connection with monetary reimbursement.⁴⁰² Most medical practitioners feel that the removal of a kidney from an individual who has given autonomous consent and faces minimum risk is an ethically acceptable action.⁴⁰³ Thus, the principle to do no harm can be justified by consent; in other words, with the principle of respect for autonomy and the constitutional right to self-determination.⁴⁰⁴ According to Kleinman and Lowy,⁴⁰⁵ living kidney donation makes an ethical compromise when the donor consents to donate his kidney. At first glance it seems as if the principle of non-maleficence prohibits any surgical intervention because of the possibility of harm. But, as mentioned previously, non-maleficence cannot be assessed without taking into consideration the principle of beneficence.

4.3.2 Beneficence

The word "beneficence" literally means well or good (*bene*) and to do (*facere*). 406 Beneficence can be defined in different ways. Generally it refers to doing good and

³⁹⁹ The recipient is harmed because he is deprived of the goods of life. In the case of end-stage renal failure the patient is deprived of life.

Schreiber in Land and Dossetor (eds) Organ replacement therapy: Ethics, justice and commerce 14.

⁴⁰¹ Schreiber in Land and Dossetor (eds) Organ replacement therapy: Ethics, justice and commerce 14.

The last requirement is regarded as questionable. A reimbursement does not influence the informed consent requirement, nor does it increase the risk to the donor. Slabbert 2010 Potchefstroom Electronic Law Journal 95.

⁴⁰³ Kanniyakonil www.lifeissues.net (Date of use: 5 April 2012).

Schreiber in Land and Dossetor (eds) *Organ replacement therapy: Ethics, justice and commerce* 13.

⁴⁰⁵ Kanniyakonil www.lifeissues.net (Date of use: 5 April 2012).

⁴⁰⁶ Kanniyakonil www.lifeissues.net (Date of use: 6 April 2012).

the active promotion of goodness, kindness and charity. 407 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 to avoid or minimise harm. 408 Although this principle is of great importance, it does not prescribe that life must be preserved at all costs. 409 The medical practitioner who makes an oath to "do no harm" is not promising never to cause harm but rather that he will try to create a positive balance of good over inflicted harms. 410 Beneficence imposes a limited duty because a medical practitioner has a duty to provide beneficial treatment to any or all of his patients, but he has the option of choosing who to admit into his practice. 411 However, beneficence does impose a number of moral rules. The most general rules 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. 412

In order to achieve these obligations, medical practitioners have to commit to three *prima facie* obligations. Firstly, a medical practitioners needs to ensure that he can deliver the benefits that he professes. To obtain this, medical practitioners need rigorous and effective education and training before and during their professional lives. Secondly, a medical practitioner needs to ensure that he can offer each patient net benefit. This obligation requires a medical practitioner to be clear about the risk and probability of harm and benefit when he assesses a patient. In the context of beneficence it is of high moral importance to be able to supply a high probability of benefit, such as a cure for a life-threatening disease. Ensuring that a patient is supplied with the various probabilities of benefit or harm, empirical

⁴⁰⁷ Moodley K "Beneficence" in Moodley K (ed) Medical ethics, law and human rights 57.

⁴⁰⁸ Moodley in Moodley (ed) *Medical ethics, law and human rights* 57.

⁴⁰⁹ Karnani 2008 Northeast Florida Medicine Supplement 3.

Beauchamp TL "The 'four principles' approach to health care ethics" in Ashcroft RE *et al* (eds) *Principles of health care ethics* 5.

⁴¹¹ Karnani 2008 Northeast Florida Medicine Supplement 4.

⁴¹² Beauchamp and Childress *Principles of biomedical ethics* 199.

⁴¹³ Gillon 1994 British Medical Journal 185.

⁴¹⁴ Gillon 1994 British Medical Journal 185.

information is needed; which can only be obtained by the last of the *prima facie* obligation – effective medical research.⁴¹⁵

The principle of beneficence has a direct influence on the kidney transplant procedure. When performing a kidney transplant, the recipient and donor are harmed by the mere fact that surgery is performed on them. However, a donor kidney of the highest possible quality is immediately available to be transplanted to the recipient. In this case, the benefit is clearly in favour of the recipient; yet the donor is harmed for this benefit. The question here is: is it ethically acceptable that the kidney donor must be "harmed" without receiving any benefit? When answering this question it must be borne in mind that beneficence is not obligatory in some cases. For instance, the donation of a kidney is not a moral obligation.

There are authors like Gillon that are of the opinion that the net medical benefit argument does not work insofar as the donor's role in the transplant is concerned, because the donor takes a risk without any corresponding medical benefit. Followers of this argument base their argument on going back almost 2 500 years to the time of Hippocrates. According to the Hippocratic Oath, a medical practitioner may only impose harm if he believes that it will produce net medical benefit for that particular patient. However, the author is of opinion that in the case of the kidney donor, the benefit should not be limited to a medical or physical benefit. The kidney donor definitely benefits psychologically by means of altruism and, of course, if the kidney donor is allowed to be legally remunerated for his donation he also receives a financial benefit. It should also be kept in mind that the kidney donor is not "seriously

⁴¹⁵ Gillon 1994 British Medical Journal 185.

Kidney recipients benefit significantly from a living kidney donor. The one-year survival with a deceased-donor kidney is 94%, but with a living kidney donor, survival rises to 98%. The five-year survival increases from 80% to 90%. Munson in Steinbock (ed) *Oxford handbook of bioethics* 214.

⁴¹⁷ Kanniyakonil www.lifeissues.net (Date of use: 6 April 2012).

⁴¹⁸ Kanniyakonil www.lifeissues.net (Date of use: 6 April 2012).

⁴¹⁹ Gillon R "Transplantation and ethics" in Thomasma D and Kushner T (eds) *From birth to death* – *science and bioethics* 109.

⁴²⁰ Gillon in Thomasma and Kushner (eds) From birth to death 109.

harmed". This has been shown by various researches.⁴²¹ The reality of these two principles is that one cannot be honoured without violating the other; and this is where the doctrine of double effect has to be taken into account.

4.3.3 The Doctrine of double effect

The doctrine of double effect was formulated with the purpose that an act may have both a good and bad effect, thus a benefit may be regarded as ethical even if some harm occurs. As discussed earlier, the principle of non-maleficence and beneficence cannot be applied without the one violating the other. However, these two principles in relation to a kidney transplant can be applied together if the four requirements of the doctrine of double effect are satisfied.

The first requirement is that the act performed must be good. Any form of organ donation is regarded as a virtuous act; thus, a kidney transplant is a good act. The second requirement is that the good accomplished must be at least as immediate as the harm. When a kidney transplant procedure is performed, the donor is harmed by the transplant. He experiences pain and discomfort. However, these conditions are tolerable, will not lead to the death of the donor and will be cured in due time. Py means of the same kidney transplant procedure the recipient of the kidney is helped in his critical stage and he receives the benefit of a much better quality of life as guaranteed by the constitutional right to life discussed in chapter 2. The donor is also not left without any benefit whatsoever — he receives a spiritual and psychological benefit. Thus, immediacy of good and harm can be proven. The third requirement

Living with a single normal kidney is possible without any extreme complications. Most people with a single kidney still have a normal life with no problems. Any decrease in kidney function is usually mild. A study was done where kidney donors between the ages of 20 and 37 were followed. Most of them had normal function and most problem were the same as for people of the same age with two kidneys. Long-term risks to a kidney donor are small. With consideration to the surgery, the harm is also minimal; after the removal of the kidney the donor may be sore for a few weeks but that is all. This pain may also be less if surgery is done through laparoscopy (a small cut). Griffith D "Living with one kidney" www.myoptumhealth.com (Date of use: 8 April 2012).

Beauchamp and Childress *Principles of biomedical ethics* 162.

⁴²³ Beauchamp and Childress *Principles of biomedical ethics* 162.

⁴²⁴ Kanniyakonil S "The principle of double effect and its relevance in bioethics" www.lifeissues.net (Date of use: 10 April 2012).

⁴²⁵ Kanniyakonil www.lifeissues.net (Date of use: 10 April 2012).

is that the intention of both parties must be good. 426 Concerning a kidney transplant, both the donor and the recipient's intentions are good. The donor has the intention of helping the recipient in his critical stage and the recipient has the intention of recovering to be a much healthier person and increasing his quality of life. The final requirement is that there must be a proportionate reason for causing the harm. 427 With a kidney transplant there is more than enough substantial reasoning for causing the harm. Once again, the donation of the kidney will not cause the death of the donor or even serious decrease in the functionality of his kidney. Moreover, a life is saved; and if pain and discomfort is weighed up against a life, surely a life must be of greater importance? In the medicinal world presently there is a clear equilibrium between harm and benefit. The most reasonable approach regarding this matter will thus be to look at the principles of non-maleficence and beneficence together.

4.4 JUSTICE

Justice in general can be defined as "the quality of being fair and reasonable". However, with regard to healthcare, the term justice has a much broader meaning. In this sense, justice implies an impartial and fair approach to treatment and the distribution of resources. Therefore, this definition imposes an obligation on a medical practitioner that he is not allowed to discriminate against a patient by allowing his personal prejudice to directly influence his work. Various ethical and human-rights documents emphasise that discrimination will not be tolerated. It is clearly stated in the Bill of Rights that no person may unfairly discriminate directly or indirectly against anyone. However, justice in the healthcare context entails more than just not to discriminate; it also includes that resources (especially scarce resources) must be distributed equally. But equal distribution is easier said than done. There are a number of difficulties that arise, such as the unavoidable scarcity of resources and

⁴²⁶ Beauchamp and Childress *Principles of biomedical ethics* 162.

⁴²⁷ Beauchamp and Childress *Principles of biomedical ethics* 162.

⁴²⁸ Porter and Rai in Rai (ed) Medical ethics and the elderly 4.

Discrimination is not allowed on one or more of the following grounds: race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth. Section 9 of the Constitution.

the subsequent conflicts between groups competing for these sources.⁴³⁰ The principle of justice, just as its predecessor principles, imposes a number of moral rules that have to be followed. These rules include to each person an equal share according to his need, effort, contribution and merit.⁴³¹

Because justice is such a broad term, the obligations of justice have been divided as follows: respect for morally acceptable laws (legal justice), respect for people's rights (rights-based justice) and fair distribution of limited resources (distributive justice).

Legal justice entails fairness to patients from a legal perspective. It is therefore essential to have a good working knowledge of legislation regarding healthcare. And the patient in return must follow the doctor's advice and comply with the prescribed treatment.

⁴³⁰ Porter and Rai in Rai (ed) Medical ethics and the elderly 4.

⁴³¹ Beauchamp and Childress *Principles of biomedical ethics* 243.

⁴³² Moodley K, Moosa R and Kling S "Justice" in Moodley (ed) *Medical ethics, law and human rights* 73.

Moodley, Moosa and Kling in Moodley (ed) *Medical ethics, law and human rights* 73.

Examples of rights in the healthcare context include the right to healthcare, the right to be seen on time and the right to a certain standard of healthcare. In South Africa these rights are based on the Patients' Rights Charter, which in turn is based on the Bill of Rights (chapter 2) of the Constitution. Moodley, Moosa and Kling in Moodley (ed) *Medical ethics, law and human rights*

⁴³⁵ Moodley, Moosa and Kling in Moodley (ed) Medical ethics, law and human rights 74.

⁴³⁶ Moodley, Moosa and Kling in Moodley (ed) Medical ethics, law and human rights 74.

Distributive justice is probably the most important obligation regarding a kidney transplant. Distributive justice is defined by Beauchamp and Childress⁴³⁷ as fair, equitable and appropriate distribution in society determined by justified norms that structure the terms of social cooperation. Thus, concerning distributive justice, all conflicting claims must be treated fairly or just – especially in the context of scare resources.⁴³⁸ The *TAC*-case discussed earlier is a perfect example of distributive justice.

In relation to a kidney transplant there is an overwhelming disagreement over what exactly constitutes fair treatment. Most authors, such as Gillon, agree that fair behaviour constitutes treating people as equals. Yet this cannot be applied to kidney transplants. It will not be fair to give a kidney to everyone in the population, since everybody does not need a donor kidney to survive. It will, however, be better to follow the approach that people have to be treated equally in a morally relevant manner. According to this approach, persons with an equal need for kidneys should receive kidneys equally when available.

In the context of kidney transplants, a number of issues of justice may arise – such as the number of resources that should be allowed to go into this type of treatment and the fair allocation of donor kidneys. With all forms of medical treatment there is always the question of how much of the available resources should be put into a specific kind of treatment. Neither a kidney transplant nor dialysis is regarded as primary healthcare in South Africa. The majority of citizens are of the opinion that there are a lot of other factors in the healthcare context that are more important than treatment for a patient with end-stage renal failure. However, prioritising does take place concerning patients who make use of dialysis treatment.

⁴³⁷ Beauchamp and Childress Principles of biomedical ethics 241.

⁴³⁸ Gillon in Thomasma and Kushner (eds) From birth to death 113.

⁴³⁹ Gillon in Thomasma and Kushner (eds) From birth to death 113.

Gillon in Thomasma and Kushner (eds) From birth to death 113.

In the *Soobramoney* case,⁴⁴¹ the court decided that it was legitimate to adopt guidelines to determine who should receive dialysis treatment. In this case it was agreed that, by using dialysis machines in accordance with guidelines, more patients (who complied with the guidelines) would benefit than would be the case if they were used to keep patients (who did not comply with the guidelines) with chronic renal failure alive. Prioritising the treatment is more beneficial because it is directed at curing patients and not simply maintaining the chronically ill. It should be emphasised that, even in the most advances countries access to life-prolonging treatment is rationed.⁴⁴²

The next concern regarding the principles of justice is the fair allocation of donor kidneys. Two questions arise in this regard: firstly, about the process of contributing kidneys, and secondly regarding the process of allocating kidneys. The first (the contribution of kidneys) was discussed in the context of the principles of non-maleficence and beneficence, and will not be repeated here. The second process (the allocation of kidneys) takes place in accordance with guidelines. These guidelines prescribe a "gentleman's agreement" that entails that one donor kidney goes to the state and one donor kidney goes to the private medical sector. 443

The prioritising of donor kidneys does not always seem fair; yet it is justified because of the scarcity of kidneys and resource constraints in South Africa. However, if the current justice system cannot provide because of the resource constraint, an alternative that can be regarded as constitutionally acceptable should be given. Justice is an integral part of the healthcare system, and the best way to make sure

This case will only be discussed briefly in this chapter, since it was discussed in full in chapter 2 regarding the right to access to healthcare.

In South Africa, there is a prioritisation policy that divides patients with end-stage renal failure into three categories regarding dialysis treatment. Category 1 patients must be accommodated on the dialysis and transplant programme. Resources will always be found to treat these patients. Category 2 patients will only be accommodated on the programme if resources allow. Category 2 patients are also further prioritised according to who has waited the longest and who has the best chance of a good outcome. Category 3 patients will be offered optimal conservative treatment and will not be offered renal transplant therapy.

Allocation of donor kidneys were discussed in section 3.3 (the assessment process regarding kidney donation).

that justice is present in the kidney transplant programme is to rely on the words of Aristotle – "giving to each that which is his due".

4.5 CONCLUSION

This chapter sought to examine whether kidney sales would be acceptable if measured against bioethical perspectives. After discussing the four principles of bioethics it is clear that all four principles have an undeniable influence on a kidney transplant and that a kidney transplant is bioethically acceptable. The four principles also have an undeniable link with regard to the constitutional rights discussed in chapter 2 of this dissertation.

However, this is only the author's opinion. A person's opinion regarding the matter of bioethical acceptability and kidney transplants can differ according to how much weight or importance that person gives to one moral principle when it is in conflict with another principle (such as in the case of the principles of non-maleficence and beneficence). A person's view of bioethical perspectives can also be influenced by his opinion of whether the selling of donor kidneys is acceptable or not. This matter will be discussed in the next chapter.

CHAPTER 5 – TO SELL A KIDNEY OR NOT: ARGUMENTS FOR AND AGAINST THE SELLING OF HUMAN KIDNEYS

"The aim of argument, or of discussion, should not be victory, but progress." 444

5.1 INTRODUCTION

Many people profess how the procedure of organ transplants is one of the most miraculous discoveries in the world of medicine. This much is true, but what use is it if there are no organs available for transplant purposes? Presently in South Africa there is an acute shortage of available donor kidneys – in 2010 only 244 recipients received kidneys. These lucky few only represent about 1% of the community who need a donor kidney to survive. The South African Dialysis and Transplant Registry estimates that approximately 21 000 South Africans experience kidney failure. Of these, only 5 000 receive treatment; leaving more than 15 000 without treatment because of a lack of donor kidneys and an insufficient number of dialysis machines. South Africa has made numerous attempts to improve this situation, but none of these methods have been successful and there has been no improvement in the current situation.

Currently in South Africa is it illegal to sell your kidney. If a person is caught trying to sell his kidney, he can be held liable for the payment of a fine or imprisonment for a period not exceeding five years or both a fine and imprisonment. The selling of kidneys has developed from a concept only known to the black market into something that is causing debate in almost every country – as the only solution to improve the number of available donor kidneys. Illegal transplants presently occur in countries such as India, Turkey, China, Russia and South Africa. In 1999 someone

⁴⁴⁴ Quote by Joseph Joubert, French moralist and essayist, www.quoteland.com (Date of use: 16 April 2012).

Organ Donor Foundation www.odf.org.za (Date of use: 16 April 2012).

Treatment mainly refers to dialysis, which is only an interim measure that is used until a transplant is performed. Molakeng S "15 000 wait for donated organs" http://www.hst.org.za/news/15-000-wait-donated-organs (Date of use: 16 April 2012).

⁴⁴⁷ Molakeng http://www.hst.org.za (Date of use: 16 April 2012).

⁴⁴⁸ Section 60(5) of the National Health Act of 2003.

⁴⁴⁹ Friedman and Friedman 2006 Kidney International 961.

attempted to sell his kidney on eBay. The bidding reached approximately \$5,7 million before eBay intervened and had the advertisement removed. This is not the only example of such an incident: one only has to log onto Google and type in the words "kidney for sale", and you will be amazed at how many individuals are willing to sell their kidneys. All these desperate attempts to sell kidneys demonstrate the high demand that exist for the legalising of kidney sales. Yet there are still people that argue that the legal sale of kidneys is unjustified. In this chapter there will be a discussion of the arguments for and opposing the selling of kidneys.

5.2 ARGUMENTS THAT OPPOSE THE SELLING OF DONOR KIDNEYS

Kidney sales are a very controversial matter, and because of this there have developed various arguments supporting and opposing the legalisation of kidney sales. The main arguments opposing the selling of donor kidneys will follow below.

5.2.1 Exploitation of the poor by the rich would occur⁴⁵²

Opponents of the sale of kidneys are of the opinion that if kidney sales are legalised, only the rich will benefit, since only they will be able to afford a kidney. In this case, organ allocations will be based on wealth and not on need. In the author's opinion there are three possible responses to this argument. Firstly, the treatment of end-stage renal failure is high, regardless of the recipient's financial situation. A kidney transplant itself may be a costly procedure (costing as much as R250 000)⁴⁵⁴ but

The amount of R250 000 includes the ImmunoPro Rx medication that must be taken in the first three months. After the procedure, the costs of a kidney transplant is approximately R10 000

⁴⁵⁰ Richardson "Man tries vital organ eBay" to sell on http://www.theregister.co.uk/1999/09/03/man tries to sell vital/ (Date of use: 18 April 2012). In 2011, a man once again tried to sell his kidney on Craigslist for \$75,000 http://www.wayodd.com/kidney-for-sale-on-craigslist-for-75000-v/9736 (Date of use: 18 April 2012). In 2012, one of the leading classified websites known as Dubizzle.com had to remove yet another kidney-for-sale advertisement. The kidney was advertised as in a flawless condition and was available for Dh200,000 Kapur V "Another kidney goes on sale on Dubizzle.com" www.emirates247.com/news/emirates/another-kidney-goes-on-sale-on-dubizzle -com-2012-01-25 (Date of use: 18 April 2012).

This chapter will only entail a short discussion of the arguments for and against the selling of kidneys, since authors such as Prof. Slabbert has already discussed this concept in depth.

⁴⁵² Kleinsmidt A and Moosa MR "Organ transplant ethics" in Moodley (ed) *Medical ethics, law and human rights* 286.

⁴⁵³ Herring J Medical law and ethics 388.

renal dialysis⁴⁵⁵ may exceed this cost, making a transplant the better option.⁴⁵⁶ According to Prof. Tony Meyers, the National Kidney Foundation's chairperson, kidney disease is one of the most expensive diseases to treat.⁴⁵⁷ Secondly, it may be unfair; but in reality the rich already have access to quicker and higher-quality medical treatment than the poor.⁴⁵⁸ Furthermore, in some cases the rich already buy kidneys from the black market and thus, with or without being legally allowed to obtain a kidney in this manner, they do – leading to the rich being in the position to get a kidney before the poor in any case. Lastly, if the poor are allowed to sell a kidney they are not exploited. On the contrary, they are given an opportunity to get themselves out of poverty.⁴⁵⁹ By legalising the sale of kidneys, the poor will have an additional choice to change their financially disadvantaged situation. The author would like to emphasise that if a person is allowed to sell a kidney, the option alone does not force him to do so – it only gives him an additional option to improve his circumstances instead of taking another opportunity away.

5.2.2 Informed consent cannot exist where payment is an undue inducement

Opponents of kidney sales are concerned that people who sell their kidneys will be driven to do so by poverty. It has been suggested that if a person sells his kidney out of desperation, his consent is regarded as invalid. There are two possible responses to this argument. Firstly, if kidney sales are allowed it will most probably be lawfully regulated. Thus, one will only be allowed to sell one's kidney after giving proper consent. Secondly, it can be questioned whether being driven to act out of

per annum as opposed to renal dialysis of R200 000 per annum. Information supplied by Prof RS Britz (rsbritz@gmail.com) (29/04/2012).

Renal dialysis costs the government more or less R200 000 per patient per year. De Klerk A "A simple answer to kidney disease" http://www.mg.co.za/article/2011-04-04 (Date of use: 19 April 2012). According to Nurse R du Toit, a nurse at Medi-Clinic Upington, renal dialysis can costs from R40 000 to R60 000 per month for a private patient. It must be borne in mind that dialysis is not a cure for end-stage renal failure.

⁴⁵⁶ Molakeng www.hst.org.za (Date of use: 18 April 2012).

⁴⁵⁷ De Klerk http://www.mg.co.za/article/2011-04-04 (Date of use: 19 April 2012).

⁴⁵⁸ Herring Medical law and ethics 388.

⁴⁵⁹ Murphy SR "Eight ethical objections to an organ market and why they're wrong" http://www.lewrockwell.com/orig6/murphy-s2.html (Date of use: 19 April 2012).

⁴⁶⁰ Herring Medical law and ethics 388.

⁴⁶¹ Herring Medical law and ethics 388.

poverty can be regarded as coercion.⁴⁶² The simple answer is no: lacking wealth does not pre-empt making rational decisions.⁴⁶³ If a person sells his kidney, his autonomy is not infringed; rather the opposite: this person is given a choice (he is not forced) to improve his financial situation.

5.2.3 Selling a kidney is an affront to human dignity

One of the strongest arguments of the opponents of kidney sales is that selling a kidney is a devaluation of the body and human life. 464 Pope John Paul II supports this argument. He is of the opinion that buying and selling organs violates "the dignity of the human person". 465 Some argue that this is a valid argument, seeing that the commercialisation of the human body will reduce the human body to a mere net worth. Others feel that this argument is a very vague notion and it is difficult to identify the precise harm that it can cause. 466 Gill and Sade 467 are of opinion that even if a kidney is for sale it does not render the donor incapable of exercising free will. This will only happen if the body part for sale is a necessity for continued existence (which a kidney is not). Gill and Sade⁴⁶⁸ take this argument even further and state that a person's kidney is not his humanity. Humanity is what gives humans their dignity and intrinsic value; thus their ability to make rational decisions. In the author's opinion, whether the selling of a kidney is an affront to human dignity or not should be looked at in perspective and not in isolation. The arguments regarding the constitutional right to human dignity should also be borne in mind when one has to decide whether selling a kidney is an affront to human dignity or not. It should be compared as such: which is a worse offence to human dignity – selling a kidney or letting someone die of renal failure because there are not enough kidneys available?

Herring *Medical law and ethics* 388.

⁴⁶³ Friedman and Friedman 2006 Kidney International 961.

⁴⁶⁴ Herring Medical law and ethics 390.

⁴⁶⁵ Friedman and Friedman 2006 Kidney International 961.

⁴⁶⁶ Herring Medical law and ethics 390.

Cohen CB "Public policy and the sale of human organs" 2002 (12) *Kennedy Institute of Ethics Journal* 55.

⁴⁶⁸ Cohen 2002 Kennedy Institute of Ethics Journal 55.

5.2.4 Poor people will undergo risky procedures out of financial desperation

Another argument often stated is that people living in poverty will take the risk of a selling a kidney out of financial desperation. The truth is that people do a lot worse to escape and prevent poverty. In West Africa, the majority of parents living in poverty have no other choice than to sell their children into slavery for as little as \$20 a year per child. His act cannot even compare to selling one's kidney. In this situation, children's lives are destroyed simply to avoid poverty. People are more than willing to live a life of crime to escape poverty. For example, women (and men) who experience poverty often turn to prostitution; others may start to steal or even murder merely to survive. In the author's opinion the above examples cannot even begin to compare to selling one's kidney. In all the examples, people destroy their lives and self-worth to avoid poverty. Selling a kidney to avoid poverty will not destroy a person's life or self-worth. Furthermore, all these examples include two parties who are harmed: the person who commits the crime and the person affected by the crime. As previously discussed, selling a kidney does not harm a person and neither is another party affected by it.

5.2.5 Public opinion

It has been suggested that the public is so revolted by the idea of selling kidneys that the law should match this strong opposition. However, statistics suggest that this may not be the case. One survey found that between 40 and 50% of those questioned thought it should be permissible to pay for organs. In another survey, the voters were asked, "should people be able to sell human organs?" Only 18% of the voters felt that one should never be able to sell their organs. In contrast, almost 65% voted that people should be allowed to sell their organs.

Sheil M "Children sold as slaves in West Africa" http://www.abcnews.go.com/WNTstory?id=131004&page=1#.T5khmntniQyw (Date of use: 19 April 2012).

⁴⁷⁰ Herring Medical law and ethics 389.

⁴⁷¹ Herring Medical law and ethics 389.

A total of 4 934 voters took place in the survey. The results were the following: a) Yes without restriction of regulation – 21% (1 066 votes); b) Yes but closely regulated – 44% (2 172 votes); c) No except for a few exceptional situations – 12% (637 votes); d) No, never – 18% (898

people are not revolted by the idea of kidney sales can be seen in a debate that took place before a capacity crowd at the Asia Society and Museum in New York. By the end of the debate, those who favoured the selling of organs went from 44% to 60%, whereas those opposed to it only changed from 27% to 31%. 473

5.3 ARGUMENTS IN FAVOUR OF SELLING KIDNEYS

5.3.1 A competent person has the right to make informed decisions about their body parts⁴⁷⁴

A lot of authors in favour of kidney sales substantiate their argument by emphasising autonomy. As mentioned in the previous chapters, respect for autonomy and the right to self-determination is of great importance in the whole process of kidney transplants. By not allowing kidney sales, the autonomy of a person is ignored, because if sales are not allowed the donor cannot exercise his autonomy and decide whether or not he would like to sell his kidney. Supporters of this argument are of the opinion that it is not only ethical to sell a kidney but a right, because it is their body and their life – they have the right to decide what to do with both. In the opinion of Friedman, individuals are in control of their own body parts, even to the point of inducing risks to their health. It should be borne in mind that if a person is in control of his body, it automatically implies that he owns his body. Thus, if you own something you should be permitted to sell it if you wish. The current situation, however, is that

votes); and e) I don't know/don't care – 3% (161 votes). Cline A "Is it ethical to let organs be sold on the open market?" http://www.atheism.about.com/library/ (Date of use: 20 April 2012).

This debate was attended by leading persons in the transplant community, such as Amy Friedman, Lloyd Cohen and James Childress. Knox R "Should we legalize the market for human organs?" http://www.npr.org/tenplates/story/ story.php?storyId=90632108 (Date of use: 20 April 2012).

⁴⁷⁴ Kleinsmidt and Moosa in Moodley (ed) Medical ethics, law and human rights 286.

⁴⁷⁵ Matas AJ "The case for living kidney sales: Rationale, objections and concerns" 2004 (4) American Journal of Transplantation 2009.

Savulescu J "Biotechnology; ethics and the free markets" http://www.practicalethicsnews.com/practicalethics/2008/06/setting-a-minim (Date of use: 20 April 2012).

Friedman AL "Payment for living organ donation should be legalized" 2006 (333) *British Medical Journal* 747.

there is no ownership rights regarding the human body, and the legalisation of kidney sales could only occur if these rights exist.⁴⁷⁸

5.3.2 Permitting the selling of kidneys has a number of benefits⁴⁷⁹

There are a number of benefits that will occur if kidney sales are allowed. A donor will benefit financially from the sale of a kidney. As mentioned by the arguments against the selling of kidneys, the financial benefit that a donor receives could help him to escape or prevent poverty. Prohibiting the poor from selling a kidney still leaves them in the same situation – poor. If the possibility of being paid for a kidney is not permissible, it eliminates the chances for the poor to improve their financial situation. Arguments in favour of a financial incentive is based on the possibility that such a system would increase the supply of kidneys; thus saving lives that may otherwise be lost due to the lack of available kidneys. Financial incentives will most likely induce people to act as donors who would otherwise not have done so. Another way of looking at the financial incentive is that it will not decrease the current number of kidney donations.

Thus, from the above it is clear that both the donor and the recipient will benefit from legalising kidney sales. Currently, the donor is the only person involved in the transplant process who does not receive a benefit. The recipient receives a kidney and his quality of life is increased; the medical practitioners involved receive remuneration for their services; but the donor – who in reality offers up a kidney – does not receive a benefit. Furthermore, it can be argued that in the case of the public sector the state will also receive a benefit from legalising kidney sales: they will save money. As previously mentioned, kidney dialysis is a very costly treatment. If the government is allowed to buy kidneys, they can save money on dialysis by rather

⁴⁷⁸ Slabbert M "This is my kidney, I can do what I want with it (property rights and ownership of human organs)" 2009 *Obiter* 499.

Kleinsmidt and Moosa in Moodley (ed) Medical ethics, law and human rights 286.

⁴⁸⁰ Kleinsmidt and Moosa in Moodley (ed) Medical ethics, law and human rights 286.

⁴⁸¹ Friedman and Friedman 2006 Kidney International 961.

Smith J "Legalizing the sale of human organs: Necessary for survival" www.voices.yahoo.com (Date of use: 21 April 2012).

⁴⁸³ Gill and Sade 2002 Kennedy Institute of Ethics Journal 19.

offering a patient a kidney transplant in the place of renal dialysis. Therefore, it is clear that legalising the sales of kidneys is a win-win situation for the kidney donor, recipient and the public sector.

5.3.3 Society allows persons to make informed decisions about other risky activities⁴⁸⁴

Arguments against the sale of kidneys propose that people living in poverty are so desperate that they will undergo risky procedures. Yet, society has no problem with the fact that people are already allowed to make informed decisions about risk-associated activities. Currently, there is the practice of payment for drug tests on human subjects. It is mostly wealthy people who sign up to be subjects of these tests. The tests are described as unpleasant, inconvenient and not free of risk. It is possible to implement standards that offer satisfactory protection to test subjects, and as long as these standards are met it is considered acceptable to be paid as a subject of a drug test. Furthermore, it seems that the benefits of drug testing are considerable. But kidney sales can be analogous to drug testing, since the benefits of kidney sales are considerable, and proper regulation can ensure satisfactory protection for the kidney donor. Yet the sale of kidneys (but not drug testing) is frowned upon.

Another example of allowed risky activity is people who sign up for military services. Military service is known to be dangerous, but one is allowed to have a force made up of "paid volunteers". All In the case of military services, it is allowed to pay people to participate in a high-risk activity; and it is well known that many enlistees are from the lower end of the economic spectrum. All Yet, once again people are not allowed to take the risk of selling their kidneys if they suffer of poverty. Other examples of activities that people are allowed to participate in, even though there is an undeniable risk involved, are skydiving, smoking, working on an oil rig and refusing medical

⁴⁸⁴ Kleinsmidt and Moosa in Moodley (ed) Medical ethics, law and human rights 286.

⁴⁸⁵ Gill and Sade 2002 Kennedy Institute of Ethics Journal 34.

⁴⁸⁶ Gill and Sade 2002 Kennedy Institute of Ethics Journal 34.

⁴⁸⁷ Gill and Sade 2002 Kennedy Institute of Ethics Journal 35.

⁴⁸⁸ Gill and Sade 2002 Kennedy Institute of Ethics Journal 35.

treatment. It can also be argued that other practises of the poor to make money are distasteful, for instance cleaning toilets or other hard labour. Yet these activities are not outlawed. Why is the selling of kidneys outlawed then?⁴⁸⁹

5.3.4 The demand for a black market will be diminished

Because the sale of kidneys is currently illegal and the need for kidneys is so big, it has led to the existence of an underground black market. The problem with a black market is that the kidney transplants are done in secret, which usually involve poor and dangerous conditions. In this case the donor has no legal recourse (e.g. if he does not get paid or if he suffers complications) because his conduct is illegal. If kidney sales are legalised, the kidney donor will be allowed to enter into a legal contract and thus be allowed to take legal action if he is not remunerated. He can also seek medical help if complications related to the procedure arise. Furthermore, if kidney sales are legalised the black market will slowly start to diminish because there will no longer be a need for it. Many practices that were once frowned upon are now acceptable. The world and everything in it is changing constantly.

After discussing all the arguments that oppose and support legalising the sale of kidneys it is clear that the best option would be the legalisation of kidney sales.

5.4 CONCLUSION

This chapter sought to examine the arguments in favour of and against the selling of human kidneys. The passing of time leads to inevitable changes of what is seen as acceptable by the community. The law is designed to govern. Society's moral compass is not set in stone – it is ever fluctuating – and the law needs to take heed of these developments. After discussing all the arguments that oppose and support the legalisation of kidneys sales, it is clear that the best option would be the legalisation thereof. In South Africa, the possibility of remunerating the kidney donor can easily change from a possibility to a reality if section 60(4)(a) of the National Health Act is

⁴⁸⁹ Gill and Sade 2002 Kennedy Institute of Ethics Journal 35.

⁴⁹⁰ Slabbert 2008 KOERS 76.

implemented in the correct manner. This section could be the first step in the direction of legalising kidney sales in South Africa. It should be borne in mind that altruism is not erased if a person sells his kidney. In the case where a parent sells his kidney to take care of his children or to improve their living conditions it is still an altruistic act. Very rarely will a person sell his kidney to increase his own happiness. The author wants to emphasise that the position of not selling kidneys has not stopped the illegal buying and selling of organs. The reality is that the black market is flourishing, because it is the only resort for people who have been on waiting lists for ages and are busy dying.

All the arguments that oppose kidney sales are already true – nothing can change that. But by regulating kidney sales all the negative effects of the illegal kidney sales, such as exploitation and the poor quality of medical treatment, can be improved. The main argument that should be borne in mind is that by giving people the option to sell their kidneys does not force them to do so. They still have a choice. It can be deduced from the arguments against the selling of kidney that most of the arguments are based on emotions or morals. People are clearly not aware of the dire need for kidneys. There may be a disagreement regarding whether kidney sales should be allowed or not. Nevertheless, there is no disagreement when it comes to the shortage of kidneys in South Africa and the world. The real question is not whether a market for human organs or other bodily tissues should exist; it already does. The question is rather how we can develop the current market to benefit the patients who are in dire need of kidneys.

South Africa should seek guidance from abroad on how to improve its current situation. In the following chapter, the author will look at the transplantation legislation in Singapore and Iran for international guidance.

Section 60(4)(a) of the National Health Act 61 of 2003 stipulates that it is an offence for a person 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 reimbursement of <u>reasonable costs</u> incurred by him or her to provide such donation (own emphasis).

⁴⁹² Herring Medical law and ethics 389.

⁴⁹³ Matthews M "Have a heart, but pay for it" http://www.organselling.com/expert (Date of use: 21 April 2012).

CHAPTER 6 – A MICRO-COMPARISON WITH THE TRANSPLANT LEGISLATION OF SINGAPORE AND IRAN

"The country that is more developed industrially only shows, to the less developed, the image of its own future" 494

6.1 INTRODUCTION

If one was to draw a comparison between certain countries in terms of the number of kidney donations, the difference is startling. For instance, South Africa only averages 9,2 kidney donations per one million people, whereas a country such as Iran, which allows payment for living-donor kidneys and has one of the most successful kidney transplant programmes in its region, boasts with 28 kidney donations per one million people. It is a reality that the need for viable donor kidneys just keeps on increasing while the supply of viable donor kidneys has almost stagnated or decreased in the majority of countries. These statistics illustrate that South Africa has to take extreme measures that are constitutionally acceptable to improve its number of kidney donations.

In chapter 2 of this dissertation it was established that the legalisation of kidney sales could be regarded as constitutionally acceptable; yet the National Health Act prohibits a person from receiving any form of financial or other reward for a kidney donation, except for the reimbursement of costs associated with the donation. To make matters worse, South Africa has no case law to rely on to support the legalisation of kidney sales. Consequently, if South Africa wants to improve its current kidney donation rate it should seek guidance from abroad. Section 39(1) of the Constitution stipulates that when interpreting the Bill of Rights, international law must be

⁴⁹⁴ Marx K "A contribution to the criticism of political economy" www.marxist.org (Date of use: 24 April 2012).

It should also be mentioned that the current estimate for renal dialysis in South Africa is 70 per one million people. Bowa K "Editorial on live donor renal transplantation in South Africa" 2011 *Annals of African Medicine* 131.

Khosroshahi HT "Short history about renal transplantation program in Iran and the world: Special focus on world kidney day" 2012 (1) *Journal of Nephropathology* 6.

⁴⁹⁷ Section 60(4)(a) of the National Health Act.

considered and foreign law may be considered.⁴⁹⁸ This chapter draws a comparison between legislation in Singapore and Iran pertaining to kidney donations and how these legislative provisions could be applicable to South Africa.⁴⁹⁹

6.2 SINGAPORE AND KIDNEY DONATIONS

The Republic of Singapore is a city, state and country all in one; situated at the southernmost tip of the Malay Peninsula, and has a population of approximately 5,8 million people. Just as South Africa boasts with the fact that its cultures represent a rainbow nation, Singapore is also a melting pot of cultures, which include Malay, Chinese, Indian and European. The diversity in culture leads to a whole range of religions, such as Buddhist, Taoism, Christian, Catholic, Muslim and Hindu. South Africa and Singapore share a number of similarities, but there is one main aspect that separates them – Singapore is a developed country whereas South Africa is a developing country.

Singapore performed its first kidney transplant in 1970. At that time, their kidney donations were still based on a voluntary system. Singapore enjoyed great success with kidney transplants during that era, but needless to say the number of kidney donations was insufficient due to the fact that kidneys were harvested from individuals who voluntary agreed to be kidney donors. From 1970 to 1988, only 85 deceased kidney transplants occurred. In June 1987, in an effort to remedy the kidney shortage, Singapore adopted the Human Organ Transplant Act. The HOTA and the various amendment acts that followed had an immense impact on Singapore's kidney donations.

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⁴⁹⁸ Section 39(1)(b) and (c) of the Constitution.

It should be borne in mind that due to the sheer magnitude of information on legislation at an international level, this dissertation is restricted to provide only certain information relevant to this discussion.

Heng J "Singapore's population hits 5.18 million as at end June" www.stratstimes.com/Breakingnews (Date of use: 25 April 2012).

Fitzgibbons SR "Cadaveric organ donation and consent: A comparative analysis of the United States, Japan and China" 1999 (73) *Journal of International and Comparative Law* 93.

Vathsala A and Khuan YC "Renal transplantation in Singapore" 2009 (38) *Annals Academy of Medical Singapore* 292.

Human Organ Transplant Act of 1987, hereinafter referred to as HOTA. See Fitzgibbons 1999 Journal of International and Comparative Law 93.

6.2.1 The HOTA and presumed consent

Internationally, two main systems for organ procurement are recognised, namely the system of "opting in" and "opting out" (also known as presumed consent). In terms of the opting-in system that is followed by South Africa, a person who wishes to become an organ donor must explicitly express his consent to have his organs removed prior to or after death. The opting-in system allows a person to exercise his constitutional right to freedom of self-determination by giving his consent. It will be considered unlawful if an organ is removed without the donor's consent. Singapore, on the other hand, follows the system of "opting out". This system is one of the biggest changes that were brought on by the HOTA to improve the organ shortage. In terms of the opting-out system everyone is regarded as an organ donor unless they explicitly revoke their consent. Thus, if a person does not revoke his consent by registering his objection with the Director of Medical Services, he will be regarded as an organ donor.

When the HOTA was first implemented in Singapore, section 5(2)(a) to (e) stipulated that all Singapore citizens and permanent residents, excluding Muslims, who were between the ages of 21 and 60 years old and of sound mind would be regarded as organ donors. The Amendment Act of 2008 that was implemented on 1 August 2008 changed the position a bit. The "opting-out" system then included all Muslim residents, and if a Muslim did not want to be an organ donor he would have to revoke his consent. ⁵⁰⁸

One year later, the Amendment Act of 2009 changed the position once again, and the 60 year and older age limit was removed. Presently, section 5(2)(a) to (e) of the HOTA stipulates that all Singapore citizens and permanent residents over the age of 21 years who are of sound mind will be regarded as organ donors unless a person

For more information regarding the South African "opting-in" system see Slabbert and Oosthuizen 2007 *Obiter* 45.

⁵⁰⁵ Fourie Organ procurement 37.

⁵⁰⁶ Section 5(2)(a) of the Human Organ Transplant (Amendment) Act 2008.

⁵⁰⁷ Slabbert and Oosthuizen 2007 Obiter 45.

⁵⁰⁸ The Human Organ Transplant (Amendment) Act 2008.

The Human Organ Transplant (Amendment) Act 2009.

explicitly revokes his consent. The introduction of the opting-out system lead to an increase of kidney transplants between 1988 and 2004 – 664 deceased-donor kidney transplants were performed, yielding an average of 41,4 deceased-donor kidney transplants yearly. ⁵¹⁰

There was also a slight increase in living-donor kidney transplants. A total of 233 kidney transplants were performed, yielding an average of 14 living-donor kidney transplants yearly.⁵¹¹ It must be borne in mind that a living-donor kidney transplant has a much higher success rate and is more beneficial for the kidney recipient.⁵¹² The abovementioned kidney statistics of 1988 to 2004 clearly illustrate that the opting-out system does not have much of an effect on living-donor kidney transplants. Kidney transplant rates progressively started to decrease from 2004, and the HOTA had to be amended once again to ensure more kidney transplants. The Amendment Act of 2009 initiated the reimbursement of living donors in accordance with international and local ethical practices.⁵¹³

6.2.2 The HOTA and the reimbursement of living donors

In Singapore, almost 300 patients suffer from end-stage renal failure yearly. The country has the fifth highest incidence of kidney failure in the world, with 20,1% Singaporeans suffering from hypertension, and an additional 8,2% suffering from diabetes. Singapore's first attempt to increase their kidney donation rates was to change their voluntary system to a presumed consent system. The change of an organ procurement system, however, did not have an immense effect on living-donor kidney transplants. Consequently, it was decided that more serious steps needed to be taken in order to increase the number of living-donor kidneys – the reimbursement of living kidney donors, as stipulated in the HOTA Amendment Act of 2009. Section 14(3)(c)(i) stipulates that the living donor may be reimbursed for costs that may be

Vathsala and Khuan 2009 Annals Academy of Medical Singapore 293.

Vathsala and Khuan 2009 Annals Academy of Medical Singapore 292.

For the benefits of living kidney transplants, please see section 4.3.1 and 4.3.2 of this dissertation, as well as footnote 421.

⁵¹³ Human Organ Transplant (Amendment) Act 2009.

The National Kidney Foundation (Singapore) "Haemodialysis" http://www.nkfs.org (Date of use: 27 April 2012).

incurred by him in relation to the removal, transportation, preparation, preservation, quality control or storage of a kidney.⁵¹⁵ Section 14(3)(c)(ii) stipulates further costs that may be reimbursed, such as the costs or expenses (including the costs of travel, accommodation, domestic help or child care) or loss of earnings as far as are reasonably or directly attributable to the donor supplying his kidney.⁵¹⁶ Lastly, section 14(3) (c)(iii) stipulates that the donor will be reimbursed for any short-term or long-term medical care or insurance protection that may reasonably be necessary as a consequence of the donor supplying his kidney.⁵¹⁷

Before the Amendment of the HOTA, payment of any kind to an organ donor was prohibited. Thus, the implementation of reimbursement for the living kidney donor sparked a lot of controversy under the Singaporeans as well as the WHO. Critics of the reimbursement had two main concerns: Firstly, they were concerned that the reimbursement may open the "back door" to organ trading. The Amendment Act of 2009, however, prevented the increase in organ trading by increasing the penalties for organ-trading syndicates and middlemen. Secondly, there was the concern that the reimbursement lacks caps and detailed formulae for assessing losses. The Minister of Health was of the opinion that he preferred not to make the Act too technical, as he wanted to prevent the reimbursement from turning into an inducement. The Minister of Health decided that an inducement could be prevented as long as the amount of reimbursement was not too high. The government's view was that the reimbursement of verifiable and reasonable expenses of the kidney transplant could not constitute a payment for a kidney, and that it should rather be viewed as part of the legitimate costs of treating the patient.

The government also mentioned that the reimbursement to donors actually "rights a wrong". The HOTA then took a further step in terms of the Act's vagueness, and

⁵¹⁵ Section 14(3) (c)(i) of the Human Organ Transplant (Amendment) Act 2009.

⁵¹⁶ Section 14 (3)(c)(ii) of the Human Organ Transplant (Amendment) Act 2009.

⁵¹⁷ Section 14 (3)(c)(iii) of the Human Organ Transplant (Amendment) Act 2009.

Kin LM "Reimbursement of living organ donors" http://www.hpm.org (Date of use: 28 April 2012).

⁵¹⁹ Section 14(2) of the Human Organ Transplant (Amendment) Act 2009.

⁵²⁰ Kin http://www.hpm.org (Date of use: 28 April 2012).

⁵²¹ Kin http://www.hpm.org (Date of use: 28 April 2012).

instated a hospital ethics committee requirement. According to section 15B (2) of the HOTA, every transplant ethics committee will consist of not less than three persons, of whom at least one shall be a medical practitioner with no connection to the hospital, and one shall be a lay person. The purpose of the transplant ethics committee is to assess and give its written authorisation for a living kidney transplant to be carried out. The transplant ethics committee plays a very important role when it comes to verifying that the donor is not being coerced, financially induced or emotionally pressured. The transplant ethics committees work according to guidelines, and the members of the committee have to undergo training in medical ethics and they are subjected to close regular audits. 524

The reimbursements of kidney transplants are primarily done by the organ recipients. According to the Minister of Health, the issues of equity are addressed by having the rich subsidise the poor in obtaining their kidneys. The National Kidney Foundation also launched a \$10-million kidney living-donor support fund in November 2009 to provide financial assistance to live kidney donors. By April 2010, the National Kidney Fund had already reimbursed five kidney donors for their medical expenses and loss of income from donating a kidney. Additional voluntary welfare organisations have also expressed interest in giving ad hoc financial assistance. Singapore currently has approximately 22 kidney donations per one million people. Their rates are higher than that of surrounding areas such as Malaysia (4,5 kidney donations per one million people) or Hong Kong (9,6 kidney donations per one million people). The statistics are a clear indication that Singapore's legislative initiatives have increased their living-donor kidney transplant rates.

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⁵²² Section 15B(3) of the Human Organ Transplant (Amendment) Act 2009.

⁵²³ Kin http://www.hpm.org (Date of use 28 April 2012).

Kin http://www.hpm.org (Date of use 28 April 2012).

National Kidney Foundation "NKF launches \$10m 'Kidney Live Donor Support Fund' in aid of needy donors" http://www.111.nfks.org (Date of use: 29 April 2012).

⁵²⁶ Chow P "NKF fund reimburses five kidney donors" http://www.asiaone.com (Date of use: 29 April 2012).

⁵²⁷ Kin http://wwwhpm.org (Date of use: 29 April 2012).

⁵²⁸ Kin http://wwwhpm.org (Date of use: 29 April 2012).

South Africa has a lack of constitutional guidance and case law regarding kidney donations. The Constitution states that South Africa must seek guidance from International Law, and thus Singapore would be the perfect example to follow due to the cultural and religious similarities of South Africa and Singapore. 529 The National Health Act already stipulates in section 60(4)(a) that the donor may be reimbursed for the reasonable costs incurred by him to provide an organ. However, in South Africa it has not yet been decided what will be regarded as reasonable costs and who will be responsible for these reasonable costs. South African legislators could take a look at section 14(3)(c)(i) to (iii) of the HOTA and also reimburse kidney donors for direct expenses incurred as a result of the donation, such as transport and accommodation, as well as indirect expenses, such as loss of earnings and future expenses for the costs of long-term care of the donor and all medical follow-up costs. Furthermore South African legislators could also seek guidance from the Declaration of Istanbul on Organ Trafficking and Transplant Tourism⁵³⁰ that states that comprehensive reimbursement of the actual documented costs of a kidney donation does not constitute a payment but is rather part of the legitimate costs of treating the kidney recipient. The Istanbul declaration also recommends that the reimbursement should be made by the party responsible for the costs of treating the kidney recipient such as the health department of the government. The Istanbul declaration also clearly states what expenses may be reimbursed.⁵³¹ It should be borne in mind that the donor has the choice to accept the reimbursement or not. He is in no way obliged to accept the reimbursement, and can still donate his kidney altruistically.

South Africa could also establish a transplant ethics committee to evaluate whether a donor may receive reimbursement and to what extent the reimbursement will be

⁵²⁹ Section 39(1) of the Constitution.

Hereafter referred to as the Declaration of Istanbul. South Africa is a signatory to the Declaration. See also the WHO Principle 5 which allows the reimbursement of costs concerning kidney donation. World Health Organization "WHO guiding principles on human cell, tissue and organ transplantation" http://www.who.int/transplantation /Guiding _ PrinciplesTransplantation_WHA63.22en.pdf (Date of use: 18 June 2012). South Africa is a member of the World Health Organization.

Legitimate expenses that may be reimbursed: The cost of any medical and psychological evaluations of a potential living donor. The costs incurred in arranging and effecting the preperior and post-operative phases of the kidney donation. Medical Expenses incurred for post-discharge care of the donor and lastly lost income in relation to the kidney donation.

made. Instating a transplant ethics committee will insure that all reimbursements are done fairly and equally. South Africa could also take a step further regarding transplant legislation by following the Iranian model of paid and regulated kidney donations.

6.3 IRAN AND KIDNEY DONATIONS

In Ancient Greek times, Iran was referred to as "Persia" or "the land of Aryans". Today, Iran is a developing country situated in the Middle East between the Caspian Sea and the Persian Gulf and has 68 million inhabitants. 532 The first kidney transplant in Iran was performed in 1967. Since this first kidney transplant until 1985, Iran only transplanted approximately 100 kidneys due to a lack of infrastructure available to maintain and develop a kidney transplant network in the country. 533 The transplant activity was very low up until 1980, and due to this the Minister of Health decided to allow patients that were starting dialysis to travel abroad to receive a kidney transplant, which would be funded by the government. 534 From 1980 to 1985, more than 400 patients were sent to various European countries and the United States of America to receive government-funded kidney transplants. 535 From 1985 to 1987, the prevalence of patients with end-stage renal failure was approximately 25 000 (or 350 per one million persons) in Iran. ⁵³⁶ In 1988, the number of patients with end-stage renal failure started to escalate drastically, and most of these patients did not have a living related donor. 537 To make matters even worse, at this time Iran had no deceased-donor organ programme or any plans for such a programme. 538 At this time, the government-funded travel to overseas countries for kidney transplants were too expensive, and with this number of patients, completely unaffordable. All these

⁵³² Ghods AJ "Renal transplantation in Iran" 2002 (17) Nephrology Dialysis Transplantation 222.

Rupert WL "Paying kidney donors: Time to follow Iran?" 2008 (11) *McGill Journal of Medicine* 68.

Ghods and Savaj 2006 Clinical Journal of the American Society of Nephrology 1137.

⁵³⁵ Ghods 2002 Nephrology Dialysis Transplantation 222.

Ghods and Savaj 2006 Clinical Journal of the American Society of Nephrology 1137.

⁵³⁷ Rupert 2008 McGill Journal of Medicine 68.

⁵³⁸ Ghods and Savaj 2006 Clinical Journal of the American Society of Nephrology 1137.

circumstances led to the government-funded regulated and compensated living unrelated donor renal transplantation programme⁵³⁹ that was adopted in 1988.⁵⁴⁰

6.3.1 The Iranian model of paid kidney donations⁵⁴¹

Since the implementation of the Iranian model, 19 609 kidney transplants have been performed. The Iranian model led to the establishment of the Dialysis and Transplant Patient Association. The patient does not have a living related kidney donor, or if the related kidney donor is unwilling, then he will be referred to the DATPA, and they will locate a suitable living unrelated kidney donor for the patient. Volunteers that would like to donate a kidney are also referred to the DATPA. It should also be mentioned that all members of the DATPA have end-stage renal failure and that the members receive no incentive for finding the unrelated kidney donor, or for referring the recipient and donor to the transplant team. Once the kidney recipient and kidney donor have been matched, the next step is the evaluation of both the donor and recipient. The donor and recipient are both subjected to extensive clinical and psychological evaluation, as well as appropriate laboratory tests and imagining. During the evaluation, the transplant physician emphasises the advantages of using a living related donor, compared with an unrelated donor, and the scarcity of deceased-donor kidneys is also mentioned. All living kidney donors

Hereinafter referred to as the Iranian model.

Bagheri A "Compensated kidney donation: An ethical review of the Iranian model" 2006 (16) Kennedy Institute of Ethics Journal 270.

It should be borne in mind that the Iranian model of paid kidney donations does not involve the buying and selling of donor kidneys. An established amount is given to the kidney donor as a rewarding gift from the government and the kidney recipient.

^{3 421} transplants were from living related donors, 15 365 transplants were from living unrelated donors, and 823 from deceased donors. See also Ghods and Savaj 2006 *Clinical Journal of the American Society of Nephrology* 1137.

⁵⁴³ Hereinafter referred to as DATPA.

⁵⁴⁴ Ghods and Savaj 2006 Clinical Journal of the American Society of Nephrology 1137.

The European best practice guidelines for renal transplantation and the Amsterdam Forum on the care of the live kidney donor medical guide are being used for this purpose. Ghods and Savaj 2006 Clinical Journal of the American Society of Nephrology 1139.

A transplant centre at the Shiraz University asks all kidney transplant candidates to wait up to six months for a possible deceased kidney to become available. Ghods and Savaj 2006 *Clinical Journal of the American Society of Nephrology* 1137.

are further subjected to an assessment by the donor selection panel to assure that their consent is voluntary. 547

The Iranian model does not leave any gap for an organ broker or agency to intervene. All transplant teams belong to university hospitals, and the government pays all the hospital expenses in relation to the kidney transplant.⁵⁴⁸ After the kidney transplant, the government provides the kidney donor with a governmental donor award of approximately \$1 200, and the kidney recipients are provided with immunosuppressive drugs at a subsidised reduced rate. 549 Furthermore, the majority of kidney donors also receive a rewarding gift (as arranged and defined by the DATPA) from the recipient before the kidney transplant. If the recipient is poor, the rewarding gift will be sponsored by a charitable organisation, known as the Charity Foundation of Special Diseases. 550 All kidney donors and recipients need to apply to the Association for Supporting Renal Patient (which is also a charity organisation). The kidney donor needs to sign a pledge stating that he will not claim any kind of monetary reward from the recipient during the laboratory tests and after the kidney transplant.⁵⁵¹ The kidney recipient also signs a pledge not to compensate the kidney donor directly. After the kidney transplant, a number of documents, which include the pledges, are submitted to the Charity Foundation for Special Diseases, which will then pay the kidney donor a fixed amount. 552

The Iranian model also prevents any transplant tourism. Foreigners are not allowed to undergo kidney transplants from living unrelated Iranian kidney donors, nor are they permitted to volunteer as kidney donors to unrelated Iranian recipients. ⁵⁵³ Unfortunately, Iran has no national transplant registry (as previously mentioned, neither does South Africa) to report the short- and long-term results of all kidney

From 1986 to 2000, the donor selection panel consisted of nephrologists, transplant surgeons and members of nursing staff. Since 2000, the panel acts independently – a first session of the transplant nephrologists followed by a session of the members of the surgical team. Ghods and Savaj 2006 *Clinical Journal of the American Society of Nephrology* 1137.

⁵⁴⁸ Ghods 2002 Nephrology Dialysis Transplantation 224.

Ghods and Savaj 2006 Clinical Journal of the American Society of Nephrology 1138.

Bagheri 2006 Kennedy Institute of Ethics Journal 271.

Bagheri 2006 Kennedy Institute of Ethics Journal 271.

Bagheri 2006 Kennedy Institute of Ethics Journal 271.

Rupert McGill 2008 McGill Journal of Medicine 68.

transplants. However, the fact that the Iranian model has eliminated the transplant waiting list in Iran says enough.

6.3.2. Ethical issues pertaining to the Iranian model.

6.3.2.1 Arguments supporting the Iranian model

Many issues that are usually associated with paid kidney donations have been prevented by the Iranian model. One of biggest problems (namely the intervening of an organ broker or organ agency) has been eliminated by the existence of the DATPA, and because the government pays for all hospital expenses in relation to the kidney transplants.⁵⁵⁴ The main criticism that is usually raised concerning paid organ donations is that if payment for kidneys is legalised then only the rich will be able to afford a kidney while the poor will have to go without. The elimination of the kidney transplant waiting list in Iran benefits the rich and the poor. Everyone in Iran has equal access to all transplant facilities, and if a recipient is too poor to provide the kidney donor with a rewarding gift, then it is awarded by a charitable organisation.⁵⁵⁵ The Iranian model had no influence whatsoever on the deceased-donor programme that was established in 2000. Between 2004 and 2005, there was a 12% increase regarding the programme, and there are a number of reasons for the slow increase – such as infrastructural deficiencies and cultural barriers.⁵⁵⁶

One of the most important and ethical influences that the Iranian model has is the elimination of coercive living related donors. Because of the Iranian culture, coercive living related donors are very common. A kidney donation done by a volunteer is much more ethically acceptable than a living related donation done with some degree of family pressure or emotional coercion. Furthermore, the many illegal and commercial transplants before 1988 were eliminated by the Iranian model. Prior to the model, many kidney recipients that needed a living unrelated kidney donor travelled to India where they received paid kidney transplants that could have a

Baghari 2006 Kennedy Institute of Ethics Journal 276.

Ghods and Savaj 2006 Clinical Journal of the American Society of Nephrology 1140.

⁵⁵⁶ Ghods 2002 Nephrology Dialysis Transplantation 224.

⁵⁵⁷ Ghods and Savaj 2006 Clinical Journal of the American Society of Nephrology 1140.

number of negative implications.⁵⁵⁸ It could be deduced that the most important influence of the Iranian model is the many patients whose death and suffering have been prevented.

6.3.2.2 Arguments against the Iranian model

According to the critics of the Iranian model, there are a number of ethical issues that should be taken into account. The critic's first and main concern is that the \$1 200 supplied by the government is a fixed amount and is not enough to satisfy the majority of kidney donors. The amount supplied by the government, however, is not the only gift the kidney donor receives; he also receives the additional rewarding gift from the recipient or from a charitable organisation if the recipient is financially needy. The critics still feel that this is not enough and that, just as war-injured veterans in each society receive legal and social items of benefits, the same should be offered to kidney donors. By providing financial incentive and social benefits by the government and eliminating the rewarding gifts, the Iranian model will function as a non-directed paid kidney donation programme. The possible response to this is that the Iranian model was not adopted to upgrade the socio-economic class of the kidney donors, but rather to save the lives of dying patients with end-stage renal failure.

The issue is also raised that the increased supply of donor kidneys may cause a lowering of the strict clinical selection criteria for kidney transplantation. The concern with the increased supply is that the medical practitioner may recommend transplantation sooner than would usually be advised. Further ethical issues that exist are that public education and the establishment of an Iranian donor registry is necessary. In the author's opinion, all the ethical issues pertaining to the Iranian

⁵⁵⁸ Ghods and Savaj 2006 Clinical Journal of the American Society of Nephrology 1141.

⁵⁵⁹ Baghari 2006 Kennedy Institute of Ethics Journal 279.

Ghods and Savaj 2006 Clinical Journal of the American Society of Nephrology 1141.

Ghods AJ, Savaj S and Khosravani P "Adverse effect of a controlled living unrelated donor renal transplant program on living related and cadaveric kidney donation" 2001 (33) *Transplant Proceedings* 2627.

Baghari 2006 Kennedy Institute of Ethics Journal 277.

⁵⁶³ Baghari 2006 Kennedy institute of Ethics Journal 277.

⁵⁶⁴ Ghods 2002 Nephrology Dialysis Transplantation 223.

model should not be considered as ethical issues, but rather as improvements that can be made to the Iranian model. None of these issues are serious ethical issues. The Iranian model may involve payment for a kidney, but all aspects of the model are strictly enforced by the various transplant teams and the Iranian Society of Organ Transplantations. Other strategies that are often cited by various opponents of paid organ donations, such as presumed consent, non-heart-beating deceased donors and ABO incompatible paired exchange kidney transplants, do not have the potential to eliminate or even alleviate the renal waiting lists, but the Iranian model could accomplish this. Other Strategies are serious ethical issues.

6.4 CONCLUSION

If South Africa should ever legalise the selling of donor kidneys, the Iranian model will be the perfect model to incorporate. South Africa and Iran are both developing countries with a lot of rural areas and illiterate persons. The only difference between these two countries is that Iran does not have a constitution or any human rights instruments. If the selling of donor kidneys could be regarded as constitutionally acceptable, as discussed in chapter 2 of this dissertation, then the South African government could be obliged to supply the kidney donor with an awarding gift as pertaining to the Iranian model. The kidney recipient could also provide the kidney donor with an additional gift. If the kidney donor cannot afford this gift, there could be charitable organisations that could supply these awarding gifts.

In South Africa a DATPA could also be established to locate suitable living unrelated kidney donors and to accommodate any volunteers that wish to donate their kidneys, and this association could also be subjected to strictly enforced ethical control. This type of model in South Africa could also eliminate the majority of illegal organ trading, which is steadily increasing in South Africa. If such a model is adopted in South Africa, the poor will also stand a chance to receive a donor kidney. More patients will receive kidney transplants, thus leading to more lives being saved and a decrease in the number of patients that receive renal dialysis will take place; consequently, giving

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⁵⁶⁵ Ghods and Savaj 2006 Clinical Journal of the American Society of Nephrology 1142.

⁵⁶⁶ Ghods and Savaj 2006 Clinical Journal of the American Society of Nephrology 1143.

more patients the chance to receive renal dialysis and live long enough to receive a donor kidney.

If the constitution and bioethical perspectives are truly so focused on the full patient autonomy (thus the right to self-determination in the constitution) and informed consent, then a model such as the Iranian model should be allowed, as this model gives the potential kidney donor the choice to do with his kidney as he likes and the right to receive an awarding gift for his choice.

CHAPTER 7 – CONCLUSION

"Law and order exist for the purpose of establishing justice and when they fail in this purpose they become the dangerously structured dams that block the flow of social progress." 567

At this very moment, approximately 21 000 people in South Africa are waiting. Some of them are waiting for a life-saving call that a viable kidney has finally become available. Others are waiting while they receive their renal dialysis, hoping and praying that they are one of the lucky few who will survive this ordeal. Those remaining have accepted their fate and have to make peace with the fact that they will become yet another statistic. Of the 21 000, only more or less 5 000 will be fortunate enough to receive any treatment whatsoever; thus renal dialysis or a kidney transplant. Of that 5 000, only 250 people will receive kidney transplants this year. The others will be left hoping and waiting in vain...

Although the world of medicine has seen miraculous developments in the past few decades within the sphere of organ transplantation, the law has failed to develop in accordance with these developments. However, the abovementioned harrowing statistics need not be our reality. Instituting legislation to legalise and regulate the process of remuneration for kidney donations could conceivably solve a problem that seems insurmountable at this moment. The aim of this research was to examine whether the legalisation of the remuneration for kidney transplants could be regarded as constitutionally acceptable.

In order to establish this, the relevant provisions of the Constitution were examined. As was mentioned in chapter 2, the Constitution is the supreme law of the Republic of South Africa, and any legislation that is irreconcilable with it is invalid to the extent of

⁵⁶⁷ Martin Luther King, as quoted in his letter from Birmingham Jail. Dinar http://www.africa.upenn.edu/Articles Gen/Letter Birmingham.html (Date of use: 4 June 2012).

The South African Dialysis and Transplant Registry estimates that about 21 000 South Africans are currently experiencing kidney failure. Molakeng http://www.hst.org.za (Date of use: 4 June 2012).

According to the statistics of the Organ Donor Foundation, in 2010, only 266 persons received kidney transplants, and only 119 of these were of living kidney donations. Organ Donor Foundation http://www.odf.org (Date of use: 4 June 2012).

the conflict. A number of sections in the Constitution were analysed, namely the right to life, human dignity, self-determination, privacy and healthcare. The right to life and human dignity are regarded as the most important fundamental human rights in the Constitution. These two rights are interconnected due to the fact that human dignity cannot exist without life, and a life worth living includes being treated in a dignified manner. The author is of opinion that a person receiving renal dialysis does not live a life worth living. His life consists of endless pain and suffering, which leads to a significant decrease in his quality of life, which leads to an infringement of his right to human dignity. Therefore, the right to human dignity and renal dialysis cannot exist in one space. Furthermore, the author contested why, in the *Makwanyane* case, cruel and inhumane treatment of a prisoner was regarded as constitutionally unacceptable, but yet it is regarded as acceptable to treat an end-stage renal failure patient in the exact same manner while the option of saving him of his agony exists.

The Constitution grants everybody the right to self-determination, which includes the right to make decisions over one's own body. Thus, if a person is not allowed to receive remuneration for his kidney donation, his right to self-determination is infringed. A person should be granted the choice to decide if he would like to be remunerated or not. If a person could be remunerated for his kidney donation, his right to privacy will not be affected, seeing that his identity could still remain anonymous. Everyone is granted the right to access to healthcare, and in section 27(2) the obligation is imposed on the state to take reasonable legislative and other measures within its available resources to achieve the progressive realisation of this right. The state is not realising the right of access to healthcare pertaining to endstage renal failure patients. The state merely pleads poverty and it is regarded as acceptable. Yet, if the state can afford renal dialysis, it would be able to afford kidney transplants, seeing that as mentioned in this dissertation the cost of a kidney transplant is in fact lower than keeping a patient on renal dialysis. The state should provide the kidney recipient with the alternative option of obtaining a kidney from a kidney donor who is remunerated by the state.

After careful examination of the relevant sections of the Constitution, it was found that there should be no objections against the legal payment of a kidney donor. However, the payment of a kidney donor as discussed in chapter 3 is prohibited in the regulatory framework pertaining to kidney transplants – namely the National Health Act. Nonetheless, the National Health Act is moving in the right direction by attempting to improve the current shortage of kidney by providing the kidney donor with a reimbursement for the reasonable costs incurred by him. Yet, there is no indication of what is meant by this remuneration, what the amount will be and who will be liable for the payment of the amount.

Due to South Africa's lack of constitutional guidance and case law regarding the remuneration of a kidney donor, the author sought guidance from international law, and found that Singapore's procedure of remuneration would be the perfect example to follow due to their cultural and religious similarities to South Africa. The author is of the opinion that the South African legislator should rather have taken an extra step and allowed the sales of kidneys in a regulated manner. In this case, South Africa could follow the example of the Iran's paid and regulated living unrelated kidney donors model. The author is of opinion that this model could easily be implemented in South Africa. The most important element of this model is that the payment must be regulated and monitored by an ethical committee.

This research further endeavoured to highlight the various arguments against and in favour of kidney sales. Any controversial matter will always garner widely differing opinions. It should be borne in mind that, giving people the option of selling their kidneys does not force them to do so. They still have the choice of selling or not. In the author's opinion there may be a disagreement regarding whether kidney sales should be allowed or not. Nevertheless, there is no disagreement when it comes to the shortage of kidneys in South Africa and the world. Instead of arguing whether kidney sales should be allowed or not people should rather focus their attention on finding a solution for the dire need of available donor kidneys.

Due to the controversial nature of the subject matter – arguments pertaining to kidney sales – this research sought to examine whether kidney transplants could be regarded as bioethically acceptable. It was found that, measured against the four principles of bioethics, namely autonomy, non-maleficence, beneficence and justice, kidney transplants and even the payment for kidney donors could be regarded as bioethically acceptable. It should, however, be borne in mind that this is only the author's opinion. A person's opinion could differ according to how much importance he allocates to one moral principle when it is in conflict with another principle – such as in the case of the principles of non-maleficence and beneficence.

From this research it could easily be deduced that the agony of 21 000 people waiting for kidneys could easily be relieved if the dire need for donor kidneys were to be addressed in a constitutionally acceptable manner. The lack of legislative development is the only obstacle standing in the way of those desperate for salvation. The self-same law which is supposed to protect these people is in actual fact the problem and not the solution, as it is withholding them from their only option to prolong their lives – a viable donor kidney. One is already given the option to save a life by donating a donor kidney. One should also be allowed to choose whether to save a life and be remunerated for the deed. It should be emphasised once again that if kidney sales are legalised, a person still has the choice whether he would like to sell or donate. Nevertheless, people should be granted this option in a modern constitutional society. The author is strongly of the opinion that the legalisation of kidney sales in a constitutionally acceptable manner will improve the current shortage of donor kidneys in South Africa. Furthermore, it will give hope to the thousands of patients who are waiting on a miracle. It would be reprehensible if the shortfall of legislative development is the only reason why South Africa is suffering from such an acute shortage of donor kidneys.

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