Consent to organ transplantation

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SAMEVATTING

Toestemming tot orgaanoorplanting

In die moderne era waarin ons lewe, met die gepaardgaande vooruitgang op mediese gebied, soos byvoorbeeld die navorsing in verband met die kloning van persone uit die selle van 'n skenker, is dit van uiterste belang dat die ingeligte toestemming van 'n pasiënt betrokke by orgaanoorplantings verkry word. Hierdie artikel bespreek, met verwysing na lande soos die Verenigde State van Amerika, die Verenigde Koninkryk en Suid-Afrika, probleme soos die aard van die inligting wat oorgedra moet word, die vrywilligheid van die toestemming, die verskillende vlakke van toestemming, die posisie met betrekking tot onopgeëiste liggame, die toestemming van 'n minderjarige en die posisie indien 'n defektiewe orgaan oorgeplant word.

1 INTRODUCTION

With the advancement of technology and the resultant complex medical procedures that are available today, it is extremely important that the consent of a patient be obtained prior to the performance of any transplantation. With the likelihood of tissue engineering becoming a reality in the near future and the potential for the creation of a market in organ trading it is necessary that not only the consent, but the informed consent of a patient be obtained. However, informed consent encompasses further issues such as the type of information that should be disclosed, the voluntariness of the consent, the different distinguishing levels of consent, the consent of a minor, the problems associated with the transplantation of a defective organ, and experimental organ transplantation. These issues will be discussed in relation to the legal position in a few selected countries, namely the United States of America (USA), the United Kingdom (UK) and South Africa.

2 CONSENT AS A DEFENCE TO ORGAN TRANSPLANTATION

2 1 General

Medical doctors operating on patients normally enjoy protection against claims of assault due to the consent given by the patient.

In countries that have a criminal code, the issues pertaining to the legitimacy of medical or surgical procedures are specifically provided for. The New Zealand Criminal Code[1] for instance provides that every person is protected from

1 S 61.

criminal responsibility when performing any surgical operation upon any other person for his benefit with reasonable care and skill, if the performance of the operation was reasonable, having regard to the patient's condition at the time as well as having regard to all the circumstances surrounding the case.

The Canadian Criminal Code[2] states that a person performing a surgical treatment for the benefit of the patient, is protected from criminal liability if it is performed with reasonable skill and care and it is reasonable to perform the operation.[3]

At common law, medical treatment in general, and organ donation in particular, is governed by general legal principles and is typically regarded as being *prima facie* illegal. Transplantation procedures would, however, be justified in terms of the consent given by the patient or when the procedure can be regarded as being in the public interest. Courts and legislatures have fashioned a quantitative harm threshold for the purpose of analysing the legality of such actions.

The Council of Europe's Draft Protocol stipulates that there must be no serious risk to the life or health of the donor. Whilst there is little risk of serious harm to health from living kidney donation, it cannot be said that there is no risk of some serious damage to health, *a fortiori* no risk to health whatsoever. With other organ transplantations the risk is even greater, making laws such as this unsatisfactory.[4]

2 2 The USA

Under the United States (US) Model Penal Code, consent is stated to be a defence to any offence involving "bodily injury" which is not serious. The US courts have, however, taken a restrictive view of the degree of harm to which consent can be provided as a valid defence. Inevitably, all organ removal procedures cause actual bodily harm.[5] However, the consent of the patient prevents medical doctors from being sued for battery in tort, and being prosecuted for criminal assault.

2 3 The UK

The common law in the UK provides that all actions are required to be justified where actual bodily harm is either intended or caused, even where there is consent. Where no actual harm is intended and/or caused, no public interests are implicated and consent therefore suffices to legitimate the conduct.[6] Transplant surgery *prima facie* constitutes a battery against the person. However, the ordinary meaning of bodily harm does not include medical procedures that benefit the health of the patient. "Benefit" is also regarded as having a converse meaning to "harm". The English Law Commission has proposed that the permitted threshold level of actual bodily harm be raised in order for consent to be a sufficient justificatory factor at the level of a "serious disabling injury" being caused.[7]

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2 S 45.
3 Price *Legal and ethical aspects of organ transplantation* (2000) 424.
4 247–248.
5 244–245.
6 243.
7 244.

2 4 South Africa

Consent to the removal of tissue from a dead person may be given by the deceased prior to death (eg in a will; or in a document attested by two competent witnesses of 14 years or older; or orally before two competent witnesses; or on a prescribed identity tag issued by an authorised institution).[8] It may also be given after the deceased's death by the spouse, major child, parent, guardian or any major brother or sister of the deceased.[9] A donation may be revoked before death by a donor.[10] It is submitted that a relative cannot revoke a donation after the donor's death, nor can consent be given by relatives or guardians if the deceased has forbidden it prior to death. Likewise, a donation by the deceased cannot be revoked or vetoed by one relative against the consent of another.[11] If none of the above relatives can be traced, the Director-General of Health may donate specific tissue for transplantation purposes provided that he is satisfied that all reasonable steps have been taken to trace the relatives concerned. It has been suggested that if the identity of the deceased is unknown, the director-general cannot be regarded as having taken all reasonable steps to trace the relatives. Furthermore the director-general cannot revoke his consent.[12]

As far as the consent[13] to the removal of tissue, blood and gametes of living persons are concerned, no tissue, blood or gamete may be removed or withdrawn from the body of a living person for certain specified purposes:[14]

(a) except in accordance with the prescribed conditions; and

(b) unless written consent has been granted, where such a person is a major, by that person; or where such a person is a minor, by the parents or guardians of that person.

However:

(i) in the case of the removal of tissue which is replaceable by natural processes, or the withdrawal of blood from the body of a person who is a competent witness,[15] the consent of that person to the removal of that tissue or blood will be sufficient, whether it be granted in writing or orally;

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8 S 2(1) of the Human Tissue Act 65 of 1983.

9 S 2(2)(a).

10 S 5.

11 S 2(2)(b).

12 Strauss 153.

13 See Smit *SA reg met betrekking tot anatomiese skenkings* (LLM thesis US 1979) 64–92 for a discussion of the legal principles underlying anatomical donations by living persons; for consent in general see Van Oosten *The doctrine of informed consent in medical law* (LLD thesis Unisa 1990); and for consent in surrogacy cases see Van Oosten 1990 *De Jure* 340–347.

14 S 19 of the Human Tissue Act 65 of 1983. See the regulations made in terms of s 37, eg regulations relating to blood and blood-products published in *GG* 12685 GN R1935 of 1990-08-17; and see *GG* 14596 GN R298 of 1993-02-26 which made provision for autologous blood transfusions, ie the withdrawal of blood from a person and its storage with a view to later administering it to him. See also the standards for the practice of blood transfusion in SA which have to be complied with in terms of the regulations and which were published with the assent of the Minister of Health in terms of s 37. See also the regulations published in *GG* 12695 GN R1935 of 1990-08-17 which provide for the protection of the recipients of blood, the safety of the blood supply, and the protection of blood donors.

15 Ie a person of the age of 14 years or older and who at the time when in terms of the Act anything is done in his presence or by him, is not incompetent to give evidence in a court of law: s 1.

(ii) tissue removed in the interest of his health from the body of a living person with his consent or with the consent of any other person who may in law give consent on his behalf, may be used for certain specified purposes.[16]

In cases where a person is legally capable of expressing his or her will and he or she consents to injury or harm, the action causing such harm will be lawful. Consent is a ground of justification, as the person suffering harm is legally regarded as having waived his or her right to the extent that he or she permits the actor to violate his or her interests. The actor can therefore not be held liable for the damage caused.[17] For consent to qualify as a valid ground of justification, the consent must be given freely and voluntarily, the consenting patient must have full knowledge of the extent of the prejudice and realise or appreciate fully what the nature and the extent of the harm will be. The patient must in fact subjectively consent to the prejudicial act and the consent must not be *contra bonos mores*.[18]

3 INFORMED CONSENT

3 1 General

In terms of the Convention on Human Rights and Biomedicine,[19] medical intervention may only be carried out after the person concerned has given free and informed consent to it. Before giving consent, the person must receive appropriate information as to the purpose, nature, consequences and risks of the intervention.

In common law jurisdictions, the question arises whether an action based on battery, an action based upon a breach of duty to take care, or a negligence/ malpractice action is appropriate in cases where there has been a failure of communication relating to informed consent. Since research experiments are inherently dangerous and carried out for the benefit of others, disclosure of information to the test subject must be "perfect" or "fuller than full".[20]

The Council of Europe's Draft Protocol[21] states that donors must be informed of the right of access to independent advice regarding such risks from a health professional having appropriate experience, and who is not involved in the organ or tissue removal or subsequent transplant procedures. The Council of Europe Recommendation on Living Related Liver Transplantation also stipulates that the consent of the donor must be obtained, and that a third party that is independent of the transplant team must provide the donor with a full explanation of the risks involved.

As far as information disclosure to the recipient is concerned, the Council of Europe Draft Protocol[22] requires that information as to the nature and purpose of the procedure and its risks and consequences, as well as the alternatives, be communicated. Price[23] is of the opinion that essential information regarding the

16 In terms of ss 18 and 19.
17 Neethling, Potgieter and Visser *Law of delict* (1999) 96.
18 *Idem* 100–103.
19 A 5.
20 Price 273; Giesen "Civil liability of physicians for new methods of treatment and experimentation: A comparative examination" 1995 *Medical LR* 22 46.
21 A 11.
22 A 5.
23 430.

consequences should also include potential complications and implications connected to the donor source. In Bolivia[24] the head of the transplant team is required to inform the recipient where the organ or tissue to be transplanted originated, and also of the results of tissue compatibility testing.

3 2 The USA

The US Task Force on Organ Transplantation[25] stated that a donor, when deciding to donate, must be informed, and his decision made voluntary and altruistically.

Every adult human being of sound mind has the right to determine what procedures may be performed on his or her body. A medical doctor that performs an operation without the patient's voluntary and informed consent, commits an assault.[26] Unconsented medical contact is not only criminal assault, but also battery in tort.[27]

The requirements pertaining to information disclosure, however, vary from state to state. On the one hand some states apply a "reasonable doctor" standard, which is frequently influenced by bodies of professional medical opinion. On the other hand, some states apply a "reasonable patient" standard, which requires disclosure of the information that a "prudent patient" would regard as being material to the decision whether or not to undergo the procedure, would be applied.

The question arises whether a cause of action for non-disclosure at common law would sound in battery or negligence. In the USA the proper cause of action is negligence rather than battery. In *Halushka v University of Saskatchewan*,[28] a case which concerned non-therapeutic procedures, the court held that a person is entitled to full and frank disclosure of the facts, probabilities and opinions which a reasonable man might be expected to consider before giving his consent. In *Zimmer v Ringrose*[29] the plaintiff underwent a novel and experimental method of sterilisation, but was not informed of the fact that the procedure had not been accepted by the medical profession, and that it carried a 30 per cent failure rate. The court of first instance relied on *Halushka*,[30] and held the defendants liable for battery. On appeal, the decision was reversed and the court found that *Halushka*[31] was not applicable as it dealt with non-therapeutic procedures, and in this instance the proposed sterilisation method was directed towards a therapeutic end. Using a reasonable patient standard, the defendants were nonetheless held liable in negligence for failing to discuss alternative methods with the plaintiff, and to weigh competing risks. The court applied the prudent patient standard, namely that the physician should have informed the patient that the procedure had not been approved by the medical profession, since a prudent person would have been influenced by this factor in reaching a decision.

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24 Law of 1982-03-15, s 9.
25 Report of the Task Force on Organ Transplantation *Organ transplantation: Issues and recommendations* US Dept of Health and Human Services (1986) 37.
26 *Schleondorff v Society of New York Hospital* (1914) 105 NE 92.
27 Garwood-Gowers *Living donor organ transplantation: Key legal and ethical issues* (1999) 7.
28 [1965] 53 DLR 2d 436; see also Garwood-Gowers 72.
29 124 DLR (3d) 215 as referred to by Price 435.
30 *Supra* fn 28; see also Garwood-Gowers 72.
31 *Ibid.*

In *Cryderman v Ringrose*[32] where an experimental procedure was used, the court held that the common law requires a high degree of care and also disclosure to the patient of the fact that the treatment is new and risky. The court distinguished the facts of *Halushka*[33] from this case on the same principles as *Zimmer*[34] did. The defendant was held liable in negligence as it was an experimental procedure. In *Coughlin v Kuntz*[35] the court also upheld the liability of the defendants in negligence for failing to disclose to the plaintiff that the proposed procedure was novel, unique and under investigation by a professional body.

Unfortunately, in the field of transplantation law, no case in point has been decided yet. According to Price[36] in any case of organ transplantation, a reasonable doctor would typically tell a patient of the risks attaching to the procedure and alternatives, *a fortiori* a prudent patient would wish to be so informed.

3 3 The UK

The Nuffield Council[37] recommended that the consent of the donor as well as the consequent transplantation procedure is valid if those involved in the removal of tissue from donors ensure that the explanation given to the donor is explicit about the range of intended uses of the tissue and about any risks the donor may incur either in having the tissue removed or as a consequence of its removal. As far as the appropriate standard for disclosure is concerned, the Nuffield Report[38] considered that where the procedure is non-therapeutic, there is no room for medical discretion. Consent must be explicit and all the relevant information be provided. The standard for disclosure should accordingly be generated by the needs of donors rather than the needs of recipients or the practices or views of clinicians.

The information disclosed by a professional must be done acting reasonably. He or she will be acting reasonably if doing so in accordance with a school of thought accepted as proper by a responsible body of medical opinion. Reasonableness is defined by reference to what the mythical "common person" would consider to be reasonable. Expert opinion may be presented to help determine what is reasonable in a particular context.

In *Sidaway v Board of Governors of the Royal Bethlehem Hospital*[39] the court held that the recipient must be given at least such information as fulfils the standard of disclosure of risks required by the relevant legal system. Whatever the precise determination of that standard, the recipient must receive information with regard to the risks of the operation itself and its consequences, the chances of its success, possible alternative modes of treatment, the consequences of failure and of success. An exception to disclosing information is that there was no substantial risk of grave adverse consequences to the patient.

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32 [1977] 3 WWR 109; [1978] 3 WWR 481; 89 DLR (3d) 32.
33 *Supra* fn 28.
34 *Supra* fn 29.
35 [1990] 2 WWR 737 (BCAA).
36 436.
37 In their Nuffield Council on Bioethics Working Party Report on *Human tissue: Ethical and legal issues* (1995) para 13.16; see also Clayton "Prospective uses of DNA samples for research" in Knoppers (ed) *Human DNA: Law and policy* (1997) 295.
38 Para 7.7.
39 [1985] 1 All ER 643; [1985] AC 871.

The court further held that a professional would be acting reasonable if doing so in accordance with a school of thought accepted as proper by a responsible body of medical opinion – the Bolam test.[40] The court also held that the scope of reasonableness should be the same in all cases. A restrictive disclosure for the doctor was all that was required, namely that it was for the doctor to decide what information should be given to the patient. This approach has been heavily criticised and English case law has moved away from it.

In *Pearce v United Bristol Healthcare NHS Trust*[41] the court held that in law if there is a significant risk that would affect the judgment of a reasonable patient, then it is the responsibility of the medical doctor in the normal course of events to inform the patient. According to Price[42] this would also apply to all organ transplant therapies which by their nature carry very significant risks, where rejection and the risks of infection may lead to death, and where inevitable long-term changes to lifestyle is implicated, as with heart, lung and liver transplants.

In *Poynter v Hillingdon Health Authority*[43] a one year old child sustained irreversible brain damage during a heart transplant operation. His parents claimed that the hospital clinician was negligent in failing to inform them of the risk of serious brain damage attached to the procedure. The court held that whilst there was a body of medical opinion that would have informed the parents of such a risk of brain damage, there were many other clinicians who would not have done so. Therefore it was not negligent in this case to adhere to a practice supported by such a responsible body of medical opinion, and there was no breach of duty. The court held that the exception referred to in *Sidaway*,[44] that there was no substantial risk of grave adverse consequences, was not applicable to this case. According to Price[45] the very modest risks in this case could not be confined to transplantation but was generic to operative procedures generally under anaesthetics, and therefore the decision could be justified.

In *Chatterton v Gerson*[46] the court held that once a patient has been informed in broad terms of the nature of the intervention intended, his or her consent would be real and no action would lie in battery. In *McFall v Shimp*[47] the plaintiff had a rare bone marrow disease and brought an action for the court to order his cousin, the only suitable prospective bone marrow donor in his family, to submit to procedures for the extraction of bone marrow for transplantation into the plaintiff, despite his unwillingness to do so. The action was denied as a competent adult has a right to refuse medical treatment.

In *Joyce v Merton, Sutton and Handsworth Health Authority*[48] the court held that if there are witnesses and documentary evidence showing that proper practice was not followed, only limited weight would be given to the defence of practitioners that they had followed their normal practice. In *Bolitho v City*

40 This is known as the Bolam test as it is based upon a declaration made in *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 115.
41 (1999) 48 BMLR 118 124.
42 433.
43 (1997) 37 BMLR 192 (QB).
44 *Supra* fn 39.
45 434.
46 [1981] QB 432.
47 [1978] 10 Pa D&C (3d) 90 as referred to in Garwood-Gowers 91–92.
48 27 BMLR 124.

Hackney HA[49] the court held that where there are two bodies of opposing opinion, the one brought forward for the defence can be rejected if it is not logically supportable, even if it is competent.

The Human Organ Transplants (Unrelated Persons) Regulations[50] stipulate that a registered medical practitioner must ensure that the non-genetically related donor understands the nature of the medical procedures and risks. There is a widespread public aversion to living donors donating organs to unrelated donees. This aversion is unscientific, emotional, and prejudicial. Unrelated donors are the norm for blood donation and are commonly used as bone marrow donors.[51]

The Guidance for Doctors on Transplantation of Organs from Live Donors[52] provide that doctors must satisfy themselves that consent to a donation has been given without any undue influence, including the offer for financial or material benefit. A doctor, or another appropriately qualified person, independent of the transplant team must assess the motivation of each donor. If these conditions are met, the doctor must ensure that the donor understands the risks and after-effects of the operation, is given appropriate counselling, adequate time to consider the implications of the operation and an opportunity to withdraw. Where necessary an interpreter and a translation of any written material must be provided. Doctors should also consider seeking advice from international bodies on the tests needed to establish consanguinity, and on the circumstances in which unrelated live donor transplants may be considered.[53]

3 4 South Africa

In general, where consent to the risk of harm is concerned, the consenting party must have full knowledge of the nature and the extent of the risk in order to consent to the risk.[54]

In medical procedures, a medical practitioner has a duty to inform the patient of any material risks connected to the treatment. There is a difference of opinion as to how the extent of the doctor's duty to inform the patient should be established. In *Castell v De Greef*[55] the court *a quo* employed the reasonable doctor standard to set an initial standard, namely that the court has to be led by medical evidence on what a reasonable doctor would have told the patient in the circumstances. In an appeal to the full bench, the court preferred a "reasonable patient" test whereby the doctor's duty to inform is to be established with reference to the needs and expectations of the particular patient, rather than the insights of the medical profession. According to the court this approach accords with the fundamental right to individual autonomy and self-determination and the tendency in various common law and European countries, and is contrary to the paternalistic reasonable doctor approach.[56] The court formulated the test as follows:[57]

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49 [1997] 4 All ER 771.
50 1989 (SI 2480) reg 3(2)(b); Garwood-Gowers 104.
51 Price 317.
52 Para 7.
53 *Ibid.*
54 Neethling, Potgieter and Visser 100–101.
55 1994 4 SA 408 (C) 418 *et seq.*
56 426.
57 *Ibid.*

"For a patient's consent to constitute a justification that excludes the wrongfulness of medical treatment and its consequences, the doctor is obliged to warn the patient so consenting of a material risk inherent in the proposed treatment; a risk being material if, in the circumstances of the particular case:

- a reasonable person in the patient's position, if warned of the risk would be likely to attach significance to it; or
- the medical practitioner is or should be reasonably aware that the particular patient, if warned of the risk, would be likely to attach significance to it.

This obligation is subject to the therapeutic privilege, whatever the ambit or the so-called 'privilege' may today still be."

In terms of the therapeutic privilege, medical doctors may withhold from their patients information that may, in their view, be detrimental to them. However, this approach is criticised in light of *inter alia* its violation of patient autonomy.[58]

According to Price[59] a subjective patient standard would be more appropriate, namely: what does this patient wish to know. The doctor must decide what information should be given to the patient and in what terms that information must be couched.[60] This is the test which is pervasive in general across the major civil law jurisdictions, South Africa and Australia.[61]

In *Castell v De Greef*[62] the court also held that the consenting party must have had knowledge and been aware of the nature and the extent of the harm or risk and must have appreciated and understood the nature and extent of the harm or risk. The consent must be comprehensive, that is extend to the whole transaction, inclusive of its consequences.

In the context of organ transplantation the patient should therefore have been informed of all the consequences of the transplantation, and he or she must be aware of the nature and the extent of the transplantation, and must appreciate and understand the nature and extent of the transplantation.

Where the patient did not know in broad terms the nature of the procedure, with regard to transplantation as a therapy *simpliciter*, it could constitute criminal assault. The failure to inform the recipient sufficiently of alternative treatments and the risks and consequences involved with the transplant, could lead to an action in delict.

4 VOLUNTARY CONSENT

4 1 General

The consent of the patient must be given freely and voluntary. Voluntariness must be evaluated by circumstances, the interests at stake, and the moral and legal purposes to be served. If willingness is the touchstone, this has potential to impose excessive burdens on medical practitioners procuring consent to medical procedures. The law is largely unable to police and ensure voluntariness of decision-making and, apart from setting up certain procedural criteria, protocols

58 Van Oosten *Informed consent* (1983) 423–428.
59 275.
60 *Sidaway v Board of Governors, Bethlehem Royal Hospital supra* fn 39; Garwood-Gowers 11.
61 Price 275.
62 *Supra* fn 55 425.

in place at different transplant centres should seek to provide supplementary measures to ensure that donors really do donate as a result of the exercise of free will.

4 2 The USA

The US Task Force on Organ Transplantation[63] stated that there is no reason to exclude all living unrelated donors, such as spouses and friends, from donating organs, but special care should be taken to ensure that the decision to donate is informed, voluntary and altruistic. According to Price[64] there is much to recommend in this.

Every adult human being of sound mind has the right to determine what may be done with his or her body and a medical doctor that performs an operation without the patient's informed consent, commits an assault.[65] Unconsented contact is not only criminal assault, but also battery in tort.[66]

4 3 The UK

The Human Organs Transplants Act (HOTA) establishes the requirement of voluntariness of an unrelated donor's decision to donate his or her organ. As far as undue influence is concerned, the English Law Commission[67] stated that circumstances that reduce or obliterate voluntariness and may invalidate consent include (literal) compulsion (that is physical force), coercive threats or offers ("duress") and defective beliefs induced by fraud or mistake. The British Transplantation Society[68] has also formulated guidelines in the form of written specific advice.

In *Bowater v Rowley Regis Corporation*[69] the court said with regard to the defence of *volenti non fit iniuria* that a man cannot be said to be truly "willing" unless he is in a position to choose freely. Freedom of choice predicates not only the full knowledge of the circumstances on which the exercise of choice is conditional so that he may be able to choose wisely, but also the absence of any feeling of constraint so that nothing may interfere with the freedom of his will.

With regard to consent given to medical treatment, the court of appeal in *Re T (Adult: Refusal of Medical Treatment)*[70] reversed the decision of the trial court where a woman refused consent to any blood transfusion being administered to her. She subsequently developed an abscess in her lung requiring surgery and a blood transfusion. As her decision had been influenced by her mother who was a Jehova's witness (the patient herself was not a member of the sect) the court said she had refused consent to the transfusion "in form" but not in "reality". The refusal should therefore not be binding on medical staff. The patient is entitled to receive and invite advice and assistance from others in reaching her decision, but doctors have to consider whether it really is the decision of the patient. It is

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63 Fn 25 *supra* 37.
64 329.
65 *Schleondorff v Society of New York Hospital* (1914) 105 NE 92.
66 Garwood-Gowers 7.
67 *Consent in the criminal law* 260.
68 *United Kingdom guidelines for living donor kidney transplantation* (2000) 1 *et seq.*
69 [1944] KB 476 479.
70 [1992] 4 All ER 649 (CA); see also Garwood-Gowers 105–106.

acceptable that the patient should have been persuaded by others, and it does not matter how strong the persuasion was, so long as it did not overbear the independence of the patient's decision. There must be such a degree of external influence as to persuade the patient to depart from his or her own wishes, to an extent that the law regards it as undue.[71] The "true will" of the patient is therefore regarded as a subjective state of mind.

4 4 South Africa

The consent of the patient must be given freely and voluntarily. Should the patient in any way be forced to consent to the organ transplantation, valid consent is absent.[72]

5 LEVELS OF CONSENT

5 1 General

As far as organ procurement is concerned, a distinction is made between two levels of consent, namely express (voluntary) consent (which could be strong or weak) and presumed consent (which could also be strong or weak).[73] A strong express consent system usually disregards the views of relatives in favour of the wishes of the deceased donor[74] and a weak express consent system values the views of relatives and they are permitted even to veto the deceased explicit request to donate, even if the deceased person expressly stated that he or she wished to donate.[75]

In a presumed consent system, individuals are presumed to agree to the donation of their organs unless, at some time during their life, they have indicated otherwise.[76] In strong presumed consent jurisdictions, the absence of an objection from the deceased is itself sufficient to condone organ removal, regardless of the relatives' views. Austria, Poland and Switzerland have implemented a strong presumed consent model of organ donation, namely the clearly expressed will of the deceased is the sole criterion for objection to organ removal.[77] In Austria[78] organ removal is permissible unless the deceased person expressly declared an objection to organ donation.

Under weak presumed consent laws there is no necessity to procure a "consent" to donate from relatives or anyone else, where the deceased made no explicit request but is not known to have objected. Organs can be removed where there is no objection communicated by a relative.[79] For instance in Tunisia[80] organ removal is permissible unless the deceased person expressed an objection

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71 669.
72 Neethling, Potgieter and Visser 100.
73 Price 83 92; Machado *Using the bodies of the dead. Legal, ethical and organisational dimensions of organ transplantation* (1998) 44.
74 Eg almost all states in the USA, Canada, Denmark, the Phillipines, etc. See also Gorsline and Johnson "The United States system of organ donation, the international solution and the Cadaveric Organ Donor Act: 'And the winner is . . .'" 1994 *J of Corporation L* 21.
75 Price 92.
76 Machado 45.
77 Gorsline and Johnson 21.
78 Austrian Federal Law s 62a; see also Gorsline and Johnson 22.
79 Price 96–97; see also Gorsline and Johnson 21.
80 Law of 1991-03-25, s 3; Price 94.