or if a close relative has communicated an objection to the physician. Another example of a weak presumed consent system is Norway, where organs may be removed from a deceased person if he or she had made a written or oral instruction prior to death or, in the absence of such an instruction, if neither the deceased nor the nearest relative has expressed an objection thereto, and there are no grounds for assuming that the procedure would be contrary to the fundamental convictions of the deceased or the nearest relative.[81]

Besides requiring an express consent as in England, Scotland and Wales, Norway also permit organ removal for transplantation without any consent from either the deceased or relatives, in the absence of any objection from either, consistent with allegedly presumed consent schemes.

Criticism against a presumed consent regime is that there would be a risk that organs may be removed when this had not been the wish of the person or his or her relatives. Many critics have also expressed difficulty in accepting that silence equals consent.[82] Criticism against an express consent regime is that organs will frequently not be used where the deceased would in fact have wished that they had been.[83]

5 2 The USA

In the USA a hybrid quasi-presumed consent system for organ transplantation is found.[84] The Uniform Anatomical Gift Act (UAGA)[85] stipulates that a member of a specified class of person, in the order of priority stipulated, may make an anatomical gift of all or part of the deceased person's body unless the deceased person at the time of death has made an unrevoked refusal to make that anatomical gift. Either the medical examiner (coroner) or the local public health officer may release and permit removal of any part of the dead body for transplantation where a reasonable effort has been made to locate and examine the deceased person's medical records and inform the relatives listed of their option to make or object to making an anatomical gift.[86] A search must therefore first be made to locate next of kin and to obtain their consent. If the search is unsuccessful, organs may be removed in any event in the absence of any explicit consent, unless there is evidence that the deceased person did not want to donate. This provision of the Model Law has been adopted in various states.[87]

A difference is also made between "required request" laws and "routine request" laws for organ donations. First-mentioned refers to laws that require documentation on the death certificate of a request made for organ donation and its outcome, whereas last-mentioned requires that hospitals develop policies or protocols to ensure that families are asked to donate. By 1990 twenty-six USA states and the District of Columbia had enacted required consent laws, and eighteen states had enacted routine enquiry laws.[88]

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81 Law of 1973-02-09, s 2 as referred to by Price 95.
82 Gorsline and Johnson 22.
83 Strauss *Doctor, patient and the law* (1991) 149; Price 109.
84 Price 100.
85 1987, s 3.
86 S 4.
87 Eg Louisiana (1989) La Rev Stat Ann s 2354.3 and California (1991) Cal Gov't Code s 27491.45.
88 Price 102.

5 3 The UK

In England, Scotland and Wales the Human Tissue Act[89] provides that organ removal may be authorised if the deceased had requested to donate prior to death or if, having made such reasonable enquiry as may be practicable, the person concerned has no reason to believe that the deceased had expressed an objection, or that any surviving spouse or relative objects thereto. This is a classic example of a weak express consent system.

5 4 South Africa

South Africa also has a weak express consent system. Any person may donate his body or any specific tissue thereof to be used after his or her death or give his or her consent to a post-mortem examination of his or her body.[90] Organ removal may also be authorised if the closest family do not object thereto[91] or, if none of them can be found, all reasonable steps have been taken to trace them.[92]

6 CONSENT AND THE POSITION WITH REGARD TO UNCLAIMED BODIES

6 1 The USA

At least thirteen states in the USA have enacted laws, already upheld as being constitutional, allowing authorisation to be given for the use of unclaimed bodies applicable to corneal tissue and only to corpses in the custody of the coroner.[93]

6 2 The UK

The person lawfully in possession of the unclaimed body must make such reasonable enquiry as may be practicable to ascertain that neither the deceased nor any relatives object to the removal.[94]

6 3 South Africa

Unless the body is buried, or claimed for burial by the spouse or any relative or *bona fide* friend of the deceased within 24 hours after the death of that person,[95] the body of a destitute person will be at the disposal of the inspector of anatomy in whose area the body is.[96] The person in charge of an institution or any other person in whose care such a body is, may not hand it over to any person other than a spouse, relative or friend who is known to him, unless the person requesting it produces to him an order of a magistrate authorising the handing over of the body to that person.[97]

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89 1961, s 1(2); World Health Organisation *Legislative responses to organ transplantation* (1994) 373.
90 S 2(1)(a) and (b) of the Human Tissue Act 65 of 1983.
91 S 2(2).
92 *Ibid.*
93 Price 100 127–128.
94 Human Tissue Act of 1961; Skegg "Human tissue Act 1961" 1976 *Medicine, Science and the Law* 193 197; Price 101.
95 S 10(1).
96 Subject to the provisions of ss 2 and 8 of the Human Tissue Act 65 of 1983.
97 S 10(2).

If a body has not been buried, or claimed for burial by a spouse, relative or friend, within 24 hours after the death of the deceased, the person in charge of the institution or any other person in whose care the body is must forthwith direct a notice to that effect to the particular inspector of anatomy.[98]

An inspector of anatomy may by written order direct that the body be handed over to a specific institution situated within the area.[99] He or she may not issue such an order if he or she suspects on reasonable grounds that the deceased at the time of his death was suffering from a disease specified by the Director-General.[100] A body handed over to an institution may be used by the institution concerned for medical or dental training, research, the advancement of medicine or dentistry, or therapy, including the use of tissue concerned in any living person or for the production of a therapeutic, diagnostic or prophylactic substance[101] or for the supply, in its discretion, of any specific tissue to any other institution or any medical practitioner or dentist.[102]

The person in charge of an institution to which a body has been handed over,[103] must keep and preserve that body for a period of at least 14 days before it may be used. However, if the said person deems it advisable, any tissue of such a body may be removed and preserved separately.[104]

7 CONSENT OF A MINOR

7 1 General

Another important question to consider is whether a minor should decide for him- or herself whether to consent to an organ transplant operation, or whether his or her parents should consent on his or her behalf.

According to the World Health Organisation[105] no organ may be removed from the body of a living minor for the purpose of transplantation, but other regenerative body materials may be donated. A few jurisdictions have adopted this statement.[106]

In many countries a competent minor may refuse consent to a transplant procedure provided that he or she is able to understand the nature of the decision, the anticipated benefits of the transplantation and the implications of refusal.

7 2 The USA

In Florida, Benny Angrelo, aged fifteen years, refused a third liver transplant and decided to take no further anti-rejection medication. The Florida courts respected his decision in view of his capability to make such a decision for himself, and he died the next year. However, capacity will be judged against the intended procedure.

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98 S 11(1).
99 S 12(1).
100 S 12(2)(a).
101 S 4(1)(a).
102 Ss 4(1)(c) and 12(3).
103 In terms of an order under s 12(1).
104 S 13(1).
105 *Guiding principle* 5.
106 Eg Germany (Act of 1997-11-05, s 8(1)) and the Russian Federation (Law of 1992-12-22, s 3).

It has been stated in a host of cases that living donation of organs by minors must be subject to prior court approval.[107] In *Re Minister of Social Services and P*[108] the parents refused to consent to the liver transplant of their one year old child, and the child was due to die without the transplant. The court deferred to the wishes of the parents and found that the parents had properly considered wider issues than the purely medical ones, for instance the reduced quality of life caused by the perpetual drugs the child had to take.

According to Price[109] this is a case with great resonance as the liver transplant procedure has a good success rate and there are limited long-term implications surgically, and the parents' caring is limited in time. It was a balancing of quality- and quantity-of-life issues, with the views of the parents bearing heavily upon the quality-of-life, which won.

7 3 The UK

In *Gillick v West Norfolk and Wisbech Area Health Authority*[110] the court held that a minor is competent to give consent to the particular intervention at hand when he or she achieves a significant understanding and intelligence to enable him or her to understand fully what is proposed.

The donation of an organ is more serious than the donation of blood or most other tissues. In *Re W*[111] the court felt that a minor could be a competent blood donor, but doubted whether he or she could ever be competent to be a living organ donor.

The Nuffield Council Working Party Report[112] stated that as far as xenotransplantation is concerned, a higher level of maturity than normal is required, and recommended that parental consent be obtained before such a procedure is carried out on a minor.

In *Re M (Child: Refusal of Medical Treatment)*[113] a fifteen year old girl suffered sudden heart failure and could not survive without a heart transplant. She refused to consent, against her parents' wishes, as she would feel different with someone else's heart. She understood that she would die without the transplant, but persisted and also said that she would not like to take drugs for the rest of her life. The High Court ordered the transplantation to proceed, as all the implicated risks had to be weighed against the certainty of death, and the transplant was found to be in her best interest. Of importance was the suddenness of the crisis and the lack of time for the minor to come to terms with the implications of the treatment. The court did not decide whether she lacked the capacity to consent. Where a minor lacks capacity to consent, the parents must decide, subject to a decision by the courts that their decision is not in the best interest of the child.

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107 Eg *Hart v Brown* (1972) 289 A 2d 386; see also Garwood-Gowers 135.
108 (1990) 69 DLR (3d) 134.
109 442.
110 (1985) 3 All ER 402, referred to as the Gillick test; Garwood-Gowers 125.
111 [1992] 3 WLR 758 767F.
112 Nuffield Council on Bioethics *Animal-to-human transplants: The ethics of xenotransplantation* (1996) para 7.24.
113 [1999] 2 FCR 577 (Fam Div).

In *Re T (A Minor) (Wardship: Medical Treatment)*[114] a child was born with a life-threatening liver defect requiring a liver transplant. The parents refused consent fearing the quality of his life afterwards. Medical experts assessed the liver transplant as having a good chance of success. The High Court decided that the transplant would be in his best interests and that the decision of the mother to refuse to consent was not the decision of a reasonable parent. On appeal the court reversed the decision and held that it was not the question whether the decision was that of a reasonable parent that dictated, but what the welfare of the child was. In this case the welfare of the child was intertwined with the predicament and attitude of the mother, who would have to care for him through the surgery and for many years afterwards. Her views were extremely important and it was an error in law for the trial court to have ignored them. The court held that it was not in the best interest of the child to give consent to the transplant.

7 4 South Africa

The person giving consent must be capable of volition.[115] He or she must mentally be developed enough to realise the implications of his or her actions.[116]

The removal of tissue, blood and gametes may be effected only with the consent of the parents or guardian of a minor.[117] The consent must be in writing, except in the case of blood or tissue replaceable by natural processes, where oral consent will suffice.[118] In the case of minors of 14 years or older, who are mentally competent, no parental consent is required before replaceable tissue and blood may be removed.[119]

8 DEFECTIVE ORGAN TISSUE

8 1 General

Even though informed consent was given, an organ recipient may sometimes receive diseased or malignant tissue from a donor presenting a risk to him or her. Successful litigation may follow in terms of fault liability, the tort of negligence, delict, breach of contract or strict liability under products liability.

8 2 The USA

In *Ravenis v Detroit General Hospital*[120] two patients received a cornea from the same donor and both lost an eye due to infection. The court held the hospital liable in malpractice for failure to test and select the donor properly.

Strict liability may also follow out of the law of products liability, or through the principles of commercial law, where a defective organ was transplanted. In *Carter v Inter-Faith Hospital of Queens*[121] blood has been held to be "goods". As far as private medical treatment is concerned, where the supplier acts in the

114 [1997] 1 All ER 906 (CA).
115 Neethling, Potgieter and Visser 100.
116 *R v Taylor* 1927 CPD 16; *R v Sagae* 1932 NPD 236.
117 S 18.
118 *Ibid.*
119 *Ibid*, read with s 1(v).
120 (1975) 234 NW 2d 411; see also Anderson and Copeland "legal intricasies of organ transplantation: Regulations and liability" 1994 *J Missouri Bar* 143.
121 (1969) 304 NYS 2d 97.

course of business, it is likely that the contract would be regarded as one for "services" rather than a contract for sale of "goods". In *Perlmutter v Beth David Hospital*[122] even though blood was given, the court regarded the transaction as a supply of "services".

8 3 The UK

In *Sumners v Mid-Downs Health Authority*[123] a cancerous kidney was transplanted into a patient who subsequently developed cancer from the kidney. This kidney was removed and the patient received a second kidney and survived. The high court rejected the action for negligence in failing to detect the cancer. The hospital, however, admitted liability for failing to inform the recipient and to remove the kidney immediately as soon as they were informed that the donor had cancer.

Strict liability may also follow out of the law of products liability, or through the principles of commercial law, where a defective organ was transplanted. Products liability regimes are operative under the European Products Liability Directive.[124] The Consumer Protection Act[125] creates strict liability in respect of defective products, leaving open the question whether defective transplanted organs or tissues constitute "products". The Nuffield Council Working Party Report[126] was of the opinion that contaminated blood or a defective transplanted organ are likely to be regarded as defective products regardless of the information given to patients. The Royal Commission on Civil Liability and Compensation for Personal Injury[127] made the same recommendations.

Price[128] is of the opinion that in the UK blood or body products should be "goods" within the meaning of the Sale of Goods Act[129] whenever they are dealt with commercially. The same terms would be implied by statute into a contract for the supply of services where goods are supplied therewith.[130] There is a need for quality control as far as this aspect is concerned for the protection of the recipient and society in general, especially in the context of xenotransplants where the nature and the extent of the risk is largely unknown. However, animal organs are in any event undoubtedly regarded as "products" or "goods" in law.

8 4 South Africa

Should a defective organ or tissue be transplanted, an action in delict would be appropriate. The claimant would have to prove the negligence of the medical doctor to ensure that the organ or tissue was not defective before it was transplanted. A person is negligent if the reasonable person would have acted differently, and he or she would have acted differently if the unlawful causing of damage was reasonably foreseeable and preventable.[131] In *Kruger v Coetzee*[132] the court formulated the test as follows:

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122 (1954) 123 NE 2d 792.
123 (1996) (unrep) as referred to by Price 425.
124 1985.
125 1987.
126 *Human tissue* para 12.57 as referred to by Price 426.
127 (1978) Cmnd 7054-1 (the Pearson Report) as referred to by Price 426.
128 426.
129 1979.
130 Ito the Supply of Goods and Services Act of 1982.
131 Neethling, Potgieter and Visser 100; Van der Walt and Midgley *Delict: Principles and cases* (1997) 133; Snyman *Criminal law* (1995) 199.
132 1966 2 SA 428 (A) 430.

For the purpose of liability, *culpa* arises if: a *diligens paterfamilias* in the position of the defendant:

- would foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss; and
- would take reasonable steps to guard against such occurrence; and

the defendant failed to take such steps.

If the wrongdoer, in this case the medical doctor, possesses proficiency or expertise in regard to the allegedly negligent conduct, it affects the application of the reasonable man test. In such a case the test is that of the so-called reasonable expert, namely the reasonable medical doctor.[133] The medical doctor is negligent if the reasonable medical doctor in his or her position would have acted differently, and he or she would have acted differently if the unlawful causing of damage was reasonably foreseeable and preventable. The same expertise cannot be expected from a general practitioner as from a specialist.[134] It normally is a specialist carrying out the organ transplantation, therefore the medical specialist will be negligent if he or she did not ensure that the transplantable organ is free of disease as the reasonable medical specialist in his or her place would have ensured that (unless it was indeterminable) and would have prevented the organ from being transplanted.

In some instances the hospital is responsible for the testing of the applicable organ, and an action in delict would then rather lie against the hospital.

9 EXPERIMENTAL FIELD

9 1 General

If an experimental field is entered into, the patient's informed consent must be obtained. The courts must scrutinise the existing scientific basis for the belief in the potential efficacy of the proposed treatment. If a medical doctor departs from the accepted methods of treatment, the degree of departure from normal practice enhances the precautions necessary to satisfy the standard of care. The standard itself does not change. Stricter requirements of information disclosure is required by law and ethics with regard to experimental therapeutic procedures, contrasted with therapy *simpliciter*, due to the higher degree of risk involved.

9 2 The USA

In the USA, stricter requirements of information disclosure are required by law and ethics with regard to experimental therapeutic procedures, contrasted with therapy *simpliciter*, due to the higher degree of risk involved.

It might constitute negligence to offer a xenotransplant before scientific research had reached a certain stage. In *Karp v Cooley*[135] the court dismissed the claim of the patient that there was an insufficient base of research on animals to justify moving to the first mechanical heart devices, and relied on a vaguely worded and signed consent form and applied standard malpractice evidentiary

133 Neethling, Potgieter and Visser 135; Van der Walt and Midgley 158–159.
134 *Van Wyk v Lewis* 1924 AD 438 444.
135 (1974) 493 F2d 408.

standards. Price[136] is of the opinion that the court was unduly lax and lenient by not examining the limited animal research pre-dating the transplant in the absence of any peer review of the protocol, and did not give proper weight to the experimental nature of the procedure. It seems that a medical doctor will be justified in taking greater risks in an attempt to provide some effective treatment where the patient's condition is very serious, and the standard treatment is ineffective.

9 3 The UK

The Advisory Group Report on the Ethics of Xenotransplantation[137] accepted the existing legal framework surrounding consent, and considered that specific information should always be given regarding *inter alia* the source of the tissue; the breeding, genetic modification and raising of animals; the degree of suffering to which the animals would be exposed; the nature of the tissue to be transplanted; the fact that the donor source presents greater risks than the norm and the potential psychological and social effects that xenotransplantation could have, considering specific information that people might react in a hostile or uncertain way to a xenotransplant recipient.

There is a paucity of judicial guidance that if the court placed the emphasis on the therapeutic nature of the procedure, the fact that it was also experimental might be regarded as collateral to the therapy to which consent had been obtained in broad terms. In *R v Mental Health Commissioner ex parte X*[138] the court stated that the applicant should have realised that the use on him was novel and the full implications with use on young men had not been studied, since trials had only involved older men and animals. In *Newbury v Bath District Health Authority*[139] the court held that there were certain circumstances under which a patient would be entitled to be told that a certain operation was not the normal treatment, and this would be so where the treatment involved was either entirely new, or relatively untried.

The question arises whether a cause of action for non-disclosure at common law would sound in battery or negligence. Where the patient did not know in broad terms the nature of the procedure, with regard to transplantation as a therapy *simpliciter*, an action for battery would lie. The failure to inform the recipient sufficiently of alternative treatments and the risks and consequences involved with the transplant could lead to a civil action for negligence. It is unsure whether, where a recipient does not know the source or origin of the organ or where the organ presents an above-average risk to him or her, he or she could be said to know the "nature" of the procedure. A potential action in negligence/malpractice would follow where the patient knows, but might be unaware of some of the implications (risks) relating to the transplant and the alternatives.

9 4 South Africa

In South Africa, stricter requirements of information disclosure with regard to experimental therapeutic procedures is required in terms of common law, due to the higher degree of risk involved.

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136 429.
137 *Animal tissue into humans* 114.
138 (1988) 9 *BMLR* 77 (QB).
139 (1999) 47 *BMLR* 138 (QB) 150.

10 CONCLUSION

Medical doctors that operate on their patients normally enjoy protection against claims of assault due to the consent given by the patient. However, for valid consent in the USA, the UK and South Africa, the consenting patient must have full knowledge of the extent of the prejudice and must fully realise or appreciate what the nature and the extent of the harm will be and the consent must be given freely and voluntarily. For informed consent, the person must receive appropriate information as to the purpose, nature, consequences and risks of the intervention. Since research experiments are inherently dangerous, disclosure to the patient must be "perfect" or "fuller than full". Essential information regarding the consequences should also include potential complications and implications connected to the donor source. Donors must also be informed of the right to have access to independent advice about risks by a health professional having appropriate experience, and who is not involved in the organ or tissue removal or subsequent transplant procedures.

In the USA, a medical doctor that performs an operation without the patient's voluntary and informed consent, commits a criminal assault as well as battery in tort. The requirements of information disclosure vary from state to state. Either a reasonable doctor standard, which frequently gives great sway to bodies of professional medical opinion, or 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 as to 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 the UK, the consent of the donor and the procedure can only be 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, consent must be explicit and all the relevant information be provided. The recipient must be given at least such information as fulfils the standard of disclosure of risks required by the relevant legal system. In South Africa, a reasonable patient test is applied, whereby the doctor's duty to inform the patient is to be established with reference to the needs and expectations of the particular patient rather than the insights of the medical profession. This obligation is subject to the therapeutic privilege, namely that 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. 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.

As far as voluntary consent is concerned, in the USA, the UK and South Africa the consent of the patient must be given freely and voluntary.

In the USA a hybrid quasi-presumed consent system for organ transplantation is found. A member of a specified class of person, in the order of priority stipulated, may make an anatomical gift of all or part of the deceased person's body unless the deceased person at the time of death has made an unrevoked refusal to make that anatomical gift.

In the UK and in South Africa, a weak express consent system is prevalent as organ removal may be authorised if the deceased had requested to donate prior to death or if, having made such reasonable enquiry as may be practicable, the person concerned has no reason to believe that the deceased had expressed an objection or that any surviving spouse or relative objects thereto.

Authorisation is allowed in the USA, the UK and South Africa for the use of unclaimed bodies applicable to corneal tissue and for further use only to corpses in the custody of the coroner where the relatives of the deceased could not be found.

In the USA, a minor may decide for him- or herself whether to consent to a transplant operation, but living donation of organs by minors must be subject to prior court approval. The minor must be capable of making such a decision for him- or herself. Capacity will be judged against the intended procedure. In the UK, a minor is competent to give consent to the particular intervention at hand when he or she achieves a significant understanding and intelligence to enable him or her to understand fully what is proposed. Where he or she lacks capacity to consent, the parents must decide, subject to a decision by the courts that their decision is not in the best interest of the child. Donation of an organ is more serious than donation of blood or most other tissues. As far as xenotransplantation is concerned, a higher level of maturity than normal is required, and parental consent must be obtained before such a procedure is carried out on a minor. In South Africa, the person giving consent must, as in the USA and the UK, be capable of volition. He or she must have reached a sufficient level of mental development to realise the implications of his or her actions. However, the removal of tissue, blood and gametes may be effected only with the consent of the parents or guardian of a minor, and must be in writing, except in the case of blood or tissue replaceable by natural processes, where oral consent will suffice. In the case of minors of 14 years or older, who are mentally competent, no parental consent is required before replaceable tissue and blood may be removed.

An organ recipient may sometimes receive diseased or malignant tissue from a donor presenting a risk to him or her. In the USA, a hospital was held liable in malpractice for failure to test and select the donor properly. Strict liability may also follow out of the law of products liability or through the principles of commercial law where a defective organ was transplanted. In the UK, an action for negligence in failing to detect the cancer was rejected by a court. The hospital, however, admitted liability for failing to inform the recipient and to remove the kidney immediately as soon as they were informed that the donor had cancer. As in the USA, strict liability may also follow out of the law of products liability or through the principles of commercial law where a defective organ was transplanted. In South Africa, an action in delict would be appropriate against the medical specialist should a defective organ or tissue be transplanted, if the specialist could foresee the possibility of the defect in the organ and did nothing to prevent the transplant thereof. In many instances the hospital is responsible for the testing of the applicable organ, and an action in delict would then rather lie against the hospital, as in the UK and the USA.

If an experimental field is entered into, the patient's informed consent must be obtained. In the USA, stricter requirements of information disclosure are required by law and ethics with regard to experimental therapeutic procedures, contrasted with therapy *simpliciter*, due to the higher degree of risk involved. It might constitute negligence to offer a xenotransplant before scientific research

has reached a certain stage. In the UK there are certain circumstances under which a patient would be entitled to be told that a certain operation was not the normal treatment, namely where the treatment involved was either entirely new, or relatively untried. Where the patient did not know in broad terms the nature of the procedure with regard to transplantation as a therapy *simpliciter*, an action for battery would lie. The failure to inform the recipient sufficiently of alternative treatments, and the risks and consequences involved with the transplant, could lead to a civil action for negligence. A potential action in negligence/ malpractice would follow where the patient knows, but might be unaware, of some of the implications (risks) relating to the transplant and the alternatives. In South Africa, as in the USA and the UK, stricter requirements of information disclosure with regard to experimental therapeutic procedures are required, due to the higher degree of risk involved. The existing legal framework surrounding consent can be accepted in this field. It is suggested that specific information should always be given regarding *inter alia* the source of the tissue; the breeding, genetic modification and raising of animals; the degree of suffering to which the animals would be exposed; the nature of the tissue to be transplanted and the potential psychological and social effects that xenotransplantation could have, considering specific information that people might react in a hostile or uncertain way to a xenotransplant recipient. If the donor source presents greater risks than the norm, this should be conveyed to the recipient.

The Sexual offences Act was . . . enacted in the context of a system of law in which all who participate in a prohibited act are guilty of having participated in that act and liable to the same punishment as the principal offender . . . Thus, a man who pays for sex and the woman who receives the payment are equally guilty of criminal conduct and liable to the same penalties . . . And if there is any discrimination, such discrimination can hardly be said to be unfair. The Act pursues an important and legitimate constitutional purpose, namely to outlaw commercial sex. The only significant difference in the proscribed behaviour is that the prostitute sells sex and the patron buys it. Gender is not a differentiating factor. Indeed one of the effective ways of curbing prostitution is to strike at the supply. Two points of note here are . . .: first, the prohibition is gender neutral, it punishes both female and male prostitutes; and second, guilt and punishment are equal for both the prostitute and the customer. In the circumstances any "discrimination" resulting from the prostitute and the customer being dealt with under different provisions of the law cannot be said to be unfair.

Ngcobo J in Jordan v S 2002 11 BCLR 1117 (CC) *paras* 13–15.