

alteration of either the theory or technique of moral education, and no limitation of results to specific occupational or other non-cognitive characteristics of participants. The cognitive-developmental approach is suitable for anyone who is functioning at a stage below that maximally attainable given the individual's more general cognitive (Piagetian) and social perspective taking stage. Further, one might argue that MDs would do well to suspend their emotions and 'intuition' in dealing with medical ethical problems, given the arbitrary, inconsistent, and non-rational bases of these perspectives. In this light, training in the use of comprehensive logic, an encompassing social perspective, and a profound respect for the rights and dignity of the individual would seem to be highly desirable for medical students.

Conclusion

Gillon's final comment, that in medical ethical training we should concentrate on impartial analysis of a broad range of practical alternatives and encourage the student to 'develop his own informed but autonomous decisions', is not greatly disparate from our own position. Indeed, a major component of the Blatt and Kohlberg technique of moral education is to promote critical analysis of alternate solutions, leading to autonomous moral decisions. The cognitive-developmental approach assiduously avoids preaching specific solutions (the content of moral reasoning), focusing on the structure of reasoning employed in arriving at solutions. What this approach does that many others do not is to enhance the student's ability to deal with the moral principles involved in a medical-ethical dilemma as opposed to inculcating merely expedient, utilitarian, or conventionally popular solutions.

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Kidney transplants: a reply to Sells

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I read very carefully Robert Sells' reply to my paper on the supply of kidneys for transplantation. I readily concede that the attitude of the medical profession towards kidney transplantation is a factor in inhibiting the supply of kidneys, indeed I gave considerable weight to the point myself. I persist in the view, however, that there are other factors principle among which are the framework, wording and policy of the Human Tissue Act. Sells makes four points. The first is that the present supply of kidneys for transplantation is approximately one third of those required each year. This appears almost as an afterthought in the last sentence of the penultimate paragraph. I made it my starting point. It is, after all, the crucial issue. The second point Sells makes is that the Human Tissue Act is unimportant or 'non-problematical' in inhibiting the supply of organs. Third, Sells identifies as 'the single most important impediment' the reluctance of the medical profession to refer dead patients with functioning kidneys as donors. Finally, Sells states categorically at the outset that the supply of organs would not be significantly increased by changing the law to an opting out principle. The posture adopted by Sells is, in other words, that which I discussed under the heading of, retain the existing law with increased publicity and education, and dismissed as unlikely to produce significant improvement in the foreseeable future.

The lack of kidneys

May I comment briefly upon these points made by Sells? As regards the first, the lack of kidneys, I took and take the view that we ought to be giving prominence to this fact and asking why it comes to pass. This is particularly so in light of the fact that it is now nineteen years since Parliament passed the law, the express purpose of which was to facilitate transplantation surgery and that kidney transplants have been an available form of therapy for some thirteen or so years. By relegating this

unseemly fact to the very end of his paper and devoting all the rest to a description of transplantation in general and his particular experience in Merseyside an impression is created which is in my view unfortunate and possibly misleading: keep the present structure and let us pioneers carry on educating our fellow doctors and things will change. But the progress has been from 200 transplants in 1969 to 700 in 1977. Accepting Sells' estimate that this 700 is one third of the required number and noticing an increase of 500 in 8 years, it will be one if not two decades before enough kidneys become available even if the situation improves considerably. A lot of people will have died unnecessarily in that period for want of a kidney.

The Human Tissue Act

In seeking the reason for this state of affairs, Sells makes his second point, the Human Tissue Act is not important. He accepts that legal fuddy-duddies like me may be put out by the fact that the 'equivocal language is infuriating', but dismisses the problems involved in interpreting the law. The transplant surgeon bases his interpretation of the law 'on the basis of common sense as well as legal accuracy', and so saying the problems vanish. Leaving aside for a moment the finer implications of this approach, let me take this point further. In dismissing the significance of the Human Tissue Act in affecting the supply of kidneys Sells asserts that the onus is on me to prove that it is significant. He then argues that in proving its significance I must prove two things: that kidneys have not been donated because relatives could not be brought to the hospital in time, or, if contacted, a significant number of them objected to the removal of kidneys. Well, I admit that if I am making a case I must offer proof, but I cannot see why I should be tied to these two particulars. I will not repeat the points I made before. My position can be stated shortly and without detail as follows. The Human Tissue Act was passed in 1961 to facilitate transplantation surgery. Transplantation of kidneys became an accepted practice in about 1966. After thirteen years still only one third of the required number of kidneys is available. The law is an instrument (though not the only one) to reflect social views and effect change. The legal instrument represented by the Human Tissue Act has clearly failed to achieve its stated objective. The law was posited, *inter alia*, on the education of doctors and their response. If the response has been inadequate how long is the society prepared to wait and tolerate an inadequate legal machinery while doctors slowly incorporate into their consciousness and into their practice the expressed views of society and Parliament? Is it not legitimate and appropriate to devise an alternative mechanism more suited to achieving the desired goal? In addition to this general argument,

I would take issue with Sells in his distinction between two factors or forces, the Human Tissue Act and the reluctance of doctors. The latter is to blame, the former unimportant. But can such an easy distinction be made? The Human Tissue Act is more than a set of words it is a framework, it sets the context, not only legally but socially and ethically in which transplantation is performed and considered and regarded. Could it not be that the reluctance of doctors Sells identifies is a product of the environment created by the framework as well as the particular wording of the Human Tissue Act? It seems to be that this is very probably the case. I would go so far to say that if Sells wishes to discount the importance of the Human Tissue Act, the onus is on him to show that the lack of response from doctors is entirely unrelated to the Act, not only its particular words but also the climate it creates. If it is the case, as I argued, that doctors looking after patients who may be potential donors simply do not want to be involved in the consultations and confrontations required by the Act, then their reluctance is directly related to, not independent of the Act. One passage in Sells' paper hints at this when he describes his practice at Liverpool. A member of the transplant team interviews the relatives of the donor, rather than have the donor's doctor do so, since, 'It seems that when the donor's doctors interview the relatives, the refusal rate may be higher'. If the donor's doctor is a less successful advocate of transplantation when he becomes involved, it seems just as likely, if not more so, that he prefers not to embark on the exercise at all and simply refrains from calling the transplantation team.

'Opting out'

Given this unsatisfactory state of affairs, I argued that the legal framework be changed to allow for a system of opting out. Sells not only opposes this but says it would be irrelevant. Taking the opposition first, what reasons does Sells give? In my paper I asked what was the basis for the opposition to changing the law, as I could find none except an unpersuasive reference to safeguarding freedom and a perceived but undocumented public opposition. The first reason Sells offers is, 'the medical evidence he presents earlier, but it is not clear at all how this can serve as a reason for not changing the law, particularly in view of the two thirds shortfall of kidneys. The second reason offered is a, 'well publicised objection (in other spheres)' to contracting out. This is no better than the undocumented public opposition mentioned above. No source is cited. It just will not do. To oppose change when legislation is failing and people are dying unnecessarily, without a jot of evidence is to substitute prejudice for policy. Indeed, as pointed out, the view that was taken by the British

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Transplantation Society in its Report in 1975 was that what evidence there was suggested the mass of the public did not share the misgivings attributed to them. Turning now to Sells' assertion that in any event the supply of kidneys "would not be significantly increased by changing the law to an 'opting out' principle", again no evidence in support is offered. Sells' argument must be that the reluctance of doctors is the key, this is independent of the legal framework and so any change in that framework is irrelevant. I take issue with this on three grounds. First, I have suggested that the response of doctors cannot be divorced from the framework and consequent environment created by the 1961 Act. Thus, if this framework is changed it could well be, and in my view would be, the case that doctors would change their attitude also. Second, a change in the law to introduce contracting out would remove the other problems I mentioned in my paper which bedevil the existing practice of transplantation. Third, it is self-evident that a system of contracting out would at least potentially increase dramatically the number of kidneys available for transplantation. There would still, of course, be the problem of the medical team in charge of the dying or dead donor communicating with the transplantation team. To meet Sells' argument (while not accepting it) that the donor's doctors would still be reluctant, it is not beyond the wit of man to devise an administrative scheme whereby this communication could be established routinely as a matter of course. A provision calling for the routine notification of the hospital administration of all cases falling into certain categories (based on suitability for transplantation) could be laid down. The administrator could then be empowered to set in motion the necessary inquiry concerning contracting out and establish communication with the local transplant team. This team would thereafter take the initiative concerning all future steps.

Some general comments

May I finally, in what is already too long a reply, make two points of a general nature. First, the major part of Sells' article draws on his experience at Merseyside which is one of considerable success. It should not for a moment distract us from the central point that all is not well when hundreds who could benefit from a kidney transplant each year must be left to die or at best to hope for dialysis, and I choose my words with no desire for hyperbole or drama but as an accurate reflection of reality. Second, Sells plays down the difficulties intrinsic in the existing law by saying in effect that they are not real. This I think is quite misleading. The several distinguished Committees set up to consider the needs to reform the law, the considerable volume of literature, written by doctors as well as others, not to mention the numerous Bills intro-

duced into Parliament suggest otherwise. Sells surmounts the obstacles in the existing law by adopting a particular interpretation of the various provisions and then regarding this interpretation as the definitive one. Others have not been so easily persuaded. For example, Sells refers to attempts made to identify *the* (my emphasis) relatives but does not offer any help in determining which relatives are to be included in this process, bearing in mind that the Act speaks of, 'any surviving relative'. He dismisses problems related to the meaning of the phrase, 'such reasonable inquiry as may be practicable', by arguing that, 'the doctor knows . . . it would not be practicable to conduct inquiries for, say, one month . . .; such delay would be incompatible with the maintenance of healthy organs for transplantation'. Of course it would. But, such an interpretation is of course one-sided, addressing itself only to the needs of the person waiting for the kidney. The Act was concerned also to allow certain people the right to object and it is not clear that the law is respected if their views are interpreted away, not in the unlikely case of a month's inquiry but perhaps in the decision that a couple of days, a day or even half a day is too long to be practicable. Practicable becomes practical but they are not the same.

In the light of the foregoing I repeat my call for the introduction of contracting out. The consultation document promised the Department of Health for the Autumn of 1978 never materialised. Things go on as before. Too many still die unnecessarily from untreated renal failure.

Postscript

Today, December 21, 1979, I received a copy of the Code of Practice on The Removal of Cadaveric Organs for Transplantation drawn up by the Government Working Party. Detailed comment must await another occasion. Perhaps the following points are in order.

- 1) The opening sentence refers to the continuing lack of kidneys.
- 2) One of the reasons offered is uncertainty about the procedures leading to transplantation. Such procedures include those laid down by the Human Tissue Act.
- 3) That such a Code offering, *inter alia*, a detailed explanation of the Human Tissue Act was thought necessary contradicts Sells' view that the provisions of the Act are non-problematical.
- 4) On a point of detail, the section on 'Approach to Relatives' repeats the 'liberal' interpretation of S1 (2) favoured by the DHSS Guidance Circular and Sells. This is not surprising. Of the nineteen members of the Working Party, fifteen are doctors and two are nurses. (It is not clear that this composition equipped it to speak with equal authority

on matters of law, ethics and morality as well as medicine). As I suggest, however, this interpretation is only one view. The law as written seems to be less dismissive of the interests of those given the power of veto.

5) Nothing would please me more than to see the Code of Practice bring about an increased supply of kidneys. Unfortunately, I regard it as an inadequate response to a problem which can only be solved by a more radical approach.