Letterhead of HONG KONG COLLEGE OF PHYSICIANS
香港內科醫學院的信頭
(Incorporated in Hong Kong with limited liability)

30 December 1998

Chairman
Subcommittee on Human Organ Transplant Ordinance
Legislative Council
Legislative Council Building
8 Jackson Road
Central
Hong Kong
(Attention: Ms Doris Chan)

Dear Ms Chan,

Re: Human Organ Transplant Ordinance

Thank you for your letter on the captioned subject. I would like to present the views of our College for your reference.

(1) The Ordinance is for prohibiting organ trade. This is of vital importance as anomaly in one case will have a profound and long-lasting impact on the success of voluntary organ donation programme in the community.

(2) On the other hand, the Ordinance should not be perceived to hinder attempts to save life. Many a time, potential recipients, particularly those of liver allografts, are very ill or in coma. It will not be possible to interview them before the operation. Section 5 subsection (5), the requirement that “the donor and the recipient have each been interviewed separately by a person whom the Board considers to be suitably qualified to conduct such an interview and the person has reported to the Board on the donor's and recipient's understanding of the matters...” needs modification.

(3) It is difficult to disprove organ trade and the practical solution is to ask the donor and the recipient or his/her representative to sign an affidavit before the operation.

(4) The consideration to perform a transplant operation is a clinical one and should be raised by two experienced professionals not involved directly in the transplantat operation. At least one of these professionals should be in-charge of the care of the patients and know the details about the clinical information. The need for an operation should be suggested by them to the potential recipient or, if he/she is unconscious, his/her next-of-kin and a decision on operation will be made after careful deliberation. The next-of-kin and their ranking should be defined clearly by law.

(5) In general, consent from recipient is necessary.

(a) Morally, the recipient, after successful transplantation, may feel that he or she owes his or her life to the donor. This may not be the recipient's wish, and it is possible that the recipient may suffer from such “moral obligation” for the rest of his or her life.

(b) The recipient may not wish to subject the living donor to the risk of morbidity nad mortality related to surgery. It is possible that after regaining consciousness, the recipient may sue the Board or hospital for the (I) morbidity/ mortality of the donor and (ii) for the life-long moral obligations to the donor inflicted on him by the successful surgery.

(6) The donor, recipient or his/her next-of-kin, and other relevant parties can be interviewed by members of the Human Organ Transplant Board if the Board considers such processes can help clarify the situation. But this must be done promptly so as to expedite the transplant operation if the clinical need so demands. The Board may have to rely on the affidavit mentioned in (1) for excluding the involvement of organ trade.

(7) The Committee noticed the difficulties in the application of the Ordinance were related to characteristics unique in living nonrelated liver transplantation. These features are summarized as follows:

(a) Liver transplantation from a living donor carries substantial risk. It is very

difficult for members of the Human Organ Transplant Board, many of whom are laypersons, to decide on whether the operation should go ahead, especially when donor is not closely related to the recipient.

(b) It is not easy to decide in advance whether a patient with liver disease should undergo liver transplantation. Some patients with fairly marked degree of liver dysfunction are able to recover completely.

(c) Asking all 'potential' liver recipients to sign a consent form expressing their willingness to receive a graft before they deteriorate will be impractical. It is even more difficult if their consent are to direct towards designated donors.

(d) When their liver conditions deterioate, the patients will suffer from impairment of sensorium. This will hamper their judgment and invalidate their decision.

(e) The condition is often so critical that patients' relatives or other parties concerned are compelled to make decisions after short notification. Such decisions may not be the best ones and relatives may regret subsequently.
It is even more difficult to ask members of the Human Organ Transplant Board to decide. It is doubtful any objective criteria would be available for facilitating them to make decisions.

(f) Circumstances surrounding living nonrelated kidney transplantation and living nonrelated liver transplantation are very dissimilar. In the former case, patients can be supported by dialysis, patients' relatives can have ample time to calm down to think carefully, the Human Organ Transplant Board can have ample time to investigate whether organ trade is indeed involved, medical personnel can have ample time to be certain whether the donor is fit to donate and whether he/she is the best one to do so. In the latter case, time constraint itself puts pressure on parties concerned and this is against the principle that donors should be free from any form of coercion before taking part in an organ transplantation.

(g) The risks of living nonrelated liver transplantation to the donor are substantial and can only be justified if the donor derives much psychological gains from such altruistic act. This takes place only if the donor and recipient are very strongly

emotionally linked. In prinicple, any other form of living nonrelated liver transplantation should not be supported.

Yours sincerely,

Dr CS Li
Chairman, Professional & General Affairs Committee
Hong Kong College of Physicians

cc: Dr. Richard Yu, President, Hong Kong College of Physicians
Dr. Loretta Yam, Hon Secretary, Hong Kong College of Physicians