Directed Donation and Ownership of Human Organs

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This article explores the issue of donation of organs from deceased donors for transplantation into a specified recipient. It argues that proper account should be taken of the principles underlying the Human Tissue Act 2004, which grant the donor a form of proprietary control. Three hypothetical scenarios are then used to draw out the implications of these principles for existing regulatory policy and the common law response to excised human organs. The article concludes that the law should be understood as recognising ownership in organs removed from living and deceased persons and as offering opposition to the prohibition of directed donation that can only be coherently removed by reform of the 2004 Act.

1. Introduction

In England, Wales and Northern Ireland, 'appropriate consent' is required by the Human Tissue Act 2004 for the removal, storage and use of organs from deceased donors for the treatment of others.[1] This legislation is silent on whether or not donation may be 'conditional' upon the recipient being in (or not being in) a specified group. Conditional donation had, however, been addressed in an earlier report issued by the Department of Health in 2000.[2] That report had been issued in response to an incident occurring in 1998 in which the relatives of a deceased man had agreed to organ donation on the condition that the organs went to white recipients. His liver and kidneys had been accepted and transplanted into three white people. The 2000 report rejected not only racist conditions, but all conditions on that basis that 'to attach any condition to a donation is unacceptable, because it offends against the fundamental principle that organs are donated altruistically and should go to patients in the greatest need'.[3] The breadth of that conclusion also seemed to rule out donation being 'directed' to a specified individual. Thus, the UK has operated for over a decade according to a regulatory policy that stands in stark contrast to that adopted across the US States, all of which explicitly permit directed deceased donation.[4]

The policy adopted following the 2000 report was relied on in 2008 to deny Rachel Leake a transplant using a kidney from her deceased 21-year-old daughter, Laura Ashworth.[5] Laura was on the NHS Organ Donor Register as a prospective deceased donor and had told her friends and family that she was willing to be a living donor for her mother, but had not begun the formal process before her death.[6] Since Laura's family were prevented from directing that one of her kidneys be given to her mother, who was suffering from kidney failure, Laura's

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1 ss. 1 and 5. In Scotland, the Human Tissue (Scotland) Act 2006 requires 'authorisation', rather than 'appropriate consent'.

2 See DH (Department of Health), An Investigation into Conditional Organ Donation: The Report of the Panel. (HMSO, London 2000).

3 ibid [6.1].

4 See D Price, Human Tissue in Transplantation and Research: A Model Legal and Ethical Donation Framework (CUP, Cambridge 2009), 276 and s.11(a) of the Uniform Anatomical Gift Act 2006.

5 See HTA (Human Tissue Authority), 'HTA Statement on Directed Donation of Organs After Death' (14 April 2008).

6 See BBC, 'Mother Denied Daughter's Organs', http://news.bbc.co.uk/1/hi/england/bradford/7344205.stm (12 April 2008).

kidneys were given to others on the national waiting list. This evoked public concern leading to the adoption of a new policy in March 2010.[7]

The 2010 guidance accepts that an organ may be allocated to a specified individual in some instances, but it does this by maintaining opposition to directed allocation of organs from deceased persons and supporting 'requested allocation'.[8] Organs from deceased persons are to continue to go unused if the donor or their relatives insist that they go to a specified individual only. Allocating to a specified individual is, nonetheless, now expressly countenanced in 'exceptional circumstances' where consent has been given *unconditionally* and the individual specified as a preferred recipient is a relative or friend of long standing with a recognised clinical need for the organ.[9] In such circumstances, a request will be considered but priority is to continue to be given to those patients in urgent clinical need and therefore likely to die within a few days if they do not receive an organ. This is the policy now implemented by the UK body tasked with responsibility for organ allocation: NHS Blood and Transplant Organ Donation and Transplantation Directorate (NHSBT OTD).[10]

This article will argue that attempts to prohibit or stringently restrict directed donation are challenged by a proper understanding of the principles underlying the Human Tissue Act 2004 and those principles presuppose property in human organs. In particular, it will be argued that the 'rule-preclusionary conception of property',[11] should be recognised as providing coherent philosophical underpinnings for the principles of the 2004 Act and recent common law developments. Three hypothetical scenarios will be outlined to facilitate discussion of, first, the regulatory differences between living and deceased directed donation and the legal import of the 2010 guidance; secondly, the possibility of a private law remedy for negligent destruction of an organ removed for directed living donation; and thirdly, the issues raised by directed donation of a deceased person's organs to the decision-maker (self-directed donation) and directed donation where a mistake is made concerning the recipient (misdirected donation).

2. *The 2004 Act and its underlying principles*

Under the 2004 Act a person who removes, stores or uses 'relevant material'[12] from a deceased person for the purposes of transplantation commits a criminal offence unless that person reasonably believes that 'appropriate consent' has been obtained or that the activity is not one for which such consent is required.[13] 'Appropriate consent' is defined by reference to who may give it.[14] In the case of a deceased adult, such consent can be given or withheld by the deceased before their death, a nominated representative (if there is no prior decision), or a person who stood in a qualifying relationship to the deceased (if there is no prior decision or nominated representative).[15] The position of a deceased child is similar: consent may be

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7 See DH, Requested Allocation of Deceased Donor Organ (UK Health Administrations, London 2010).

8 See ibid esp [25].

9 See ibid [3].

10 See ibid [24].

11 Seminally advanced in D Beyleveld R Brownsword, Human Dignity in Bioethics and Biolaw (OUP, Oxford 2001), ch. 8.

12 Defined in s 53 as all material that 'consists of or includes human cells' with specified exclusions. Excluded from the definition are gametes and embryos, hair and nails from the body of a living person, and human material created outside of the body (such as cell lines): ss 53(2) and 54(7).

13 ss 1, 5, and Sch. 1(1), para 7.

14 ss 2 and 3

15 s 3(6). Qualifying relationships, ranked in order in s 27(4), are the individual's (a) spouse or partner, (b) parent or child, (c) brother or sister, (d) grandparent or grandchild, (e) niece or nephew, (f) stepfather or stepmother, (g) half-brother or half-sister, and (h) friend of long standing. Where there is more than one person *at the same level of the hierarchy*, the consent of one will be sufficient: s 27(7).

given by the deceased child before death, a person with parental responsibility, or by a person in a qualifying relationship.[16] The donor is therefore legally empowered to determine whether or not an organ is posthumously transplanted or, in the case of an adult, transfer that decision-making power to a person of their choosing. Only if they cannot or do not exercise this power before their death do the default rules come into effect, whereby it transfers to persons with specified relationships to the deceased.

In an *opt-in* system of organ acquisition of this type, the decision-making powers granted to donors do not yield to the competing claims of those in desperate need of life-sustaining organs. This contrasts with systems of *conscription* in which donors are not empowered to make decisions on the posthumous removal and transplantation of their organs; and their interests thereby automatically yield to the interests of those at the top of the waiting list. It also contrasts with *opt-out* systems in which the interests of donors require assertion (by opting-out) to override the claims of those in need. In opt-out systems, the interests of those in need are thereby treated as more important, unless donors or others empowered to opt-out feel strongly enough to object in the recognised way.

Any system granting decision-making powers to donors and their representatives—whether (as a matter of law or practice) opt-in or opt-out—potentially raises the spectre of directed donation. Within formal opt-in systems, where consent to deceased organ donation is a necessary legal condition, attempts to prohibit or restrict directed donation face a difficult justificatory burden.[17] As has just been pointed out, the central feature of a formal opt-in system like that of the 2004 Act (and the Human Tissue (Scotland) Act 2006) is that the claims of those with a therapeutic need for an organ are *always* subject to the will of the deceased or the deceased's representatives. A directed donation changes the position of the specified recipient in the sense of removing any opposition based on the rights or interests of the donor or representatives, *by virtue of their waiver*. Directed donation does not, however, bolster the claims of those others who could benefit from transplantation of the organ; their claims remain overridden and they are therefore not potential beneficiaries of the organ at the point of allocation.

The specific relationship between the donor and their organs is not explicitly articulated by either the 2004 Act or the background legal principles. How then are we to account for the legal protection granted to individuals to control the therapeutic use of their organs even after their death? It is tempting to account for the negative control given to the source of the organs in terms of donor ownership and there is growing academic support for such an approach.[18] English law has, however, been historically antagonistic to the idea of ownership of a body or its parts. It was a long asserted maxim that the common law recognises no property in a dead body or its parts, though this principle has its origins in early judicial decisions that have been misinterpreted or otherwise lack authority.[19] We shall see later that the courts are edging closer to acknowledging that the source has ownership interests in excised organs and tissues (see section 4, below).

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16 s 2(7).

17 One of the reviewers has pointed out that the Human Tissue (Scotland) Act 2006 contains a provision, s.49, which expressly permits conditions to be attached to the authorisation of removal and use of parts of the body of a deceased person, but that provision does not apply to authorisation for transplantation. Thus, the Scottish Act prohibits conditions being attached to donation for transplantation. The 2004 Act contains no such provision.

18 See e.g. R. Hardcastle, Law and the Human Body (Oxford: Hart Publishing, 2007) and Price (n 4) ch. 8.

19 See, in particular, the discussion of *Williams Haynes' case* (1614) 12 Co REP 113 (Lent Assise) and *Exelby v Handyside* (1749) 2 East PC 652 (CCP) in P Matthews, 'Whose Body? People as Property' (1983) CLP 193-239, 197–198 and 208–210, respectively. See also PDG Skegg, 'Medical Uses of Corpses and the "No Property" Rule' (1992) 32(4) Med Sci Law 311-318.

A definition of property will be offered here merely to specify the proposition that I am seeking to justify and apply: namely, that the features of the 2004 Act presuppose property in excised organs. It is therefore no objection to my thesis that others define property differently—a more restrictive definition is, for example, offered by Honoré who identifies 11 elements in his account of property.[20] Property rights and related terms are used here to refer to situations where the rights-holder—the owner—has a particular relationship with a specified object. That relationship is aptly captured by what Beyleveld and Brownsword have referred to in chapter 8 of their book *Human Dignity in Biolaw and Bioethics* as the 'rule-preclusionary' conception of property.[21] Under this conception, to claim that an individual owns some object is to recognise their *prima facie* right to legitimately use or exclude others from using that object on the basis that that individual stands in a particular relation to it.[22] That relationship is one that precludes having to provide a case-by-case justification every time that individual wishes to use the object or exclude others from using it. Accordingly, once it is shown that I have property in an object, the burden of proof is on those who wish to restrict my use of that object or use it themselves. This conception only permits others to use my property where they have my consent or a right that overrides my property right (because their right protects an interest that is more important than that justifying my proprietary claim in the first place).

Rights clearly cannot be exercised by dead persons, so any property rights have to be exercised prior to death or by others after death. The law recognises the continuance of some property rights in this way in the legal enforceability of wills and such continuing obligations are consistent with rule-preclusionary control. While death may weaken or remove the property rights of the deceased, death cannot, however, generate additional property rights for the deceased. Thus, my claim that the 2004 Act grants rule-preclusionary property to the source with continuing obligations after death would be refuted if it were the case that a living person did not have such rights over their organs while alive (which will be addressed in section 5, below).

What, then, distinguishes the claim that excised organs should not be used for the treatment of others without my consent *because* those organs are the source's property from the claim that those organs should not be used for this purpose *because* this would violate the right to freedom of religion or *any other right* not derived from or reducing to a rule-preclusionary property right? Beyleveld and Brownsword answer, by elaborating on the rule-preclusionary conception of property in response to a similarly phrased question of their own, that property is characterised *substantively* by a right to use or exclude others from using an object and that the *function* of a justification based on a property right is that it precludes the need to consider whether a more specific right justifies every instance of this control.[23] Thus, recognition of (rule-preclusionary) property in excised organs would imply exclusive use—subject to waiver or the overriding rights of others—without the need to show that every particular use invokes a specific right. We have seen that the 2004 Act grants a negative right to donors and their representatives, which amounts to negative exclusive control over the donor's organs, *and* that that control turns on nothing more than the donor's identity as the source of the organ in question. In other words, a tenet of the 2004 Act is that the relationship

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[20] See AM Honoré, 'Ownership' in AG Guest (ed), Oxford Essays in Jurisprudence (OUP, Oxford 1961), 107–147. Honoré's theory has recently been applied to the human body in M Quigley, 'Property and the body: Applying Honoré' (2007) 33 *JME* 631-634.

[21] See Beyleveld and Brownsword (n 11). Their definition is described as 'especially persuasive' in Price (n 4) 232.

[22] See ibid 172.

[23] Ibid, 177.

between the source and the organ is such that the source is to have exclusive negative control even when the particular use is one that the source has no subjective interest in.

A number of objections could be made to characterising the 2004 Act as recognising (rule-preclusionary) property in excised organs. For a start, the 2004 Act imposes regulatory restrictions beyond requiring consent; in particular, it explicitly prohibits *commercial dealings* in bodily material intended for transplantation. More specifically, it prohibits giving or receiving a reward for the supply, or offer to supply, any 'controlled material', unless the person in question has been permitted to lawfully engage in the activity by the Human Tissue Authority (HTA).[24] The rule-preclusionary conception of property does not, however, require the salability of all property. This follows from the fact that this conception does not recognise an absolute right to do anything one wishes with the object of one's property, rather it holds that one has a *prima facie* right to do what one wishes with that object (a positive property right) or a *prima facie* right to prevent others doing what they wish with that object (a negative property right), or both. Within the rule-preclusionary conception, recognition that I have property in this laptop in no way implies that I may use it as a weapon nor does recognition of property in a gun—or in this case an organ—imply that I may sell it. The Court of Appeal, in a case in which it was held that there could be property in sperm to which we will return in section 5, noted that

> there are numerous statutes which limit a person's ability to use his property—for example a land-owner's ability to build on his land or to evict his tenant at the end of the tenancy or a pharmacist's ability to sell his medicines—without eliminating his ownership of it.[25]

It also did not consider it necessary in this case—*Yearworth v Bristol NHS Trust*—to examine whether the source could sell his sperm before concluding that it could be owned by the source. In fact, the Human Fertilisation and Embryology Act 1990 states that for the purposes of licensed activities 'no money or other benefit' is to be given or received in respect of the supply of gametes unless authorised by directions.[26]

The only instance where the 2004 Act refers to property in body parts is in the exclusion from the prohibition of commercial dealings of material 'which is the *subject of property* because of an application of human skill'.[27] Note that this exclusion refers only to material that is property *by virtue of the application of human skill*; it does not exclude human material that is property for other reasons from the prohibition on commercial dealings. In response to an earlier claim to this effect,[28] Herring and Chau object that 'it is hard to conceive of a reason' why the exception would single out property acquired by the application of skill from property acquired in some other way.[29] Instead, they opine, 'Parliament was indicating that the application of human skill is the only way a body can become property'.[30] Note, however, that the s 32 prohibition of commercial dealings could not make an exception for property rights acquired by the source by virtue of their relationship to material removed from their

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[24] s 32(1)(a) and (3). 'Controlled material' is defined in s 32(8)/(9) as any material that 'consists of or includes human cells', is (or is intended to be) removed from a body and is intended to be used for transplantation. Embryos, gametes and material that is the subject of property because of an application of human skill are excluded from the definition.

[25] [2009] EWCA Civ 37 [45].

[26] s 12(1)(e).

[27] s 32(9(c), my emphasis.

[28] SD Pattinson, *Medical Law and Ethics* (1st ed.) (Sweet & Maxwell, London 2006) 473.

[29] J Herring and PL Chau, 'My Body, Your Body, Our Bodies' (2007) 15 Med L Rev 34–61, 39.

[30] ibid.

bodies *if* the source is to be prohibited from selling their material for transplantation.[31] Parliament's intention to prohibit the source from selling his or her body parts while allowing subsequent commercial uses of material that has been altered by the application of human skill, therefore, clearly provides a coherent rationale for restricting the exclusion from prohibition to property acquired only in the way specified.[32] Indeed, in the subsequent *Yearworth* case, the Court of Appeal referred to s 32 and similarly concluded:

> But, although the subsection [containing this exception] would fortify the view that the common law treats parts or products of a living human body as property if they have been subject to an application of human skill (which, presumably, has changed their attributes), the effect of the subsection could not be to confine the common law's treatment of such parts or products as property if otherwise it would rest on a broader basis.[33]

This article has hitherto only briefly explored the 2004 Act's underlying principles—and in the process noted that, if a particular definition of property is adopted, the 2004 Act implies (as a matter of justificatory coherence) that the source owns his or her organs. This conclusion coheres with Price's view that 'conceptions of property…reflect implicitly both the fundamental character and the philosophical underpinnings of such consent schemes, inherently identifying with property entitlements inhering in the tissue source'.[34] This article will now consider whether the principles underlying the 2004 Act can be reconciled with those in the 2000 report and 2010 guidance outlined in the introduction above?

3. The principles of the 2000 report and 2010 guidance

The 2000 and 2010 documents seek to rely on principles that reject the claim of the recipients specified by the donor to the organ in question. Both documents conclude that unless the donor gives blanket, unconditional consent, no organ should be considered for allocation and any preference should be treated as refusal of consent. The principles invoked are, however, not sufficient to support this conclusion in the light of those of the 2004 Act.

The 2000 document, as quoted in the introduction, relies on a 'fundamental principle' with two parts: organs should be donated 'altruistically' and organs should go to 'patients in the greatest need'.[35] The force of the second part of this principle must now be challenged in the context of the 2004 Act. We have seen that the needs of those who could benefit from an organ (relied on by the 'greatest need' principle) are not sufficient to override the interests or desires of the donor or the person to whom the power of consent/refusal is transferred (relied on by the absolute requirement to obtain consent). In short, appeal to an obligation to prioritise those with the greatest need cannot be viewed as a sufficient reason for prohibiting directed donation in an opt-in system. The first part of the cited principle, the appeal to altruism, carries no additional justificatory force. All donors must be acting altruistically, in the sense of out of concern for the interests of persons other than themselves, unless they stand to benefit from the donation. Both the 2004 Act and its predecessor make it a criminal offence for the donor to extract a financial benefit or equivalent from donation.[36] There is only one benefit potentially gained by donors who donate to specified persons that is not

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31 For an argument against the blanket prohibition of selling one's own organs see SD Pattinson, 'Paying Living Organ Providers' (2003) Web JCLI and 'Organ Trading, Tourism, and Trafficking within Europe' (2008) 27 Med Law 191–201.

32 Thus, the provision is actually neutral on the issue in question here.

33 N22 [38].

34 Price (n 4) 232.

35 DH (n 2) [6.1].

36 s 32 of the 2004 Act and s 1 of the Human Organ Transplantation Act 1989, respectively.

generally gained by those who donate to the general pool of those in need—the satisfaction of believing that they could directly assist someone they care for or even love. But a conception of altruism that is so narrow that it is opposed to other-benefitting actions motivated by love is too controversial to be asserted by fiat. In any event, such a narrow conception is not treated as having normative force when dealing with other transplantation issues (see section 4, below).

The 2010 guidance states that 'there are two key principles which underpin the UK organ donation programme—the absence of conditionality and the requirement that patients are treated equitably'.[37] The first of these, the absence of conditionality, is said to be justified on the basis that '[c]onditionality offends against the fundamental principle that organs are donated voluntarily and freely and should go to patients according to the agreed criteria'.[38] The first part of this principle has not been shown to support the conclusions reached in the 2010 guidance. The notion of 'appropriate consent' undoubtedly implies voluntary and free donation, but why is donation to a specified individual less voluntary or free than unconditional donation? *Perhaps* the guidance seeks to refer (indirectly and without evidence of probability) to the possibility that allowing directed deceased donation will lead to friends and relatives undermining the free and voluntary choice of some donors by pressuring them to select a particular recipient.[39] But reliance on the principle of free and voluntary choice in this way would be open to challenge on multiple grounds. For a start, the approach of the 2010 guidance directly undermines the free and voluntary decisions of some potential donors, namely those who freely and voluntarily wish to donate only to a specified individual. The result of their free and voluntarily choice is ruled out—they must either not donate or donate unconditionally with a mere expression of a preference. What is more, the receipt of apparently unconditional consent does not guarantee that the decision was free and voluntary—the donor could have been unduly pressured to express a preference or to donate at all. If this is really the concern, then guidance should be focused on ensuring that steps are taken to check that the decision was free and voluntary, rather than adopting blanket assumptions about the decision-making process based entirely on its outcome. A mere appeal to a principle of voluntary and free choice is not a sufficient reason for restricting the choices of donors. The second part of this principle—organs should go to patients according to the agreed criteria—assumes the very conclusion that it is invoked to justify, namely that compliance with the agreed criteria should trump the donor's will.

The second principle of the 2010 guidance, equitable treatment, claims that the existing allocation procedures 'are designed to ensure that patients are treated equitably' and that means that '[d]onated organs are allocated in a fair and unbiased way according to the agreed criteria'.[40] This principle also has two parts: organs are to be allocated in a 'fair and unbiased way' and that way is to be determined by the 'agreed criteria'. In an opt-in system, the only organs eligible to be allocated in a fair and unbiased way are those acquired as a result of consent. If the donation is directed, the pool of potential recipients is reduced to one. The only reason offered for allocation to none being more 'fair and unbiased' than allocation to one, is that this contravenes the 'agreed criteria'. Once again this reasoning seeks to resolve by assertion the very issue in contention. A justification is required and, as already stated, in an opt-in system that justification must not require the interests of those in need of organs to outweigh the will of the donor.

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[37] DH (n 7) [10].

[38] ibid.

[39] Such a fear may even focus on particular groups, such as perhaps older people or the (capacitated) mentally challenged.

[40] DH (n 7) [10].

4. Scenario 1: living and deceased directed donation

To facilitate discussion of directed donation and ownership in human organs intended for transplant, three scenarios will be outlined in which the donated organs are a suitable match for a specified recipient. This is the first:

> Anna is on the kidney transplantation waiting list. Her brother Otto volunteers to be both a living and a deceased kidney donor, stating that in no circumstances are his kidneys to be used to treat anyone other than Anna. The living kidney transplant is approved by the HTA, but Otto dies in a tragic car accident on his way to the hospital for the operation. The Royal Northern Hospital transplants Otto's kidneys into Anna.

In this scenario, Otto's consent for both living and deceased directed donation is to be understood as displaying recognition that transplants rarely last the life time of the patient, rather than as the product of clairvoyance. It bears a superficial resemblance to the Laura Ashworth case outlined in the introduction, but has been tailored to focus on two issues: (a) whether a distinction is properly draw between living and deceased directed donation and (b) the legal implications of a transplant centre ignoring the 2010 policy.

A. The regulatory response to directed donation from a living donor

Where the donor is alive, the 2004 Act only requires 'appropriate consent' for the *storage* and *use* of the organ for specified purposes, including transplantation.[41] Appropriate consent is again defined by reference to the person who may give it, but is principally restricted to the donor.[42] The donor cannot transfer the decision-making power to another, but there is provision for those with parental responsibility to make decisions on behalf of children who are unable or unwilling to make a decision[43] and for consent to be 'deemed' to have been given where it is in the best interests of an incapacitated adult to do so.[44] Removal of the organs is governed by the common law (which requires the removal to be with consent or lawful under the Mental Capacity Act 2005 to avoid what would otherwise be a trespass)[45] and by s 33 of the 2004 Act. Section 33 makes it an offence to remove or use 'transplantable material' from a living person for the purposes of transplantation, unless permitted by regulations and approved by the Human Tissue Authority (HTA). Thus, the 2004 Act's appropriate consent provisions do not apply to the removal of organs from a living donor, but additional conditions have to be satisfied such as the need for the HTA's approval.

The HTA and the secondary legislation recognise three types of living donation: directed donation to a specific recipient known by the donor (genetically or emotionally related donation), directed donation to a recipient unknown to the donor in exchange for an organ being received by someone known by the donor (paired and pooled donation), and non-directed donation (altruistic non-directed donation).[46] No non-directed donation (or even directed donation to an unknown recipient) was ever authorised by the predecessor to the

41 s 1(e)/(f)).
42 s 2(2) and 3(2).
43 s 2(3).
44 s 6 and Human Tissue Act 2004 (Persons who Lack Capacity to Consent and Transplants) Regulations 2006/1659, reg 3(2)(a).
45 See SD Pattinson, *Medical Law and Ethics* (2nd ed.) (Sweet & Maxwell, London 2009), 476–480.
46 See Code of Practice 2, Donation of solid organs for transplantation [26] and Regulations 2006/1659, reg 12(4)/(5).

HTA under the previous legislation.[47] Even now, non-directed donation remains rare. Of the 961 living organ transplants that took place in the UK in the year between 1 April 2008 and 31 March 2009, only 15 were non-directed donations distributed by the national allocation system.[48] In the above scenario Otto could have directed his organ to Anna, because he has, *ex hypothesi,* obtained the approval of the HTA. In the above year alone, 927 of such genetically related living kidney donations took place. It also follows that Laura Ashworth would have been able to direct her organs to her mother, without being prepared to donate to anyone else, had she still been alive and able to go through the formal process of living donation.

As others have noted, there are two coexisting organ transplantation regimes operating here and in many other jurisdictions: a cadaveric system governed by criteria tracking impartial justice and a living organ donation system governed by autonomy and permitting partiality.[49] However, in so far as the 'fundamental principles' outlined in the 2000 and 2010 documents support the prohibition of directed deceased donation, they also apply to directed living donation. The greatest need, altruistic motivation, absence of conditionality, and equitable treatment principles are nonetheless set aside or applied differently with regard to living directed donation. These principles must therefore be rejected as 'fundamental', unless we are able to identify other overriding fundamental principles that apply to directed living donation but never apply to directed deceased donation, *or* we are able to identify reasons why they apply differently in the two situations. The problem is, however, that there is little leeway for arguing that death alters the balance between the interests of the donor and those of potential recipients (so that the greatest need and equity principles operate differently or other principles come into effect), because in a formal opt-in system the interests of the donor remain overriding. In short, within the framework of the 2004 Act, to permit living directed donation while prohibiting deceased directed donation stands in need of a justification that is not provided by the 2000 report or the 2010 guidance.

B. The regulatory response to directed donation from a deceased donor

In this scenario, the guidance is ignored by the Royal Northern Hospital. The 2010 guidance expressly states that 'a request for the allocation of a donor organ *can be considered* in exceptional circumstances' *only once* it is 'first established that the consent or authorisation to organ donation is unconditional'.[50] For the avoidance of any doubt it goes on to state that this means that the consent is 'not conditional on the request for the allocation of a donor organ to the specified relative or friend of long standing going ahead'.[51] Nonetheless, the 2004 Act does not require the approval of the HTA, NHSBT or any other body once appropriate consent has been obtained. The hypothetical hospital's actions therefore violate no provision in the 2004 Act. In fact, the guidance completely lacks legal force because no

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47 Under the Human Organ Transplants Act 1989, the approval of the Unrelated Live Transplant Regulatory Authority (ULTRA) was required prior to a living organ transplant, unless the recipient was genetically related to the donor. On the practices of ULTRA see DH, Human Bodies, Human Choices: The Law on Human Organs and Tissue in England and Wales. A Consultation Report (DH, London 2002) [14.29]

48 NHSBT, Transplant Activity in the UK: 2008-2009 (London 2009) 7.

49 See MT Hilhorst, '"Living Apart Together": Moral Frictions between Two Coexisting Organ Transplantation Schemes' (2008) 34 JME 484-488; AJ Cronin and D Price, 'Directed Organ Donation: Is the Donor the Owner?' (2008) 3 Clinical Ethics 129-131, 128; AJ Antonia and JF Douglas, 'Directed and Conditional Deceased Donor Organ Donations: Laws and Misconceptions' (2010) 18(3) Medical Law Review 275–301.

50 DH (n 7) [3] (original emphasis).

51 Ibid.

other civil or criminal issue arises for which the donor's consent is not a complete answer. This is not a case where the actions of the Royal Northern Hospital can reasonably be said to violate any other laws, such as the anti-discrimination legislation (e.g. the Equality Act 2010).[52] Indeed, the hospital has done no more than it would have done, perfectly lawfully, if Otto had survived to be a living donor. NHSBT ODT cannot even insist that donations subject to directed and requested allocation are referred to the panel set up to provide advice in this area: the Requested Allocation Oversight Group.[53] The NHSBT simply lacks enforcement powers. As Douglas and Cronin have pointed out 'the Requested Allocation policy [i.e. that of the 2010 guidance] is relevant only to the NHSBT and can be readily avoided by those who wish to prioritise their nearest and dearest if they gain the cooperation of the local transplant centres'.[54] In a later article, those authors note that:

> As it [the 2004 Act] does not prohibit conditional or directed donations, and these are not illegal *per se,* it could be possible for donors to bypass NHSBT ODT's national allocation policy by requiring their organs to be used only in their own locality or NHS Region.[55]

Unfortunately, the Laura Ashworth case demonstrates that in practice, local transplantation centres are extremely reluctant to go against the policies of NHSBT and the HTA.

5. Scenario 2: negligent destruction of organ following a living directed donation

There are further issues that we still need to explore before returning to directed deceased donation and these are encapsulated by the following scenario:

> Bob is suffering from end stage kidney failure and in need of a kidney transplant. His wife, Maram, volunteers to donate one of her kidneys. A kidney is successfully removed in an operation at the Royal Northern Hospital, but it is then handled without due care and thereby rendered unusable for transplantation. Bob and Maram suffer serious mental distress and psychiatric injury as a result of the loss of the organ and Bob's consequent progressive decline.

A. Private law claims over organs excised from living persons

In the above scenario neither Bob nor Maram will have a claim against the Royal Northern Hospital in negligence, bailment or any other cause of action unless they can establish a proprietary or possessory interest in the damaged kidney. This is because they have no contract with the NHS hospital[56] and the possibility of an action in negligence in the absence

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52 Cf the actions of the Northern General Hospital and the NHS allocation body (then the United Kingdom Transplant Service Support Authority) in July 1998 when accepting a donation that was *conditional* upon the recipients being white. The subsequent investigation led to the 2000 report, which concluded that complying with racist views would contravene the legislation then in force, the Race Relations Act 1976: see DH (n 2) [5.1]–[5.4].

53 See DH (n 7) [25].

54 JF Douglas and AJ Cronin, 'Requested Allocation of a Deceased Donor Organ: Laws and Misconceptions' (2010) 36 JME 321.

55 AJ Cronin and JF Douglas, 'Directed and Conditional Deceased Donor Organ Donations: Laws and Misconceptions' (2010) 18(3) Med L Rev 275–301, 299. These authors also convincingly argue that if a family makes a donation unconditional only because of NHSBT's insistence that conditional donation is unlawful, the consent could be regarded as 'vitiated by this misinformation and as a result any failure to honour the request would become illegal' (*ibid,* 297).

56 *Pfizer Corporation v Ministry of Health* [1965] AC 512 (HL); *Reynolds v Health First Medical Group* [2000] Lloyd's Rep Med. 240 (CC).

of any ownership rights over the kidney was effectively rejected by the recent decision of the Court of Appeal in *Yearworth v North Bristol NHS Trust*.[57] This case concerned the claims of a group of men whose sperm had been destroyed by being negligently allowed to thaw. The sperm was being stored by the defendant NHS Trust to preserve the option for the six claimants to become fathers should chemotherapy damage their fertility. The claimants pleaded their case in the tort of negligence and, upon the invitation of the appeal court, the law of bailment. The Court of Appeal held that it would be a 'fiction' to consider damage to a substance generated by the body inflicted after its removal as constituting personal injury to the source.[58] The court was led to this conclusion by the 'paradoxes and…ramifications' that would otherwise follow, including the implications of the contrary view for 'several other bodily substances and parts'.[59] There is therefore little doubt that this case prevents damage to excised organs being regarded as personal injury for the purposes of the tort of negligence.

The Court of Appeal went on to rule that the claimants did have an ownership interest in the damaged sperm sufficient to found an action in negligence, but chose to evade further questions of whether that cause of action would ultimately enable the men to claim for their mental distress and psychiatric injury. The Court instead chose to find for the claimants in the law of bailment considering the measure of damages in bailment more akin to contract and therefore more favourable to the claimants. The scenario above invites the question as to whether either Bob or Maram have a proprietary or possessory interest in the excised kidney sufficient to found a claim in negligence or bailment.

Over a century before *Yearworth,* an exception to the no property in the body maxim had been carved out in the Australian case of *Doodeward v Spence*.[60] The majority of the High Court of Australia held that a preserved fetus had become property. In Griffith CJ's view, property could be acquired by 'the lawful exercise of work or skill' on a human body that was lawfully in possession as it had thereby obtained 'some attributes differentiating it from a mere corpse awaiting burial'.[61] In *Dobson v North Tyneside HA* the Court of Appeal of England and Wales was prepared to accept this view, but ruled that a brain preserved in paraffin for autopsy did not thereby become property.[62] The Court of Appeal again invoked this principle in *R v Kelly* to uphold the defendant's conviction for the theft of body parts from the Royal College of Surgeons.[63] It thereby confirmed that a corpse or body part can be property if it has 'acquired different attributes by virtue of the application of skill, such as dissection or preservation techniques, for exhibition or teaching purposes'.[64] The *Dobson* and *Kelly* decisions are reconcilable if property is understood to be acquired by the application of work and skill *with an appropriate intention* (i.e. without an intention to assert ownership the object's attributes are not regarded as changed by preservation alone). In *Dobson* the preservation had been to comply with the Coroners Rules without the intention of retaining it for any other purpose,[65] whereas in *Kelly* the preservation had been *for the purpose of retaining* for uses relating to teaching and exhibition.

In *Kelly,* Rose LJ went on to declare that

> the common law does not stand still. It may be that if, on some future occasion, the question arises, the courts will hold that human body parts are capable of being property for the purposes of section 4 [of the

57 [2009] EWCA Civ 37.
58 Ibid [18]–[24], esp [23].
59 Ibid [23].
60 1908 6 CLR 406 (HCA).
61 Ibid 414.
62 [1997] 1 WLR 596 (CA)
63 [1999] QB 621 (CA)
64 Ibid, 631 (Rose L.J.).
65 [1997] 1 WLR 596, 602 (Gibson J).

> Theft Act 1968], even without the acquisition of different attributes, if they have a use or significance beyond their mere existence. This may be so if, for example, they are intended for use in an organ transplant operation, for the extraction of DNA or, for that matter, as an exhibit in a trial.[66]

The Court of Appeal in *Yearworth* had no need to take this path; it could easily have treated the storage of sperm as property within the work and skill exception to the no property rule on the basis that skill had been applied to the sperm, in its preparation and preservation, with the intention of enabling the future creation of a child. The attributes of the sperm had therefore been relevantly altered by the application of skill. Nonetheless, the Court explicitly chose not to decide the case in this way.[67] Instead, it ruled that the men had ownership in their sperm on the basis that it had been (i) generated and ejaculated by their bodies alone and (ii) the 'sole object of the ejaculation of the sperm was that, in certain events, it might later be used for their benefit'.[68] In the judgment of the Court of Appeal, it did not matter that the men could no longer 'direct' the use of their sperm once it had been removed. The resultant interest was one of ownership because the Human Fertilisation and Embryology Act 1990 'assiduously preserves the ability of the men to direct that the sperm be *not* used in a certain way: their negative control over its use remains absolute'.[69]

At first blush, the reasoning in *Yearworth* is not directly transferrable to the scenario with which we are concerned here: the sole object of the removal of Maram's kidney was not that it might be later used for her own benefit. Further, the Court of Appeal expressly restricted itself to the facts before it:

> The present claims relate to products of a living human body intended for use by the persons whose bodies have generated them. In these appeals we are not invited to consider whether there is any significant difference between such claims and those in which the products are intended for use by other persons, for example donated products in respect of which claims might be brought by the donors or even perhaps by any donees permissibly specified by the donors.[70]

Matters are not, however, that simple. In refusing to simply apply the *Doodeward* principle, the Court of Appeal noted that that principle was devised as an exception to a principle, itself of exceptional character, relating to the ownership of a human corpse.[71] The Court of Appeal should not thereby be taken as rejecting the *Doodeward* principle—it was bound by precedent and the 2004 Act to accept that property can be acquired by the application of skill to legitimately acquired resources. Nonetheless, the Court did not fully explain how these two methods for acquiring property in body parts and bodily products fit together. The most coherent answer is that the *Yearworth* principle applies to the source and the *Doodeward* principle applies to others who come into lawful possession of material no longer subject to the ownership claims of the source.

The Court of Appeal also did not explicitly articulate its notion of property, but the conclusion reached is, nonetheless, compatible with the rule-preclusionary conception of property outlined above. The ownership interest that the men were recognised to have over their sperm constituted a *prima facie* right to exclude others from using or harming their sperm without their consent and that right (granted on the basis of their relationship to the

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66 [1999] QB 621, 631.

67 [2009] EWCA Civ 37 [45]. As Price notes, the work and skill exception 'would have served to have conferred rights on the Unit not the men themselves': Price (n 4) 257.

68 Ibid.

69 Ibid.

70 Ibid [45].

71 Ibid.

sperm) was one that precluded them having to provide a case-by-case justification for excluding any particular use or harm. The rule-preclusionary conception of property does, however, have implications that could be considered contrary to other common law principles. Beyleveld and Brownsword have argued that the rule-preclusionary conception of property directly implies ownership over my living body and its attached parts.[72] Yet, the Court of Appeal in *Yearworth* cites a common law principle to the effect that a person does not own his or her living body or its parts.[73]

The rule-preclusionary conception of property implies ownership of the body and its attached parts, according to Beyleveld and Brownsword, because if I do not stand in that relationship to my body and its parts then I cannot stand in that relationship to any other object.[74] That is because howsoever my body and its parts are metaphysically related to me—whether I am my body or I have an existence that is separable from my body—I act through my body and it is therefore more important for my purposes (whatever those purposes are) than any other object. Thus, *if* anything stands in such a relation to me that it is necessary for the protection of my primary rights that I be granted rule-preclusionary control over it, it is my body and its attached parts. My having rule-preclusionary control over my living body is therefore implied, as a matter of justificatory consistency, by my having preclusionary control over any other object.

Yet, in *Yearworth*, the Court of Appeal stated that,

> The common law has always adopted the…principle: a living human body is incapable of being owned. An allied principle is that a person does not even 'possess' his body or any part of it: *R v. Bentham* [2005] UKHL 18, [2005] 1 WLR 1057. Notwithstanding these principles, the law compensates by making an elaborate series of rules for the protection of the body and bodily autonomy: see, eg, *Airedale NHS Trust v Bland* [1993] AC 789.[75]

In the cited case of *R v Bentham*, the House of Lords held that a man was not in possession of an imitation firearm within the Firearms Act 1968 when he pushed his fingers into the material of his jacket to give the impression that he has a gun. Lord Bingham, giving an opinion with which the other Lords agreed, held that

> One cannot possess something which is not separate and distinct from oneself. An unsevered hand or finger is part of oneself. Therefore, one cannot possess it….A person's hand or fingers are not a thing. If they were regarded as property for purposes [sic] of section 143 of the 2000 [Power of Criminal Courts (Sentencing)] Act the court could, theoretically, make an order depriving the offender of his rights to them and they could be taken into the possession of the police.[76]

This is a unanimous decision of the House of Lords and, as Lord Bingham suggests, holding the body and its attached parts to be 'property' for the purposes of English law would have consequences for legislation (such as the cited 2000 Act) that were clearly not intended by Parliament. Further, the 'appropriate consent' requirement of s 1 of the 2004 Act does not apply to the removal of tissue from a living person.

To conclude that English law rejects the rule-preclusionary conception of property would, however, be too hasty. The law—by, for example, the torts of trespass to the person and the crimes of assault—does grant rights to persons over their body and attached parts that satisfy

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72 Beyleveld and Brownsword (n 11) 182–183.

73 [2009] EWCA Civ 37 [30]

74 See Beyleveld and Brownsword (n 11) 182.

75 [2009] EWCA Civ 37 [30].

76 [2005] UKHL 18, [8].

the substantive and functional features of rule-preclusionary control. That is to say that the law recognises that persons have a *prima facie* right to exclude others from using, harming or even touching their body or its attached parts without their needing to offer a case-by-case justification for so excluding others. The Court of Appeal hinted at this when it referred to the 'elaborate series of rules for the protection of the body and bodily autonomy'. The law recognises these as *personal rights*, even though they share the core features of (rule-preclusionary) property rights. The law therefore simply restricts the terminology of property and ownership to a sub-class of objects that may be subject to rule-preclusionary control. That large sub-class comprises those objects that can, in practical terms, be treated as separate and distinct from living persons. Control over this sub-class of objects is properly distinguished because these objects are not composite of a person's physical integrity and adopting different terminology facilitates this expression of hierarchy between the living body and other objects.[77] Thus, references to 'property' and 'ownership' within English law refer only to rights over a class of objects that stand in a weaker relationship to persons than their living bodies and their attached parts.

Analysing the *Yearworth* decision by reference to the rule-preclusionary conception has explanatory force. Once it is accepted that I have rule-preclusionary control over my living body (including attached body parts and unreleased bodily products), it becomes simple to explain why I have rule-preclusionary control over body parts and products that are removed from my body with the intention of controlling its subsequent lawful use. In such circumstances, the removal of the bodily material involved no attempt to abandon it and thus I retain rule-preclusionary control over that material—though harm to it once removed is generally not on a par with harm to it when attached.[78] This analysis also supports the much earlier decision of a Magistrates' Court to convict a man, who cut locks of hair from the back of a girl's head without her consent, of assault and *larceny*.[79] In contrast, if bodily material is removed for another purpose, my future intentions towards it will sometimes be such that I can properly be said to have abandoned it and, in any event, rights over things that are not part of my body are not absolute.[80]

We now have a principled basis by which to address the hypothetical scenario: Maram had rule-preclusionary control over her kidney and her consent to its removal did not involve her abandoning it because it was removed with the intention of transferring ownership to Bob. From general legal principles, until ownership is transferred, Bob does not even have a contractual interest in receiving the organ.[81] There can be no doubt that once transplantation has taken place ownership has transferred (and at that point he will have rule-preclusionary control over its use, whether the organ remains attached or is subsequently removed from his body). But does the transfer take place at the point that the organ is in the possession of the hospital (which acts as bailee) or does it only take place at the point of transplantation? The 2004 Act, if understood as recognising (rule-preclusionary) property in organs, implies the latter. This can be understood by asking whose consent would have been required to change the intended recipient between removal and transplantation (if the kidney had not been rendered unusable), and whose consent would now be required to put the organ on public display or to do any of the other activities for which consent is required by the 2004 Act. The

[77] Cf. Hardcastle (n 18) 146–150 and Price (n 4) 240–241, 267.

[78] It follows that theft is not on a par with slavery, trespass to goods is not on a par with trespass to the person, etc.

[79] *R v Herbert* (1961) JCL 163.

[80] The 2004 Act renders it lawful to treat as 'waste' bodily materials removed during surgery and related medical procedures when they cease to be stored or used for a specified purpose: s 44. See also the discussion of abandonment in Price (n 4) 251–252.

[81] The prohibition of commercial dealings prevents Bob from lawfully providing the consideration necessary for a contractual relationship to arise.

2004 Act defines the person who may give consent to the specified activities as the person from whose body the material is derived.[82] Bob does not become that person until the organ has been successfully transplanted. It therefore follows that the hospital's negligence has interfered with Maram's property rights but not Bob's and so only Maram has a property interest sufficient to found an action against the hospital.

5. Scenario 3: self-directed and misdirected deceased donation

Scenario 1 explored the contrasting regulatory responses to directed living and deceased donation, and rejected the defensibility of this regulatory difference. It was argued that the 2004 Act recognises that donors have negative rule-preclusionary control over organs removed from them for the purpose of transplantation, whether they are removed before or after death, and this prevents a distinction being drawn between directed living and deceased donation on the basis of the interests of those in need of organs. Scenario 2 focused on the nature of the rights of living persons over organs removed for the purposes of transplantation and it was argued that the notion that a living person can have rule-preclusionary property in their excised organs is also consistent with recent common law developments. We are now in a position to explore the implications of this analysis for directed deceased donation and the following scenario will be used to facilitate discussion:

> Hannah is on the liver transplantation waiting list, but not the Super Urgent Liver list. Her life partner Eve appoints Hannah as her 'nominated representative' thereby empowering Hannah to consent, or refuse, to donation on her behalf after her death. Eve dies at the Royal Western Hospital following an asthma attack. Hannah requests that Eve's liver be transplanted into her if it is clinically suitable and, if it is not, donated to the person at the top of the waiting list. The transplant coordinator at Royal Northern Hospital negligently concludes that the liver is unsuitable for Hannah and it is transplanted into the person at the top of the Super Urgent Liver list.

In this scenario, Hannah is *both* authorised decision-maker and intended recipient. She may act as decision-maker because, under the terms of the 2004 Act, Eve has validly transferred to her the power to provide appropriate consent.[83] Her exercise of this power is self-benefitting and therefore has the superficial appearance of a conflict of interest. This need not detain us because this is only an actual conflict of interest if she is required to exercise the decision-making power in another's interests. The Act does not in this way constrain the negative rule-preclusionary control granted to anyone recognised as able to give appropriate consent and Hannah's appointment is in no way conditional upon her decision being other-benefitting—indeed, the facts suggest that Eve has granted the power to Hannah for this very purpose. Hannah is therefore no more prevented from providing a valid consent to self-directed donation than she could be prevented from refusing to consent to donation at all merely to frustrate the wishes of Eve's loved ones.

The issue of misdirected donation has not arisen in any English case—and is unlikely to arise unless a local transplant centre is willing to go against the 2010 guidance by accepting an organ subject to the donor's direction. If it did arise, it could give rise to criminal liability under the 2004 Act because the donor has not provided appropriate consent. This is subject to s 5 of the 2004 Act, which states that a person does not commit an offence if they reasonably believe that appropriate consent has been obtained or is not required. In the scenario above, there would have been appropriate consent had the belief that the liver was not clinically

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[82] See s 3.

[83] Ss 3(6)(b)(ii) and 4.

suitable been true, but since this belief was negligently reached was it therefore unreasonable to believe that appropriate consent has been obtained? A jury may conclude that it was, but no prosecution could occur in the first place without the consent of the Director of Public Prosecutions (DPP) under s 50 of the 2004 Act.

The 2004 Act provides no civil redress for lost organs,[84] but there has been some discussion of the common law response in the American case of *Colavito v New York Organ Donor Network*.[85] Colavito, suffering from end-stage renal disease, was the intended recipient of two kidneys from the body of his close friend, which had been donated by the friend's wife. The New York Organ Donor Network sent the left kidney to Florida for the treatment of Colavito, but his physician discovered that it was irreparably damaged by aneurysms. Upon requesting the right kidney from the New York hospital, he was informed that it had already been allocated to another recipient. It was subsequently discovered that *both* kidneys were histo-incompatible with Colavito's antibodies and so could not have been successfully transplanted in any event. Colavito brought an action for, *inter alia*, conversion. The District Court noted that the (US) case law had only recognised narrow quasi-property rights of the next-of-kin in a deceased's body and then only for the purposes of proper disposal, before concluding that common law public policy was opposed to recognising broad property rights in a cadaver.[86] On appeal to the Second Circuit of the United States Court of Appeals, Judge Sack noted that support for the no-property rule was largely derived from cases decided decades before organ transplantation became viable and there was 'by no means a modern consensus that body parts are excluded from conversion actions at common law'.[87] Further, he opined, claimants such as Colavito asserted property because they have 'a practical use for the organ, not a sentimental one'.[88] The matter went to the New York Court of Appeals to consider whether, under New York law, Colavito could maintain an action for conversion. That Court observed that no previous case had 'strayed meaningfully from the doctrine that there is no common-law property in a dead body', but accepted that there could be circumstances in which actionable rights in the body or organ of a deceased person may arise.[89] Nonetheless, no common law right to the organ could vest in 'a specified donor of *an incompatible kidney*'.[90] The case then finally came back before the Second Circuit, which supported the dismissal of the claim on the basis that 'Colavito could not have derived a medical benefit from the organ and did not "need" it'.[91]

The conclusion reached in the *Colavito* litigation is supportable on the principles of English law as analysed at the end of section 5—any property in the kidney never transferred to Colavito.[92] Any claim for misdirection must therefore rest with the deceased's family.[93] In the scenario with which we began this section, the issue of whether property has, at the relevant time, transferred from the decision-maker to the intended recipient does not arise, because Hannah acts as both. Instead, the issue is simply whether an organ removed from a deceased person in these circumstances can properly be said to be property at all. *Colavito* therefore adds little to the present discussion beyond additional recognition that the historical

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84 A point also made by RN Nwabueze (2008) 'Donated Organs, Property Rights and the Remedial Quagmire' (2008) 16 Med L Rev 201-224, 209.

85 *Colavito v New York Organ Donor Network* 356 F Supp 2d 237 (EDNY 2005); 438 F 3d 214 (2nd Cir 2006); 6 NY 3d 820 (NYCA 2006); 8 NY 3d 43 (NYCA 2006); 486 F 3d 78 (2nd Cir, 2007).

86 356 F Supp 2d 237, especially 246.

87 438 F 3d 214, 224.

88 Ibid.

89 8 NY 3d 43, 53.

90 Ibid, my emphasis.

91 486 F 3d 78, 81.

92 The reliance on the 2004 Act being equally supportable in the case of a deceased donor.

93 Cf Cronin and Price (n 49) 130.

no-property maxim need not bind present day common law courts. We must now consider the impact of the oft-cited common law maxim to the effect that there is no property in a dead body or its parts.

It was noted above that scholars have questioned the pedigree of this maxim.[94] The first case where it was actually used to support the decision itself was *Williams v Williams*, decided towards the end of the nineteenth century, where Kay J said: '[i]t is quite clearly the law of this country that there can be no property in the dead body of a human being'.[95] This *first instance* decision relied on earlier *obiter dicta* from a case concerned with a *buried* corpse for this assertion[96] and it represented only one of multiple grounds cited for the decision.[97] In *Kelly,* however, the Court of Appeal accepted that 'however questionable the historical origins of the principle' it was now part of the common law that 'neither a corpse nor parts of a corpse are themselves and without more capable of being property protected by rights' and any change to this 'must be by Parliament'.[98] It is my contention that the enactment of the 2004 Act represents such a change. Interpreted by reference to the rule-preclusionary conception of property, the 2004 Act grants negative property rights over organs (and various other types of bodily materials) to the deceased and permits the deceased to transfer those rights before death. There is therefore a principled basis for revising the common law position with regard to private law claims over organs from deceased persons that are damaged or misdirected and that principle has Parliamentary approval. Thus, in her capacity as legal decision-maker, Hannah should be regarded as having a sufficient proprietary interest in the liver to found an action in bailment or conversion for the misdirection of the organ.

6. Conclusion

This article has not argued that directed deceased donation is, all things considered, morally defensible. A utilitarian seeking to maximise utility or a rights-based theorist recognising extensive positive duties could properly raise objections to the existing opt-in system or object to the likely consequences of allowing directed donation, such as organs being allocated to non-optimal recipients (e.g. those with low post-transplant life expectancy). The conclusion that directed donation is substantively morally acceptable would require the interests of those who wish to restrict or control therapeutic use of their organs after death to outweigh the interests of those in greatest need of the organs. Nonetheless, the 2004 Act's adoption of a *formal opt-in system* implies that, *as a matter of underlying legal principle*, (a) donors' interests do have such weight and (b) donors have (rule-preclusionary) property in their organs. Further, the donor's property interest, so understood, can be transferred to another under the terms of the 2004 Act. These principles stand in opposition to existing policy restrictions on directed donation and judicial reluctance to recognise property in the body parts of deceased persons, but do support the recent decision in *Yearworth.* Thus, those who wish the organs of deceased persons to be allocated for transplant purely impartially in accordance with greatest need and to deny that we have property rights over our organs, can only maintain regulatory coherence by reforming the 2004 Act.

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94 See n 19.
95 (1882) 20 ChD 659 (Ch) 662-663.
96 *R v Sharpe* (1857) Dears & B 160, 169 ER 959 (CCR).
97 See Matthews (n 19) 210-212 and Skegg (n 15) 312.
98 [1999] QB 621, 630-631.