ORGAN TRANSPLANTS IN GHANA: FINDING A CONTEXT-APPROPRIATE AND PRACTICALLY WORKABLE ETHICO-LEGAL POLICY FRAMEWORK

A thesis submitted to the University of Manchester for the degree of Doctor of Philosophy in Bioethics and Medical Jurisprudence in the Faculty of Humanities

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ABSTRACT

ORGAN TRANSPLANTS IN GHANA: FINDING A CONTEXT-APPROPRIATE AND PRACTICALLY WORKABLE ETHICO-LEGAL POLICY FRAMEWORK

PhD in Bioethics and Medical Jurisprudence

The University of Manchester
Divine Ndonbi Banyubala
October 2014

Ghana is undertaking strenuous efforts to make organ transplantation a routine surgical procedure by the end of 2014. Thus far, some 20 test kidney transplants using living related organ donors have been carried out in Ghana. However the current practice of retrieval, retention and use of (deceased) human organs and tissues following pathological services is not done in accordance with the requirements of existing law. Also, the time of human death, its relationship with obtaining organs for transplant as well as the sociocultural sensitivity Ghanaians attach to death and dying are not explored in that context. Furthermore, there is no coherent examination of the various interests and rights recognised by Ghanaian law in deceased human bodies despite that fact that progress in medicine and biotechnology has recast the value in human biomaterials.

Consequently, given that organ transplantation is new to Ghana; that there are no ethical, legal and professional governance frameworks specific to the sector; that there are concerns about a systemic culture of inappropriate retention and use of human body parts following pathological services; that there is illicit trade in human body parts (ova, sperm etc.); and that Ghana is undertaking test kidney transplants in the absence of specific ethical, legal and clinical guidance addressing the controversies surrounding the permissible uses of human organs and tissues; this doctoral thesis argues that examining these ethico-legal controversies within the Ghanaian socio-legal setting constitutes an essential step in the quest for context-appropriate and practically workable regulatory and governance frameworks for the emerging transplant sector in that country.

Towards this end, the thesis discusses indigenous thinking around death (Post-mortem Personality Identity Renegotiation (PPIR)), ancestorship and the position of Ghanaian customary law on ownership interests and rights in deceased bodies and their parts and points policymakers to how the socio-legal peculiarities of the Ghanaian regulatory context could be exploited to achieve the dual aims of finding an adequate balance between, on the one hand, protecting individual, family and societal interests, and on the other hand, promoting the social utility aims of organ transplantation and science research. It concludes by proposing that i) the desired regulatory balance could be achieved through legal foresighting, and ii) that any such regulation must affirm the recognition of property interests in (deceased) bodies by Ghanaian customary law as that reflects the cultural, social and constitutional values of the that regulatory context.
DECLARATION

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.
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DEDICATION

For the memory of my late Dad, Mr. Banyubala Yenyi;

For ‘Daddy’s Little Princess’, Phebe Jimawen Ndonbi-Mbillah, and

For my lovely wife and Queen, Ms Charity Lamisi Mbillah.
ACKNOWLEDGEMENT

In acknowledging the help that I received from others in completing this PhD thesis, I must begin by thanking God for his ever abiding mercies and for seeing me through the most challenging times especially during the passing on of my late dad when I had just begun this programme and when many factors combined to rob me of the opportunity to say a final farewell to him. Thank you for giving me education-my inheritance (as you often reminded me). I wish to apologise to the many people who were instrumental in this work, but who for want of space, cannot be specifically mentioned here. If any of them reads this thesis without seeing his or her name, may s/he remember that the appreciation of their efforts is warmly and firmly etched in my heart.

The following people cannot however go without mention.

First and foremost, I must record my greatest debt to my supervisors Dr. Sarah Devaney and Prof. Søren Holm. I am also unboundedly grateful to Dr. Muireann Quigley who was my supervisor for the first year of this programme. I am indebted to you all for the enormous intellectual, academic, and emotional support and guidance you provided me. It made my work a lot easier and I couldn’t have asked for more.

I further wish to thank Prof. Rebecca Bennett, Prof. Margaret Brazier, Prof. Matti Hayry, Dr. Iain Brassington, Prof. John Harris and Dr. Charles Erin. They have been a source of great inspiration, encouragement and help to me in many ways.

To my fellow students on the Bioethics and Medical Jurisprudence PhD programme, many thanks for your comments on the various drafts of this thesis, the discussions and friendships. Special thanks to Beverley Clough, David Gibson, and Dr. Malcolm Oswald for the conversations, the great ideas, the constructive advice and for being such wonderful friends.

I also wish to thank the anonymous reviewers for the parts of this work that have been published. Their insightful comments proved very useful.

I also wish to thank my colleagues at ‘42 Colliery Street’ both past and present for all the help and support during the good and bad times. Furthermore, I wish to thank Rev. Alex Kufuor, Dr. Kofi Owusu, Mr. Ebenezer Tetteh and Mrs. Mercy Chimsi Tetteh for your special friendships, care and support.

I am most grateful to the Government of Ghana for sponsoring this research through Ghana Education Trust Fund (GETFund). I offer special thanks to Hon. Likpalimor K. Tawiah for being instrumental in the funding arrangements. I also express my sincerest appreciation to my cousin, Mr. Samuel Yacham, for taking very good care of the house in our absence. May God richly bless you.

I wish to specially thank my sweetheart, my love, my queen, and my wife Ms. Charity Lamisi Mbillah for her unmatched patience, sacrifice and support; and our little angel, ‘Dad’s Little Princess’ Phebe Jimawen Ndonbi-Mbillah for having to keep you with your grandparents during the period. I apologise for missing out on those very interesting milestones and promise to make it up to you.

Finally, I wish to thank Rev. Dr. Johnson Mbillah and Mrs. Rose Mbillah for accepting to look after our little angel while we pursued our academic dreams. Lamisi and I agree we couldn’t have done the fantastic job you people did on her. Your sacrifice will be eternally remembered.
REFLECTIONS OF THE AUTHOR

Divine Ndonbi Banyubala graduated with a BSc. (medical sciences) and MBChB degrees from the University of Ghana Medical School in 2003, and LLB from the University of Ghana in 2011. After coming face to face with the ethical and legal dilemmas confronting healthcare professionals he proceeded to pursue a Master’s degree in Health Care Ethics and Law at the Centre for Social Ethics and Policy (CSEP), School of Law, University of Manchester in the UK in the 2006/2007 academic year.

Upon returning home he was assigned additional responsibilities. He was tasked to establish the first and only Medico-Legal Department for Ghana Health Service (GHS)/ Ministry of Health (MoH) compelling him to reluctantly abandon clinical work in 2010. In his role as founder head of that department, he advised the Director-General of the GHS on issues of healthcare ethics and law, professionalism, regulation and policy. He also liaised with and assisted the Ministry of Justice and Attorney’s Department to deal with clinical negligence claims against healthcare professionals in public institutions in Ghana, as well as providing lectures to pathologists on how to be good expert witnesses in court. He further worked as an adviser to the Ghana Medical and Dental Council (GMDC). For example, he gave lectures on medical ethics and law to practitioners during continuing professional development programmes (CPDs) and was also responsible for giving lectures to newly qualified doctors and dentists on issues of professional ethics and conduct. He was instrumental in getting the GMDC to come on a working visit in September 2010 to the GMC and GDC of the UK to learn and share experience in best practices in professional regulation.

He also sat on a number of committees:
i) Public Health Committee of the GHS which worked closely with the Parliamentary Select Committee on Health and helped pass a number of Acts (Health Institutions and Facilities Act, 2011; Mental Health Act, 2012; Health Professions Regulatory Act, 2012; Public Health Act, 2012 among others);

ii) Disciplinary Committee of GHS;

iii) Ethics and Professionalism Committee of Korle-Bu Teaching Hospital (premier hospital in Ghana); and the

iv) Ad Hoc Committee on the Harmonisation of Codes of Ethics for Medical Doctors in the West African sub-region- West African Health Organisation (WAHO).

He combined these roles with teaching. He taught, on a part-time basis, Health Law and Ethics (MSc.) at the School of Health and Allied Sciences, College of Health Sciences, the University of Ghana.

As a result his research interests are wide-ranging. These border on; healthcare ethics, professionalism, ethics education, organ transplantation and use of human biomaterials more generally, biotechnology, public health ethics and policy, clinical negligence, research ethics and regulation among others.

He intends to set up a Directorate at the Ministry of Health to work towards institutionalising healthcare ethics and law in Ghana. To that end, he is seeking collaboration from researchers desirous of and interested in advancing healthcare ethics and law in the context of the developing world particularly sub-Saharan Africa.

The journey thus far has not been rosy; it has been arduous and dotted with uncertainties and risks. Due to his passion to serve the most deprived in society he founded an NGO- Health Aid,
Ghana in 1998 that provided health education and services to many rural communities in Saboba district. As a student activist and later leader of the Junior Doctors’ Association of the Korle bu teaching hospital he remained dissatisfied with the conduct of some of his professors and colleagues towards some patients especially the most vulnerable. He was also dissatisfied with aspects of the Ghanaian healthcare system that he considered unfair both to the patients who depended on, and the healthcare professionals who worked in, it. His activism led him to take up a leadership position in the Ghana Medical Association (GMA) as honorary Secretary from 2003-2006. He continues to serve on the GMA’s annual public lecture committee. His distinguished service in that capacity led to some policy changes that contributed to tame the tide of exodus of Ghanaian doctors to other countries for greener pastures. He was given a meritorious award for his distinguished service to the Greater Accra Division of the GMA in 2009.

The passion to do what is right and fair led him to apply to study medical ethics and law here in Manchester in 2006. However this came at a cost. At the time, he was pursuing residency in ENT surgery at both the Ghana College of Physicians and Surgeons and the West African College of Surgeons. The Ministry of Health and the Ghana Health Service had granted him leave to come and pursue the programme because complaints about unethical practices of professionals as well as clinical negligence claims had assumed worrying proportions. Surprisingly, while the ministry and the West African College were happy to let him interrupt his programme for a year, his head of department of ENT surgery in Korle-bu teaching hospital and the then Rector of the Ghana College of Physicians and Surgeons insisted the programme had nothing to do with ENT surgery. As such, he was to either choose ENT surgery or medical ethics and law. This development rather deepened his conviction. He thought that if trainers of doctors
could feel convinced that ethics and law had nothing to do with medical training, then ethics and law was exactly what Ghana’s health system needed.

Happily, this initial skepticism about ethics and law has now given way to the realisation of the urgent need for ethics education and training for the healthcare sector. His perseverance as well as the excellent education, inspiration and support he received from CSEP/ School of Law here at the University of Manchester, combined to make this possible. He intends to maintain that relationship.

Publications

A number of publications form a substantial part of this doctoral thesis:


**Book Reviews**


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<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AOMRCs</td>
<td>Academy of Medical Royal Colleges</td>
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<tr>
<td>CKD</td>
<td>Chronic Kidney Disease</td>
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<tr>
<td>CSM</td>
<td>Cerebro-Spinal Meningitis</td>
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<tr>
<td>DCD</td>
<td>Donation after Circulatory Death</td>
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<td>DDR</td>
<td>Dead Donor Rule</td>
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<td>DH</td>
<td>Department of Health (UK)</td>
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<td>EEG</td>
<td>Electro-Encephalogram</td>
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<tr>
<td>GCPS</td>
<td>Ghana College of Physicians and Surgeons</td>
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<tr>
<td>GHS</td>
<td>Ghana Health Service</td>
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<tr>
<td>GMA</td>
<td>Ghana Medical Association</td>
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<tr>
<td>GMDC</td>
<td>Ghana Medical and Dental Council</td>
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<td>HTA</td>
<td>Human Tissue Act</td>
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<tr>
<td>IHR</td>
<td>International Health Regulations 2005</td>
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<tr>
<td>KBTH</td>
<td>Korle Bu Teaching Hospital</td>
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<td>MCS</td>
<td>Minimally Conscious State</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>NCDs</td>
<td>Non-Communicable Diseases</td>
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<td>NDC</td>
<td>National Democratic Congress</td>
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<td>National Health Insurance Scheme (Ghana)</td>
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<td>New Jersey Declaration of Death Act (USA)</td>
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<td>New Patriotic Party</td>
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<td>Principles-Based Regulation</td>
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<td>PHC</td>
<td>Population and Housing Census</td>
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<td>PPIR</td>
<td>Post-mortem Personality Identity Renegotiation</td>
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<td>Permanent/ Persistent Vegetative State</td>
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<tr>
<td>TADA</td>
<td>Texas Advance Directives Act (USA)</td>
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<td>Tuberculosis</td>
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<td>UDDA</td>
<td>Uniform Determination of Death Act (USA)</td>
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<td>World Health Organization</td>
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<td>WACS</td>
<td>West African College of Physicians and Surgeons</td>
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<td>YF</td>
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PART I: INTRODUCTION
CHAPTER 1

1.1 General Introduction

Biotechnological advancement is most often the herald of good news. Arguably, this news has some duality about it. On the one hand, is the issue of new and limitless possibilities, news of hope; hope of a new treatment, a new cure, a longer, healthier and, arguably, a better and happier life. On the other hand, is the issue of the ethical and legal uncertainties that the new biotechnology presents. Human organ transplantation is one such biotechnological advancement that has gripped doctors, philosophers, politicians, theologians, and legal experts alike for over half a century. The ethico-legal issues surrounding human organ transplantation have been the subject of much intense and extensive ethical and legal scrutiny and controversy.¹ Yet the concerns around transplantation surgery were not uninformed. Some commentators have observed that the fears that attended transplant surgery (and perhaps this still holds true today) related to its power and potential to transform mortals into ‘gods who defied death’.² Mortality is seen as a ‘normal’ human condition and the prospects of this ‘normal’ state of affairs of the human condition being supplanted by a defiance of death (‘not normal’) is a transition that many might have found to be unsettling.³

Since the first successful human organ transplant in 1954 by Murray and his team in Harvard⁴ in the USA, a host of previously unimaginable possibilities offered by transplant

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³ Ibid.
surgery, have acted in combination with improved scientific knowledge, especially in immunology, to expand the frontiers of transplantation surgery.⁵

Undoubtedly, developments in human organ transplantation have over the last two decades ‘opened up the possibility of transplanting an increasing number of human organs’.⁶ Today many organs and tissues can be safely transplanted. These include the heart, corneas, pancreas, arteries, lungs, kidneys, liver, intestines, parts of the brain, genetic material, bone marrow, cell transplants to aid muscle disorders, skin, limbs⁷; facial transplants⁸ and ovaries.⁹ Even uterine transplant¹⁰ experiments have taken place for some time now and the results, though encouraging, have been of varied success.¹¹ But it nonetheless continues to attract interest from some contributors¹² and subsequent developments have cast doubt on the initial skepticism that

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¹⁰ The world’s first mother-to-daughter uterine transplant is reported to have been carried out by researchers from the University of Gothenburg. For details and the massive international interest that it generated see; [http://www.sahlgrenska.gu.se/english/news_and_events/news/News_Detail/world-unique-uterus-transplantation-performed-in-gothenburg-.cid1097607](http://www.sahlgrenska.gu.se/english/news_and_events/news/News_Detail/world-unique-uterus-transplantation-performed-in-gothenburg-.cid1097607), accessed October 29, 2012.


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attended uterine transplants. It is predicted that in the not too distant future the transplant of sexual organs, ‘stomach, spinal column, and the whole brain itself’ may all become a reality.

Over the years transplantation has become the preferred treatment option for end organ failure in many parts of the world bringing relief and improved quality of life to many patients. Indeed what was an ‘experimental, risky and very limited treatment option fifty years ago, is now routine clinical practice in more than 80 countries’. As a result, this doctoral thesis takes as a baseline the assumption that transplantation surgery has done a lot of good; continues to do a lot of good, and is good in and of itself, even though its introduction was characterised by ethical and legal uncertainties.

Unfortunately, access to organ transplantation is limited or non-existent in large parts of Africa with Nigeria being the only country in West Africa where routine transplants are currently being carried out. There has however been great international interest in organ transplantation with commitment to deal with the issue of restricted access and to explore the possibility of


15 Thomasma, op. cit., 333.


17 In the UK, for example, about 3, 100 lives were said to have been saved and improved in 2012-13 through the donation of 1, 212 deceased organs. For further details see NHS Blood and Transplant, Annual Review 2012-13: Saving and improving lives; www.nhsbt.nhs.uk/annualreview/download/nhsbt_annual_review_2012-13.pdf, accessed October 21, 2014. Also for information about how a paralysed man has been able to walk again following pioneering cell therapy see Walsh, Fergus, ‘Paralysed man walks again after cell transplant’ BBC News, www.bbc.co.uk/news/health-29645760, accessed October 21, 2014.

18 Persy, P. Veerle et al, ‘Prevention and Transplantation in Chronic Kidney Disease: What is Achievable in Emerging Countries?’ Nephron Clin Pract 115 (2010): c122-c132 at c125; see figure 3 showing African countries where transplantation is available at the time of publication. It must be pointed out that the situation may have changed because Ghana has carried out successful test transplants since 2008 and hopes to begin routine transplantation by the end of 2014.
making kidney transplantation a routine treatment option for patients with Chronic Kidney Disease (CKD) across the world through collaboration among all the actors. One of the critical issues identified for urgent action is that all countries starting or developing transplantation programmes need adequate legal and professional frameworks to govern human organ donation and transplantation together with effective and transparent regulatory oversight systems.

In response to this international interest, Ghana first piloted test transplants involving living related donors in Korle Bu Teaching Hospital (KBTH), the nation’s premiere hospital in 2008. These test transplants, however, have been, and are being, conducted in the absence of any specific legislation on organ donation and transplantation activities. Consequently, the focus of this thesis is to critically evaluate the ethico-legal dilemmas that may arise in relation to human organ donation (both living and deceased) and transplantation (specifically kidney transplantation) in Ghana – a developing country.

1.2 Overview

This thesis is comprised of three Parts. Part I serves as a general introduction to the Ghanaian socio-legal context to facilitate our understanding of the relevant factors, Part II captures the main body of this doctoral thesis. It consists of three published or publishable papers. I draw the papers in Part II together in Part III as the conclusion to the thesis and point to areas of future

19 Ibid. and Garcia, Harden and Chapman, op. cit.
research and collaborative work. In this section, I briefly sketch the contents of the various parts of this doctoral thesis.

1.2.1 Part I

Part I consists of five (5) chapters. It provides a general introduction to the thesis and the Ghanaian socio-legal context. These opening chapters provide a general overview of the research context, introduce the research problem, and outline the methodological, legal and philosophical approaches adopted throughout the thesis. A preview of the main body of the thesis through a concise summary of the articles that form the basis of it is also provided. It exposes the challenges facing patients with end-stage renal disease in West Africa in general and Ghana in particular. The chapters do not go to great lengths in critically appraising the ethico-legal concerns surrounding the retention and use of human biomaterials for transplantation and science research. Rather, the purpose here is to show that despite the good ends served by organ transplantation, the means to securing those ends remain dogged by philosophical, cultural, and legal challenges and controversies among others.

Chapter 2: ‘Setting the Scene’ is a context setting chapter. It provides an overview of the socio-political environment of Ghana. It then highlights the burden of kidney disease as a matter of public health concern in that country. It provides a brief account of the state of organ transplants, particularly kidney transplants, in West Africa in general and Ghana in particular. Finally, it makes Ghana’s desire to set up a comprehensive organ transplantation programme manifest and raises from the outset, some of the ethical and legal issues that must be addressed during the regulatory process in that context.
Chapter 3: ‘The Ethical and Legal Background to this thesis’ provides a generic review of some common ethical and legal debates around organ transplantation. I explore debates around: i) the ever widening supply v. demand gap in human organs and tissues for transplantation and the controversies surrounding the various proposals to meeting the needs of transplant patients, ii) the definition of death, its uneasy relationship with organ retrievals for transplantation and the role of law in the definitional process, and iii) ownership or proprietary interests and rights in human biomaterials including posthumous interests among others.

Chapter 4: ‘Framework for Research and Methodological Approach’ sets out more clearly what the focus of this doctoral thesis is. I examine the following ethico-legal controversies within the Ghanaian socio-legal setting: i) the definition of death, its relationship with organs transplants and the role of law in that process; ii) whether the dead retain some interests in the Ghanaian traditional setting and how any such interests may inform the regulation of the nascent transplantation sector in that context; iii) whether Ghanaian law, unlike its English counterpart, recognises ownership rights in deceased bodies and puzzles that policymakers ought to avert their minds to when considering regulation of the sector in Ghana; and iv) the appropriate approach to regulating organ transplants in Ghana’s pluralistic socio-legal environment.

Chapter 5: ‘Philosophical and Legal Approaches’ gives concise accounts of some of the ethical and legal approaches adopted in addressing the issues raised by the research questions posed. I consider philosophical arguments touching on cognitive or personhood death; biological or clinical death; biographic death; whole or total brain death as well as brainstem death. This is because though Ghana is undertaking strenuous efforts to make kidney transplantation a routine surgical procedure by the end of 2014, the determination of death and its relationship with organ retrievals for transplantation have not been examined in that context. I argue in support of the
brainstem death criterion and propose that Ghana adopts it when considering a formal definition for human death in that country. Also, I consider the theory of rights because organ transplantation unavoidably raises questions about the interests and rights of individuals, their families and the public. As a consequence, I discuss posthumous interests and harms and show through the concept of ancestorship that such interests exist within the Ghanaian traditional setting. I locate this rights discourse in a consequentialist framework because the debates around organ transplantation are often conducted on the presumption of its utility; the good ends that it serves. This theoretical framework is well—suited for the purposes of this doctoral research because it has two dimensions – the good and the right and does not support an exclusively individualistic approach to rights. Finally, given that the use of human biomaterials (whether deceased or living) raises questions about ownership rights in such materials, I examine the concepts of ownership and self-ownership and explore some common legal justifications for them. I provide a brief explanation of Ghana’s legal system and highlight the constitutional protections accorded customary law, cultural and family rights. These protections have serious implications on how individual, familial and societal interests are balanced in that setting.

1.2.2 Part II

The second part of my thesis is divided into three chapters, each comprising a paper that has either been published or is under consideration for publication. These papers centre on some of the core issues I consider necessary, even if insufficient, for crafting an appropriate regulatory regime that is both facilitative of the social utility aims of organ transplantation and expressive of the social, moral and legal values of the Ghanaian regulatory context.
The first paper ‘Death in Ghana: Sociocultural Implications for Organ Transplant Regulation’ as set out in chapter 6 situates the clinical, ethical and legal controversies surrounding the definition of death and its uneasy association with organ retrievals for transplantation in the Ghanaian socio-legal context. It is hoped that doing so will bring a new perspective to the debate and enrich our ethico-legal discourse on the subject. This paper is motivated by the fact that though Ghana is making strenuous efforts to make organ transplantation a routine surgical procedure by the end of 2014, it has no ethical or legal framework to guide the process. I argue that the success of a transplant programme will depend in part on the availability of organs from all ethically acceptable sources (deceased, living related and unrelated). This being so, I discuss indigenous thinking around death through the concept of Post-mortem Personality Identity Renegotiation (PPIR) and point policymakers to how they could take advantage of PPIR to promote the social utility aims of any organ transplantation programme in Ghana. Furthermore, I consider the nature of the role of law in defining or determining death. I consider the merits of a statutory definition of death and conclude that given the socio-legal context of Ghana and the UK experience, a judicial rather than statutory definition is workable. I recognise that though these are just a few of the myriad of concerns that are associated with organ transplantation, clarifying the issues around the definition and confirmation of the time of death, and the nature of role that the law should play in this process is an important step in setting up an appropriate and comprehensive regulatory regime for the emerging sector of organ transplants in Ghana.

The second paper ‘Posthumous Organ Retention and Use in Ghana: Regulating Individual, Familial and Societal Interests’ set out in chapter 7, examines the question of whether individuals retain interests or can be harmed after death, particularly within the context of
deceased organ retrieval, retention and use. I argue that posthumous interests and or harms can and do exist in the Konkomba (and wider Ghanaian) traditional setting through the concept of ancestorship, a reputational concept of immense cultural and existential significance in this setting. I adopt Joel Feinberg’s account of harms as a setback to interests and show that crafting a socio-culturally sensitive regulatory framework does not necessarily exclude the donation of (deceased) human biomaterials for transplant and science research. Indeed, when customary values are explored with open-mindedness and sensitivity it may be shown that such donation can form part of the important customs of some communities in this jurisdiction. Accordingly, a context-appropriate governance framework could utilise the cultural value of ancestorship as an incentive to encourage organ donation in the Ghanaian traditional setting.

The third paper ‘Customary Law and ‘Ownership’ of Deceased Bodies: Regulatory Puzzles for Ghana’ as set out in chapter 8, revolves around the vexed issues of; i) agreeing an appropriate regulatory framework in Ghana’s pluralistic socio-legal context; and ii) whether Ghanaian law recognises ownership or proprietary interests in human biomaterials. The paper acknowledges the pluralistic nature of Ghana’s legal system. It then examines the difficulties that may arise when agreeing an appropriate regulatory framework for organ transplants in that setting. I argue that the challenges of regulating in a pluralistic environment can be effectively dealt with through reliance on the reflexive capacity of legal foresighting as set out by Laurie and colleagues. The paper also shows that the no property in a corpse rule at common law is now punctuated with exceptions and is of doubtful validity. It then examines Ghanaian customary law and shows that contrariwise it appears to recognise property in human bodies (at least deceased bodies) and vests such proprietary interests in the customary family of the deceased and in their sources during life. This seems to conform to the libertarian concept of self-ownership. If this
analysis of Ghanaian case law is correct, then it presents regulatory puzzles for regulating the emerging sector in Ghana. I conclude by arguing that for the regulatory regime to have legitimacy it should reflect the social, cultural and legal (or constitutional) values of the Ghanaian socio-legal context and tread the path of progress charted by Ghanaian customary law on this subject.

1.2.3 Part III

In Part III I draw all the papers in the second part together. I conclude that the constitutional protections accorded to customary law, cultural and family rights in the Ghanaian regulatory context make it imperative to examine how the ethico-legal issues raised by the uptake of organ transplantation may impact the social, cultural, legal and constitutional values in that country. I then propose the use of legal foresighting as a helpful tool to examine how the existing legal, ethical, social and cultural assumptions may be challenged with the view to determining how the law may be appropriately deployed in that regulatory context. It is hoped that this doctoral thesis will provoke and inform regulatory dialogue among the relevant stakeholders (bioethicists, health professionals, lawyers, lawmakers, policymakers, religious and traditional leaders etc.) on the comprehensive regulation of the use of human biomaterials particularly for the emerging organ transplants sector in Ghana.
CHAPTER 2

SETTING THE SCENE

2.1 Some Contextual Clarifications

I provide in the sections below, a brief overview of Ghana’s socio-political environment and highlight the burden of end-stage renal failure in that context. It is my hope that these clarifications will prove helpful to understanding the issues that are the subject of this doctoral thesis.

Ghana is a developing country and as such technology, in general, and biomedical technological advancement in transplantation surgery in particular, are slow to reach her. Having said this, Ghana is making significant progress in its developmental agenda. It is now classified as a middle income country albeit at the lower end of the scale.¹ One of the landmarks of progress is good democratic governance- her democratic credentials are touted as the success story from Africa-West Africa.²

The country returned to constitutional governance in 1992 after short spells of democratic governance interspersed with a good number of coup d’états which characterised a large part of her immediate post-independence struggle. The principles of good governance and the rule of law have gradually been deepened over the period and ‘Ghana is said to have made significant

strides and can be described as a success story among efforts towards democratic consolidation in Africa’.³

Ghana’s nascent democracy was put to the test following the tense and closely fought 2008 and 2012 general elections. In 2008 the country had to endure three sets of voting which resulted in the defeat of the incumbent New Patriotic Party (NPP) by the opposition National Democratic Congress (NDC). The winner could only be declared after voting in the small rural Tain Constituency of the Brong Ahafo region while the 2012 general elections saw an eight month-long legal tussle in Ghana’s Supreme Court.⁴ The tension and uncertainty that the legal challenge produced dissipated when the Supreme Court upheld the Electoral Commission’s declaration of the incumbent President (H.E. John Dramani Mahama of the NDC) as validly elected⁵ and the leader of the opposition NPP and first petitioner Nana Addo Dankwa Akufo-Addo promptly conceded defeat to the admiration of all. This has led some commentators to argue that Ghana’s democratic establishment ‘survived the closeness and intensity of the 2008 elections because it has developed stabilizing characteristics’⁶ including the maturity of its political parties and the important role played by other institutions such as the Peace Council.⁷

Contrasting the democratisation processes in Ghana and Nigeria shows that Ghana is well ahead of most of her West African neighbours. This has led some commentators to suggest Ghana,

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⁴ Presidential Election Petition, Nana Addo Dankwa Akufo-Addo and Others v John Dramani Mahama and Others [2013] SCG.
⁵ Ibid, particularly the Judgement of President of Panel, William Atuguba JSC.
Botswana and Mauritius as models of good and stable democracies worthy of emulation by other African nations.  

According to the 2010 Population and Housing Census (PHC) figures Ghana’s population stands at about 25 million. Ghana is, arguably, a highly religious nation and this observation is confirmed by the 2010 PHC figures which show that 94% of Ghanaians profess a religious faith. Christianity is the dominant religious faith and constitutes about 71% of the population; followed by Islam 18%, and then Traditional African Religions which constitute about 5% of the total population. This is very important in the context of organ transplantation as religious, cultural and traditional practices surrounding death and dying are important factors for consideration particularly in respect of human organ and tissue retrieval, retention, donation and transplantation. I will explore the socio-cultural sensitivities that Ghanaians often attach to the deceased when I examine the ethical, clinical, cultural and legal uncertainties surrounding death and dying in chapter 6.2 with the hope that the issues raised will provide useful insights that will inform policy and regulation of organ transplants in Ghana.

Non-Communicable Diseases (NCDs) are becoming a major concern in the developing world already overburdened with communicable diseases such as malaria, haemorrhagic fevers (especially yellow fever (YF) and Ebola), cerebro-spinal meningitis (CSM), tuberculosis (TB), HIV/AIDS and diarrhoeal diseases among others. Some of these communicable diseases have attracted international attention and led WHO member countries to sign the first health treaty in

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10 Ibid.
2005- International Health Regulations (IHR)\textsuperscript{11} geared towards curbing these public health events of international concern without unnecessary interference with international trade and traffic.

Even though one may legitimately question why Ghana a resource-poor country that is saddled with communicable diseases such as malaria and cholera should be committing resources to the development of a transplantation programme, I do not address this question in this thesis. My focus here is that given that organ transplantation is already taking place, how do we ensure that it is conducted in a manner that is legally, ethically, socially and culturally appropriate in that regulatory context.

In the next section I provide a concise account of the increasing burden of non-communicable diseases such as hypertension, diabetes and obesity as important causal factors for chronic kidney disease (CKD) in Ghana.

\section*{2.2 Increasing Burden of Non-Communicable Diseases in Ghana}

Resource-poor countries, including Ghana, face a new threat to the health of their people; the increase in NCDs such as hypertension.\textsuperscript{12} This upsurge in cases of diseases such as Hypertension, Diabetes, Obesity and others led the Ministry of Health (MoH) and Ghana Health Service (GHS) to develop a new policy aimed at healthy lifestyle modification as a means to

\textsuperscript{12} World Health Organisation, 2008-2013 \textit{Action Plan for Global Strategy for Prevention of Noncommunicable Diseases}, \url{http://whqlibdoc.who.int/publications/2009/97892}. Governments, development partners and civil society were called upon to take urgent steps to deal with the increasing burden of NCDs in low- and middle-income countries and its serious implications for poverty reduction and economic development. Also see Naicker, Saraladevi, ‘End-stage renal disease in sub-Saharan and South Africa’ \textit{Kidney International} 63 (2003): S119-S122.
combat their spread. Part of the efforts by the MoH and GHS to contain the upsurge in cases of hypertension and other NCDs led the ministry to include them in the legislation on public health-the Public Health Act, 2012 (Act 851). For instance, the prevalence of hypertension is estimated to constitute 30% of the adult population of Ghana. Similar findings are reported by other researchers in other parts of Africa.

In Ghana hypertension is recognised as one of the commonest causes of CKD. An earlier autopsy study showed that hypertension alone accounted for about 42% of the causes of CKD in Ghana. However, recent research findings demonstrate that the contribution of hypertension to renal disease appears to have increased, accounting for about 47% of all cases of end-stage renal disease and is now an issue of huge public health concern. This trend is reported in similar studies in Nigeria where hypertension accounted for about 61% of the cases of chronic renal failure. The data is further collaborated by other findings in sub-Saharan Africa that establish hypertension as a major cause of end-stage renal disease. Studies carried out in some sister countries show that CKD is also a worrying cause of child mortality and morbidity in Africa.

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17 Ibid.
Although, CKD is common in Africa, accurate and comprehensive epidemiological data on the prevalence of the disease is either limited to hospital-based figures or lacking.\textsuperscript{21} In Ghana, for example, anecdotal evidence shows that CKD is on the ascendancy. Indeed, hospital-based figures from the Korle Bu Teaching Hospital (KBTH) indicate that the prevalence is rising. Records at the renal dialysis unit of the department of medicine of the hospital reveal that 2010 saw a 38\% rise in the number of new cases of end-stage renal failure over the 2009 figure. These data from the renal unit of the KBTH further indicate that 15\% of all medical admissions and 10\% of all deaths at the department of medicine are due to chronic kidney disease and that the patients are mostly aged between 20 and 50 years of age.\textsuperscript{22} The data is comparable to similar studies conducted in Nigeria where 10\% of hospitals admissions were attributable to CKD.\textsuperscript{23}

\textbf{2.3 Cost Challenge Facing Most Patients with Chronic Kidney Disease in Ghana}

As in most parts of Africa, the needs of the majority of patients in Ghana with CKD are unmet due to the lack of adequate resources.\textsuperscript{24} There is little logistic, therapeutic and care support for patients with CKD in Ghana. Haemodialysis centres are few and expensive and often

\textsuperscript{22} This is unpublished data presented at clinico-pathological meetings at the hospital. Also, as the founding head of the Medico-Legal Unit of the Ministry of Health/ Ghana Health Service (MoH/GHS) and resource person for the Ghana Medical and Dental Council (GMDC), in matters of healthcare ethics and law, I have been actively involved in health care ethics, policy and regulation. This information came to my attention partly in that capacity. Further, I visited the Renal Unit of the KBTH where the kidney test transplants are being carried out to assess, at first hand, the ethical, legal and administrative structures currently in place as of September, 2012; to determine what the gaps are (if any) and to suggest ways of effectively regulating the sector. I met with a Renal Physician specialist at the Unit who provided me with insights into the Unit’s practices and also examined the records available. Also see the coverage granted the Head of the Unit and Chairperson of Ghana National Kidney Foundation, Dr. Charlotte Osafo, ‘Chronic Kidney diseases on the increase in Ghana’ \textit{GNA} (March 10, 2011); \url{http://www.ghananewsagency.org/details/Health/Chronic-Kidney-diseases-on-the-increase-in-Ghana}, accessed April 16, 2012. Also see Arku, Jasmine, ‘Dialysis centre inaugurated at Cape Coast Hospital’ \textit{Graphiconline} (August 15, 2013); \url{www.graphic.com.gh/news/health/12025-dialysis-centre-inaugurated-at-cape-coast-hospital.html}, accessed, December 12, 2013.
\textsuperscript{23} Naicker, \textit{op. cit}.
beyond the reach of the majority of patients with CKD. Prospective patients are expected to deposit $3,600 being the cost of thrice weekly haemodialysis for three months and $600-$800 for catheter insertion and access formation (or the Cedi equivalent). These bring the total costs before commencement of dialysis to about $4,400.00 USA Dollars. The costs become even more incalculably burdensome if the cost of erythropoietin, a long term treatment associated with CKD and stated to cost about GH¢ 310.00 ($105) per injection, is added. It is further stated by the Unit that when the deposit is exhausted, treatment will be discontinued to prevent the renal dialysis unit of the hospital from running into debt.  

Sadly, haemodialysis is not one of the benefit packages under the National Health Insurance Scheme (NHIS) in Ghana. Apart from acute renal failure (which is covered under emergency care) haemodialysis for CKD is paid for by the patient whether in a public or private health facility. The cost of dialysis is generally of grave concern not only to the emerging economies but also for developed countries.  

It has, therefore, become necessary to rethink the strategy for a more comprehensive and sustainable mechanism for the management of patients with CKD in Ghana. This is because transplantation is said to be the best and the most cost-effective treatment option for patients with CKD.

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25 Korle Bu Teaching Hospital, information documents for prospective patients and their sponsors to the Renal Dialysis Unit, dated September 4, 2012.
27 Persy, P. Veerle et al, ‘Prevention and Transplantation in Chronic Kidney Disease: What is Achievable in Emerging Countries?’ Nephron Clin Pract 115 (2010): c122-c132. Understandably, though there are no figures comparing the costs of kidney transplants to those of chronic dialysis in Ghana it is trite knowledge that while the initial costs for kidney transplants, might seem high, the long-term dialysis costs are burdensome and economically unsustainable by most health systems. For example, statistics from the UK indicate that the cost benefit of kidney transplantation compared to dialysis is said to be about £24, 100.00 per year for each year that the patient has a functioning transplanted kidney. For further information see NHS Blood and Transplant, Facts Sheets: Cost-effectiveness of transplantation (October, 2009); www.organdonation.nhs.uk/newsroom/fact_sheets/cost_effectiveness_of_transplantation.asp, accessed October 23, 2014.
2.4 The State of Organ Transplantation in West Africa

Kidney transplantation is still in its infancy in a large part of sub-Saharan Africa with the exception of South Africa. For the entire West African sub-region transplantation is currently only being carried out routinely in Nigeria. Ghana is expected to commence routine transplantation by the end of 2014. To this end, she has taken keen interest in facilitating the skills acquisition of her health care workers, especially some of the workers of Korle-Bu teaching hospital, the premier teaching hospital in Ghana. As indicated in chapter 1 above, a number of test kidney transplants (using living related donors only for the time being) have already been carried out. The first test transplants were successfully carried out in 2008 and then in 2009, 2011, 2012 and 2014. Thus far a total of twenty (20) transplants from living donors have been carried out with the support of some UK-based doctors and the Transplant Links Community. Another set of transplants are slated for December 2014 after which Ghanaian doctors are expected to start routine transplantation surgery at the Korle-bu teaching hospital.

Undoubtedly, some of the ethical-legal concerns that arose in the fifties following the advances in transplant technology in the developed world remain relevant today in developing countries such as Ghana. In order to develop a comprehensive and appropriate governance framework for the emerging organ transplant sector in Ghana careful consideration must be given to the following ethical-legal issues: i) defining, determining or confirming death and its

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30 Transplant Links (TLC) is a UK registered charity that supports emerging countries in the management of CKD. They offer teaching, advice and carry out living kidney transplantation with the aim of ensuring that sustainable transplant programmes become possible in the future. It was established in 2006 by a group of British doctors with vast experience in transplant surgery and desirous of sharing their knowledge and expertise. For a more detailed look at their activities see; [http://www.transplantlinks.org/](http://www.transplantlinks.org/).
relationship with transplant surgery; ii) what the nature of the role of law in this process ought to be?; iii) whether the dead retain any interests in the Ghanaian socio-cultural context, if so, what might these entail and, if not, might conscription of deceased organs and tissues for morally important courses such as transplantation be a workable public policy option in that setting?; iv) how to appropriately and effectively regulate the varied interests (societal, familial, individual, etc.) in a pluralistic legal environment such as Ghana so as to facilitate the social utility aims of biotechnology on the one hand, and respecting the values (cultural, constitutional or legal, philosophical, etc.) of the regulatory context on the other; v) whether Ghanaian customary law, unlike English law, recognises ownership and proprietary interests or rights in (deceased) human bodies or parts thereof, and if so, who the interest or right-holders may be (that is whether these rights or interests vest in the individual, society or family), and vi) the challenges any such recognition might present to policymakers when considering a workable regulatory framework for organ transplants in Ghana.

I acknowledge that these are just a few of the myriad of the ethico-legal issues that need addressing when developing a workable and comprehensive regulatory framework for organ transplantation. These are, nonetheless, important ones, as getting any one of them wrong could have serious implications for public trust in, and support for, organ donation and transplantation in particular and the permissible uses of biomaterials for science research more generally.

Some of these concerns which have been satisfactorily resolved, or remain largely unresolved, or which have been unsatisfactorily dealt with in the UK with well-developed structures for human organ donation and transplantation services will be critically examined in the course of this study. It is hoped that the ensuing analysis will help draw out areas of best
practice that Ghana can learn from, and or identify potential pitfalls that ought to be avoided by
developing countries such as Ghana.

Before I examine the ethico-legal concerns raised by the issues that are the subject of this
doctoral thesis, I provide in the next chapter a general but concise account of the ethical and legal
debates that commonly characterise discussions surrounding organ transplantation.
CHAPTER 3

THE ETHICAL AND LEGAL BACKGROUND TO THIS THESIS

3.1 Some Relevant Ethico-Legal Arguments

The ethico-legal questions surrounding human organ transplantation are many and varied. Some of the legal and ethical controversies often border on the following broad areas of concern: the stark reality of shortage of human organs and tissues and how to increase the supply to meet the increasing demand; the definition of human death, whether any such definition should be statutorily or judicially determined and its relationship with organ transplantation; whether or not the dead retain some interests posthumously, if so, how the surviving interests of the decedent should be balanced against those of the family and society; whether or not ownership and proprietary interests or rights should apply to human biomaterials and who the interest or right-bearer(s) might be; and whether these interests or rights should be subject to market forces among others. For example, an admission of posthumous interests or rights will have serious ramifications for organ transplant regulation especially in respect of deceased organ donation in a sociocultural setting in which such interests or rights are held to exist. These broad areas of ethico-legal concern will be briefly examined in the ensuing sections.

3.1.1 Is there a shortage of human organs and tissues?

There is evidence\(^1\), and a general consensus, that the dearth in human organs and tissues is, or is near, a crisis level globally.\(^2\) For instance, figures from NHS Blood and Transplant show

\(^1\) For example about 466 people died in the UK in 2013 while on active transplant waiting list and a further 7,332 patients remained on the waiting at the end of March, 2013. These figures exclude 3,030 others who were
that as of 31/03/2014 the total number of kidney transplants for the year stood at 3,257 yet the number of patients registered on the kidney transplant list was 5,881. Furthermore, statistics from the Eurotransplant International Foundation which is a cooperation involving seven countries (Austria, Belgium, Croatia, Germany, Luxembourg, Netherlands and Slovenia) indicate that as at 31/12/2013 whilst kidney transplants from deceased and living donors were 2,951 and 1,402 respectively, the active recipient organ needs on the waiting list for kidney transplant in respect of the same stood at 10,757. It is estimated that about 115,703 patients are on the transplant waiting list in the USA and that about 5,412 listings for kidney transplant alone were removed due to death. Crucially, the waiting period appears to be on the ascendency and that while a new name was added to the transplant waiting list every 18 minutes in the late 1990s this had decreased to every fourteen minutes in 2001 and was expected to further fall to every ten minutes by 2005. These statistics conform with the position of most commentators who point to the organ shortage as a problem that demands new, innovative and urgent ways of dealing with.


Skeptics, however claim that the choice of terminology such as demand, supply and shortage is misconceived and that the term organ shortage as employed is ‘neither self-evident nor unproblematic’. Others have argued for a new and innovative model of organ donation education with a broader focus on both the demand and supply sides of the organ shortage problem. Nonetheless, the statistics are self-evident and the yawning gap between the demand and supply sides of the human organ and tissue problem with the associated twin evils of long waiting periods and needless deaths, is aptly described by some as ‘a major crisis, and a major scandal’. 

The need for human organs may become less acute, if and when the hurdles to the development of artificial organs and xenotransplantation are overcome in the future thereby rendering the ethics of procuring organs from humans moot. It has thus been suggested that ‘transplantation of organs such as kidney, liver, heart, and lungs may well be a passing phase in medical technology until alternative means of substituting lost function are found’. When we are able to produce new hearts, lungs, and kidneys among others then we would have made giant strides in biotechnological advancement where each human organ will have a corresponding spare part ready to be called into action as and when needed. Until then, the evidence of a severe

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Erin and Harris, op. cit.


shortage in transplantable human organs and tissues appears unassailable and any attempt to suggest otherwise may be either misunderstanding or misstating the real challenges confronting transplantation surgery today.

Since the overall object of this doctoral thesis is to examine how comprehensive governance frameworks may be fashioned out in the Ghanaian regulatory context, it becomes important to consider the ethical and legal defensibility of the various sources of organs and tissues. As a consequence, we shall next consider some of the common debates aimed at ameliorating the shortage of human organs and tissues for transplantation and science research.

3.2 Meeting the increasing demand in human organs and tissues

3.2.1 General Considerations

A number of strategies have been suggested as the means by which the demand-supply deficit may be overcome or at least reasonably bridged. But the means by which the much desired increase in supply is to be achieved is contested.

Some commentators especially Harris\textsuperscript{14} and Audi\textsuperscript{15} have proposed the donation lottery. Briefly, the Survival Lottery is modelled on consequentialist claims. It proposes that in the wake of patients dying due to organ shortage, everyone be given a sort of lottery number. When two or more patients need organs and can be saved by transplants, but there are no suitable organs, then the doctors or operators of the lottery may push a central computer to supply at random a suitable donor by literally dropping the number of ‘death’. The person will then be killed and his organs distributed among the patients.

\textsuperscript{14} Harris, \textit{op. cit.}\textsuperscript{15} Audi, Robert, ‘Organ Transplant’ \textit{Utilitas} 8 (July, 1996): 149-150.
Harris argues, I think, cogently, that it might be rational to accept the survival lottery on prudential as well as utilitarian grounds even though the practical effect of operationalising such a lottery might be imposing mandatory saintliness on the society that adopts such a policy and that there are no compelling objections to his Survival Lottery. Others have remained skeptical about the lottery, not least its utility and workability. Singer points out that the major drawback of the Survival Lottery is that ‘it removes the natural disincentive to imprudent action’ since individuals who cause their own ill-health may not feel the need to be responsible. He however concedes that Harris was aware of the difficulty and sought to cure the mischief by arguing that it would be unfair to include those who are the cause of their misfortune. None the less Singer points out, correctly, that the complexity and multi-factorial nature of disease causation would make identifying such persons impossible in practice. The scheme is therefore unlikely to work because it does not possess enough disincentives for all the risk bearers. I am consensus ad didem with Singer in respect of the practical implications of making such a scheme work.

Nelson, on the other hand, argues that the Survival Lottery as suggested by Harris unfairly favours those in need of organs (Y and Z) as it appears to exclude them from the draw. To cure the scheme of this apparent unfairness Nelson suggests that Y and Z be part of the draw. However, it appears to me that the Survival Lottery as intended under the Harrisian model was conceived prior to the allocative or distributive considerations and therefore not exempting Y and Z from entering the lottery. Indeed, if my understanding of The Survival Lottery is correct, then all were liable under the Harrisian scheme rendering parts of Nelson’s criticism otiose. This

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17 Singer, op. cit., 219.
18 Ibid., 221.
19 Nelson, op. cit.
does not however diminish the illumination and clarification that his work has made to the Harrisian Survival Lottery.

Presumed consent has also been supported by some contributors as a way of increasing organ supply. It has been argued that dead bodies should be conscripted and treated as a public resource without the need for consent by relations. It is submitted that the objections by society to deceased organ donation by the family and relations of the dead is inherently irrational and that presumed consent is an ethical and effective way of increasing the supply of human organs. But others have remained skeptical arguing that death does not necessarily mean that the dead body 'ceases to matter at all'. It has thus been argued that the interests we have in what can or cannot be done to our bodies in death outweighs those of patients with end stage organ disease requiring transplantation. The skepticism that is associated with opting-out or presumed consent is reflected in the fact that while some countries such as Spain and Sweden have adopted it as a means of increasing donor organs, others such as the USA and the UK have been reluctant to do so. However, there is increasing evidence that presumed consent alone

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27 It must be pointed out that Wales has a Human Transplantation Act 2013 which seeks to implement a soft opt-out system by 2015. But whether this will encourage a rethink by the English remains to be seen. For details see http://wales.gov.uk/docs/dhss/consultation/120618billen.pdf, accessed October 29, 2012.

It has been further argued that the time to apply preconditioning to solid human organs might have arrived and that such a practice has the potential of increasing the availability of human organs and tissues by ‘allowing the use of marginal donors’\footnote{McNally, S. J., Harrison, E. M., Wigmore, S. J., ‘Ethical considerations in the application of preconditioning to solid organ transplantation’ J Med Ethics 31 (2005): 631-634, 633.} and that any discussions of the ethico-legal ramifications associated with its application is welcome.

The quest for solutions to the organ shortage problem has led others to propose the use of prisoners as a source of organs for transplantation. It is contended that this provides prisoners the unique opportunity to either save their lives, both physically and spiritually, or to have their prison sentences commuted.\footnote{de Castro, L. D., ‘Human organs from prisoners: kidneys for life’ J Med Ethics 29 (2003): 171-175.} It is argued that doing so will provide the prisoners a wonderful window of opportunity to make amends especially if donation is made to assert their religious belief and is performed as an act of sacrifice for the atonement of their sins.\footnote{Ibid.} As a result, even though it is conceded that the prison is a restrictive environment, it is none the less argued that ‘prisoners can still make genuinely independent decisions’\footnote{Ibid., 171.} and that a general proscription of prisoners as organ donors ‘unjustifiably deprives them of a unique opportunity to engage in productive acts that stand to be beneficial not only to renal patients but to themselves’\footnote{Ibid., 173.}.

Additionally, some commentators have argued in support of a policy of selective acceptance of

\begin{itemize}
\item Ibid.
\item Ibid., 171.
\item Ibid., 173.
\end{itemize}
conditional organ donations and criticised the reasoning behind a sweeping ban on all conditional organ donations.\footnote{Wilkinson, T. M., ‘What’s wrong with conditional organ donation?’ \textit{J Med Ethics} \textbf{29} (2003): 163-164.}

Considering the various sources of organs, and the ethically and legally appropriate ways of increasing the donor pool, will help Ghana deal effectively with issues of organ shortage while respecting societal concerns. A regulatory or oversight system must recognise the sensitivities that various communities attach to issues of human death, if it is to be effective. Some of the contextual factors that are deemed to have important ramifications for organ transplant regulation in the Ghanaian socio-legal context are considered in chapters 6.2 and 7.4 respectively below.

In the next section I provide a concise account of the debates on whether or not we should, alongside altruism, introduce incentives and in some exceptional circumstances even permit a market in body parts as a way of maximising organs for transplantation.

\textbf{3.2.2 Human Organs or Tissues and the Market of Repugnance?}

Whether the marketplace ought to include human organs and tissues as one of its prized commodities is a vexed issue. This is understandable, at least from a Ghanaian perspective, because the marketplace typically and traditionally evokes a spectre of men, women and children displaying various merchandise in every available space; on the ground, table tops, head-pans and so on, shouting themselves hoarse, their discordant voices are drowned in the cacophony of tolling hand bells all intended by the traders to outdo one another in attracting the most buyers to their wares.

For some, the marketplace ought not to be allowed to accommodate human organs and tissues as merchandise. For the proponents of this view, doing so ‘dangerously undermines
human dignity by obscuring the difference between being human and marketing,\textsuperscript{35} a shift in attitude that is inimical to our collective humanity. Some commentators have however pointed out that it might be ‘an error to assume that non-commodification always has a benign effect on the way we discuss our values’\textsuperscript{36} and that inappropriate politicisation of goods can and could equally have some deleterious effect on our collective values. Regulation of this sector must therefore be informed by these communal goals and values if it is to remain relevant in this rapidly changing area of medicine.\textsuperscript{37}

Joralemon argues that the first decade of successful organ transplantation saw a remarkable meeting of minds worldwide where trading in human organs (both living and dead) for financial gain was considered unethical.\textsuperscript{38} However, over the years there appears to have been a well-orchestrated shift in the ethical discourse on buying and selling organs. He submits that despite the shifting rhetoric, the bioethical debate is bound to fail to lessen opposition to organ sales because ‘money and vital organs occupy distinct moral universes for substantial numbers of health professionals and members of the public at large’.\textsuperscript{39} According to Joralemon these universes constitute an irreconcilable dichotomy such that any attempts at bridging them will likely suffer a serious setback.\textsuperscript{40} This non-commercial stance is further supported by the claim that human organs and tissues should not be objects of commerce and should not be the subject

\begin{itemize}
\item \textsuperscript{35} Marino, Ignazio R., Cirillo Claudia, and Cattoi, Alessandra, ‘Market of organs is unethical under any circumstances’ \textit{BMJ} \textbf{325} (October, 2002): 835, 835.
\item \textsuperscript{36} Grady, F. Mark, ‘Politicization of Commodities: The Case of Cadaveric Organs’ \textit{The Journal of Corporation Law} \textbf{20} (Fall, 1994-1995): 51-68, 68.
\item \textsuperscript{37} Devaney, Sarah, ‘Regulate To Innovate: Principles-Based Regulation of Stem Cell Research’ \textit{Medical Law International} \textbf{11} (2011): 53-68.
\item \textsuperscript{38} Joralemon, Donald, ‘Shifting ethics: debating the incentive question in organ transplantation’ \textit{J Med Ethics} \textbf{27} (2001): 30-35.
\item \textsuperscript{39} Ibid, 34.
\item \textsuperscript{40} Ibid.
\end{itemize}
of market conditions.\(^{41}\) This, it is argued, is because human organs and tissues are an integral part of the identity of persons and thus constitute their inherent value as individuals and that nation states should rather strive to protect and incentivise the notion of the gift of life.\(^{42}\) Others argue that the attempt to bridge the demand and supply gap in human organs and tissues based on the disputatious market or commodity model where ‘one could buy or sell body parts…lies at the heart of repugnance to the concept in that it shows a fundamental disrespect for the status of the human body’.\(^{43}\)

Many have however doubted the relevance of the continued over-reliance on altruism in contemporary bioethical discourse especially in relation to human organ and tissue donation.\(^{44}\) It is contended by proponents of this viewpoint that some form of incentives could and should be implemented alongside the reliance on altruism.\(^{45}\) It is argued, quite persuasively, that if donors are given priority over non-donors should they themselves require a transplant during their lifetime, then many more individuals would be willing to donate because it may be ‘seen as a self-interested interaction that promotes both one’s own wellbeing and that of others’.\(^{46}\) As a result, it is suggested that we should use incentives but not payments to recruit living donors and that we should restrict access to transplants by those who fail to donate or enter the donation lottery.\(^{47}\) On my part, I find no ethically compelling reasons why incentives cannot and should


\(^{42}\) Ibid.


\(^{47}\) Audi, *op. cit.*
not, where appropriate, be used to encourage more people to donate their biomaterials for organ transplantation or science research. Indeed, attempts at drawing a moral distinction between payment for organs per se and payment for the willingness to donate appears ethically dubious as any person selling his or her organs could always claim that he or she is doing so because of his or her willingness to prolong or save the life of the recipient-buyer. This may explain the position of the Nuffield Council on Bioethics\textsuperscript{48} that their stepwise presentation of the various forms of interventions to encourage and promote human tissue and organ donation does not represent a movement from the ‘ethical’ to the ‘unethical’.

Other commentators consider incentives central to encouraging organ donation and have therefore suggested that, where appropriate, markets could and or should be seen as an essential part of increasing the supply of these gifts of life.\textsuperscript{49} Proponents are quick to point to what they see as the hypocrisy that characterises the ethics of buying and selling human organs and tissues and suggest an ethical market\textsuperscript{50}- a well regulated monopsonistic market with a public body such as the NHS as the single buyer and seller.\textsuperscript{51} Some have argued that the fear of exploitation of the poor and vulnerable is not and cannot be enough grounds to justify restriction or exclusion of markets in the search for answers to deal with the scarcity of human organs and tissues.\textsuperscript{52} It is contended that the focus of the debate should be on legalising the sale of organs and establishing

\textsuperscript{52} Savulescu, J., ‘Is the sale of body parts wrong?’ \textit{J Med Ethics} 29 (2003): 138-139.
a fair price\textsuperscript{53} and that on the contrary controlled and regulated compensation is likely to improve safety for both donors and recipients.\textsuperscript{54}

The issue of sale of body parts has recently received some currency in the local media in Ghana following reports of sale of sperm\textsuperscript{55} and ova\textsuperscript{56} by students and some unemployed to private fertility hospitals. If the reports are anything to go by then it is a great worry since all these are happening in an unregulated environment. Understanding the ethical and legal arguments that are often invoked by both proponents and opponents alike and the institutional arrangements that give practical effect to them is crucial for effective legislation and regulation. This thesis, therefore, situates these ethico-legal concerns in the Ghanaian socio-cultural context with the view to identifying key issues that ought to inform the regulation of the emerging transplants sector in that country.\textsuperscript{57}

Another sensitive issue of great importance revolves around the ethical, clinical, legal and policy uncertainties associated with the (re) definition of death and its relationship with organ retrieval for transplantation especially deceased organ donation. We shall briefly consider this vexed issue in the next section but a fuller examination of the controversy is presented in chapter 6.

\textsuperscript{53} Friedman and Friedman, \textit{op. cit.}
\textsuperscript{54} Friedman, Amy, L., ‘Payment for living organ donation should be legalised’ \textit{BMJ} \textbf{333} (7 October, 2006): 746-748.
\textsuperscript{56} ‘Girl Dies After selling ‘Ova Eggs’ At Pro-Vita Hospital’, Peacefmonline.com, http://news.peacefmonline.com/tools/printnews/news.php?contentid=52614; \textit{Girl Dies After Selling ‘Ova Eggs’}, http://www.ghanatoghana.com/Ghanahomepage/girl-dies-selling-%e2%80%9c%e2%80%80%e2%80%9d, accessed October 3, 2012. A 20 year girl, a school dropout, was reported dead after she offered her ova for sale at the cost of GH¢1,200.00 (about $600) at Pro-Vita Fertility Hospital, located at Tema near Accra-Ghana. She is alleged to have died when she went to have her eggs harvested at the hospital without the knowledge of her parents.
\textsuperscript{57} I consider the current law and practice relative to the retention and use of human biomaterials in Ghana in chapter 7.2.
3.3. Defining Death and its Relationship with Retrieval of Organs for Transplant

3.3.1 Death and Its Shadows

In this section I consider the controversies that surround the different perspectives (medical, social, legal, etc.) on how human death can or ought to be defined. Undoubtedly, of the biotechnologies that medicine has known, none may have had its ethico-legal challenges conducted, literally, in the shadow of death and with such intensity as transplantation surgery.58 When death occurs, how it is defined, confirmed and the purpose that such determination or definition serves as well as whether such definition should be statutorily determined are all strongly contested issues.59

Traditionally, attempts at defining the moment of death have aimed at identifying the time that the human body has permanently or irreversibly ceased to biologically function as a whole.60 This irreversible cessation of biological function of the human organism as a whole was determined, in early times, by using putrefaction as a proxy; then in the 19th century by cardio-pulmonary function.61 However, by the turn of the 20th century, successes in biotechnology particularly in intensive care medicine challenged the cardio-pulmonary criterion because it became possible in certain cases to restore lost cardio-pulmonary function.62

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58 Arguably, advances in intensive care medicine leading to controversies around withholding and withdrawing treatment can be similarly characterised. I thank Prof. Holm for this point.
60 Powner, Ackerman and Grenik, op.cit.
62 Ibid.
Understandably, this led some skeptics to question the ethical and legal defensibility of transplanting a heart from someone whose death was determined using irreversible cessation of cardiac function as the criterion.\footnote{Veatch, Robert M., ‘Donating Hearts after Cardiac Death- Reversing the Irreversible’ \textit{New England Journal of Medicine} \textbf{359} (August, 2008): 672–673 and Truog, R. D., ‘Brain Death- Too Flawed to Endure, Too Ingrained to Abandon’ J. L. Med. & Ethics \textbf{31} (2007): 273-281.} It has been argued that ‘if a heart is restarted, the person from whom it was taken cannot have been dead according to cardiac criteria’,\footnote{Veatch, \textit{op. cit.}, 673.} and any organ retrievals from such a body is ending a life by organ removals thereby violating the Dead Donor Rule (DDR).\footnote{I provide a brief explanation of the DDR as employed in this analysis in chapter 6.3.1 footnote 57.} However, it is counter-argued that this apparent illogicality disappears when it is understood that there is a distinction between permanent and irreversible cessation of cardio-pulmonary functions. That whilst \textit{permanent} admits possibility, \textit{irreversible} does not, and that doctors normally use permanent cessation of cardio-pulmonary function as a valid proxy for irreversible cessation allowing for a timely determination of death.\footnote{Bernat, James L., ‘How the Distinction between “Irreversible” and “Permanent” Illuminates Circulatory-Respiratory Death Determination’ \textit{Journal of Medicine and Philosophy} \textbf{35} (2010): 242-255.}

The rapid developments in organ transplantation might be argued to have acted as a catalyst for the renewed urgency to redefine death.\footnote{Brazier, M. and Cave, E., \textit{Medicine, Patients and the Law} [5th edition] (London: Penguin Books, 2011), 494-495.} It is argued that the French neurosurgeons (Mollaret and Goulon) were the first to attempt in 1959 to define, or rather redefine, death using cessation of brain, rather than cardio-pulmonary function.\footnote{Jackson, \textit{op. cit.}, 558 and Wijdicks, Eelco F. M., ‘The Diagnosis of Brain Death’ \textit{The New England Journal of Medicine} \textbf{344} (April 19, 2001): 1215-1221.} However, brain death or irreversible coma was to be formally defined in 1968 by the Ad Hoc Committee of the Harvard Medical School\footnote{Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Death, ‘A Definition of Irreversible Coma’ \textit{Journal of the American Medical Association} \textbf{205} (1968): 337-340.} which was specifically setup to examine the definition of death. Subsequently, the brain death criterion has, arguably, gained general acceptance among the medical and legal fraternities.
especially in the developed world. Some commentators contend that the whole-brain death concept provides the most satisfactory expression of our understanding of the concept of death of the human organism. Others maintain that the current policy of employing brain death as death of the human organism encompassing the cessation of total brain function including brainstem death is restrictive and undermines efforts at increasing the organ donor pool and that an adoption of a definition of death that is centred on the death of the higher brain functions (cognitive death) may be a desirable and necessary step. Proponents of this viewpoint maintain that ‘the moment of death is not a medical but a social decision that can vary as the times and technology change, and that what is distinctly human about us is affect and cognition, not possible when the higher brain function has permanently vanished’. This viewpoint is however challenged on the grounds that death, just like life, is a biological phenomenon and any attempt to redefine ‘death to a preconceived social or political agenda’ would seem ethically dubious. Although socio-cultural practices surrounding death are not denied, it is nonetheless argued on this account, that death is essentially an event and not a process because, as Bernat demonstrates, ‘given that alive and dead are the only possible underlying states of an organism, the transition from the state of alive to the state of dead is necessarily sudden and instantaneous, at least in concept, because there is no intervening state’. Bernat rejects the higher brain death formulation of death as unsatisfactory and argues that there is sufficient public consensus for the development of uniform rules allowing the adoption of the

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70 It is important to observe that though there is general consensus about the ethical and legal defensibility of brain death differences still persist. For a more nuanced examination of these issues see paper 1 as set out in chapter 6 below.


72 Thomasma, op. cit., 337.

73 Ibid., 341(emphasis added).


75 Ibid., 331.
whole-brain criterion of death across the world. Indeed, it is persuasively submitted that higher brain death or cognitive death is not the absolute death of the human organism and the two should never be treated as one and the same thing.\textsuperscript{76} It is particularly important to re-examine some of these claims within the Ghanaian traditional setting where human death is conceived of as a process rather than a point event.\textsuperscript{77}

Another challenge to the strict biological conception of death (the view that death is a point event) is seen in the Japanese socio-cultural context where it is held that ‘life and death cannot easily be harmonized with the concept of beginnings and endings pinpointed to a certain moment nor with a requirement for survivors to relinquish the body of the deceased immediately upon the determination of death’\textsuperscript{78} making any worldwide consensus as advocated by Thomasma unlikely in the near future. Additionally, it has been cogently submitted that

a wide remit for the determination of death is crucial to this field because the problem of death is not only simply a technical problem of the brain and its workings but also about how experiences of mortality are mediated by social understandings of death and dying…this means understanding death and dying at the place where biology and biography meet at their intersections with society and history.\textsuperscript{79}

For instance, indigenous Konkomba\textsuperscript{80} philosophical thinking posits that death does not extinguish all existence. Death is understood to be a process through which the living transit from the world of the living to that of ancestry. The ancestors are understood to live on and


\textsuperscript{77} I discuss these considerations in detail in chapter 7.4.


\textsuperscript{80} The Konkomba are the second largest ethnic group in the Northern Region of Ghana. Their beliefs mirror the beliefs of almost all other ethnic groups in Ghana. As a result, the arguments, inferences and conclusions in this thesis have a huge potential for generalisation.
continue to interact with the living through the ever present world of ancestry. As such certain peri-mortem events may undermine one’s ascent to ancestorship.\(^\text{81}\) Similarly, Hardacre demonstrates that the issue of death is not just a biological, social, or cultural issue but religious as well citing Buddhists and Shinto views on brain death and organ transplantation.\(^\text{82}\)

Interestingly, the UK does not recognise whole-brain death as death of the human body. Rather the brainstem death criterion for the determination of death is preferred as evidenced by the 1998 and 2008 Codes of Practice for Diagnosis of Brain Stem Death issued by the Department of Health (DH) and Academy of Medical Royal Colleges (AOMRCs) respectively.\(^\text{83}\) But critics have pointed out that it is morally troubling to retrieve organs from people whose hearts and lungs may still be functioning.\(^\text{84}\) It is then claimed that it may be proper to admit a dualism in our criteria for defining death: one criterion for somatic death and another for personhood (cognitive) death.\(^\text{85}\)

Many may be apprehensive if the dualist argument were to succeed. Dualism in the definition of death might seem unwarranted and the point is strongly, and rightly, I think, made that whatever our conception of death is, it would seem more pragmatic to consider

the brain, the heart, and the lungs as forming a ‘cycle of life’ which can be broken at any point; looked at in this way, there is no need to speak of two types of death…it is simply that different criteria, and different tests, can be used for identifying that the cycle has been broken.\(^\text{86}\)

\(^\text{81}\) For a detailed exploration of the concept of ancestorship and how that founds posthumous interests in the Ghanaian socio-cultural setting and the potential implications of that on deceased organ donation see chapter 7.4.

\(^\text{82}\) Hardacre, \textit{op. cit.}, 594-598.


\(^\text{84}\) Veatch, \textit{op. cit.}


\(^\text{86}\) Mason and Laurie, \textit{op. cit.}, 524.
Furthermore, the purpose (s) that the definition or redefinition of death seeks to serve is also shrouded in controversy. It is contended that the history of the development of the concept of brain death and the subsequent adoption of the brain death criterion for defining death are acts that are ‘closely linked to developments in organ transplantation’ but which are at best scientifically and philosophically dubious. It has been strongly argued that brain dead individuals are not dead and any attempt by doctors to kill such individuals for the good of others cannot be justified. This is because the ‘recognition of brain death as a criterion of death made it possible to source organs from persons who could be declared legally dead even though their hearts were still beating’.

Some commentators however argue, quite forcefully, that the brain death concept did not evolve to benefit organ transplantation as claimed and that a careful examination of the ‘historical approach to this issue will demonstrate that both had an entirely separate origin’. It is contended that whilst organ transplantation is attributable to advances in immunology and surgery, the need for the definition (redefinition) of death is due to advancement in intensive care techniques.

Whilst it is conceded that developments in intensive care medicine made it necessary to reconsider what death is, it is equally undeniable that ‘a significant trigger to rethink our definition of death was the development of transplantation, which highlighted the need for speed

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in diagnosing death and removing organs from the body’.\textsuperscript{92} Plausibly, biotechnological advancements in intensive care medicine and in surgery and immunology may have developed in parallel, both calling into question the sufficiency of traditional conceptions and understandings of the definition of death. It nonetheless seems indisputable that even though the definition of death did not necessarily arise to benefit transplantation; it is legitimate to argue that organ transplantation appears to have been the most, if not \textit{sole}, beneficiary of the redefinition of death.\textsuperscript{93}

There is also uncertainty about whether societal uneasiness with the definition of death and its relationship with transplants is better dealt with by having a statutory rather than judicial definition of death. These controversies will engage our attention in the ensuing section.

3.3.2 A Statutory or Judicial Definition of Death?

Should the definition of death be set out by the law and, if so, what form should the defining law take? Should it be statutory, or should it be left to the courts to develop, in common law jurisdictions, through the doctrine of \textit{stare decisis} or judicial precedent? There are a number of benefits that a legal definition of law brings these include; i) \textit{criminal law} reasons such as proving causation in cases of homicide\textsuperscript{94} (murder and manslaughter) as well as the common law rule of Year and A Day\textsuperscript{95}; ii) \textit{inheritance} purposes for determining the order of death of say a testator and beneficiary or two relatives when this occurs around the same time in a common accident; iii) \textit{civil law} reasons such as terminating marriages and other legal partnerships; iv)

\textsuperscript{92} Brazier and Cave, \textit{op. cit.}, 494-495.

\textsuperscript{93} This claim will be defended in the paper on ‘Death in Ghana: Sociocultural Implications for Organ Transplant Regulation?’ as set out in Chapter 6 below.


\textsuperscript{95} This common law rule which holds that death shall not be held to have been caused by harm unless the death takes place within a year and a day of the harm being caused is still valid law in Ghana. See Section 64 (e) of the Criminal Offences Act of Ghana, 1960 (Act 29 as amended).
medical law reasons such as respecting the DDR and dealing with sensitive cases such as women in Permanent or Persistent Vegetative State (PVS) or Minimally Conscious State (MCS) who are pregnant; and iv) finally for Tax purposes because donatio inter vivos may not attract an inheritance tax.

In fact Brazier and Cave have pointed out that proponents of a statutory intervention have maintained that the definitions of death have not only altered over time, but doctors and judges have also constantly moved the goalposts. As a result, there is the need for a debate about regulation as this will provide a unique opportunity for the public to get involved and educated on the subject matter and also express their views on troubling cases such as the use of anencephalic infants as organ donors and the problems of post-mortem pregnancies. Conceivably, all these factors appear to have operated to make the public ‘unwilling to surrender control of such matters lightly to the medical profession’. Proponents of a legal definition of death have thus assumed that nothing short of a statutory definition will suffice. But some practical difficulties with a statutory definition of death include the need to continually review the statute or its legislative instruments to meet the demands of a fast-moving field like biotechnology and transplants. This is not only time-consuming; it also requires a robust and efficient institutional arrangement as well as sufficient expertise and resources. Brazier and Cave argue that in the UK (England and Wales), for example, a proactive judiciary has

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96 For a concise explanation of the DDR see chapter 3.3.1, footnote 65 above.
97 For a very insightful discussion of the reasons oft advanced in support of legislation see Brazier and Cave, op. cit., 500.
98 Ibid., 498-500.
99 Mason and Laurie. op. cit., 532.
100 Brazier and Cave, op. cit., 495.
101 For a more comprehensive discussion of the merits and demerits of a statutory definition of brain death see chapter 6 especially section 6.4.

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‘introduced certainty into the debate’\textsuperscript{102} making a case for statutory intervention less compelling today. Additionally, it is suggested that medical innovation and expertise ‘alter and do so faster than can the law’\textsuperscript{103} and that it is both necessary and desirable to keep the definition of death as a medical fact, changes in which can easily be ‘accommodated within the law without any requirement for further legislation’\textsuperscript{104}.

A number of developed countries including the USA have legislations that recognise whole-brain death as the legal standard for the determination and confirmation of death. Brain death is established at law in all the 50 states in the USA but it must be observed that two states (New York and New Jersey) have specific laws or regulations ‘in place to accommodate persons who object to declarations of death grounded in neurological criteria on religious grounds’\textsuperscript{105}.

As afore-stated, unlike the USA, the UK (England and wales) has no statutory definition of death but rather the definition of death is firmly established by the courts through judicial precedent as set out in case-law.\textsuperscript{106} The brainstem criterion for death is the legally accepted standard of determining death. The position of the law was laid in the case of \textit{Re A}.\textsuperscript{107} The case involved a minor, A, who suffered severe head injuries which the doctors concerned with his care agreed, made him brain stem dead. The family was however opposed to the switching off of the ventilator necessitating the instant suit. The court, per Johnson J, held that it ‘had jurisdiction to make…a declaration that the child was dead’\textsuperscript{108} and that turning off the ventilator would not

\textsuperscript{102} Brazier and Cave, \textit{op. cit.}, 498.
\textsuperscript{103} Mason and Laurie, \textit{op. cit.}, 532.
\textsuperscript{104} Brazier and Cave, \textit{op. cit.}, 498.
\textsuperscript{107} \textit{Ibid.}
\textsuperscript{108} \textit{Ibid.}
be unlawful. This position of the law was later confirmed by the House of Lords (now the Supreme Court) in the celebrated case of *Airedale N. H. S. Trust v Bland*. 109

In Ghana, clinicians rely on the cessation of cardio-pulmonary function and dilated and fixed pupils for the confirmation of death even though there are no specific guidelines for diagnosing death. Consequently, it is plausible to argue that since ‘pupils in brainstem-dead patients are classically fixed and dilated’ 110, Ghana may have by implication unwittingly approved the brainstem dead criterion as the standard diagnosis of death. Though, the declaration of death by permanent or irreversible cessation of cardio-pulmonary function alone may seem extremely rare and insufficient in the 21st Century due to the advances in biotechnology, consensus on the definition of death continues to elude us.

Brain death is widely accepted, but there is no unanimity as to whether it ought to be whole-brain death (USA), higher brain death (cognitive or personhood death), or lower brain death (brainstem death) as adopted by the UK (England and Wales). Besides, not all the countries (for example Israel) with advanced biotechnologies accept brain death as legal death suggesting that the definition of death involves much more than mere advances in biotechnology. After all, ‘the brutal reality may be that, however death is defined, and whether such a definition is enshrined in statute or not, diagnosing death will always be a matter of concern’ 111 because death remains an unsettling reality of our common humanity. 112 It is important to observe that critically interrogating the ethico-legal concerns around the definition of death, its relationship with organ

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111 Brazier and Cave, *op. cit.*, 500.
transplants and whether such definition should be enshrined in a statute were largely conducted in the context of the developed world.

As a consequence, re-examining these issues within the socio-cultural context of a developing country such as Ghana would be beneficial in a number of ways. For example, this will bring a new perspective to the debate and enrich our ethico-legal discourse on the subject matter. More importantly, the findings arising therefrom may illumine the way to appropriately and effectively regulate the emerging organ transplantation sector and related matters in Ghana. This doctoral thesis seeks, in part, to do so through paper 1 as set out in chapter 6 where the concerns around the re-definition of death, its relationship with organ retrievals for organ transplant (and science research generally) and whether any such definition ought to be statutorily or judicially determined are examined in detail.

Before then it is important to point out that the question whether legal ownership or property rights apply or should apply to the human body and its parts is both affirmed and denied in equal measure. We now briefly evaluate some of these arguments in the next section.

3.4 Legal Ownership Interests and Rights in Human Biomaterials

It is my limb, my eye, my body; I may therefore do as I please with it, seems to be the intuitive response that most people have in respect of their bodies and the bundles of rights that may accrue from them. If so, might I go to the doctors (or through other means) to have my fingers chopped off for sale or have my eye gouged out and auctioned to raise money to save millions of starving children? Wouldn’t that be a very morally praiseworthy thing to do; sacrificing for the needy? This suggestion would seem counterintuitive and most will find it troubling indeed. On the other hand, if a research scientist were to take some tissue from me and
develop a therapy from my cell line and commercialise the therapy it would seem equally
counterintuitive to suggest that I do not own my cell line and therefore could not claim a right to
a share in the profits. This demonstrates that though the notion of proprietary interests or rights
in human bodies appears to be deeply ingrained in human consciousness, assertions of self-
ownership have long been the subject of immense philosophical scrutiny and contestations. 113
Clearly, then, any claims of legal ownership or proprietary interests and rights in human
biomaterials cannot be settled by intuitions alone. A more nuanced and reflective approach may
be called for. The advent of biotechnologies especially in genetics and organ transplantation may
have recast the human body as valuable property and thus given renewed currency to the ethico-
legal considerations of the question of property or ownership in the human body. 114

The common law does not seem to bring any more clarity to the property question. Some
commentators argue that the law on the human body is ‘currently in a state of confusion and
chaos’. 115 It is submitted that the courts have on occasions also dithered over the property
question vacillating between no property, quasi-property and privacy rights in the body. 116 In the
celebrated USA case of Moore v Regents of the University of California 793 P 2d 479 (Cal 1950)
the court seemed to affirm the common law rule of no property in the human body by holding in
part that Moore had no property in his excised tissues and that only property can be converted.
However in the UK (England and Wales) the court held in R v Kelly and Lindsay 117 that once a
human body or a part thereof has had some work or skill applied to it, it is capable of being

114 Mason, Kenyon and Laurie Graeme, ‘Consent or Property? Dealing with the Body and its Parts in the
563.
116 Ibid.
117 [1998] 3 All ER 741.
property. This case was decided relying on an Australian case of Doodeward v Spence (1908) 6 CLR 406 at 413-444 which held that

…when a person has by the lawful exercise of work or skills so dealt with a human body or part of a human body that it has acquired some attributes differentiating it from a mere corpse awaiting burial he requires a right to retain possession of it, at least as against any person not entitled to have delivered to him for the purposes of burial.\(^\text{118}\)

But the court in Dobson v North Tyneside Health Authority\(^\text{119}\) held that merely fixing human tissue in paraffin wax apparently is no sufficient skill or work to ground any property rights in the specimen. Then in the case of AB and Ors v Leeds Hospital NHS Trust\(^\text{120}\) the court per Gage J upheld the no property in the corpse rule. It was similarly held a year later in R v Bentham\(^\text{121}\) that we legally neither possess nor own our bodies. But in Yearworth and Others v North Bristol NHS Trust\(^\text{122}\) the Court of Appeal recognised a right to property in sperm. The decision in Yearworth may not be entirely novel since there seems to be evidence to support the proposition that some parts of the human body, generally regenerative parts, could have some property value.\(^\text{123}\) Whether the court would have so declared if the part in question was a solid organ or non-renewable body part is a matter of conjecture which would be resolved with time. It is suggested that the no property in a corpse rule as developed at common law is a reflection of the socio-cultural and religious ambivalence that society attaches to dead bodies founded on the intuitive belief that somehow the human body retained its dignity even after death.\(^\text{124}\) But what

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\(^{\text{118}}\) For a fuller discussion of this see Brazier and Cave, *op. cit.*, 544.

\(^{\text{119}}\) [1996] 4 All ER 479.

\(^{\text{120}}\) [2004] EWHC 644.

\(^{\text{121}}\) [2005] UKHL 18.


\(^{\text{123}}\) R v Welsh [1974] RTR 478 (urine) and R v Herbert (1961) 25 JCL 163 (hair) respectively are capable of being property in law and in R v Rothery [1976] RTR 550; a driver was found guilty of theft of a vial containing a sample of his own blood which he had provided to the police.

\(^{\text{124}}\) Mason and Laurie, *op. cit.*, 713.
is certain is the fact that modern English law remains largely rooted in this ‘old and rather dubious’\textsuperscript{125} legal rule of uncertain origin.\textsuperscript{126}

The lack of certainty at law is particularly worrisome because there are arguably genuine concerns in developing countries, that unless the property question is resolved, or at least clarified, the absence of adequate regulatory structures could leave many vulnerable people open to exploitation by any new biotechnologies reliant on human organs and tissues.\textsuperscript{127} In the specific case of Ghana, the recent contestation over the ‘ownership’ of the dead body of the Late President of Ghana\textsuperscript{128} and revelations that sperm and ova\textsuperscript{129} are being sold illegally, and people murdered and their tissues and organs (mostly blood and kidneys) removed presumably for black magic or ‘juju’ have renewed debates over the interests or rights in the human body. As a consequence this doctoral thesis examines, in part, the position of Ghanaian customary law on the ownership rights in deceased bodies and identifies some regulatory puzzles that policymakers must consider in paper 3 titled ‘Customary Law and ‘Ownership’ of Deceased Bodies: Regulatory Puzzles for Ghana’ as set out in chapter 8 below.

In the ensuing chapter I provide a brief account of the research problem, the objectives and the questions that are central to this doctoral thesis and the methodological approach adopted to answer the questions posed.

\footnotesize
\begin{enumerate}
\item \textsuperscript{125}\textit{Ibid}, 710.
\item \textsuperscript{126}Quigley, Muireann, ‘Property: the Future of Human Tissue?’ \textit{Medical Law Review} 17 (Autumn, 2009): 457-466. Also see Mason and Laurie, \textit{op. cit}. These trace the origin of the rule exposing the uncertainty that surrounded its origin and development and, to some extent, the soundness of its legal foundations.
\item \textsuperscript{128}For further discussion on the events that almost marred his funeral see chapter 4.2.
\item \textsuperscript{129}See n55 and n56 above.
\end{enumerate}
CHAPTER 4

FRAMEWORK OF RESEARCH AND METHODOLOGICAL APPROACH

4.1 Setting the Scene

Generally, the bioethical discourse in relation to human organ and tissue retrieval, retention and transplantation is often conducted in the context of the West with relatively well-developed ethical and legal frameworks, and well-resourced organisational or institutional governance structures. This research does not intend to reproduce or revisit those controversies anew. Primarily because those contestations were made in the context of developed countries and, therefore, the concerns were in most part about the sufficiency of the existing structures in dealing with the new ethical and legal challenges presented by this emerging biotechnology. For instance, in the UK (England and Wales) prior to the HTA of 2004, organ retrieval and use was specifically regulated by the HTA of 1961. However the organ retention scandals at Bristol and Alder Hey exposed the general insufficiency of the legislative, institutional and administrative governance frameworks of the time to cope with the new ethico-legal concerns that attended emerging biotechnologies such as organ transplantation.

The focus of this doctoral thesis will be to examine some of these ethico-legal challenges in the context of a developing country where no such pre-existing governance structures (specific legislation and institutional or administrative frameworks) exist. I will specifically examine the ethical and legal controversies that surround the following issues:
1. The (re-) definition of death, its relationship with retrieval of organs and tissues for transplantation as well as the nature of the role of law in defining death,

2. Whether or not the dead retain any interests in the Ghanaian traditional environment and how any such interests might impact on the social utility aims of organ transplantation especially deceased organ donation in that setting,

3. Whether Ghanaian customary law, unlike English (or common) law recognises ownership or proprietary rights in dead bodies and the puzzles regulators must address when considering regulation of organ transplantation or, more generally, the permissible uses of biomaterials in the Ghanaian socio-legal context, and

4. Finally, agreeing a regulation for organ transplant surgery in Ghana’s pluralistic socio-legal environment.

It is argued that providing clear answers to these ethico-legal problems is essential to define a consistent legal framework for the human body and its parts and to strike an adequate balance between, on the one hand, the need to protect individuals, their autonomy and their beliefs, and on the other hand, the need to supply organs for transplantations and to promote scientific research.¹

I undertake this doctoral study with this overarching goal in mind. At a more modest level, it is my hope that re-examining these ethical, legal and philosophical controversies in the Ghanaian socio-legal context, will bring a new perspective to the debate, enrich our ethico-legal discourse on the subject and inform policymakers worldwide particularly in developing countries. Furthermore, there has been no comprehensive comparative analysis of the intervention of the law in the retrieval, retention and use of human body parts in Ghana and the UK (England and

Wales) in any coherent manner.\textsuperscript{2} This doctoral thesis is, therefore, pioneering in that respect. Finally, at the practical level the expected outcomes of this piece of research would be to; i) inform regulation of the emerging organ transplantation programme in Ghana, ii) provide guidance on the administrative or institutional structures and policy choices that should define the permissible uses of human organs and tissues particularly deceased organs in Ghana, and iii) guide the debate and engagement with all stakeholders particularly policymakers, bioethicists, lawyers, lawmakers, traditional and religious leaders and the general Ghanaian public.

It is necessary at this stage to articulate in a much more coherent manner the research problem (s) that is the subject of this inquiry and the methodological approach adopted to interrogating the issues thereunder.

\textbf{4.2 Posing the Research Problem}

As a developing country, Ghana has no specific legislation, or guidelines, or any well-structured institutional or administrative frameworks in respect of human organ and tissue donation (retrieval, retention and use) and transplantation. There is no coherent guidance from the Ghana Medical and Dental Council (GMDC), or the Ghana Medical Association (GMA), and specific regulatory framework or oversight system by the Ministry of Health (MoH) and Ghana Health Service (GHS). Yet on a daily basis, be it in surgical or pathological theatres, human parts are removed, retained and or used for research and teaching. In fact, there is no process or procedure for seeking the specific consent of patients or their relatives (in the case of deceased individuals) for the retrieval, retention and use of body parts be they whole organs, parts of

\textsuperscript{2} Though human biomaterials are accorded some protections in Ghana under the Coroners Act, 1960 (Act 18); Anatomy Act, 1965 (Act 280) and the common law, there is no piece of legislation that specifically addresses their use in transplantation and science research. For arguments about the insufficiency of some of the existing regulations see Plange-Rhule, G., ‘Challenges in requesting for post mortem examination- a gap in Ghanaian law?’ Postgraduate Medical Journal of Ghana 1 (September, 2012): 34-37.
organs or tissue samples by pathologists in Ghana. Interestingly, it is claimed that, these practices notwithstanding, autopsies are conducted in accordance with best practice in pathology.³

Additionally, though the Coroners Act 1960 permits post mortem examination without consent, it does not give express authorisation for the retention of body parts after such procedures.⁴ However the Anatomy Act 1965⁵ is the only piece of legislation that regulates the examination and dissection of bodies of deceased individuals and provides for related matters. Section 1(1) vests the power to grant licences in the Minister of Health and subsection 2 of section 1 permits the licensee⁶ to carry out all, or any of the following matters:

(i) to receive in that school or institution the body of a deceased individual;  
(ii) to keep or possess therein that body;  
(iii) to examine therein that body;  
(iv) to dissect therein that body; and  
(v) to carry out any other matter specified in the licence which the Minister is of opinion is in the interests of medical science.⁷

Furthermore, section 9 enables the head of a medical school or institution to permit the retention in certain circumstances of the whole or parts of a body. Specifically section 9 (1) provides that the;

³ These disclosures came in the wake of extensive discussions with the head of the department of pathology at the Korle-bu teaching hospital and the Dean of the University of Ghana Medical School, College of Health Sciences- who is also the immediate head of the pathology department in September, 2012. Also, some of these matters came to my attention by virtue of my position as head of the medico-legal unit of the MoH/GHS. I have had a continuing engagement with the department on ways of improving upon their practices in a pre-emptive rather than reactionary manner. Further, I have had the experience of working at the Korle-bu teaching hospital; first as a research assistant at the pathology department from 1999 -2000 when I was a medical student and then as a clinician from 2003-2008.
⁴ Coroners Act, 1960, Act 18.  
⁶ Licensee is defined as either the head of a medical school or institution, to whom a licence is granted under section 1 of the Act or a teacher and medical practitioner employed in that medical school or institution or a student working under the supervision of a person referred to in (a) or (b).  
⁷ Ibid, s. 1. 2.
head of the medical school or institution may cause to be retained the whole or part of the body of a deceased individual if-

(a) he is satisfied that the retention thereof is in the interests of medical science; and
(b) the competent authorities have consented to the retention.\

A restricted interpretation of section 9 (1) may lead to the conclusion that the interests of medical science trumps all other interests (deceased, familial, etc.) under the Act. This conclusion may however prove too hasty. This is because section 9 (2) defines competent authority to mean

the executor or other party having lawful possession of the body of the deceased individual and the surviving wife or husband of that individual and, in the absence of such wife or husband, any known relative of the deceased individual falling within such class of relatives of that individual as may be prescribed.9

When section 9 subsections (1) and (2) are read together then it becomes obvious that under the Anatomy Act of Ghana, 1965 (Act 280), the surviving spouse or relative reserves a veto over the use of biomaterials of deceased family members. This has serious implications for the donation, retention and use of deceased biomaterials for science research and in particular deceased organ donation for transplantation purposes. For instance, if it can be shown that the deceased retain some interests posthumously, or that their relatives have ethically recognisable interests and rights in the organs or tissues of their deceased family members, then arguments of making deceased organs public resources or conscripting dead bodies to serve morally important courses such as transplantation will need a serious rethink in the Ghanaian socio-legal context. I establish through the concept of ancestorship in paper 2 as set out in chapter 7 that such interests

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8 Ibid, s. 9. 1.
9 It must be noted that no such prescription by the sector minister has come to the writer’s attention (emphasis added).
and rights exist in the Konkomba (and wider Ghanaian) traditional setting thus making conscription an unworkable policy option for obtaining deceased organs for transplantation in that context.

Despite these clear stipulations, human body parts, tissues and organs are reportedly routinely, retrieved, retained and used either for teaching or research without the prior consent of the surviving spouses or relatives of the deceased.\(^{10}\)

Furthermore, there is no ethical or legal framework in Ghana that specifically addresses concerns around the definition of death and its relationship with the retrieval, retention and use of deceased organs and tissues for science research or transplant surgery. This is in spite of the fact that Ghanaians attach a great deal of sensitivity (religious, social and cultural) to peri-mortem activities. It is therefore hoped that the examination of death in the Ghanaian socio-cultural setting will provide useful insights that will inform the design of any regulatory\(^{11}\) oversight system for the use of human biomaterials especially for organ transplantation.

Also, the issue of who ‘owns’ a corpse and what the nature of this ‘ownership’ entails received renewed currency in Ghana following the untimely and tragic demise of the late President of the Republic of Ghana, His Excellency Prof. John Evans Fiifi Atta Mills.\(^{12}\)

\(^{10}\) See reference to discussions held with the current and former heads of the department of pathology at the KBTH captured under n3 above.

\(^{11}\) I use ‘regulatory’ here rather loosely to encompass other governance frameworks though regulation and governance may be shown to be different. While regulation often connotes the use of the traditional command and control (hard law) legal instruments, governance is more reliant on soft law options such as self-regulation, professional guidelines and codes of practice. For a very insightful explanation of the two legal concepts see; Laurie Graeme, Harmon Shawn H. E. and Arzuaga Fabiana, ‘Foresighting Futures: Law, New Technologies, and the Challenges of Regulating Uncertainty’ Law, Innovation and Technology 4 (2012): 1-33, 14-15.

\(^{12}\) President John Evans Atta Mills died tragically on the 24th July, 2012, following an acute illness. I was privileged to have been part of the medical team which attended to him in 2006 when he was the leader of the opposition. He was diagnosed and referred for treatment in a much more technologically advanced setting. He subsequently got well and went on to win the 2008 elections in Ghana. He was an astute academic, a humble and humane man, whose incorruptibility was acknowledged by all, political foes and friends alike. His demise was
was contestation by a section of his extended family over who had the ownership or possessory rights over the body of the late President. The lack of clarity in the Ghanaian law on the question of ownership rights in dead bodies and the likely national and political embarrassment that may otherwise have flowed from a legal tussle made the Government to move swiftly for a political settlement with those members of the extended family.

Additionally, there have been recent concerns about the increasing number of murder cases in which certain body parts such as blood and kidneys are removed presumably for ritual purposes. The legal lacuna the practice exposed prompted Parliament to pass legislation to fill the gap to render unlawful ‘the illicit practice of the removal of human organs such as kidneys and the drawing of human blood’ from deceased individuals.

Finally, Ghana is desirous of making organ transplantation (at the very least kidney transplantation) a routine surgical procedure by the end of 2014. To this end, Ghana has trained some of its staff and with the support of organisations such as Transplant Links of the UK, undertaken about 20 living related kidney transplants since 2008. Worryingly, all these are happening in the absence of the appropriate ethical, legal and administrative or institutional structures required to deal satisfactorily with the ethico-legal issues associated with human organ and tissue donation and transplantation. As a result, the motivation for this piece of research therefore seen as a great loss to the country and Africa. But the State funeral was nearly marred by contestation by some family members about the failure on the part of the government to consult them adequately. They threatened to go to court to assert their right of ‘ownership’ over his body. This prompted his successor, H.E. President John Dramani Mahama to move swiftly to reach a political settlement with his extended family to avert any national and political embarrassment.

Whether these concerns reflect an actual increase in such cases is an empirical question answers to which are beyond the scope of this research. Arguably, the increased liberalisation of the Ghanaian media landscape with the proliferation of community media stations as well as increased activism by civil society organisations (such as the coalition of NGOs in health, etc.) and the increased public awareness following the consolidation of democracy in Ghana might all be contributory factors.

work is to examine some of these issues within the Ghanaian socio-legal context with the hope that the findings therefrom will serve as a useful guide for regulatory dialogue in Ghana.

I now explain in the next section the methodological approach employed in this inquiry.

4.3 Methodological Approach

4.3.1 Introduction

As discussed in the previous sections, the literature review conducted in the course of this study revealed that the ethical, clinical, legal and policy arguments made following advancements in biotechnology especially organ and tissue transplantation were disproportionately done in the context of the developed world. However, given that Ghana is a developing country with a very different socio-legal environment, a priori, suggests that a wholesale transportation of these arguments into the Ghanaian regulatory setting might prove both problematic and practically unworkable.

This doctoral thesis therefore adopts a comparative analytical approach by examining some of the controversies that were conducted in the West and situating them in the Ghanaian socio-legal environment and then suggesting key issues for consideration by policymakers when regulating the emerging organ transplant sector in Ghana. Given that there is no definition of death in Ghana, that ownership rights in dead bodies are unclear and questions of the existence or otherwise of posthumous interests in the Ghanaian socio-legal context are unaddressed but human organs and tissues are routinely retrieved, retained and used without the requisite consent and test organ transplants are being undertaken, I undertook a comparative analysis between a developed country (United Kingdom in particular England & Wales hereafter referred to as the
UK) with well-defined procedures, protocols and regulatory frameworks and a developing
country (Ghana) where no such guidelines or frameworks exist and where a significant
proportion of the populace is either illiterate or not well informed.

The choice of the UK as the appropriate comparator stems from a number of reasons. First,
the UK has a well-developed, even if not perfect, regulatory system (legal, ethical and
organisational) for human organ and tissue donation (retrieval, retention and use) and
transplantation. Second, the UK has a history of dealing with issues of unethical and unlawful
retrieval, retention and use of human organs and tissues. The occurrence of these scandals
coupled with the lively and on-going political debates and the interest of the British public in
such issues put the UK in a unique position to share its experiences with Ghana. Finally, Ghana’s
pluralistic legal system takes its source from the English common law tradition thereby
presenting a good opportunity for insightful comparative analysis.

Consequently, the objectives of this doctoral thesis are to:

1. Explore the clinical, ethical and legal controversies surrounding the definition and
confirmation of death, its relationship with human organ retrievals for transplantation
and the nature of the role of law in this process with the view to identifying the
workable policy option for Ghana,

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15 The Human Tissue Act 2004: The Human Fertilisation and Embryology Act, 1990 (as amended); NHS Blood
and Transplant Organisation.
The Report of the Public Inquiry into Children’s heart surgery at the Bristol Royal Infirmary: Learning from Bristol,
17 Ghana was a British Colony. She gained her independence on March 6th, 1957, under the leadership of H. E.
Dr. Kwame Nkrumah as the founding President. Ghana was the first sub-Saharan country to do so.
2. Examine the question whether individuals retain interests or can be harmed after death in the Ghanaian traditional setting and find out how, within the context of deceased donations, the conclusions reached may influence organ transplant regulation in Ghana,

3. Evaluate the position of Ghanaian customary law on ownership or proprietary interests and rights in (deceased) human biomaterials and show how these may present some puzzles for regulating organ transplantation in that context, and

4. Identify an appropriate way to regulate organ transplantation in Ghana having in mind its pluralistic legal environment.

4.3.2 Main Research Questions

This thesis therefore addresses the following specific questions connected to the afore-stated objectives in the light of the arguments already put forward:

1. Death in Ghana: Socio-cultural Implications for Organ Transplant Regulation?

2. Posthumous Organ Retention and Use in Ghana: Regulating Individual, Familial and Societal Interests?

3. Customary law and the ‘Ownership’ of Deceased Bodies; Regulatory Puzzles for Ghana?

4. What is the Appropriate way to Regulate Organ Transplants in Ghana’s Pluralistic Socio-legal setting?

Having isolated the main questions that form the basis of this doctoral thesis, I shall in the next chapter highlight some of the ethical and legal approaches adopted in the quest to finding the appropriate answers to the questions just posed.
CHAPTER 5

PHILOSOPHICAL AND LEGAL APPROACHES

5.1 Philosophical Approach

5.1.1 Introduction

I discuss very briefly the arguments surrounding the (re) definition of death. I argue that without clarifying or bringing certainty to the ethical, social, legal and clinical concerns surrounding death and dying, and its relationship with organ transplantation we run the risk of creating credibility problems for the emerging transplants sector in Ghana. As a result, I consider philosophical arguments touching on cognitive or personhood death; biological death; biographic death; whole or total brain death as well as brainstem death as human death. I support the claim that brainstem death meets the clinical, ethical, and legal requirements of human death and propose that Ghana adopts same. The full arguments are captured in paper 1 and set out in chapter 6 hereunder.

I further examine, albeit briefly, the theory of rights because rights discourse is arguably inescapable within the context of organ transplantation. For example, discussing the extant law and practice surrounding human organ retrieval, retention and use following pathological services in Ghana unavoidably raises questions about individual, familial and societal interests and rights. This is particularly acute relative to debates on posthumous interests and or harms as captured in chapter 7 below. This is because the conclusion one reaches will influence the kind
of policy proposals put forward to promote and encourage deceased organ donation for transplantation and science research.

Also, the use of human biomaterials for medical purposes, whether deceased or living, raises questions about ownership rights in such materials. For instance, there is controversy as to whether or not the human body should be the subject of proprietary interests like any other chattel; if not, why not, and if yes, who should the right-holder (s) be? Might the source (in the case of the living) be the owner of his or her body parts or might recognition of such self-ownership rights detract from human dignity and freedom? In the case of deceased individuals who should the right-holder (s) be? Or are the legal interests in human biomaterials better protected by other legal rules such as liability and inalienability rules rather than property rules? In the light of these controversies I examine the vexed issues of legal ownership or property rights in the human body much more extensively in paper 3, the full arguments of which are set out in detail in chapter 8 below.

I shall, in the ensuing sections, give concise accounts of the philosophical approaches adopted in this doctoral thesis relative to some of these controversies.

5.1.2 Rights at a Glance

The concept of a right\(^1\) is inevitably ambiguous and it is therefore not surprising that protagonists in any debate marshal rights to support their arguments. Procurement of human organs and tissues for transplantation especially deceased organs is one such controversy where

\(^1\) We may talk of legal, moral, or cultural rights among others. However, it is plausible to presume that all of these rights share a common defining feature which illumines their use in conventional rule systems. For a fuller exploration of rights see Dworkin, R., *Taking Rights Seriously* (London: Bloomsbury Publishing Plc., 2013); Sumner, L. W., *The Moral Foundations of Rights* (New York: Oxford University Press, 1989) and Waldron, J., *Theories of Rights* (Oxford: Oxford University Press, 1984).
the rights debate is unavoidable. I adopt L. W. Sumner’s\textsuperscript{2} conception of rights which in turn draws on the foundation laid by the seminal work of Wesley Newcomb Hohfeld.\textsuperscript{3} The reasons for doing so are as explained below.

Before then, it is important to state that this analysis is not intended to be a comprehensive examination of rights per se. The object here is to provide a concise account of rights as used in this doctoral thesis. It is however hoped that the brevity will not compromise, in any significant manner, the clarity required to facilitate our understanding of the contextual issues.

Sumner identifies two accounts of claims or entitlements; benefit and control accounts.

The \textit{benefit account} treats rights as \textit{protected interests}. As such a right-holder is either understood to be a beneficiary of a set of duties imposed on others or as one whose interests provide a justification for imposing such duties. These duties may either be positive or negative and the subjects of the rights may logically be either individuals, or institutions, or groups and collectivities.\textsuperscript{4} He argues that the beneficiary of any set of duties will necessarily be a holder of claims and that any such claims need not be ‘accompanied by further Hohfeldian advantages, such as the ability to waive or otherwise alienate it’.\textsuperscript{5} The right-holder therefore has a right by ‘virtue of having some interest protected by the duties borne by others’.\textsuperscript{6}

The \textit{control account}, on the other hand, treats rights as \textit{protected choices}. On this conception the right-holder has the freedom to choose among a range of options and his freedom is protected by the imposition of duties on others. Thus a right might entail a claim of non-interference against others or might simply be a form of claim since every claim necessarily includes the

\begin{itemize}
\item \textsuperscript{2} Sumner L. W., \textit{The Foundation of Rights} (New York: Oxford University Press, 1989).
\item \textsuperscript{3} Cook, Walter W., \textit{Fundamental Legal Conceptions As Applied in Judicial Reasoning: and other essays by Hohfeld Wesley Newcomb} (New Haven: Yale University Press, 1920).
\item \textsuperscript{4} Sumner, \textit{op. cit.}, 45.
\item \textsuperscript{5} Ibid, 45-46.
\item \textsuperscript{6} Ibid, 46.
\end{itemize}
power to demand performance or to waive. Sumner establishes that these two models of rights are merely different conceptions of the same concept of rights and both remain committed to the central ‘idea that the function of rights is to serve as one kind of constraint on the pursuit of social goals’. However while the ‘interest conception treats rights as devices for promoting individual welfare…the choice conception treats rights as devices for promoting freedom or autonomy’.

As intimated earlier, paper 2 locates these rights discourses in a consequentialist framework as set out by L. W. Sumner. This is useful for my purposes because the debate around human organ donation has oft been waged on the presumption of its utility; the good ends it serves. Such a theoretical framework is best suited for my research because it has two dimensions- i) that of the good and ii) that of the right which is derivative of the good.

Additionally, this framework also commits us to some global goal and holds us to the fact that what matters in any action is the ‘difference it makes to the promotion of some favoured global goal value’. At the same time it accommodates the idea that a society may also impose constraints on its rule system to sometimes ‘render the straightforward pursuit of its favoured goal either impossible or impermissible’. Might deceased organ donation be an appropriate candidate for such a restrained public policy? I argue in paper 2 as set out in chapter 7 that that might be a pragmatic public policy option when obtaining deceased organs for transplantation or science research in the Ghanaian traditional setting.

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7 Ibid.
8 Ibid, 47.
9 Ibid, 47.
10 It must be pointed out that not all are amenable to this approach because rights and collective goals can be shown to be different. This is admitted however it is also undeniable that in real life the decision to grant the enjoyment of a particular right is a political or policy consideration to be weighed against other competing rights or interests. For the fuller exploration of this kind of objection see Dworkin, op. cit.
11 Sumner, op cit., 167.
12 Ibid, 173.
13 Ibid, 182.
Furthermore, this consequentialist framework does not appear to support an exclusively atomistic approach to rights since doing so will:

…require establishing the strong thesis that our favoured goal will be best promoted by denying rights to all collectivities, regardless of their nature and of our social circumstances. Surely, we should instead expect support for a more eclectic social order which acknowledges a mixture of individual and collective rights. There thus seems no impediment, either conceptual or substantive, which could prevent us from appealing to rights in order to ground some form of polity…which honours both individualist and communitarian values.14

This is well suited for the Ghanaian socio-legal context which, as noted in paper 1 and set out in chapter 6.2, is communitarian in nature. However, the challenge that remains is whether or not in the Ghanaian traditional setting we could successfully ground our policy choices both on the pursuit of our basic goal of maximising organs15 for transplant and respecting the cultural rights of the people as guaranteed under the 1992 Constitution of the Republic of Ghana. It has been argued that this is possible if we moved away from maximising to satisficing and pre-committed ourselves to respecting the cultural rights of the communities that the policy choice is intended to benefit.16 I argue in paper 2, as set out in chapter 7 that respecting cultural values in the Ghanaian socio-legal setting might mean that conscription of deceased bodies for morally important courses such as transplantation may not be an acceptable public policy option in that setting. I nonetheless argue that having such a restrained regulatory framework that is sensitive to these socio-cultural issues may not necessarily preclude the donation of deceased biomaterials for transplant and science research in the Konkomba traditional setting.

15 I assume for the purposes of this doctoral research that there is the need to maximise supply of organs and that committing ourselves to doing so is a good thing.
16 Sumner, op. cit., 190-192.
We now turn our attention to the much disputed concept of self-ownership as an important and necessary part of addressing the broader issue of ownership or property rights in human body parts in the Ghanaian socio-legal milieu, the full arguments of which are captured in chapter 8 below.

5.1.3 The Concept of Self-ownership

The thesis of self-ownership holds that ‘every person is entitled to full private property in his own person and powers’. Consequently, to enhance human liberty, freedom and individual autonomy it is argued that people should be free to own themselves; to literally do as they please with their bodies and capacities as long as in so doing they do not harm other self-owners. It is however shown that self-ownership may not always be autonomy-enhancing and in certain cases fetters on self-ownership might actually maximise autonomy. It is argued that the implication of this libertarian thesis of self-ownership is that ‘what owns and what is owned are one and the same’ and that this inseparability of the ‘self’ and the ‘owned’ makes it problematic.

In fact, Kant argues that the concept of self-ownership is incoherent and self-contradictory:

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19 Cohen, op. cit. especially 229-244.


Man cannot dispose over himself because he is not a thing; he is not his own property; to say that he is would be self-contradictory; for in so far as he is a person he is a Subject in whom the ownership of things can be vested, and if he were his own property, he would be a thing over which he could have ownership. But a person cannot be a property and so cannot be a thing which can be owned, for it is impossible to be a person and a thing, the proprietor and the property.  

If Kant’s characterisation of the self-ownership concept is sound then it poses a great difficulty to the liberal concept of property that vests proprietary rights in persons and their powers. However as Cohen points out, the Kantian objection is question-begging as it does not show that only things can be owned and therefore fails to show that the concept of self-ownership is either contradictory or incoherent. 

Arguably, within the context of deceased bodies or their parts, if it can be shown that the body of a deceased individual is not a person or that a deceased part is a thing then this will pose a serious challenge to the Kantian viewpoint. Presumably, Kant’s criticism of the self-ownership concept is informed by his argument that persons are the source of morality and cannot therefore be treated as a mere means to their own ends or the ends of others. If this is so, then it is not apparent that it impugns the coherence of the concept of self-ownership. 

Admittedly, framing interests in human biomaterials in terms of self-ownership and proprietary rights underpinned by market or economic values ignores the pluralistic nature of the

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23 For a biting critique of Kant’s argument see Cohen, *op. cit.*, 210-213.

24 It is suggested that Kant seems to have a dualistic account of the human body: the body object (which makes permissible the sale of non-essential body parts such as hair or the amputation of a diseased foot) and the moral person as the subject. For a more informative examination of these Kantian exceptions see Dickenson, Donna *Property in the Body: Feminist Perspectives* (Cambridge: Cambridge University Press, 2007), 5-8.

values inherent in the human body (such as cultural and religious values) and may, in particular situations, be inappropriate for the determination of rights to human biomaterials.  

Consequently, Rohan Hardcastle offers the detachment principle as the solution. He argues that under this principle the creation and allocation of property rights should apply only to separated biomaterials and the property rights should vest in the source rather than a third party. It is suggested this will separate the person from the thing capable of being property thereby rendering the fear of violating human dignity otiose. It is unclear how separation or detachment creates entitlement or proprietary rights in a body part that was initially ‘unowned’ in vivo. For instance, Muireann Quigley questions the normative force of the thesis of separability and shows that despite the reliance on it by both statutory and common law to grant property rights in human biomaterials, the thesis itself gives us ‘no reason to reject property in the deceased body’. It is also not obvious from the Honoré account of ownership that the owner and the thing owned ought to be physically or conceptually separate. It is further argued, quite forcefully, that other values such as human dignity are not necessarily incompatible with the notion of property in biomaterials and may in fact enhance them.

27 Hardcastle, op. cit.
29 Ibid, 672.
30 Wall, Jesse, ‘The Legal Status of Body Parts: A framework’ Oxford Journal of Legal Studies 31 (2001), 786. It is important to note that contrary to Cohen, JW Harris argues that the concept of self-ownership is used only in a rhetorical sense rather than as indicative of property in the traditional sense. I explore Harris’s contrary view further in Chapter 8.
Finally, we next consider a concise account of posthumous interests and harms as employed in debates around organ transplants. A more detailed discussion of these within the Ghanaian traditional setting is as set out in chapter 7 especially in sections 7.4 and 7.5 below.

5.1.4 Posthumous Harms and Interests

As discussed in chapter 7 below, the retrieval, retention and use of deceased biomaterials whether in Ghana, the UK, or elsewhere is highly controversial because it engages very vexed matters including the posthumous interests and rights of the decedent and his or her family. This being so, I consider the highly contested subject of posthumous interests and or harms in paper 2, as set out in chapter 7 specifically section 5. I situate these debates within the Ghanaian traditional setting and adopt Feinberg’s account of harms as a setback to interests. This then allows me to argue through the concept of ancestorship that posthumous interests and or harms can and do exist in the Ghanaian socio-cultural environment. As such it imposes a unique obligation on families at custom that cannot be cavalierly dismissed as non-person affecting and may pose a serious challenge to treating deceased organs as public resources in that setting. Crucially, I show that given the huge existential and reputational value of ancestorship in the Ghanaian socio-cultural setting, an appropriate regulatory system could harness its value to maximise deceased organ donation in that context.

In the remaining sections of this chapter, I provide concise accounts of Ghana’s legal context; the statutory v. judicial definition of death debates; and legal justifications for granting ownership rights in human body parts as a precursor to more in-depth exploration of these issues in the ensuing chapters.

5.2 Legal Approach
5.2.1 The Ghanaian Legal Context

As this doctoral thesis situates the ethical, legal, and clinical and policy discussions surrounding organ transplantation in the Ghanaian socio-legal context, it is imperative that a concise account of the legal context of Ghana is given to facilitate our understanding of the contextual issues.

Ghana’s legal system, as with most former colonies of Britain, is founded on the common law tradition. However, unlike the UK (England and Wales), Ghana has a written constitution and now operates the 1992 Constitution of the Republic of Ghana.

Article 125 provides that justice emanates from the people and grants citizens the right to participate in the justice system through the ‘institutions of public and customary tribunals’ as well as jury and assessor tribunals.\(^{32}\) Judicial power vests in the judiciary\(^{33}\) which consists of the Superior Courts of Judicature (the Supreme Court, Court of Appeal and High Court) and such ‘lower courts or tribunals as parliament may by law establish’.\(^{34}\)

The laws of Ghana as set out in Article 11(1) comprise: (a) the Constitution; (b) Acts of Parliament; (c) Orders, Rules and Regulations made by any person or authority under a power conferred by the Constitution; (d) the existing Law; and (e) the Common Law. ‘Common law’ as employed under Article 11 (2) includes: i) the rules of law commonly referred to as common law (or judge-made or case law); ii) the rules generally known as the doctrines of equity; and iii) the rules of customary law. Customary law means the rules of law which by custom are applicable to particular communities in Ghana.\(^{35}\) Article 39 sets out a cultural objective by enjoining the State

\(^{32}\) Article 125 (1) and (2) of the Constitution of Ghana, 1992.
\(^{34}\) Article 126 (1) of the Constitution of Ghana 1992.
to take steps to encourage the integration of appropriate customary values into the fabric of national life, while Article 26 provides for cultural rights and practices. The Chieftaincy and traditional institutions are guaranteed under Article 270 and charged with the responsibility to ‘undertake the progressive study, interpretation and codification of customary law with the view to evolving…a unified system of rules of customary law’.\textsuperscript{36} It follows therefore that some of the customs and practices of the various customary communities in Ghana are of both cultural and legal significance. It is important to note that Articles 11, 26, 270 and indeed all rights under chapters 5 and 8 are among the entrenched provisions of the Constitution.\textsuperscript{37}

It is important to observe that customary law has always been administered alongside common law in Ghana’s constitutional history. For example, sections 14 and 19 of the Gold Coast Supreme Court Ordinance (No. 4 of 1876) made English Law applicable in the Gold Coast (now Ghana) alongside Ghanaian customary law. However, following the independence of Ghana on March 6, 1957 and its subsequent attainment of republican status in 1960, the Constitution and Courts Act of 1960 repealed this reception statute and English law has since ceased to apply with binding effect in Ghana. As a result cases from the UK (England and Wales), and all other countries especially the common law countries, are now of persuasive authority only.

\textbf{5.2.2 A Statutory Definition of Death?}

I examine the definition of death and consider what the proper role of law ought to be in that process, considering Ghana’s socio-legal environment. The full arguments I advance are as

\textsuperscript{37} For an understanding of all the entrenched provisions under the 1992 Constitution together with the cumbersome system for their amendment see article 290.
captured in paper 1 and set out seriatim in chapter 6. For the purposes of this doctoral research, I assume that there is consensus that law ought to play a vital role in the definition of human death especially within the context of obtaining deceased organs for transplantation. If that is so, then the question that seems to follow will be; what ought to be the nature of the role of law in that definitional process?

I adopt a comparative analytical approach through examining the transatlantic divide as to whether brain death ought to be statutorily or judicially defined. This allows us to at once draw useful lessons from, on the one hand, the experience of the USA (where death is statutorily defined) and, on the other, England and Wales (where the definition is judicially determined but guided by the extant medical professional standards) and to evaluate the practical difficulties that come with each of these options. Armed with the findings from this comparative analysis, I argue that given the practical difficulties that a mature democracy, like the USA, with relatively well-coordinated and efficient institutions is experiencing, and the UK (England and Wales) experience with judicial definition, Ghana a developing country with a pluralistic legal system should decline any invitation to define death by statute.

I also discuss the vexed issue of legal ownership in (deceased) human bodies or parts thereof in the Ghanaian socio-legal context in chapter 8. I note that anytime proprietary interests and rights are in issue there is often the need to justify them particularly in respect of human biomaterials. I evaluate some of these common justifications in the next section.

5.2.3 Justifying Ownership and Property Rights in Human Biomaterials

One of the common justifications for the natural right to ownership or proprietary rights is founded on the Lockean model which posits that mixing labour legitimates ownership provided
enough and as good is left for all. ³⁸ Understandably, the mixing labour with nature argument excites a number of commentaries. While some contributors argue that investment of labour and time is simply insufficient to create proprietary rights, ³⁹ others show that there is no such thing as natural right to full-blooded ownership and that the Lockean state of nature analysis yields proprietary rather than ownership rights. ⁴⁰ Nozick questions why mixing labour with what was originally unowned is not a way of losing what was owned rather than gaining what was not owned? ⁴¹ More importantly, it is argued that within the context of allocating rights in human biomaterials any amount of labour would seem ‘sufficient in itself to satisfy the Lockean standard, regardless of extent or type, and to that extent the philosophical foundations of the thesis seem shaky, uncertain and unconvincing’. ⁴²

These criticisms notwithstanding, some commentators such as Donna Dickenson maintain that women, for example, labour in the Lockean sense to produce ova for stem cell research thereby legitimising proprietary rights in their biomaterials. ⁴³ It is however cogently argued that since the labour mixture theory justifies proprietary rights in human biomaterials based on the assumption that detached human biomaterials are initially res nullius, if it can be shown that body parts are actually not res nullius then the theory falls apart. ⁴⁴

³⁹ Gold, op. cit., 57.  
⁴¹ Nozick, op. cit., 174-175.  
⁴³ Dickenson, op. cit., 68.  
⁴⁴ Price, op cit.
Accordingly, insofar as the common law work and or skill exception to the no property in a corpse rule draws inspiration from the Lockean labour mixture theory it ‘fails to assert sufficient justification.’

This viewpoint is supported by Sarah Devaney who argues that the work or skill exception as has been employed by the courts is insufficient justification to deprive tissue providers a right to ‘property in their excised tissue’ and accordingly founds the justification of property rights in human biomaterials (in the context of stem cell research) on justice claims.

Furthermore, while some commentators argue that the justification of property in biomaterials is better founded on liberty, autonomy or rights-based arguments, others such as J. W. Harris do so based on the principle of bodily-use-freedom. Also, other contributors adopt a social cooperation or social constructivist approach to justifying proprietary interests and rights in human biomaterials. On this social constructivist account, ownership as an open-ended right to things, is justified from values (sharing of interests) arising from co-ownership.

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45 Ibid, 254. Arguably, the application of human skill exception granted under section 32 (9) (c) of HTA 2004 is informed by the common law position which draws on the Lockean mixing labour thesis.

46 See R v Kelly and Lindsay [1998] 3 All ER 741; [1999] QB 621 (Criminal Division) and In Re Organ Retention Group Litigation [2004] EWHC 644 (QB); [2005] Q. B. 506 and section 32 (9) (c) of the HTA 2004. For a judicial concern over the logicality of the work or skill exception see Yearworth and Others v North Bristol NHS Trust [2009] EWCA Civ. 37, para 45 (d).


49 Harris, op. cit, 65.


51 Penner, op. cit., 166-188; also Cohen, op. cit.
Jesse Wall argues that there are two justificatory theories for recognising ownership and property rights in separated human biomaterial—expressive and instrumental theories of property. On the one hand, the expressive theory of property can only justify ‘control rights’; they cannot support arguments for recognition of ‘income rights’ often associated with concerns of commodification. On the other hand, the instrumental justificatory theory of property seems to justify ownership entitlements based on autonomy, personhood and liberty. It follows therefore that since to claim an income right in a biomaterial is to claim their monetary value, it is doubtful that this monetary value can follow from the right-holder’s personhood.

Accordingly, any claim that the concept of self-ownership necessarily raises a presumption that sources ought to own their bodies or biomaterials is mistaken. This leads him to argue that though both property and liability rules can protect control rights in biomaterials, ‘only property rules are able to protect income rights’ in body parts. Plausibly, then, ‘if the set of ownership entitlements that we seek to protect includes the right to income then property rights become the only set of trespassory rules that can be employed to protect the ownership entitlements’.

52 According to Wall property rights are expressive if they express the rights that a person qua person has and instrumental if they are used to produce some desired state of affairs. I note that Wall seems to use and treat justificatory techniques and justificatory theories as necessarily interchangeable. Though I note that these may be conceptually different and clarification may be useful in certain contexts, I do not pursue this difference here because I find it neither necessary nor any more illuminating for the purposes of this research.

53 By right to control is meant the right to have exclusive physical control over or possess the object of ownership. Honoré similarly argues that excludability is key to ownership. The right to income means the right to derive a benefit from foregoing the personal use of the thing. So while control rights may be said to be primarily concerned with the use of things, income rights deal with the allocation and distribution of social wealth in the object of ownership allowing the object to be treated as a commodity whose value (monetary) is determined by voluntary negotiation between the parties (buyer and seller). For detailed explanations of these see Wall, Jesse, ‘The Legal Status of Body Parts: A Framework’ Oxford Journal of Legal Studies 31 (2011): 783-804 particularly 785 and 790-792, and A. M., Honoré, ‘Rights of Exclusion and Immunities Against Divesting’ Tulane Law Review 34 (1960): 453-468.


56 Ibid, 795-797.

57 Ibid, 799.

58 Ibid, 803 (error in the original).
I explore the arguments for the use of property, liability, and inalienability rules in some detail later in paper 3 and argue in support of the view that, within the context of organ transplantation, property rules better protect interests in human biomaterials (at least deceased parts).

We now turn our attention to Part II of the thesis where the questions that are central to this doctoral research work are answered through published or publishable articles. Papers 1 and 2 have already been published in peer reviewed journals whilst paper 3 is currently under consideration for publication.
PART II: THE PUBLISHED OR PUBLISHABLE ARTICLES
CHAPTER 6

PAPER 1: DEATH IN GHANA: SOCIO-CULTURAL IMPLICATIONS FOR ORGAN TRANSPLANT REGULATION\textsuperscript{1}

ABSTRACT

Within the context of organ retrieval for transplantation, death remains a controversial subject. Understandably, there are concerns about the conception of death, how it is understood, clinically defined, determined and confirmed, as well as its relationship with organ retrievals and transplantation surgery. Even though these concerns have been the subject of extensive commentary from medical, legal, ethical and social perspectives, these have been made largely in the context of the developed world. The first aim of this article is to re-examine, in the Ghanaian socio-legal context, the ethico-legal controversy around the definition, determination and confirmation of death and its relationship with obtaining organs for transplant. It is hoped that this will bring a new perspective to the debate and enrich our ethico-legal discourse on the subject. Ghana is making strenuous efforts to make organ transplantation a routine surgical procedure by the end of this year, yet it has no ethical or legal framework to guide the process. A successful transplant programme will depend in part on the availability of organs from all ethically acceptable sources (deceased, living related and unrelated). This being so, the author discusses indigenous thinking around death (Post-mortem Personality Identity Renegotiation (PPIR)) and points policymakers to how they could take advantage of PPIR to promote the social utility of any organ transplantation programme in Ghana. Furthermore, I consider the

nature of the role of law in defining/determining death. I consider the merits of a statutory
definition of death and conclude that given the circumstances of Ghana (its socio-legal
environment) and the UK experience, a judicial rather than statutory definition is workable. The
overall aim of this article is to explore the need for an appropriate and comprehensive
regulatory regime for the emerging sector of organ transplants in Ghana.
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DECLARATION OF CONFLICTING INTERESTS

The Author declares that there is no conflict of interest.

\(^2\) Dr. Quigley was my co-supervisor when this Paper was drafted but has since left The University of Manchester and been replaced by Prof. Søren Holm.
6.1 Introduction

Concern over the issue of mortality is a ‘universal feature of human societies’, but death, evokes distinct sensibilities in different social, religious, and cultural settings. Our knowledge and awareness of the certainty of death impact on how we live and conduct our affairs and may inform and influence our peri-mortem consumption patterns. For instance, the Western conception of death posits that death signals the end of the material body as well as the social life of the deceased. In contrast, in the African traditional context, death is portrayed as a harmonious social relationship where the living and the dead meet through the ever-present world of ancestry. However, the emergence of new technologies (in the context of Africa) surrounding death such as mortuary and embalmment services are shaping funerary activities in urban parts of Africa. These services enable migrant workers to be buried at home in accordance with custom, and may work to bridge differences in peri-mortal and funerary activities between

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4 Hirschkind, op. cit., 39.


6 Ibid.

7 The concept of ancestry posits that death does not extinguish all existence. It merely represents a transition from the realm of physical existence into that of ancestry. Life and death are seen as a continuum; ‘you are born, you die, and then you continue to exist in other realms’, Barrett, R. K. and Heller, K. S., ‘Death and Dying in the Black Experience’ Journal of Palliative Medicine 5 (2002): 793-799, 795-976. In the Ghanaian and, arguably, the broader African traditional context the social environment is made up of the interaction of the worlds of both the living and the dead. Consequently, ‘death introduces forces of physical, spiritual and social rupture’ thereby enabling the deceased to transit from the state of physical imperfection to one of purity and spiritual perfection. ‘To qualify as an ancestor upon death, one must have led a good life, recognizing all relevant rules of justice and social interactions’ (Bonsu and Belk, op. cit., 44) and must have died a ‘good’ death. Upon attaining this state of piety ‘ancestors are believed to have the power to directly control the affairs of the living. They reward those who exhibit good behavior and adherence to traditional laws of existence and punish those who violate social norms and rules’ (Bonsu and Belk, op. cit., 44). As a result ancestors are often called upon by the living (commonly through the pouring of libations) for prosperity, good health, fertility, good harvest, rain, and success or even have their powers invoked to grant victories or punish perceived enemies. Simply, ancestry is traditional Ghanaian sainthood.

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Western and African societies. This is understandable because it is ‘unlikely that the religious, cultural and social practices which surround death in any society are completely free-floating, and unconnected to changing demographies’. The Western conception of death admits of some exceptions, for example: 1) posthumous organ donation as a way of rehabilitating the deceased’s social identity; and 2) artists or authors whose works are discovered posthumously. This shows that in both settings there is some belief in the possibility of renegotiating one’s social status and/or value posthumously. This point of convergence of cultures in the conception of death is explored in this paper and ways of harnessing its utility in respect of human organ/tissue donation (particularly deceased) and transplantation in the Ghanaian context are examined.

6.1.1 The State of Transplants in Ghana

Kidney transplantation is in its infancy in large parts of Sub-Saharan Africa with the exception of South Africa. In Ghana, strenuous efforts are being made to establish a human organ transplantation programme because chronic kidney disease (CKD) is now an issue of considerable public health concern there. Unfortunately, as in most parts of Africa, these efforts are hampered by the lack of resources (particularly logistics), technical expertise, and care support for patients with CKD. There is, however, great international interest in supporting resource-poor countries to make kidney transplantation a routine treatment option for patients

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9 Ibid, 347.
10 Bonsu and Belk, op. cit., 42.
13 Ibid.
with CKD.\textsuperscript{14} Driven by the public health concerns and buoyed by international interest, Ghana is expected to commence a routine kidney transplantation programme sometime in 2014 following successful test transplants (using living related donors) from 2008 to 2012.\textsuperscript{15} Arguably, in order to develop a successful organ transplantation programme it is necessary to expand the donor pool to include other ethically defensible sources such as living unrelated and deceased donors.\textsuperscript{16}

Furthermore, although Ghanaians exhibit a great deal of socio-cultural sensitivity around their dead, there is no specific law or policy framework addressing ethico-legal concerns around death and dying, or for human organ donation and transplantation.\textsuperscript{17} There is no coherent guidance from the Ghana Medical and Dental Council (GMDC), Ghana Medical Association (GMA), Ministry of Health (MoH)/Ghana Health Service (GHS) or the professional Colleges (Ghana College of Physicians and Surgeons - GCPS, and the West African Colleges of Physicians and Surgeons - WACPS). The commencement of a transplantation programme in the absence of specific legal and policy frameworks on how to clinically define, determine, and confirm death, necessitates a re-examination of the concerns surrounding death in the Ghanaian socio-cultural setting.

\textsuperscript{15} These tests were carried out with the support of Transplant Links Community (TLC), a UK registered charity that supports emerging countries in the management of CKD. They offer teaching, advice and carry out living kidney transplantation with the aim of ensuring that sustainable transplant programmes become possible in the future. It was established in 2006 by a group of British doctors with vast experience in transplant surgery and desirous of sharing their knowledge and expertise. For a more detailed look at their activities see; \url{http://www.transplantlinks.org/}, accessed 30 October, 2012.
\textsuperscript{16} I assume for the purposes of this paper that the availability of organs is an important part of developing a successful transplantation programme. As such, expanding the donor pool to include all ethically acceptable sources is desirable.
\textsuperscript{17} \textit{The Declaration of Istanbul on Organ Trafficking and Transplant Tourism}, Istanbul, Turkey, April 30-May 2, 2008, (Istanbul: The Transplantation Society with the collaboration of the International Society of Nephrology in Istanbul, 2008); \url{http://www.declarationofistanbul.org/}, accessed 03 October, 2012.
The first aim of this paper is to re-examine, in the Ghanaian socio-legal context, the ethico-legal controversy around the definition, determination and confirmation of death and its relationship with obtaining organs for transplant. It is hoped that this will bring a new perspective to the debate and enrich our ethico-legal discourse on the subject. I also examine the nature of the role of law in defining/ determining death. I consider the merits of a statutory definition of death and conclude that given the circumstances of Ghana (its socio-legal environment) and the UK experience, a judicial rather than statutory definition is workable. The overall aim of the article is to explore how policymakers could promote transplantation in a way which is consistent with and not in juxtaposition to sociocultural ideas about death in Ghana. Additionally, given that the current regulatory regime in Ghana does not have a legal definition of death, I explore problems that may be faced by agreeing a definition. I am acutely aware that these are just two issues from a spectrum of issues that would need resolving, but they are very important ones, as getting either of them wrong could have serious ramifications for public confidence in donation/ transplantation.

This article begins by providing a brief clarification of the Ghanaian socio-legal context in ‘The Ghanaian socio-legal context section’, specifically the philosophical thinking of the indigenous people which underpins posthumous renegotiation of one’s social value and status. It points to some likely socio-cultural implications of this for the regulation of the nascent transplant programme in Ghana. The article then explores the changing definitions of human death in the ‘Changing definitions of death: merely to suit transplantation purposes?’ section and demonstrates that re-definitions of death emerge as a result of a confluence of advances both in medicine and in biotechnology. It then challenges the notion that the re-definitions of death are merely aimed at procuring human organs/tissues for medical purposes particularly
transplantation surgery. In the ‘A statutory definition of death?’ section, the article explores whether or not society’s unease with re-definitions of death is better dealt with by introducing a statutory rather than common law definition of death. The article concludes by proposing that Ghana should not adopt a statutory definition, rather the definition of death should be judicially determined in accordance with prevailing medical professional standards and practices.

6.2 The Ghanaian Socio-Legal Context

6.2.1 The Legal Context

Before examining the specific issues, it is necessary to briefly explain the general Ghanaian legal environment. Ghana’s legal system, as with most former colonies of Britain, is founded on the common law tradition. However, unlike the UK, Ghana has a written constitution. The 1992 Constitution of the Republic of Ghana provides in Article 11(1) that the laws of Ghana shall comprise: (a) the Constitution; (b) Acts of Parliament; (c) Orders, Rules and Regulations made by any person or authority under a power conferred by the Constitution; (d) the existing Law; and (e) the Common Law. ‘Common law’ as employed under Article 11 (2) includes: i) the rules of law commonly referred to as common law (or judge-made or case law); ii) the rules generally known as the doctrines of equity; and iii) the rules of customary law. Customary law means the rules of law which by custom are applicable to particular communities in Ghana. Further, the influence of Islam in Ghana has left its imprint on the Ghanaian legal system. Article 39 sets out a cultural objective by enjoining the State to take steps to encourage the integration of appropriate customary values into the fabric of national life, while Article 26 provides for

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19 Islamic Law is recognised and given effect to in Ghana in the Marriage of Mohammedans Ordinance Cap 129 of 1951.
cultural rights and practices. Importantly Article 26(2) provides for the prohibition of customary practices that are dehumanising or injurious to the physical and mental well-being of a person.

Ghana’s legal system can thus be said to be pluralistic, because in addition to the common law tradition it features elements of two other traditions: the religion-based tradition (Islamic or Sharia (civil)) law and African traditional law or customary law. The recognition, relevance and application of customary law has been well established in common law which has also established that any such customary rule ought not to be repugnant to the principles of equity, good conscience and natural justice. It follows therefore that some of the practices and usages that have crystallised as custom may not merely be of cultural significance or value but of legal significance too. This explains why any regulatory regime must recognise the cultural contexts or reflect the social norms and values of the community in which the regulatory dialogue occurs.

6.2.2 The Socio-cultural Context

In most parts of Ghana death is central to much cultural and religious reflection, discourse and social practice. The proverb “Abusua do efunu” (the family loves the corpse) aptly captures the socio-cultural sensitivities that the Ghanaian generally attaches to death and peri-mortem and funerary activities. This proverb portrays and asserts the responsibility under custom of the family to and for the dead. The traditional conceptualisation of societal harmony in Ghana derives from mutual respect for the living and the ancestors. One of the philosophical

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23 McCaskie, op. cit., 417.
24 Bonsu and Belk, op. cit. Also see Barrett and Heller, op. cit., 796.
25 Bonsu and Belk, op. cit., 45.
conceptions that affect one’s candidacy for ancestorship under indigenous Konkomba philosophical discourse is Post-mortem Personality Identity Renegotiation (hereinafter referred to as PPIR). I shall demonstrate presently that this customary practice could either further or thwart the development of a successful cadaveric organ donation and transplantation programme in Ghana, depending on how it is understood and utilised.

Briefly, PPIR under Konkomba custom is the understanding that an individual’s social value and status could be improved or worsened, or, more appropriately, renegotiated depending on peri-mortem events. These peri-mortem events include the type of death, the nature of the individual’s ill-health, last wishes and actions, the immediate post-mortem details such as how the body has been treated (for example whether it is reasonably intact, covered with sores, etc.) and the kind of funerary activities and rituals performed. According to custom the belief in the capacity of these pre- and post-mortem events to affect the deceased’s ascent to ancestorship has great purchase. This respect for the body being intact is founded on the presumption that the body belongs to “Uwumbor” (the almighty maker of all - God) and the ancestors expect the elders to continue to uphold this cultural injunction. Failing to do so may not only jeopardise the deceased’s ascension to ancestorship, but also bring untold hardships, curses, misfortunes and

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26 I use the Konkomba ethnic group because their beliefs mirror the beliefs of almost all other ethnic groups in Ghana, and therefore have a huge potential for generalisation. Further, their beliefs around death and dying are particularly illuminating for my purposes. Finally, as a Konkomba I closely identify with and understand some of these belief systems and am therefore in a position to, as far as possible, accurately examine them in a more nuanced manner.

27 The writer has been fascinated by the cultural practices surrounding death and the thinking that informs these practices particularly the idea that one’s social value and status could be renegotiated posthumously. As is expected the ideas and values that underlie these indigenous belief systems are passed on through oral tradition. There is no written documentation about PPIR as espoused by the Konkomba that has come to the attention of the writer. This led me to seek deeper answers on the concept from my father (now deceased and to whom I owe a great debt of gratitude) and a number of elders of the Konkomba ethnic group of northern Ghana. The information presented here is as a result of four years of informal engagements of these connoisseurs of Konkomba indigenous values and the thinking that underpin them. Consequently, the views expressed here are attributable to these unnamed contributors.
calamities on the family and community. The channels of communication between the living and the dead are mediated through soothsayers and spiritualists. Wrongs may be remedied by performing certain specified rituals spelt out by the ancestors and lesser gods (for example the earth god; who are all emissaries of “Uwumbor”) through the soothsayer or spiritualist or both. It is understood under Konkomba customary practice and usage that dissecting a dead body or burying a body with certain parts missing offends custom, denigrates the individual, and lowers the social value of the deceased and his family. Conceptually, then, any such activity might affect the decedent’s PPIR and legitimacy as an ancestor.

This is however not the full story. Firstly, under the same custom, there are certain circumstances under which cutting open a dead body actually furthers one’s chances of becoming an ancestor. For instance, when a pregnant woman dies (and quickening has occurred) elders are enjoined to disembowel the body, take out the baby and inter both separately. This is because the death of a pregnant woman counts as ‘bad’ death and as such undermines the status of the deceased to become an ancestor. This post-mortem act therefore serves to renegotiate the social status and value of the decedent. Similarly, post-mortem examinations (where not all body parts can be returned) are not seen or understood to be acts that are inconsistent with the indigenous thinking of becoming an ancestor. Furthermore, the Konkomba custom, and arguably, the Ghanaian traditional society more generally, is

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29 This is particularly important because it is believed that when one is not buried with certain vital organs (such as the brain, heart, etc.) the spirit or soul is violated and this undermines the deceased’s status as an ancestor which reflects negatively on the bereaved family. See also an exposition on the respect for ancestors by the Asante of southern Ghana by Bonsu and Belk, *op. cit.*

30 This is the stage in pregnancy when the foetus can be felt to move.

underpinned by a communitarian ethos and is founded on the principle of collective solidarity. Doing good to the individual, to the family, the community; advancing communal goals and upholding communal values undergird all moral action. These find expression in the extended family system and the call to volunteerism referred to as “nkpawiin” in likpakpaln (the language spoken by the Konkomba). It guarantees individual rights and allows their enjoyment by emphasising and focusing on the maximisation of benefits and minimisation of the burdens on all community members through collective solidarity.

For example, when one is ill during the farming seasoning and unable to farm, “nkpawiin” can be called by him or any member of his family on his behalf for the community to dedicate a whole day to work on his farm to ensure that his farm is tended and his family is not left without food. Sometimes failure to participate in communal labour or “nkpawiin” may attract legal sanctions. Finally, in order to enhance one’s post-mortem social value some families in parts of Ghana go to the extent of using clay to improve the appearances of their dead by hiding bodily ‘imperfections such as sores on the skin’.

Conceivably, these manifestations of indigenous philosophical thinking have the potential on the one hand to undermine, and on the other hand to further, efforts to facilitate organ donation (especially cadaveric organ donation) for transplantation. Which way the pendulum swings will depend in large part on how context-appropriate the organ donation and transplantation governance structure is. As we are about to see, an appropriate governance structure may benefit from a community which believes that one’s social value can and, in certain cases, must be

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32 This is not to suggest that only males engage in farming but that the Konkomba are patriarchal.
renegotiated post-mortem, is underpinned by a communitarian ethos, and concerned about achieving communal goods and goals through the principle of collective solidarity.

6.2.3 Likely Socio-cultural Implications for Organ Transplant Regulation in Ghana

The success of any organ donation and transplantation governance will depend on how context-appropriate it is. It is my claim that the philosophical underpinnings of PPIR together with a communitarian ethos which ensures that communal goals and values are directed at doing good through the principle of collective solidarity or “nkpawiin” may be either a liability or an asset depending upon how these are understood and utilised. It is entirely plausible that if the indigenous people recognise and understand through education that transplantation and organ donation (particularly deceased donations) are ways through which social value and status can be renegotiated after one’s death, they are likely to be embraced. To this extent PPIR can be viewed as a great window of opportunity for the development of a context-appropriate organ donation and transplantation governance structure. Furthermore, when the utility of organ transplantation is well explained to reflect the communal value of doing good through the spirit of “nkpawiin,” then it might be viewed by the Konkomba community as worthy of support.

A context-appropriate organ donation and transplantation framework in the Ghanaian socio-cultural setting will be one which, among others, is respectful to and guided by indigenous communal values and principles. The fact that it might be seen as another way through which individuals and families can renegotiate their social value and status both in life and in death could provide key motivations in accepting the practice of donating organs for transplant. Otherwise there is a risk that transplantation surgery may be perceived as an enterprise that offends local custom and undermines one’s ascent to ancestorship. Any such perception, unfortunate as it may seem, could become a major stumbling block on the way towards making
transplantation a routine surgical operation in Ghana. The discussion thus far is in respect of indigenous Konkomba socio-cultural values and the thinking that belies them and, therefore, not necessarily reflective of the whole Ghanaian traditional context (even though their beliefs mirror those of most of the ethnic groups in Ghana). Consequently, any generalisation of their application and utility must be approached with some circumspection and caution. Nonetheless, the points made are relevant because they help to illustrate the importance of socio-cultural issues in determining the likely success or otherwise of organ donation and transplantation programmes and the values and policy choices that ought to inform them.

In the ensuing section I examine the changing definitions of death and argue that claims that these are solely driven by transplantation interests are not entirely borne out by historical facts.  

6.3. Changing Definitions of Death: Merely to Suit Transplantation Purposes?

6.3.1. Changing Methods of Ascertaining Death?

Arguably, of all the biotechnological advances that have impacted on medicine, none has had its ethico-legal contentions conducted, literally, in the shadow of death and with such intensity as transplantation surgery. What death is, how it is determined, as well as what purpose such determination serves, all provoke medical, legal and philosophical controversy. The determination and confirmation of death has not always been a task performed by doctors. Powner and colleagues have argued that the practice of the Hippocratic tradition was that as death approached or the dying process had begun, practitioners were typically instructed to withdraw from the care of the dying patient, thus leaving the actual confirmation of death to

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35 This is not to suggest that we should not worry if the redefinitions of death are partly motivated by transplant interests. I argue in section 6.3.2 that the claim that the redefinitions are solely motivated by transplantation interests are not borne out by historical facts even though it is no denying the fact that organ transplant interests have since fuelled the urgency of determining the time of death. I wish to thank Reviewer 2 for this point.
relatives and other lay carers. It was not until the 16th and 17th centuries, when societal concern about the fear of premature burial heightened, that physician involvement in the confirmation of death became routine practice. These concerns led, in some cases, to the promulgation of laws requiring observation of dead bodies over time before interment.

Lack of certainty in the definition and confirmation of death has dogged medical practice from then on and the associated fear of being buried alive as a result of this has, over the years, been both acknowledged and denied. Arguably, the continuing controversy in the discourse of death; how it is defined, determined, and confirmed endures because the ancient fear of premature burial might have been replaced by the fear of premature procurement of human organs for transplantation purposes.

In this section this paper offers a brief historical account of the evolution of the determination and confirmation of death and demonstrates that the definition (or re-definitions) of death has been a function of our continuing understanding of the human body, aided by innovation and advancements in medicine and biotechnology. Consequently, any claims that the motivations for the redefinition of death are solely attributable to transplantation interests are not supported by historical facts. For clarity and simplicity, drawing on the work of Gardiner and colleagues, I

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37 Great was such fear that in what could best be described as a policy decision to quell the societal uneasiness of the time, the Court of Appeal of Naples sentenced a doctor who certified the death, and the Mayor who authorised the interment of a woman who was apparently buried alive, to imprisonment; each to a term of three months for involuntary manslaughter. See The British Medical Journal 884 (Dec. 8, 1877): 819.
38 Powner, Ackerman and Grenvik, op. cit.
39 See ‘Remarkable Resuscitations’ The Lancet (April 9, 1904): 1005; ‘Premature Burial’ The Lancet (May 16, 1908): 1431. Also see ‘Buried Alive’ The British Medical Journal 1812 (September 21, 1895): 730; For an interesting historical account of how, for example, a ‘dead man’ is alleged to have grasped the throat of a doctor who had made an incision on him, apparently as part of a planned post-mortem examination see Whetstine, L. M., The History of the Definition (s) of Death: From the 18th to the 20th Century, ftp:/homer.myftp.org/eBooks, accessed October 18, 2012.
40 Powner, Ackerman and Grenvik, op. cit.
shall categorise these evolutionary trends into somatic, cardiorespiratory, and neurological stages.  

Historically, clinicians have relied on taking a careful history of the patient and the circumstances of his or her ill-health to establish death. Central to the diagnosis of death is the responsibility not to misdiagnose. So great was the responsibility not to misdiagnose that many practitioners ‘concluded that advanced putrefaction of the entire body was the only valid single test to exclude apparent death’. This is understandable because there is a ‘massive difference in moral and legal status between the living and the dead’ and there is no doubt that it is better to err on the side of caution rather than to rush and treat someone who is still alive as though he or she were dead.

Traditionally, attempts at defining the moment of death have aimed at identifying the time that the human body has permanently or irreversibly lost its integrative functions or ceased to biologically function as a whole. We have long understood the relationship between breath and the integrative functions of the human body; the link between respiration, life, and death. As such, it became customary to identify death by using a mirror or feather to assess whether there was enough breath to support life. However, concerns over premature burial by the late 18th and early parts of the 19th century, led to the crystallisation of medical opinion that the most reliable criteria for the determination of death were rigor mortis, putrefaction, and ‘as an early

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42 Powner, Ackerman and Grenvik, *op. cit.*, 1220 (emphasis added).  
44 Ibid.  
and almost certain sign the glairy eyeball, with its papillary aperture fixed in dilatation’.\(^{46}\) This first set of criteria for the determination of death in the early part of the evolution of medical and scientific knowledge may, in a broad sense, therefore be termed somatic. Of course, keeping the body until decomposition set in was not the most convenient of circumstances for confirming death. As such, within the context of a medical system which includes the ability and intention to transplant functioning organs, any biotechnological advancement in medical knowledge which promises to retain robust checks against misdiagnosis of death but which, nonetheless, helps to make the determination of death reasonably early would seem welcome.

Conceivably, the understanding of circulatory function, and its role in life and death following William Harvey’s\(^{47}\) pioneering work in 1628 may have prompted a rethink of the sufficiency and appropriateness of diagnosing death relying solely on somatic/respiratory criteria. Additionally, the invention of the stethoscope in 1816 and its subsequent use enabled medical science to include the absence of heartbeat in the criteria for establishing death.\(^{48}\) These developments in medical science deepened our understanding of the functioning of the human body. We were now in a position to link not just breath but also blood circulation and heartbeat to life and death. Death was now to be ascertained using a combination of these criteria. Thus cardiorespiratory death occurs when, after cardiopulmonary arrest, there is ‘simultaneous and irreversible onset of apnoea, unconsciousness and absence of the circulation’.\(^{49}\)

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The development of the mechanical ventilator in the 1950s and other implements like the cardiac pacemaker created serious problems for the determination of death and cast reasonable doubt on the adequacy of the cardiorespiratory criterion. This is because by the turn of the 20th century, successes in biotechnology, particularly in intensive care medicine, challenged the cardiorespiratory criterion because it became possible in certain cases to restore lost cardiopulmonary function. In some cases cardiopulmonary resuscitation, post-mortem extracorporeal membrane oxygenation, and auto-resuscitation are known to restore circulation. As a consequence, harvesting organs from individuals either too soon or when resuscitation has not been attempted and shown to have failed will be to ‘determine that someone is dead when she is not known to be dead’. Though practice guidelines are variable worldwide, there is general medical consensus in most countries that a minimum waiting time of either two or five minutes provides sufficient confidence that donation after circulatory death (DCD) is clinically, legally and ethically permissible.

Understandably, this led some skeptics to question the ethical and legal defensibility of transplanting hearts from DCD donors because ‘if a heart is restarted, the person from whom it

51 Richards, op. cit., 222.
53 Shah and Miller, op. cit., 540-585.
was taken cannot have been dead according to cardiac criteria’. 56 Arguably, then, obtaining organs from some DCD donors does not universally satisfy the dead donor rule (DDR) as a result the rule should be abandoned. 57 It is however countered that once circulation has ceased permanently, or ceased beyond the point that auto-resuscitation occurs, then ‘whether the non-beating heart subsequently is left alone, removed and not restarted, or removed and restarted in another patient is irrelevant to the circulatory status of the dead patient’ and that there is no evidence that auto-resuscitation occurs after sixty-five seconds. 58 Note that the cardiorespiratory criterion does not deny or reject the somatic criterion; rather it incorporates it into the re-definition of death.

The continuing search for a deeper understanding of the function of the human body led French neurosurgeons (Mollaret and Goulon) in 1959 to define, or rather re-define, death using cessation of brain, rather than cardiorespiratory function. 59 But brain death or irreversible coma

57 Rady, Verheijde and McGregor, op. cit., 166-168; Shah and Miller, op. cit., 540-585 and Norman, Fost, ‘Reconsidering the Dead Donor Rule: Is it important that Organ Donors Be Dead?’ Kennedy Institute of Ethics Journal 14 (2004): 249-260. The understanding of the DDR as presented is based on the work of RM Arnold and SJ Youngner who credit John Robertson as the first to have coined the term in 1988. It is an ethical rule directed at protecting vulnerable patients from being killed or exploited by doctors to further transplantation purposes. In its simplest formulation it might be considered to have two distinct meanings. First, is the ethical injunction that patients shall not be killed by organ retrievals. This will seem to imply that patients shall not be killed for the purposes of organ retrieval, even if the organs are removed after their death has occurred. It is instructive to observe that this injunction appears consistent with most of our homicide laws (murder and manslaughter). Second, is the moral proscription of taking organs from patients unless, and until, they are dead. This might be taken to mean that organs ought not to be retrieved from patients before they are actually dead even if removing the organs does not kill them. This would appear very relevant in cases of patients in penumbral states such as anencephaly, persistent or permanent vegetative and minimally conscious states. The practical implications of this prohibition may be wider than first suggested. It might in practice prohibit living donations even those involving paired organs such as kidneys or partial transplants of unpaired organs such as liver, lungs and pancreas or whole heart and lung transplants. In sum the DDR ensures that patients are not killed by or for organ retrievals. For further details see Arnold, R. M. and Youngner, S. J., ‘The Dead Donor Rule: Should We Stretch It, Bend It, or Abandon It?’ Kennedy Institute of Ethics Journal 3 (1993): 263-278.
58 Bernat et al, op. cit.
was to be formally defined in 1968 by the Ad Hoc Committee of the Harvard Medical School which was specifically set up to examine the definition of death. Death was defined as either the ‘irreversible cessation of circulatory and respiratory functions, or the irreversible cessation of all functions of the entire brain, including the brain stem’. Critics have since mounted compelling evidence to show that patients in this state do not exhibit irreversible cessation of all functions of the entire brain and that some even continue to perform certain functions such as haemostasis, wounding healing, circulating blood, maintaining body temperature and gestating foetuses-functions not known to be performed by corpses. These criticisms led to the refinement of the whole-brain death concept to total brain failure. This notwithstanding, total brain failure is still vulnerable to the same criticisms levelled against whole-brain death. Some have accordingly argued that the concept of brain death is too flawed, does not fit into any coherent ‘biological or philosophical understanding of death’ and confuses the imminently dying with the dead. As such the Uniform Determination of Death Act (UDDA)’s requirement of ‘irreversibility’ of respiration, circulation, or all functions of the entire brain are, at best, unacknowledged legal fictions. Consequently, a more credible alternative to the brain death criterion and dead-donor

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60 Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Death, ‘A Definition of Irreversible Coma’ *Journal of the American Medical Association* 205 (1968): 337-340; For details on claims that the contribution of others prior to the Harvard definition have not been properly acknowledged see Machado, C., ‘The first organ transplant from a brain-dead donor’ *Neurology* 64 (2005): 1938-1942.


64 Shah, Truog, and Miller, ‘Death and Legal Fictions’, *op. cit.*

65 Truog, ‘Brain Death- Too Flawed to Endure’, *op. cit.*

66 Truog and Robinson, ‘Role of brain death and the dead-donor rule’, *op. cit.*, 2391.


68 Shah and Miller, ‘Can we handle the truth?’ *op. cit.*, 540-585 and Shah, Truog and Miller, ‘Death and Legal Fictions’, *op. cit.*
rule is to obtain organs based on the ethical principles of nonmaleficence and respect for persons. 69

Subsequently, the brain death criterion has, arguably, gained general acceptance among the medical and legal fraternities, especially in the developed world, even though some have remained skeptical about defining lifelessness without a requirement for the absence of cardiorespiratory function. 70

Generally, the points of departure have been around what brain death entails. Some have argued in support of the whole-brain death as the concept that provides the most satisfactory expression of our understanding of the concept of death of the human organism. 71 Other commentators argue in support of death of higher brain functions (cognitive/personhood death) maintaining that ‘the moment of death is not a medical but a social decision that can vary as the times and technology change, and that what is distinctly human about us is affect and cognition, not possible when the higher brain function has permanently vanished’. 72 However, some contributors have shown that the loss of brainstem function is the distinctive and decisive factor in whole-brain death and that, for all intents and purposes, brainstem death is the ‘essential and sufficient component for the diagnosis of death’. 73 In fact the UK (England and Wales) defines death as ‘the irreversible loss of the capacity for consciousness, combined with the irreversible loss of the capacity to breathe’ and argues that since irreversible cessation of brain stem function

69 Truog and Robinson, ‘Role of brain death and the dead-donor rule’, op. cit. Interestingly, not all commentators who deny the legal and ethical coherence of the brain death criterion agree with the proposal by Truog and Robinson. For a fuller rejection of Truog and Robinson’s alternative policy see Potts and Evans, ‘Does it matter that organ donors are not dead?’ op. cit. 406-409.

70 Powner, Ackerman and Grenvik, ‘current controversies’, op. cit.


will produce this clinical state, the ‘irreversible cessation of the integrative function of the brainstem equates with the death of the individual’. It is important to note here that the new AOMRC guidelines, under certain conditions, treat the irreversible loss of circulation as a sufficient basis for determining brain death. This set of criteria used in defining death relative to the brain is referred to as neurological criteria.

To ground a diagnosis using brainstem criterion the following clinical criteria must be fulfilled:

1. ‘Establishment of a specified condition which has led to irreversible brain damage.

2. Exclusion of potentially reversible causes of coma and apnoea.

3. Absence of brain-stem reflexes’.

4. Exclusion of confounding factors such as potentially reversible causes of the coma and apnoea (for example depressant drugs, electrolyte, metabolic, endocrine or circulatory abnormalities).

Diagnosing death using neurological criteria is not entirely new. It has been used internationally over the last four decades. Gardiner and colleagues demonstrate that diagnosing death using brainstem death is safe. They do so by arguing that an observation of the estimated 10,000 confirmed diagnoses of death using the brainstem criterion in the United Kingdom alone

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75 AOMRCs, Code of Practice. op.cit. I wish to thank Reviewer 1 for this point.
76 Bosnell and Madder, op. cit., 290. I use this paper because it captures, in my opinion, the essentials of the UK’s criteria and guidance and also because of its brevity and clarity.
over the last decade, in addition to the numerous patients (particularly in countries like Japan) being maintained on mechanical ventilation for prolonged periods after satisfying neurological criteria for death shows that none has regained brain function. Interestingly, not even the most ardent critics of brain death deny this claim.

The greatest attraction for the brainstem criterion for the diagnosis and confirmation of death is that it is physician-led, simple, practical and not constrained by biotechnology. Also, a comparison of the diagnostic criteria of countries that recognise whole-brain death, such as the United States of America (‘US’) and Australia, shows that a clinical examination is also required for the diagnosis and that confirmatory tests are obligatory. This shows that while the differences between brainstem and whole-brain concepts may be significant in theory, these are less apparent in practice. Nonetheless, brainstem death remains an ‘emotive subject’ because lay people continue to have difficulty coming to terms with the fact that a warm, perfused body can be said to be dead.

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79 Truog and Robinson, ‘Role of brain death and the dead-donor rule’, op. cit. particularly at 2392.
80 The clinical tests for confirmation of brain-stem death are generally aimed at eliciting six cranial nerve functions. This is because the cranial nerve nuclei, with the exception of cranial nerves I, II and the spinal component of XI, are located in the brain-stem. For a positive test result the clinician must demonstrate that the following cranial nerve reflexes are absent: 1. Pupils should be fixed in diameter and unresponsive to light mediated by cranial nerves II and III but the clinician must exclude certain drugs, or globe or craniofacial trauma; 2. Nystagmus or any eye movement should not occur when each ear is instilled with ice cold water mediated by cranial nerves II and III but the clinician must exclude certain drugs, or globe or craniofacial trauma; 3. There should be no corneal reflex mediated by cranial nerves V and VII; 4. There should be no facial or limb movement when supraorbital pressure is applied mediated by cranial nerves V and VII but must exclude certain drugs, locked-in syndrome or trauma to the cervical spine; and 5. There should be no gag reflex following stimulation to the posterior pharynx or cough reflex following suction catheter passed into the trachea mediated by cranial nerves IX and X but must exclude certain drugs, post-hyperventilation apnoea and trauma to the cervical spine. It must be noted that confirmatory or supplementary or ancillary tests are not required. The representation here adopted from the works of Gardiner and colleagues; Gardiner et al ‘diagnosis of death’, p. i20 table 6 and supplemented by the work of Bosnell and Madder; Bosnell and Madder, op. cit. at 292 particularly table1.
It is worth noting that the use of neurological criteria in the determination and confirmation of death does not deny or reject the cardiorespiratory criteria. They are merely a means of diagnosing death early with precision and where any doubt remains a reversion to the older criteria is not disapproved off. Paradoxically, the monumental scientific and biotechnological advancements made over time have done little to ease our fear of misdiagnosis of death and in many ways may have actually compounded the problem.83 Finally, as demonstrated above, even though our understanding and the criteria we use for the diagnosis of death may have both evolved over time, ‘our duty remains the same, to make timely diagnosis of death whilst avoiding any diagnostic errors; an obligation medical professionals cannot and should not abdicate’.84

Unfortunately, critics of brain death maintain that it is morally troubling to retrieve organs from individuals whose hearts and lungs might still be functioning.85 Tännsjö claims that it may be proper to admit a dualism in our criteria for defining death: one criterion for somatic death and another for personhood (cognitive) death.86 Indubitably, even though ‘irreversible loss of consciousness and the irreversible loss of spontaneous respiration are each individually necessary for death—neither is sufficient on its own’.87 Many may be apprehensive if the dualist argument were to succeed. Dualism in the definition of death might seem unwarranted. This is because admitting two separate definitions will complicate rather than clarify matters. It will most likely leave the public and health professionals confused as to what death is, when dead is dead, and whether and when DDR will apply. It will make it even more difficult to defend

83 Richards, op. cit., 221.
against claims that changes in the definitions of death are solely to serve transplantation purposes, and might lead to a real likelihood of public opprobrium and disapproval. These uncertainties may in combination act to undermine the whole transplantation enterprise. The point is strongly (and I think rightly) made that whatever our conception of death is, it would seem more pragmatic to consider “the brain, the heart, and the lungs as forming a ‘cycle of life’ which can be broken at any point; looked at in this way, there is no need to speak of two types of death…it is simply that different criteria, and different tests, can be used for identifying that the cycle has been broken”.\(^{88}\)

What the above developments demonstrate is the need for a readiness to adjust our criteria or tests for establishing death in light of developments and progress in science and medicine. Conceivably, altering our diagnostic methods or criteria need not, and must not, diminish our duty not to misdiagnose death.\(^ {89}\)

As has been shown, brain death is widely accepted, but there is no unanimity as to whether it ought to be whole-brain (total brain failure) or brainstem death. Nonetheless, a critical analysis of the criteria for determination of brain death shows that despite the international divide on whole-brain and brainstem death concepts the criteria used to determine and confirm death are identical around the world and are essentially clinical. This is crucial in the context of Ghana because biotechnology being generally expensive is not readily accessible even in tertiary healthcare institutions due to resource constraints. Under those circumstances the utility of a brain death criterion that is less dependent on biotechnology, but nonetheless remains robust, cannot be overstated. Countries such as Ghana should therefore take a cue from the United


\(^{89}\) *Ibid*, 523.
Kingdom and adopt the *brainstem* death criterion. This must however be done taking cognisance of the socio-legal context of the country.\(^90\)

### 6.3.2 Are the Changes Merely to Suit Transplantation Purposes?

It has been argued that *brain death* does not equate to biological death and its acceptance as law, especially in the United States, was motivated by the desire to retrieve vital organs for transplantation occasioning an egregious moral wrong which is an affront to the DDR.\(^91\) Giacomini claims that neither biotechnological progress, nor the age-old uncertainty over the definition of death, constituted enough grounds to trigger the need for the re-definition of death.\(^92\) This, he argues, is because at the time that *brain death* was defined EEG was still in its embryonic stage of development, and was ‘neither necessary nor sufficient diagnostic evidence for redefining death’\(^93\) yet it was presented as one of the reasons informing the change in definition. Furthermore, as discussed above, it is argued, quite legitimately, that the UDDA in its current form relies on unacknowledged legal fictions for the sole purpose of advancing transplant interests and therefore lacks transparency.\(^94\)

But has the picture been accurately and fairly painted? I will argue presently that it has not. On the contrary, the brain death concept did not evolve *solely* to benefit organ transplantation as claimed because a careful examination of the ‘historical approach to this issue will demonstrate

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\(^91\) Nair-Collins, *op. cit.*


\(^93\) *Ibid*, 1478.

\(^94\) Shah and Miller, ‘Can we handle the truth?’, *op. cit.* and Shah, Truog, and Miller, ‘Death and Legal Fictions’, *op. cit.*
that both had an entirely separate origin’. As has been shown above, a number of advancements in biotechnology and medicine enhanced our understanding and evaluation of the functioning of the human body. At the same time there was a parallel development in immunology which revolutionised transplantation surgery from the 1960s. Whilst organ transplantation is attributable to advances in immunology and surgery, the need for the definition (re-definition) of death is due to advancement in the use of biotechnology in intensive care medicine. This viewpoint is shared by some commentators opposed to the brain death criterion. Plausibly, then, if organ transplantation had not developed it could not have been the basis (sole or otherwise) for the re-definition of death as opponents argue. Furthermore, it is arguable whether, if organ transplantation ceased today, concerns around the definition of death would become moot. It is claimed that if and when substitutes to the use of human organs for transplantation become a reality, the concept of brain death will disappear. This appears to be an interesting proposition indeed. If we admit that developments in immunology and intensive care medicine created problems for the traditional notion of death then the leap to the conclusion that if the use of deceased organs in transplantation ceased the concept of brain death will disappear, is one which is at best speculative. As argued above, historical facts show that even when the somatic and cardiorespiratory criteria were in use, uncertainty around death characterised by the fear of premature burial remained a societal concern.

Admittedly, though the influence of advances in biotechnology on the bioethical discourse around the definition, determination and confirmation of death is palpable, this is not because

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97 Shah and Miller, ‘Can we handle the truth?’, op.cit.; Truog and Robinson, ‘Role of brain death and the dead-donor rule’, op. cit.
biotechnology _per se_ has altered our traditional notion(s) of the definitions of life and death. Instead, as Bernat notes, ‘technology has generated cases that previously were impossible—cases that have made us aware of definitional ambiguities of which we had been previously unaware and have forced us to make distinctions and clarifications’. While, I acknowledge that developments in biotechnology and medicine made it necessary to reconsider what death is, it is equally undeniable that ‘a significant trigger to rethink our definition of death was the development of transplantation, which highlighted the need for speed in diagnosing death and removing organs from the body’.  

Conceivably, different conceptions of death may ‘inflect the way that the human body becomes an object of biomedical attention and management’ not least in the context of organ donation and transplantation. However, as has been argued, the development of the diagnosis and confirmation of brainstem death evolved independently to organ transplantation. Interestingly, no motive is ascribed to the change in definition of death from the somatic to cardiorespiratory criterion. It is my contention that the advances in biotechnology and medicine are the sufficient factors that have accounted for the changes in the definition of death. Transplantation surgery however became a key beneficiary of this scientific progress and society is the better for this coincidence of developments.

### 6.4. A Statutory Definition of Death?

Unquestionably, countries (such as Ghana) trying to establish transplantation programmes must not only deal with the definition of death as currently understood by medicine but also

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102 Bosnell and Madder, _op. cit._
determine whether such a definition should be enshrined in statute or left to the courts to develop in common law jurisdictions. Capron and Kass argue in support of a statutory definition of death and claim that a statutory definition will bring uniformity, and serve as the best way to balance the conflicting needs for clarity, precision, flexibility, public involvement and scientific accuracy in the definition of death. As a result, there is the need for a debate about regulation as this will provide a unique opportunity for the public to get involved and educated on the subject matter; express their views on troubling cases such as the use of anencephalic infants, Permanent Vegetative State (PVS) or Minimally Conscious State (MCS) patients as organ donors; and discuss issues of post-mortem pregnancies. It has therefore been argued that a good statutory definition will be one that accommodates the informed preference of the public as the dominant factor in determining what, essentially, is an issue of choice for society. Arguably, all these factors seem to have operated to make the public ‘unwilling to surrender control of such matters lightly to the medical profession’.

6.4.1. The US Experience

In the United States statute recognises whole-brain death as the legal standard for the determination and confirmation of death. Total brain death is now established at law in all the 50 states in the US but two states (New York and New Jersey) have specific laws or regulations ‘in place to accommodate persons who object to declarations of death grounded in neurological

103 Capron and Kass, op. cit.
104 Mason and Laurie, Law and Medical Ethics, op. cit., 532.
106 Brazier and Cave, op. cit., 495.
criteria on religious grounds’. The ethico-legal challenges presented by advancements in biotechnology were brought to the fore in the United States in the case of *In re Quinlan*. This tragic case involved 22-year-old Karen Quinlan who, under unclear circumstances, reportedly ceased breathing. Resuscitative measures proved ineffective and neurological tests conducted later by medical experts confirmed that she was in a chronic and persistent vegetative state and ventilator-dependent rather than brain dead. The case involved issues of definition of death; the prolongation of life using medical technology hitherto undreamed of and its impact on the rights of the incapacitated patient, her family and society, and the bearing of these on the constitutional right and scope of judicial responsibility among others. However, for the purposes of this article I limit the considerations to the definition of death. The father, a devout Catholic, sought the termination of the life support measures sustaining the daughter which he considered to be extraordinary measures. The medical and neurological experts were certain that, according to the Ad Hoc Committee of Harvard Medical School’s criteria, Karen was not brain dead. The case was considered to be significant because, as the court observed:

…the determination of the fact and time of death in past years of medical science was keyed to the action of heart and blood circulation, in turn dependent upon pulmonary activity, and hence cessation of these functions spelled out the reality of death. Developments in medical technology have obfuscated the use of the traditional definition of death.

The hospital treating her sought a declaratory judgment on whether using the neurological criteria developed by the Ad Hoc Committee of Harvard, as well as similar criteria to determine

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the death of an individual whose cardiopulmonary functions are artificially sustained, is in accordance with ordinary and standard medical practice. The New Jersey Supreme Court upheld the decision of the trial court that Karen was not brain dead. It is instructive to note that, in reaching its decision, the court stated that medical obligation is related to the standards and practice prevailing in the profession. Further, that there was also a non-delegable judicial responsibility to settle such matters. Accordingly, the courts must respond to the challenges that these cases raise.

The Supreme Court of Washington in the case of re Bowman is one example. Here Matthew Bowman, aged 5, was hospitalised in September 1979, as a result of severe injuries inflicted on him by a nonfamily member. He was subsequently declared brain dead by the attending physician and thus medically dead. The hospital sought to withdraw his life-support, but the Department of Social and Health Services acting as his guardian (because his parents could not be traced at that time) petitioned the court of first instance, challenging the decision of the hospital. It must be noted that the state of Washington did not have a statutory definition of death at the time. The trial court held that

the legal definition of death…must coincide with the prevailing medical opinion. Since the prevailing medical opinion recognizes that a person dies when irreversible loss of brain function occurs, the irreversible cessation of brain activity constitutes death under Washington law.

The petitioners appealed to the Supreme Court of Washington. The issues that fell for determination were: 1) whether law or medicine should define the standards establishing when death occurs; 2) if law is to define those standards, should the brain death standard be adopted;

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and 3) if the standard is adopted, what role should medicine have in defining the criteria for determining whether the standard has been met. The Supreme Court asserted that as a matter of law, death could be determined using either cessation of cardiopulmonary function or irreversible cessation of total brain function including the brain stem and this ought to be determined in accordance with accepted medical standards. The Court went further to state that this standard reflects both the former common law standard and the changes in biotechnology.\(^{113}\)

Some commentators have, however, argued that the court’s adoption of dual standards in the *Bowman* case and its failure to articulate guidelines, or recognise either of the two criteria that had allowed death to be determined by case law, constituted substantial defects in the court’s decision.\(^{114}\) Pamela Ryan argues that judicial decisions may not bring certainty and clarity to the determination of death and provide little or no guidance for doctors acting in different contexts. Accordingly, she argues that in order ‘to achieve uniform treatments by the states, a determination of death standard applicable for all purposes requires statutory enactment rather than judicial adoption,’\(^{115}\) and that the Uniform Determination of Death Act 1981\(^{116}\) (hereafter, the ‘UDDA’) passed in the United States is an effective example.

Interestingly, the problems with statutory law were made manifest in the case of *Barber v. Superior Court*.\(^{117}\) where two physicians were charged with murder and conspiracy to murder after discontinuing the treatment of a severely brain damaged 55-year-old man (Clarence Herbert) at the request of the deceased’s family when there was virtually no chance for recovery.

\(^{113}\) 94 Wn.2d 407, 617 P.2d 731 (1980), 421.
\(^{116}\) Uniform Determination of Death Act (UDDA) adopted by all States in the USA following its recommendation by the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.
It is argued that the *Barber* prosecution arose as a result of the gap between statutory law (in this case criminal law) and recent developments in biotechnology.\(^{118}\) These unsettling events added to the urgency for legislative reforms in many States in the United States. These cases highlighted the fact that though medicine through biotechnology had developed new techniques for irreversible cessation of brain function while cardiopulmonary support is given, it was uncertain whether these were recognisable at law.\(^{119}\) The goal of the UDDA was, therefore, to extend ‘the common law to include the new techniques for the determination of death’.\(^{120}\)

Some have remained unconvinced of the propriety of courts venturing into making clinical decisions about life-and-death which they consider to lie in the medical rather than legal realm.\(^{121}\) As such, it is not surprising that Section 1 of the UDDA sought to assure the medical community of its professional independence by providing that the determination of death must be made in accordance with accepted practice. Nonetheless, Ryan argues that ‘by providing that accepted medical standards regulate determinations of death, the UDODA reconciles the need for cognizable legal and medical standards with the need for adaptability to scientific changes’.\(^{122}\)

This argument has some bite. Conceivably, biotechnology will continue to improve and by leaving the fine details of what tests to apply in diagnosing death to be determined by doctors the UDDA contains the flexibility to accommodate changes in medical knowledge and

\(^{118}\) Lingerfeldt, M. S., ‘The Current State of Termination of Medical Treatment Case Law’ *Nova Law Journal* 9 (1984-1985): 159-182, 170. Mr. Herbert’s death occurred on September 6, 1981 as such it was section 7180 of the 1981 *Health and Safety Code of California* that was in force since the UDDA was yet to be adopted in California. This Code though different from the UDDA, recognised brain death. However, Mr. Herbert was not brain dead; rather the issue bordered on whether intentionally withdrawing treatment from a patient in a vegetative state was unlawful or criminal under existing law.


\(^{120}\) Ibid.

\(^{121}\) Lingerfeldt, *op. cit.*, 180-182.

\(^{122}\) Ryan, *op. cit.* 1526.
biotechnology. For example, the usefulness of having a statutory definition came to the fore in the case of *Strachan and Another v John F. Kennedy Memorial Hospital*. The plaintiffs, the parents of the deceased, a suicide victim, brought an action against the hospital and its administrator and attending physicians alleging the tort of outrage and holding them responsible for inappropriate handling of a dead body after the hospital failed to release the body of their son following an assessment and a determination by the medical doctors that he was brain dead. The Supreme Court of New Jersey held that according to the UDDA the suicide victim was dead and that the hospital negligently withheld the dead body of the victim from his parents, causing them emotional distress.

Nonetheless, a statutory definition remains vulnerable to challenge in other respects. First, since the specific criteria and tests (confirmatory or ancillary) are discretionary it is entirely possible that doctors in different states or even different hospitals in the same state may employ different sets of tests to achieve the same ends. It is not implausible then that under such circumstances different sets of tests might produce the odd situation where a patient in the same position may be deemed brain dead in one state or hospital and not so in another, rendering the uniformity sought under the UDDA illusory. It might be countered that the medical profession will be trusted to cure any such mischief by defining uniform criteria and tests for determining that death has occurred as anticipated under section 1 of the UDDA. But the fact that non-uniformity can happen indicates decisively that a statutory definition is not the panacea after all. This state of affairs is confirmed by research findings that policies around death in the United

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123 538 A.2d 346 (N. J. 1988).
124 Ibid.
States are still ‘remarkably heterogeneous, even amongst some of the nation’s most vaunted medical institutions’.\footnote{Bartscher, J. F. and Varelas, P. N., ‘Determining Brain Death- No Room for Error’ \textit{American Medical Association Journal of Ethics} \textbf{12} (November, 2010): 879-884, 879.}

A similar finding was made by Eun-Kyoung Choi and colleagues who observed that though there is reasonable legal uniformity in the United States on brain death, clinical standards are various. As a result, there is the urgent need for a unified national standard for minimum clinical and procedural requirements for determining brain death.\footnote{\textit{Ibid}, 879-884 and Choi, et al, \textit{op. cit}.} The problems inherent in a statute are exemplified by the amendment to the New Jersey Declaration of Death Act (NJDDA) and Administrative Code.\footnote{Brown, \textit{New Jersey Law Revision Commission Draft Final Report Relating to New Jersey Declaration of Death Act}, January 7, 2013; \url{http://www.lawrev.state.nj.us/UDDA/njddaDFR010713.pdf}, accessed March 1, 2013.} It was argued that the ‘adoption and periodic revision of regulations that dictate the clinical diagnosis of brain death are unusual, unnecessary and, in fact, impede the clinical practice of brain death declaration’.\footnote{\textit{Ibid}, 8-9.}

It might be countered that the concern of heterogeneity of practices or the inability of statutory law to keep pace with fast moving developments in biotechnology and medicine may be ameliorated by; (1) better co-ordination at the governmental levels (e.g. Federal level in US) or (2) delegated authority to make amendments by way of regulations.\footnote{I wish to thank one of the reviewers of this paper for this point.} However, as experience in the United States has shown, these have had limited success. In fact, the New Jersey Law Revision Commission was persuaded by the arguments of the New Jersey Hospital Association and the State Board of Medical Examiners ‘that regulations setting forth medical standards to govern declarations of death by neurological criteria do not and cannot keep up with
the clinical practice’ and may even delay brain death determination. More importantly, the fact that the definition of death has been modified from whole-brain death to total brain failure following further scientific evidence re-affirms the viewpoint that having a statutory definition may provide certainty in the short term but this may be at the expense of reflexivity and responsiveness- essential ingredients of regulating biotechnology.

Finally, the 2013 cases of Marlise Muñoz and Jahi McMath both in the United States where death is statutorily defined show that a statutory definition does not guarantee certainty. Marlise was aged 33 and pregnant but was declared brain dead following suspected pulmonary embolism. Her husband sought to honour her wishes by requesting that she be removed from the ventilator. The Texas hospital refused arguing that under Texas Advance Directives Act (TADA) life-sustaining treatment could not be withheld or withdrawn from a pregnant patient. The husband then sued the hospital and successfully argued that TADA had no application to brain dead individuals. Jahi was aged 13 when she was pronounced brain dead by a California hospital following adeno-tonsillectomy. The hospital sought to remove the ventilator, but her family objected and won a temporary restraining order preventing the hospital from discontinuing life-support treatment. The family later negotiated her transfer to an undisclosed location presumably for further treatment. As both Jahi and Marlise were deceased, it ought to have been clear that neither should have been the subject of treatment. The fact that both cases occurred in states where brain death is statutorily defined demonstrates that statutory definition does not

131 Brown, op. cit., 12.
132 Shah and Miller, ‘Can we handle the truth?’ op. cit.
134 For more information on these two cases see The Bioethics Program; Introducing an Online Symposium on the Munoz and McMath Cases posted by Meyer, Michelle N., Union Graduate College- Icahn School of Medicine at Mount Sinai Bioethics Program; http://thebioethicsprogram.wordpress/2014, accessed January 27, 2014.
necessarily remove the social, cultural, ethical, legal and emotional uncertainties associated with brain death.\(^\text{135}\)

### 6.4.2. The UK (England and Wales) Experience

The United Kingdom has had its fair share of the challenges in respect of the disconnect between the law and developments in medical technology. However, its approach to dealing with the ethico-legal concerns raised by biotechnology has been different. Unlike the United States, the United Kingdom has no statutory definition of death; rather the definition of death is firmly established by the courts through judicial precedent. The *brainstem* criterion for death is the legally accepted standard of determining death. The position of the law was laid in the case of *Re A*.\(^\text{136}\) The case involved a minor, A, who suffered severe head injuries which the doctors concerned with his care agreed, rendered him brain-stem dead. The family was however opposed to the switching off of the ventilator, necessitating the instant suit. Johnson J held that the court ‘had jurisdiction to make...a declaration that the child was dead’ and that turning off the ventilator would not be unlawful. This position of the law was later confirmed by the House of Lords in the case of *Airedale NHS Trust v Bland*.\(^\text{137}\)

Acknowledging the rapid pace of biotechnological advancements in medicine, the United Kingdom relies on policy guidance from the AOMRCs\(^\text{138}\) which publishes the professionally accepted standard criteria and tests for determining death and the courts uphold their authoritativeness.\(^\text{139}\) The lesson, it is argued, is that ‘the normal organs of legal regulation often


\(^{138}\) It is important to note that it is the AOMRCs, rather than the GMC, that issue guidance on these matters.

appear powerless in the face of new technology’. In respect of biotechnology, a ‘good’ and effective regulatory tool must be inherently malleable due to its rapidly changing and unpredictable nature. As a result this invites a move away from the traditional ‘command and control’ or rule-based regulatory approach (without discussing regulatory theories and strategies in this paper) to a more sophisticated approach such as principles-based regulation (PBR) which is both ‘reflective and facilitative of the process of scientific innovation’ even though its own shortcomings and paradoxes are well acknowledged.

The attitude of the actors in both jurisdictions is worth commenting on. Whilst in the United States there was, for unexplained reasons, almost an immediate groundswell of opinion that the common law was somehow incapable of responding to the emerging ethico-legal issues presented by new medical technology, there was no such apprehension in the United Kingdom. Rather, the actors in the United Kingdom were more trusting that the judges, guided by responsible medical opinion, could resolve any concerns.

The attractiveness of the United Kingdom’s position is that it takes advantage of the inherent flexibility in common law that enables the law to deal with novel situations without creating a vacuum. Consequently, a proactive judiciary in the United Kingdom has through case law

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141 Even though I do not go into regulatory theory here, it is nonetheless important to point out that what amounts to and or counts as good regulation is itself a matter of controversy. For further and better considerations of good regulation see Baldwin R., Cave, M. and Lodge, M., Understanding Regulation: Theory, Strategy, and Practice [2nd edition] (Oxford: Oxford University Press, 2011), 25-39.


‘introduced certainty into the debate’.144 making a case for statutory intervention less compelling today. Additionally, since all doctors practising in the United Kingdom are expected to be guided by responsible professional opinion as set out in guidance by the medical colleges, the fear of heterogeneous criteria and tests is ameliorated. Further, medical innovation and expertise ‘alter and do so faster than can the law’.145 It is, therefore, both necessary and desirable to keep the definition of death as a clinical/judicial matter, changes in which can easily be ‘accommodated within the law without any requirement for further legislation’.146 The merit here is that the need to continually change statutes and or their legislative instruments to accommodate changes in clinical practice, which is a time-consuming and costly exercise, is removed.

In consonance with the practice in the United Kingdom, the Ghana College of Physicians and Surgeons should develop a code of practice as a guide to clinicians for diagnosing and confirming death and it is expected that the Ghanaian judiciary would, like their English counterparts, uphold its authoritativeness. This approach is particularly suited for the Ghanaian context because of the absence of effective and efficient institutions, expertise, logistics and resources to effect legislative changes timeously.

The mode of exercising the law-making powers of the Ghanaian Parliament is set out in article 106 of the Constitution of the Republic of Ghana. However, translating these into practice can be a daunting task. For example, the author has since 2008 been part of a number of

144 Brazier and Cave, Medicine, Patients and the Law, op. cit., 498.
145 Mason and Laurie, Law and Medical Ethics, op. cit., 532.
146 Brazier and Cave, op. cit.
legislative reforms in the MoH/ GHS and the practical constraints make consideration of a judicial definition of death in the Ghanaian context imperative.147

Additionally, the constitutional requirement for the recognition and adoption of customary rules of law as part of the common law of Ghana calls for a definitional approach that is inherently flexible to accommodate the nuances of custom. A statutory definition lacks the required malleability. As demonstrated, countries with relatively well developed institutions and where statutory definition was adopted, such as the United States, acknowledge the practical challenges associated with a statutory definition. Consequently, developing countries such as Ghana must be aware of these challenges when considering the nature of the role that law ought to play in the definition of death, and are thus encouraged to decline any invitation to define death through statute.

6.5 Transplantation, Defining Death, and Ghana: Concluding Remarks

This article has examined efforts being made by Ghana to make organ transplantation a routine surgical procedure. Some reflections on the Ghanaian socio-legal context and how these may inform the policy dialogue going forward have been considered. If Ghana is to succeed in its efforts, then some of the issues that ought to be addressed by policy-makers must necessarily include an appropriate governance structure that is fit for purpose. To this end, the following ought to engage the attention of the framers of any potential legislation. First, the policy/regulatory framework ought to be forward looking and must go beyond the current restricted practice of kidney transplantation using organs from living related donors to a

147 The repeal of a number of healthcare regulations proved to be an extremely challenging exercise. It took at least 12 years to pass the Mental Health Act, 2012, (Act 846); about eight years to pass the Health Institutions and Facilities Act, 2011, (Act 829) and 10 years to pass the Public Health Act, 2012 (Act 851). Furthermore, the legislative instrument to operationalise key aspects of the Ghana Health Service and Teaching Hospitals Act, 1998 (Act 525) has since not been passed.
comprehensive transplantation programme reliant on all other ethically defensible sources. Second, Ghana should, in addition to the cardio-respiratory criterion, formally adopt \textit{brainstem} death because it meets the ethical, clinical and legal standards of defining death and is more applicable in the context of Ghana because it is less dependent on technology for its confirmation. Further, it is hoped that the definition of death and issuance of clear policy guidelines on death will help lessen any societal anxiety around death and organ retrievals. However, in so doing, the legal/ policy framework must be informed by and sensitive to the relevant sociocultural considerations if the transplantation governance structures are to gain social legitimacy.

In conclusion, there is cross-cultural variation in the conception and construction of death. This might be due in part to the fact that ‘death evades an immutable objective definition and instead is understood in subjective terms that are culturally and historically regulated’.\textsuperscript{148} Socially, as demonstrated, in both Western and Ghanaian socio-cultural contexts the theory of posthumous identity renegotiation has some purchase. Family members may donate the organs of a loved one in order to renegotiate or rehabilitate their identity posthumously or the artist whose artwork is discovered posthumously may have his or her identity renegotiated favourably.\textsuperscript{149} This culturally mediated variation in the conception of death has in the 20\textsuperscript{th} century been further compounded by biotechnology. In the specific case of Ghana, I have argued that the nature of the role of the law in defining death should be through case law as in the United Kingdom. The pluralism of values in Ghana and the recognition of customary law by the Ghanaian socio-legal context make this imperative.

\textsuperscript{148} Whetstine, \textit{op cit.}, 66.  
\textsuperscript{149} Bonsu and Belk, \textit{op. cit.}
What appears incontrovertible though is the fact that concerns over death will remain with us. After all, ‘the brutal reality may be that, however death is defined, and whether such a definition is enshrined in statute or not, diagnosing death will always be a matter of concern’. \(^{150}\) because death remains an unsettling facet of our common humanity. It is my hope that this discussion will form the basis for constructive debate by bioethicists, legal experts, theologians, healthcare professionals and policymakers in our quest towards the development of organ donation and transplantation governance structures that are more context-appropriate, especially in emerging economies such as Ghana.

\(^{150}\) Brazier and Cave, \textit{op. cit.}, 500.
CHAPTER 7

PAPER 2: POSTHUMOUS ORGAN RETENTION AND USE IN GHANA: REGULATING INDIVIDUAL, FAMILIAL AND SOCIOETAL INTERESTS

ABSTRACT

The question of whether individuals retain interests or can be harmed after death is highly contentious, particularly within the context of deceased organ retrieval, retention and use. This paper argues that posthumous interests and/or harms can and do exist in the Konkomba (and wider Ghanaian) traditional setting through the concept of ancestorship, a reputational concept of immense cultural and existential significance in this setting. I adopt Joel Feinberg’s account of harms as a setback to interests. The paper argues that a socio-culturally sensitive regulatory framework does not necessarily exclude the donation of (deceased) human biomaterials for transplant and science research. Indeed, when customary values are explored with open-mindedness and sensitivity it may be shown that such donation can form part of the important customs of some communities in this jurisdiction. Accordingly, a context-appropriate governance framework could utilise the cultural value of ancestorship as an incentive to encourage organ donation in the Ghanaian traditional setting.

7.1. Introduction

This article argues through the concept of ancestorship that posthumous interests and/or harms can and do exist in the Ghanaian socio-cultural setting. It sets the scene by showing some legitimate concerns that belie the current law and practice of the retention and use of human biomaterials in Ghana. It then examines, through a brief account, the debates that followed the organ retention scandals in Bristol and Alder Hey in the UK (England and Wales) with particular reference to the interests of the deceased, society and the family and suggests that similar organ retention ills in Ghana give rise to the need to learn from the UK (England and Wales) experience and proactively address them.

In order to facilitate the understanding of the contextual issues, the paper provides a brief account of the Ghanaian socio-legal environment and its respect for family and cultural rights in section 6.4. Feinberg’s account of harms as a setback to interests is then adopted in section 6.5. This allows us to establish the contentious nature of the notion of posthumous interests and harms, and show that most protagonists in the debate do not deny the moral defensibility of respecting the reputations and wishes of dead people.

Ancestorship is a reputational issue of great cultural and existential importance in the Ghanaian socio-cultural setting. As such it imposes a unique obligation on families at custom that cannot cavalierly be dismissed as non-person affecting and may pose a challenge to conscription of deceased organs in that socio-legal context. However, crafting a socio-culturally sensitive regulatory framework does not necessarily preclude the donation of (deceased) human biomaterials for transplant and science research. Indeed, when the contextual issues are explored with open-mindedness and sensitivity it can be shown that such donation can form part of the important customs of some communities in this jurisdiction. Accordingly, the article argues that
a regulatory framework which is sensitive to socio-cultural issues could utilise the value of ancestorship as an incentive to encourage organ donation in the Konkomba (and wider Ghanaian) traditional setting.

It is necessary first to show that the current practices surrounding the retention and use of human biomaterials in Ghana, particularly following pathological services, give rise to some legitimate concerns. These will next engage our attention.

7.2 Current Law and Practice in Organ Retrieval, Retention and Use in Ghana

Human organs and tissues are routinely retained for varying lengths of time without the appropriate or required consent in Ghana. These collections comprise various surgical specimens, tissue samples and blocks, whole organs or various parts of the body (from both living and deceased providers). Most of these are preserved in pots and kept in the museums of medical schools for the purposes of medical education and research. Others are retained, sometimes for indefinite periods, following coronial investigations. There is no formal legal or professional framework for securing the requisite consent for the retention of organs/ tissues and body parts following autopsies. According to the head of the pathology department of the premier hospital in Ghana, surgical specimens are kept for up to six (6) weeks before they are discarded while specimens of cancers are retained for much longer or indeterminate periods.²

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² The Konkomba are the second largest ethnic group in the Northern Region of Ghana. Their beliefs mirror the beliefs of almost all other ethnic groups in Ghana. As a result, the arguments, inferences and conclusions in this paper have a huge potential for generalisation.

³ These matters came to my attention when I held discussions with the head of department of pathology at the Korle-bu teaching hospital in Accra. It is the premiere referral facility in Ghana. The discussions were in respect of concerns from amongst the doctors about the need to assist them develop the appropriate frameworks (ethical and legal) to guide their practice. Further, I have personal knowledge of some of these matters because I worked in Korle-bu teaching hospital from 2003-2008 (not much has changed since then) and by virtue of my position as founding head of the medico-legal unit of the GHS.


⁵ See note 3 above.
There are two forms of post-mortems in Ghana. These are coronial autopsies and hospital or consent autopsies. Coronial autopsies are required by law to be carried out when a cause of death is unknown, unexplained, or suspicious. Though the Coroners Act permits autopsies without the specific consent of either the dead or their families, it does not give express authorisation for the retention of body parts after coronial investigations have ended. Also, the Anatomy Act regulates the examination and dissection of dead bodies and provides for related matters. However, it is section 9 that permits deceased organ retention by the head of a medical school or institution but subject to two conditions; i) the retention being in the interests of science; and ii) the consent of the relevant competent authority. Section 9 (2) defines competent authority to mean:

the executor or other party having lawful possession of the body of the deceased and the surviving wife or husband of that individual and, in the absence of such wife or husband, any known relative of the deceased falling within such class of relatives of that individual as may be prescribed.

Unfortunately, a legislative instrument to prescribe and rank the class of relatives was never promulgated. This omission is vitally relevant within the context of obtaining deceased organs for transplantation particularly in relation to posthumous interests and rights. In Ghana, for the purposes of inheritance, there are two main systems of heritage- patrilineal and matrilineal.

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6 Coroner’s Act of Ghana, 1960 (Act 18) specifically section 2. For the role of other professionals such as social workers in rendering support services to bereaved families under these circumstances kindly see Drayton J., ‘Organ Retention and Bereavement: Family Counselling and Ethics of Consultation’ Ethics and Social Welfare (September, 2011): 227-246.
10 See the section 15 (First Schedule) Civil Liability Act, 1963 (Act 176). For patrilineal inheritance family member means (i) mother and father, (ii) wife, son and daughter, (iii) brother and sister, and (iv) father’s brother. For the matrilineal system family means (i) mother and father, (ii) wife, son and daughter, (iii) brother and sister, (iv) mother’s mother, (iv) mother’s sister, and (vi) sister’s son, sister’s daughter, and mother’s sister’s daughter. This
Understanding how these inheritance systems work in the Ghanaian traditional context will inform how competing post-mortem interests and rights might be balanced in a socio-culturally sensitive legal framework governing organ retention.

Hospital autopsies, on the other hand, are only conducted with the prior consent of the deceased’s family when doctors determine that doing so will help to understand and/or explain a medical condition or advance medical knowledge, research or education. Hospital autopsies are neither regulated by a specific law nor guided by any professional code of practice in Ghana, with consent to them often being procured from relatives by the clinician (usually a junior doctor) and captured in the medical records of the deceased. There are no explicit requirements to ascertain the wishes of the deceased or their family.

In the face of the clear stipulations of the Anatomy Act of Ghana, 1965, (Act 280) and despite awareness of the role of the Ghanaian family in post-mortem events, human biomaterials are routinely retained on daily basis without the requisite consent. In the meantime we are reassured that despite the fact that there is no framework to guide their practice, organ/tissue retentions by pathologists are done in accordance with best practice. This would seem implausible since best practice in pathology will require clearly defined standards against which will seem to suggest some hierarchy even though this is not explicitly stated in the Act. Importantly, the careful observer will note that both lists exclude the husband. The explanation might be that this reflects the customary norm where husbands are generally expected to be the breadwinners for the family. A husband could therefore not qualify as a dependent under the estate of the spouse. This state of affairs has changed quite significantly since the coming into force of the 1992 Constitution. Spousal rights are provided for under article 22 and it can be inferred with a high level of confidence that any attempt to exclude the husband this way may be unconstitutional when articles 1(2) and 2(1) (a) and (b) are read together. Furthermore, under Ghanaian customary law a spouse is not considered part of the customary family of his or her partner and this might have a direct consequence for decision-making around deceased organ donation. I explore Ghanaian customary law in relation to interests/rights in deceased human bodies in detail elsewhere. The Konkomba run a patrilineal system of inheritance.
aberrant behaviours can be measured. In the absence of specific ethical and legal frameworks to guide the organ retention process, it is conceivable that it may be subject to abuse. This state of affairs presents a number of challenges for Ghana.

7.2.1 The Concern

Obtaining human biomaterials (from both the living and the dead) in Ghana has become a hotly debated subject for a number of reasons. First, Ghana is making strenuous efforts to make organ transplantation a routine surgical procedure by the end of 2014. Test transplantation of kidneys (using living related donors) have been carried out since 2008 with the assistance of Transplant Links Community, a UK-based charity that helps developing countries to make kidney transplantation feasible in those countries. Second, there are increasing concerns about obtaining ova and sperm from people (young persons; mostly students) for IVF by hospitals (both public and private) in the absence of legal clarification of the permissible uses of human parts and products, whether in reproductive health or other areas of health research and practice. Third, the illicit practice of stealing or selling body parts for the purposes of black magic popularly referred to as ‘juju’ is a recognised problem among persons working in

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14 Codes of Practice will undoubtedly set clear standards for the guidance of the professionals and when these are flouted sanctions ought to be applied. For the importance of codes of practice and conduct see Kennedy, I., The Bristol Inquiry- Interim Report: Removal and Retention of Human Material- The Inquiry into the Management of care of children receiving complex heart surgery at The Bristol Royal Infirmary (London: The Stationery Office: Crown Copyright), 40 para 131; The Forensic Science Regulator, Department of Justice, Home Office and The Royal College of Pathologists (PUB 291012, 2012) Code of practice and performance standards for forensic pathology in England, wales and Northern Ireland, 5.; The Royal College of Pathologists and The Institute of Biomedical Science- The retention and storage of pathological records and archives [3rd edition] (2005) and ss. 26 and 28 of HTA 2004.

15 Transplant Links Community (TLC), is a UK registered charity that supports emerging countries in the management of Chronic Kidney Disease. They offer teaching, advice and carry out living kidney transplantation with the aim of ensuring that sustainable transplant programmes become possible in the future. It was established in 2006 by a group of British doctors with vast experience in transplant surgery and desirous of sharing their knowledge and expertise. For a more detailed look at their activities see; http://www.transplantlinks.org/, accessed October 30, 2012.

mortuaries in Ghana. Fourth, there is a general unease from within the medical community, especially pathologists, about a long-standing culture of systematic and paternalistic retrieval, retention and use of human materials without the specific consent of the dead or their families.18

In relation to attempts to establish a transplantation system for Ghana, there is concern by policy-makers and medical professionals that any perception by the public that Ghanaian doctors are part of the illicit trade in human body parts may prove costly on a number of counts. First, the public outcry against any such practice might be irredeemably damaging to the reputation of the profession and its members. Second, it may heighten concerns surrounding death and organ retrievals and therefore lower public support for the nascent transplantation programme in Ghana. These could then force us into a reactionary rather than proactive search for an appropriate governance structure for human biomaterials in Ghana.

It is opportune at this stage to examine some of the arguments made in respect of our respect for the interests of the dead and the rights of families vis-à-vis societal interests through the debates that ensued in the UK (England and Wales) following the organ retention scandals in Bristol and Alder Hey.

17 Sjaak, van der Geest, ‘Between Death and Funeral: Mortuaries and the Exploitation of Laminality in Kwaku, Ghana’ *Africa* 76 (2006): 485-501, 489. The Komfo Anokye Teaching Hospital (KATH) in Kumasi (the second largest teaching hospital in Ghana) is in the news for failing to account for bodies of some deceased babies that have gone missing. The public speculation that the bodies may have been sold by orderlies of the hospital prompted a mob attack on the hospital and its staff. The Ministry of Health has since ordered an investigation into the matter and a review of the hospital’s standard operating procedures. The Chief Executive has also been relieved of his post. Worryingly, two of such cases involving the Tema General and Winneba Hospitals are currently before the High Court. For more details see KATH baby missing saga: Health ministry axe hospital CEO; [http://www.myjoyonline.com/news/2014/march-25th/kath-baby-missing-saga-health](http://www.myjoyonline.com/news/2014/march-25th/kath-baby-missing-saga-health), accessed March 26, 2014.

18 See note 3 above.

7.3. Posthumous Interests, Societal Interests and Family Rights

The organ retention scandals that came to light at Bristol Royal Infirmary and The Royal Liverpool Children’s NHS Trust (Alder Hey) were arguably the watershed in the governance of human biomaterials in the UK (England and Wales). Revelations of these practices arose during an investigation into the care of children receiving complex cardiac surgeries at Bristol. The evidence given at the Bristol inquiry triggered an investigation into organ retention practices in the wider NHS and Coronial Services. The inquiries confirmed that there was a culture of systematic full-scale removal and retention of human biomaterials within the NHS. The retention was in large part without the necessary consent of the parents and relatives of the deceased. The inquiries identified a number of failings including a culture of paternalistic attitudes towards bereaved relations; poor management practices; some confusion over the role of the coroner; and malpractices in pathology services across the NHS. These events culminated in the enactment of the HTA 2004 in England and Wales and later, the HTA 2006 in Scotland.

Ghana is currently experiencing human organ retention problems, some of which mirror the organ retention scandals experienced in the UK. As shown in section 7 (2) above, retention of human biomaterials in Ghana is not currently routinely undertaken in compliance with the existing legislation, which requires that retention be carried out only with the consent of the...

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22 Ibid.
23 See section 1 (2) (b) of Human Tissue Act, 1961 of the UK (England and Wales).
25 See n3 above.
family of the deceased. However, human organ retention (whether in Ghana, the UK or elsewhere) is a highly contested subject because it often engages very vexed matters including the posthumous interests and rights of the decedent and his/her family and it is these which must first be explored.

The organ retention scandals in the UK (England and Wales) excited clinical, ethical and legal commentaries as well as policy discussions. Some commentators have argued against the appropriateness of the use of the word ‘consent’ in the context of post-mortem human material retrieval, retention and use and have proposed ‘authorisation’ as a better alternative. Others have gone further; not only do they argue that it is immoral to require consent for deceased organs but that we should consider making the dead body ‘the charge and responsibility of the state’. It is claimed on this account that ‘the dead cannot be harmed’. As such our reverence for dead body parts is becoming a kind of vitalism which ought not to have veto over their use in the service of our collective good. Harris argues that though consent plays a primordial role in healthcare practice because it protects the autonomy

\[\text{27 Anatomy Act of Ghana, 1965 (Act 280).}\]
\[\text{30 Arguably, while consent necessarily implies the existence of an autonomous choice maker, authorisation does not. The Redfern report argues that in the case of children, the legal authority granted persons with parental responsibility is restricted to the best interests considerations of the child. It will however seem inappropriate to talk about best interests in the context of a dead child. Further, in respect of families of a deceased adult, family members may be content to allow organ donation but may not want to be burdened with the requirements of informed consent. It is to be noted that authorisation has since been adopted into law in Scotland; see sections 29, 30, 31, 32 and 33 of HTA (Scotland) 2006.}\]
and welfare of the individual, its role in posthumous organ retention and use can be problematical.  

Autonomy involves the capacity to make *choices*, it involves acts of the will, and the dead have no capacities – they have no will, no preferences, wants nor desires, the dead cannot be autonomous and so cannot have their autonomy violated.

As a result, he argues, conscription of dead bodies for important moral purposes is both ethically and legally defensible and should be seriously considered if people fail to authorise their use.

Richards also argues that apart from the right to testamentary disposition, including provisions for funerary activities and related matters, traditionally, the dead did not have a right to decent burial in the West. Consequently, any claim by the family for the control or possession of the body of their loved one for purposes of disposal is merely a ‘greater claim to sympathetic consideration, not a greater obligation or right to dispose of the body’.

Other contributors make the argument that we have a moral obligation to donate our organs posthumously because it comes at no cost, pain or risk to us, and that it is immoral to refuse to consent to such donation. Requiring consent before obtaining deceased organs, although

35 Harris, ‘Law and regulation of retained organs’ op. cit., 538 (emphasis added).
36 Ibid, 548.
38 Harris, ‘Law and regulation of retained organs’ op. cit., 533.
40 Emson, op. cit., 126-127.
understandable, is ‘misguided’\footnote{Spital and Taylor, \textit{op. cit.}, 302.} as such deceased organs should be treated as a public or societal resource\footnote{Troug, R. D., ‘Are Organs Personal or a Societal Resource?’ \textit{The American Journal of Bioethics} \textbf{5} (2006): 14-16.} because ‘others have a greater need for them when we are dead’.\footnote{I thank Dr. Sarah Devaney for this point.}

In support of this claim, Harris, for example, employs choice and interests conceptions of rights and casts doubt on the existence of posthumous rights in any tangible way.\footnote{Harris, John, ‘Organ procurement: dead interests, living needs’ \textit{J. Med. Ethics} \textbf{29} (2003): 130-134, 131. His argument is primarily that the possible large benefits to the living outweigh the small harms to the interests of the dead. I thank Prof. Søren Holm for this point.} The argument is simple and effective. On the choice theory of rights, the dead have no autonomy and therefore no interests to protect. On the interests theory the dead have no welfare interests to protect (although some critical/persisting interests such as reputation, will and welfare concerns for loved ones may survive the decedent). He accords these a weak priority because they are non-person affecting\footnote{Harris, ‘Law and regulation of retained organs’ \textit{op. cit.}, 535-537.} and must yield to ‘reasonable demands of public interests’.\footnote{\textit{Ibid}, 538.}

Since the dead subject has ceased to be the subject of person affecting morality, since he or she has neither autonomy rights nor interests to protect and only some rather attenuated persisting or critical interests, if any, his or her wishes do not have the primacy that rights and person-affecting interests can claim in moral argument.\footnote{Ibid, 538.}

This argument might seem persuasive in a society where there is an individualistic approach to autonomy. However, it will be of limited effect in a society such as that in Ghana that believes in the concept of ancestry; is communitarian in nature and is underpinned by the principle of ‘nkpawiin’ or collective solidarity. I shall argue that given that ancestry holds that the dead continue to exist in other realms, continually interacting with the living, then it is conceivable that the interests of the dead are not necessarily attenuated upon physical death. As a
consequence, the interests of the living are, in many cases, inextricably linked and sometimes subservient to, the interests of the dead. This is why the dead are commonly referred to as the ‘living-dead’ in the African traditional context.\(^48\) Under those conditions the primacy of the interests of the living is not as obvious as it first appears. It follows then that any assumption that the interests of ancestors and their relations will be accorded a lower priority than those of a living third party might prove problematic. Neither is it immediately apparent that these interests can be dismissed as conclusively non-person affecting.

Even in societies in which the concept of ancestry is alien, conscription has its own critics. These claim that the death of an individual does not mean that the deceased ‘ceases to matter at all’\(^49\) and that the interests of the family cannot be cavalierly dismissed.\(^50\) It is further argued that the interests we have in what can or cannot be done with our bodies after death outweighs any right of the sick to deceased organs.\(^51\) Furthermore, Giordano argues that consent of the family matters because it is the relatives of the decedent who have the ‘strongest entitlement’\(^52\) to the body of their loved one. As a consequence, retrieving organs from those who ‘refuse consent’\(^53\) is not ethically defensible.

Similarly, Brazier questions the defensibility of the claim that ‘neither the deceased…nor their family’ have the final say in decisions touching on posthumous organ retention and use.\(^54\)

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\(^54\) Brazier, ‘Retained organs’ *op. cit.*, 555.
According to her, to do so will be to fail to place sufficient weight on ‘deeply held religious and cultural beliefs’ and the respect accorded the dead the world over.\footnote{Ibid, 550.}

Brazier argues that any policy prescription which discounts the interests of the deceased and their family is doomed because people will feel outraged and reject it.\footnote{Brazier, ‘Retained organs’ \textit{op.cit.}, 557.} Interference with the disposal of the dead in breach of the dictates of their beliefs or values may constitute a violation of their rights under article 9 of the European Convention on Human Rights.\footnote{Brazier, ‘Retained organs’ \textit{op.cit.}, 559. Also see Article 26 of the Constitution of the Republic of Ghana and section 1 of HRA 1998 of the UK.} Finally, she argues that claims by some commentators that we disregard family interests are not borne out by our shared values throughout the history of organ retentions.\footnote{Brazier, ‘Retained organs’ \textit{op.cit.}, 565.} Contrariwise, evidence from the UK (England and Wales) organ retention scandals show that non-consensual retention and use of body parts had a deleterious effect on many families including damage to family values as well as their emotional, psychological and psychiatric well-being.\footnote{Sque, M., Long T., Payne S., Roche R. W., and Speck P., ‘The UK post-mortem organ retention crisis: a qualitative study of its impact on parents’ \textit{Journal of Royal Society of Medicine} \textbf{101} (2008): 71-77 and Brazier, ‘Retained organs’ \textit{op.cit.}, 565.} Though this does not in any way imply that body parts may never be removed without express consent, it places a heavy onus on those making the demands for organs to show that there is ‘greater necessity than the respect for the deceased’s bodily integrity’..\footnote{Brazier, ‘Retained organs’ \textit{op.cit.}, 565.} This is because while the good that deceased organs confer matters, equally the ends to achieving the good also matter.\footnote{Ibid, 567.}

As pointed out from the outset, this paper examines the interests of the dead and their family in the Ghanaian traditional setting. In order to facilitate our understanding of the contextual issues, it is necessary to provide a concise account of the Ghanaian socio-legal context relevant for our purposes.
7.4 The Ghana Socio-Legal Context

7.4.1. The Legal Context

The legal regime reflects the peculiar cultural and social circumstances in Ghana. This is not meant to be a detailed constitutional analysis. Rather, the discussion here is intended to point policy makers to issues that may be relevant to the social legitimacy of any dialogue on the choice of a regulatory framework for the governance of human biomaterials in Ghana. As a former British colony, Ghana’s legal system is founded on the common law tradition. The 1992 Constitution of the Republic of Ghana provides in article 11 (1) (e) and (2) that the laws of Ghana shall include the common law, doctrines of equity and customary law. By customary law is meant the ‘rules of law which by custom are applicable to particular communities in Ghana’. The legal point to be made here is that some of the practices and usages that have formed custom are of both cultural and legal significance.

Additionally, article 26 (1) provides that every person is ‘entitled to enjoy, practise, profess, maintain and promote any culture, language, tradition, or religion subject to the provisions of this Constitution’. Also, the constitution provides for the right to ‘freedom of thought, conscience and belief’ and for the ‘protection and advancement of the family’.66

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62 Sections 14 and 19 of the Gold Coast Supreme Court Ordinance (No. 4 of 1876) made English Law applicable in the Gold Coast (now Ghana) alongside Ghanaian customary law. Ghanaian law has also been influenced by Islamic law (civil) and given effect in the Marriage of Mohammedans Ordinance Cap 129 of 1951. The Ghanaian legal system is therefore pluralistic. This explains why common law as understood and employed in the Ghanaian socio-legal context includes case law, doctrines of equity and customary law rules. However, following the independence of Ghana on March 6, 1957 and its subsequent attainment of republican status in 1960, the Constitution and Courts Act of 1960 repealed this reception statute and English law has since ceased to apply with binding effect in Ghana. Ghana, as a democracy currently operates the 1992 Constitution as its supreme law. As a result cases from the UK, and all other countries especially the common law countries, are now of persuasive authority only.

65 Constitution of the Republic of Ghana, Article 21 (1) (b).
Furthermore, Article 1(2) establishes the Constitution as the supreme law of Ghana and Article 2(b) allows any person alleging that an act or omission contravenes or is inconsistent with the Constitution to bring an action for a declaration to the effect. Additionally, Article 12 provides for the protection of the fundamental human rights and freedoms as enshrined in Chapter Five (5) of the Constitution including cultural and family rights. However, an allegation that an act or omission is inconsistent with, or is in contravention of, any provision in the constitution will need to be proved before the Supreme Court which is the only court with jurisdiction to interpret such constitutional matters. The act or omission must however not be caught under the exception in Article 26 (2) which prohibits customary practices that the Court may find dehumanising or injurious to the physical and mental well-being of a person. However, if it is an action alleging a violation of a protected right (cultural, family etc.) then, procedurally, per Article 33 of the Constitution of Ghana the High Court is the court of first instance with the right to appeal to the Court of Appeal and then to the Supreme Court. Similarly, if the alleged violation or contravention is in public interest or health and safety then these may be adjudged reasonable and lawful under the Coroners’ Act of Ghana, 1960 (Act 18) or Public Health Act of Ghana, 2012 (Act 851) particularly sections 10 (2), 50, 168, 169 and 170.

Also, under the directive principles of state policy, policy-makers are encouraged to integrate appropriate customary values into the fabric of national life. Importantly, the Constitution guarantees traditional institutions such as Chieftaincy in article 270 and charges them to ‘undertake the progressive study, interpretation and codification of customary law with the view to evolving, in appropriate cases, a unified system of rules of customary law’. As shown above,

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68 Constitution of the Republic of Ghana, Article 272 (b) and (c), (Emphasis added).
cultural rights\textsuperscript{69} are entrenched in the 1992 Constitution and policymakers are encouraged to incorporate appropriate customary rules and values into national and public policy.\textsuperscript{70}

The challenge, however, is whether or not in the Ghanaian traditional setting we could successfully ground our policy choices both on the pursuit of our basic goal of maximising organs\textsuperscript{71} for transplant and respecting the cultural rights of the people as guaranteed under the 1992 Constitution of the Republic of Ghana. It has been argued that this is possible if we moved away from maximising to satisficing and pre-committed ourselves to respecting the cultural rights of the communities that the policy choice is intended to benefit.\textsuperscript{72} Acting in a way that in the short term appears to disservice our goal of obtaining organs can be a rational strategy if there are very good reasons for so acting. This is particularly important because ours is a pluralistic community and pluralism ought to be sufficiently valued. As such we should as far as practicable, avoid policy choices that may appear theoretically alluring but which nonetheless have a high likelihood of offending sensibilities and therefore more likely than not to create deep-seated public resentment. The short term gains of such policy choices might pale into insignificance when compared with the irredeemably damaging effects these are likely have on our objective of maximising human materials for the benefit of transplant patients, science and society.

As stated in section 7.1, one such customary practice which, with the appropriate policy choice, could further the purposes of organ transplantation in the Konkomba socio-cultural setting is the concept of ancestorship.

\textsuperscript{69} Constitution of the Republic of Ghana, Article 26.
\textsuperscript{70} Constitution of the Republic of Ghana, Article 39.
\textsuperscript{71} I assume for the purposes of this paper that there is the need to maximise supply of organs and that committing ourselves to doing so is a good thing.
7.4.2 The Socio-Cultural Context

Indigenous Konkomba (and wider Ghanaian) philosophical thinking is that there are two
distinct ends for the dead at custom which appears to follow the all or none principle - the
deceased becomes either an ancestor or a non-ancestor. While ancestors are highly venerated and
understood to live on and to continue to interact socially and spiritually with the living and dead
worlds, the non-ancestors are ‘dead’ to both the eternal and external worlds. The basic thesis
underlying the concept of ancestorship among the Konkomba of northern Ghana posits that death
does not extinguish all existence. Life and death are understood as a continuum. You are sent
into the physical world through birth, you live and you are recalled by the sending entity through
death and you continue live in other realms.73 To qualify as ancestor one must have led a ‘good’
life- recognising all the relevant rules of justice and social interactions74 and must have died a
‘good’ death.75

There is however some conceptual flexibility that allows an otherwise unqualified person to
become an ancestor. A number of interesting scenarios may obtain both in theory and practice to
living a ‘good’ life and dying a ‘good’ death. The first is that when both conditions are met then

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74 Bonsu, S. K. and Belk, R. W., ‘Do Not Go Cheaply into That Goodnight: Death-Ritual Consumption in
75 This paper does not discuss the thesis of good or bad death. It only explores how a transplant regulatory
framework could benefit from such a thesis and draws attention to some conceptual inconsistency inherent in the
thesis in the Konkomba traditional setting and shows how this inconsistency could be harnessed for the purposes of
maximising organs for transplant. It is not claimed that all non-consensual organ retrievals necessarily make a death
a bad death. Suffice to say that the Konkomba believe that dying is a process as such peri-mortem (period
immediately before, at and period immediately after) events may contribute to making a particular death count as
either bad or good at custom. Generally, ‘bad’ death in the Konkomba (and wider Ghanaian) traditional setting
includes death by suicide; death of a pregnant woman; drowning; execution.; death in a place and situation where
the required customary rites cannot be performed; and burial without certain vital organs such as brain and heart.
These deaths have the potential to thwart the reputation of the decedent as ancestor. As a result, any post-mortem
practices that offend the customs of any particular community and adjudged by the community to be a violation of
their cultural or family rights, or inconsistent with a specified constitutional provision, may be challenged in the
appropriate court. It follows then that not all non-consensual organ retention and use may be either unlawful or
unconstitutional. For more information about what constitutes ‘good’ or ‘bad’ death see Nukunya, G. K., *Tradition
and Change in Ghana: An introduction to Sociology* (Accra: Ghana Universities Press, 2011) and Seale, C., and
the individual is a clear candidate for ancestorship. On the other extreme is when a person has lived a ‘bad’ life and died a ‘bad’ death. It will seem incontestable that this individual is a clear candidate for non-ancestor. However, it is possible to have two other scenarios that can produce hard cases at custom. It is entirely possible for a person who has otherwise lived a good life, through brute luck, to die a bad death. Under this condition the status of the decedent can be renegotiated at custom and his/her reputation as an ancestor restored. For example the death of a pregnant woman who has otherwise lived a good life counts as a bad death. This has the potential to set back her ultimate interest to be thought of as an ancestor. To avoid this, the baby is removed from the woman’s body and both interred separately. This act renegotiates her reputation as an ancestor.

Similarly, bad death occurs when an individual who has otherwise lived a good life in accordance with all the relevant customary norms and values dies under circumstances where it is not possible to perform the appropriate funerary activities as demanded by custom. Some parts of the body of the deceased (such as hair, nails and a piece of her burial clothes) may however be procured and put into the shell of a kapok fruit. This is then brought to the customary home (as the dead person) and given a fitting burial in accordance with the dictates at custom.\footnote{Such customary decisions are made by the traditional head of family or clan or community with the consent and concurrence of the principal elders of that family, clan or community as the case may be. Where uncertainty remains it is resolved by consulting spiritualists of traditional deities and soothsayers. A decision from this consultation is final.}

There is however another scenario which has not received the needed consideration at custom. This is the situation where the deceased who lived a bad life dies a good death. I will argue that the conceptual flexibility must cover this scenario if it is to retain its internal coherence and consistency. Conceptual certainty obtains only when both criteria are either present or absent. It follows then that the presence or absence of any one of the criteria is not a
sufficient condition to disqualify a deceased individual as an ancestor. If this is true then a person who lives a bad life but dies a good death should be able to have his reputation renegotiated as an ancestor. Just as removing a dead baby from the body of its deceased mother, or the bringing of parts of a dead body home are acts that are deemed appropriate at custom to rescue the reputations of individuals posthumously, so should the donation of body parts of a deceased family member for life-saving transplantation or the good of science and society. This will seem to be in accordance with the communitarian ethos that is the basis of the Konkomba traditional context and expressed in the principle of ‘nkpawiin’. Looking at the value of ancestors at custom and the desire of many to be thought of as such posthumously, it could serve as a great incentive to encourage community members who otherwise would not have donated their organs to do so.

7.4.3 Why Reputation as an Ancestor Matters

Within the Ghanaian traditional setting, it is possible to identify a complex network of bundles of posthumous interests and/ or harms beyond emotional distress and psychological welfare. Reputation as an ancestor under indigenous Konkomba custom and usage confers the power on the decedent to intervene in the affairs of the family or community in very significant ways. Ancestors are deemed (whether real or perceived) to have power to directly control the affairs of the living. They reward those who exhibit good behaviour and adherence to traditional laws, and punish those who violate social norms and rules. As a result, families often prioritise the interests of ancestors over their individual or collective interests.

Furthermore, the bereaved family has a collective interest in their loved one being thought of as an ancestor. This is because any such reputation reflects positively on the family as well.

77 ‘Nkpawiin’ translates as collective solidarity.
78 Bonsu and Belk, op. cit., 44.
Additionally, ancestors are known to intercede on behalf of their families/communities by granting good health, fertility, good harvest and victories in war. Also, the family has an interest in avoiding the calamities, misfortunes and harms that are known and understood to accompany non-adherence to their traditional norms and values which they consider to be significant. In fact, Mbiti captures it succinctly that if ancestors are:

improperly buried…it is feared by the relatives or offenders that the living-dead would take revenge. This would be in the form of misfortune, especially illness, or disturbing frequent appearances of the living…People are, therefore, careful to follow the proper practices and customs regarding the burial or other means of disposal of dead bodies. 79

When families have genuine fears and interests of this nature, it is not enough to say that these concerns are unscientific, irrational or weird. These are the experiences, values and real life situations of these people. We ought to give sufficient weight to ‘expectations that flow from the complex cultural and existential beliefs, where truth is entangled in what it means to be part of the human condition’. 80 To dismiss these as squeamish will be to devalue, dehumanise and strip them of their dignity.

As Brazier and Sque et al rightly observe, some of the bereaved families in the Alder Hey and Bristol organ retention scandals had been seriously injured by the conduct of the doctors involved such that a case could be made that bereaved families are entitled to be protected from such conduct. 81 The fact that our sharpest scientific tools are still too blunt to measure these does not conclusively deny their existence. This might actually be indicative of the fact that there is more to be known about the human condition than science alone can currently offer. If the claim

that (legal) rights are social facts is reasonably true, then by their very nature some rights are, and will remain, context-relative. As a result, instead of viewing the beliefs of another social context that we are not familiar with as necessarily lacking in logic or rationality, and therefore mistaken, we need to recognise the reality of our different social circumstances.

7.5 Posthumous Interests and Harms

Posthumous interests and or harms remain irredeemably controversial partly because of the Epicurean argument of the absence of the subject and its counterintuitive conclusion that death is not ‘such a bad thing after all’. The issues are further complicated by the fact that harm in its customary usage is unavoidably vague. Even when we have settled on the conception of harm we wish to use, contextual issues may lead to different subjects being capable of harm or being in a harmed condition. In the context of deceased organ donation, there is controversy as to whether obtaining organs without the express consent of the dead or their families could harm the interests of the dead and/or their relatives. If so, what might any such harm entail? If not, might conscription of transplantable organs of the dead be a rational public policy? Though these issues have been the subject of extensive ethico-legal commentary, these have not been adequately explored in the context of developing countries such as Ghana. This paper situates the discussion in the traditional Ghanaian context and shows that the interests of the dead and or

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83 We may talk of legal, moral, or cultural rights among others. However, it is plausible to presume that all of these rights share a common defining feature which illumines their use in conventional rule systems. For a fuller exploration of rights see Dworkin, R., *Taking Rights Seriously* (London: Bloomsbury Publishing Plc., 2013); Sumner, L. W., *The Moral Foundations of Rights* (New York: Oxford University Press, 1989) and Waldron, J., *Theories of Rights* (Oxford: Oxford University Press, 1984). I am also mindful here of the fine line between arguing that some rights are context-relative and the likelihood of slippage into the universalism v. relativism debate. I wish to state that no such slippage is intended as such any suggestion to that effect is regrettable.


their relatives may prove weighty enough to defeat the plausibility of conscription of transplantable deceased organs as a rational public policy.

I draw on the work of Feinberg\(^86\) on the concept of harm as a setback to interests (including posthumous interests). There is however some dispute as to whether or not the dead can ever be harmed\(^87\) on the basis that the ‘dead have no interests and are beyond both harm and benefit’\(^88\). Proponents argue that the absence of an interest bearer makes any talk of posthumous interests senseless\(^89\). This claim is however rebutted by other commentators who establish, albeit from different perspectives, that posthumous interests do exist and their violation may warrant legal and ethical protection.\(^90\) Feinberg argues that for something to count as an interest certain conditions must exist: include some degree of ulteriority, stability and permanence. He states:

To say that something would be “in my interest” is to say that it would increase my ability or opportunity to satisfy those of my ulterior wants that are themselves the bases of interests, those goals in whose advancement I have a stake.\(^91\)

\(^86\) Ibid.
\(^88\) Patridge, op. cit, 244. Also see Callahan, op. cit. 346; Savulescu, ‘Death, us and our Bodies’ op. cit. and Taylor, op. cit.
\(^91\) Feinberg, op. cit., 55.
As a result, mere passing desires/wants and inclusive ends will not count as interests on this conception.  

Having settled on the concepts of harms and interests our next task is to establish whether or not there are interests that survive the interest bearer. If so, whether or not such interests can be setback and their bearer harmed as a consequence. It is necessary to take a brief look at interests as used by Feinberg. He shows that interests to one’s well-being may be conceived in two ways: welfare interests (which by definition are the minimal nonultimate goals of a person) and ulterior interests (the ultimate goals and aspirations of the person). Feinberg categorises human actions into those that are self-interested and those that are not self-interested. The not self-interested acts are those that when done do not promote the interests of the actor and may actually be, in certain cases, against the legitimate interests of the actor. Self-interested acts are further divided into those acts that are either other-regarding or self-regarding. Other-regarding acts are those that promote the actor’s desire for the well-being of others, at least, as an end in itself. The self-regarding interests are subdivided into directly self-regarding (acts aimed at promoting the actor’s exclusive ulterior interests) and indirectly self-regarding (acts that promote the well-being of others but only as a means to promoting the ulterior interests of the actor).

Welfare interests are thus those basic things (health, food, shelter, material resources etc.) that are necessary for human survival and as a precondition to achieving our ultimate goals. As such welfare interests may rightly be said to be typically, but not entirely, of instrumental value.

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92 Ibid, 55-56.
93 Ibid, 65-95 especially 74.
to the possessor. Other contributors however establish that there is such thing as posthumous harms even though the means they adopt to achieving that end differ.

I find Feinberg’s approach much more suitable for the Ghanaian context. He argues persuasively that since the objects of a person’s interests are largely futuristic and often outside his immediate experience, ‘the area of a person’s good or harm is necessarily wider than his subjective experience and longer than his biological life’. The class of interests that die with a person are generally self-regarding while those that are capable of surviving him are other-regarding and/or public oriented goals such as good reputation, promoting social or political causes or the well-being of loved ones. It is significant to note that even those who dispute the existence of posthumous interests do not deny the ethical and legal defensibility of respecting the reputations and wills of dead people.

Indubitably, in the Ghanaian traditional context, being thought of as an ancestor is a reputational goal which is inextricably linked to the welfare of the deceased’s family. When this reputational interest is thwarted or set back the deceased can be harmed. For example, imagine a community in which the qualification at custom for ancestorship includes being buried with one’s heart. Also imagine a decedent whose ultimate goal had been to be thought of as an ancestor. To achieve this goal the decedent expresses his wish to be so buried to his family or

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94 Ibid, 57-59.
95 Feinberg grounds his conception in harms as setback to interests; Pitcher uses the dualistic account (ante-mortem/post-mortem) and identifies the ante-mortem person as the subject of harm; Johansson argues in support of posthumous harms using the fusion of times account; Levenbook adopts the loss account of harms to achieve the same effect while Tomasini does so from a phenomenological perspective.
96 Feinberg, op. cit., 86.
97 Ibid.
98 For example, Partridge grounds the justification of respect for the reputation and wishes of the dead by appealing to moral agency, moral personality and social contract theory rather than in the concept of surviving interests; Callahan accounts for the respect for posthumous wishes by reference to intrinsic value, virtuous behaviour and wrongful failure of virtue while Taylor accounts for respect for the wills, reputations and wishes of the dead using the rule-consequentialist approach. Harris, on the other hand, accepts that some interests may survive the dead but argues they are not person-affecting and therefore can be set aside when balanced against person-affecting interests.
loved ones prior to his demise. The family will have a duty imposed on it, at least at custom, not to thwart the actualisation of his ulterior interest, and may even act to promote it. Within the transplant context, this might mean a refusal to consent to the removal of his transplantable heart unless an appeal to some greater necessity can be made. A failure without reasonable cause will amount to a wrongful breach of their duty resulting in a violation of the deceased’s rights at custom and harm to his ultimate interests of being respected as an ancestor.

Furthermore, relatives may genuinely have other-regarding interests in the well-being of their loved one as an end in itself—whether or not their own interests are advanced. As shown above, in the Konkomba traditional setting, these interests may be properly conceived of as common, interrelated, interdependent and intertwined family interests directed towards the common object of making their dead relative an ancestor. Each family member has a self-regarding as well as other-regarding interests in respecting the wishes of the dead and these interests may not be treated cavalierly nor overridden by the state for the benefit of either science or a third party or a stranger.

The view that there is a continual relationship between the living and the living-dead is not limited to belief in ancestors. According to Fisher the relationship between the dead and the living is not only ongoing; it also has an ethical dimension. As a result ‘when the interests of the dead are promoted, not only is the ongoing connection between the living and the dead respected, but also the dead are benefited’. 99

Encouraging people to be, at least, minimally good Samaritans is a desirable thing but to demand that people be compelled against their legitimate interests to do good to strangers would seem ethically or legally dubious unless exceptional circumstances can be established. It is however not immediately clear to us that this condition of exceptionality or greater necessity is

99 Fisher, op. cit., 568.
satisfied by merely claiming that a stranger to whom the now deceased owed no specific duty prior to his demise may benefit from all or some of his organs. The refusal of the family to donate organs under those circumstances cannot be said to have been done at the expense of, or without due regard to, the interests of the stranger in need of organs. In this case the cost to the family and the deceased are incalculably burdensome. Since no one is deemed morally blameworthy when they are unable to help another because their legitimate interests may be irredeemably damaged in life, it should not matter in death if it can be shown that such a setback to their surviving interests and the interests (self- and other-regarding) of their family is likely to occur. In the unavoidable situation where the interests of family and their deceased compete with the interests of nonfamily members in need of organs for transplant, it is reasonable to expect the family to act to protect family interests (whatever these interests turn out to be). It is insufficient to claim that such interests are simply emotional and squeamish.

Nonetheless, it does not follow that accommodating such customary beliefs will necessarily thwart the social utility aims of maximising human biomaterials for organ transplantation and science research. Given the cultural importance attached to ancestorship as shown above, exploring such contextual issues in a sensitive manner may not only show that such an approach can actually further the social utility aims of organ transplantation, but that it is also more likely to yield the additional benefits of engendering the trust and support of local communities in Ghana.

7.6 Conclusions

The strong protection accorded the traditional Ghanaian family coupled with the entrenched nature of cultural rights in the 1992 Constitution of Ghana mean that a regulatory system purporting to govern the retention and use of (deceased) human biomaterials must take the
wishes of the deceased and their families into account. However, as has been pointed out, though a customary community may allege that non-consensual organ retention and use may be offensive to its customs and practices, it must demonstrate before Ghanaian courts that any such act or omission contravenes some specified constitutional provision or violates some constitutionally protected rights (e.g. cultural and/ or family rights) and that the retention and use is neither in the interest of public health and safety nor dehumanising or injurious to the physical and mental well-being of any person. Importantly, these constitutional protections explain why the current organ retention ills in Ghana are even more problematic.

Also, the issues explored here show that the organ retention problems in the UK are not unique to it. Countries such as Ghana where these issues are now being dealt with can learn valuable lessons from how the UK handled its challenges. Ghana can reflect on how the UK’s experiences serve as a useful guide to crafting policy choices that are appropriate for its socio-legal context.

Being an ancestor in the Konkomba traditional setting is a reputational issue of immense cultural significance. Families are obligated at custom not to interfere with such rights the violations of which carry consequences at custom. This is because “the living-dead are still ‘people’ with;

interest in what is going on in the family...They are the guardians of the family affairs, traditions, ethics and activities. Offence in these matters is ultimately an offence against the forebears who, in that capacity, act as the invisible police of the family and communities.”

In consonance with the views expressed by McGuinness & Brazier and Hamer & Rivlin the decedent, as ancestor, has a direct moral worth in the Ghanaian traditional context. The

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100 Mbiti, op. cit., 82.
consequences of failing to respect the wishes of the dead are such that they are capable of setting back the interests of both the decedent and his family members. It follows then that these interests may be rightly conceived to be at once both non-person affecting and persons-affecting (usually all members of the traditional family). As a result, the argument that deceased interests are necessarily non-person affecting fails in this context.

Indeed the GMC’s ethical guidance to doctors to the effect that patient confidentiality continues after death, and the exemption of a decedent’s information under section 38 (d) of Freedom of Information (Scotland) Act, 2002, appear to affirm the ethical and legal defensibility of posthumous interests or harms.

As shown above, in Ghana a disregard for the interests of the dead and their traditional family as a way of increasing deceased organs for transplant, might not only be unlawful, but also unconstitutional. If we are committed to the collective goal of increasing organs for transplantation then we need to argue for conceptual consistency. For example, if under the concept of ancestorship someone who has led a ‘good’ life but died a ‘bad’ death can have his reputation as an ancestor rehabilitated, so must someone who lived a ‘bad’ life and died a ‘good’ death. Since automatic qualification or disqualification as an ancestor only obtains when the two criteria are both present or absent, the absence of either must receive the same treatment at custom if conceptual consistency is to be maintained. So those who led ‘bad’ lives but died ‘good’ deaths should also be able to have their reputations rehabilitated if they or their families donate their organs to save the lives of transplant patients.

102 This should be an incentive which will undoubtedly encourage a lot more to donate especially when understood and viewed from the Konkomba traditional principle of ‘nkpawiin’ or collective solidarity. For a similar ingenious and innovative incentive package for prisoners in the Philippines see de Castro, L. D., ‘Human organs from prisoners: kidneys for life’ J Med Ethics 29 (2003): 171-175.
Respecting the interests of the dead by safeguarding their reputation at custom as ancestors is a cultural right that a transplant policy that hopes to have social legitimacy in the Konkomba (wider Ghanaian) traditional setting must recognise. Though this might, on a utilitarian calculus appear less maximising, it may in fact be the better maximiser in the long run since any such policy is more likely to engender public cooperation and support. After all, a consequentialist approach ‘tells us that a right is genuine just in case the social policy of recognizing it in the appropriate rule system is the best means of promoting some favoured goal’.  

Additionally, since one’s reputation as ancestor can be rehabilitated without the need for bringing the whole body home for burial, then conceptually organ donation generally, and deceased organ donation in particular, may not be inconsistent with ancestorship. This is another reason that a commitment to our collective goal of encouraging more people to donate their organs cannot afford to gloss over in the Ghanaian traditional context. Having the patience to understand and respect the cultural rights and values of communities by engaging them in honest discussions on their own terms is a better policy choice. To discount these as mere pre-scientific superstition or as weird beliefs lacking in logic or rationality might be itself irrational and counterproductive.

Summing, a transplant regulatory framework that is context-appropriate could ride on the cultural value of being an ancestor as an incentive in the Konkomba traditional setting to encourage organ donation for transplant and science research. Respect and recognition of such customary and family values may engender the trust and support of the people and thus serve as a workable guide for the development of law and policy for organ transplantation in Ghana where family and cultural rights are constitutionally protected.

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Chapter 8

PAPER 3: CUSTOMARY LAW AND ‘OWNERSHIP’ OF DECEASED BODIES: REGULATORY PUZZLES FOR GHANA

ABSTRACT
In Ghana the need to clarify rights and interests in dead bodies and parts thereof has become acute in the face of strenuous efforts to regulate the permissible uses of human biomaterials particularly in organ transplantation. However, developing an appropriate governance framework presents a number of challenges. For the purposes of this paper I focus on challenges arising out of i) settling on an appropriate regulation within a pluralistic environment and ii) addressing the issue of ownership or property interests and rights in dead bodies in that context. The paper provides insights into the pluralistic nature of the Ghanaian socio-legal context and examines the difficulties that may arise when settling on an appropriate regulatory framework for organ transplantation in such an environment. I argue that given the pluralism of the Ghanaian legal context a pragmatic and workable approach to regulating organ transplants will be through legal foresighting. It also briefly explores ownership and property interests and rights in human biomaterials and argues in support of the supremacy of property rules in protecting interests in human body parts especially in respect of organ donation for transplantation. Furthermore, given that the Ghanaian legal system is founded on the English common law tradition, I discuss the ‘no property in a corpse rule’ in English law and examine whether or not Ghanaian law recognises ownership or property interests and rights in dead bodies and conclude that it does. I then draw out puzzles for consideration by policymakers for
the regulation of the emerging organ transplantation sector in Ghana and conclude that any such statutory enactment ought to tread the path of progress laid by Ghanaian customary law.
8.1 Introduction

The controversy surrounding the use of human biomaterials especially for medical and scientific research is not new; however advances in biotechnology, particularly human organ transplantation, have recast the value in human biomaterials and reignited this debate. Treating human biomaterials as valuable commodities has unavoidably given renewed currency to the ethico-legal considerations of the question of property or ownership in the human body. The apparently simple question ‘who owns my body?’ conceals a number of legal and philosophical complexities. This is because the concept of ownership or property is notoriously elusive. Despite this elusiveness, we seem to ‘share an intuitive sense of what ownership or proprietary rights are or entail’. The value of dead bodies beyond the grave has compelled courts and society to confront and unravel the ethico-legal concerns around property in biomaterials.

In Ghana the need to clarify the rights and interests in dead bodies and parts thereof has become acute because strenuous efforts are being undertaken to regulate the permissible uses of human biomaterials particularly in organ transplantation. Developing an appropriate governance framework presents a number of challenges. For the purposes of this paper I focus on two of these; i) settling on an appropriate regulatory approach within a pluralistic environment; and ii) dealing with ownership or property rights in dead bodies in Ghana.


3 For a very useful discussion about the different ways of valuing and using the human body see Gold, n 2 above. and Harcastle, n 1 above at 3-12.


6 Ibid.
The paper provides insights into the Ghanaian socio-legal context and acknowledges its pluralistic nature in section 8.2. It then examines the difficulties that may arise when settling on an appropriate regulatory framework for organ transplantation in such an environment. I argue that given the pluralism of approaches within the Ghanaian legal system a pragmatic and workable approach to regulating organ transplants can be achieved through legal foresighting. The paper then briefly explores the concepts of ownership and property interests and rights in section 8.3 and argues in support of the supremacy of property rules in protecting interests in human bodies especially in organ transplantation. It is important pointing out that though the challenges of regulating biotechnology have been extensively considered, there is arguably little or no commentary on regulating biotechnologies in Ghana’s pluralistic legal environment. It is therefore hoped that doing so will illumine the regulatory dialogue in that context.

Given that the Ghanaian legal system is founded on the English common law tradition, I discuss the evolution of the ‘no property in a corpse rule’ in the law of England and Wales (hereinafter referred to as English law) in section 8.5 and examine whether or not Ghanaian law recognises ownership or property interests and rights in dead bodies in section 8.6 concluding that it does. It then draws out puzzles for consideration by policymakers for the regulation of the emerging organ transplantation sector in Ghana in section 8.7 and concludes that any statutory provisions ought to tread the path of progress laid by Ghanaian customary law.

8.2 Fashioning an Appropriate Regulatory Framework in a Pluralistic Environment

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As explained in chapter 5 section 2 and later in chapters 6 and 7 above, the Ghanaian legal system recognises customary law and provides a favourable environment for its expression and expansion. Article 11 (1) (e) of the 1992 Constitution of Ghana provides that the laws of Ghana shall include the common law. Article 11 (2) provides that the common law as employed in Ghana shall comprise the rules of law commonly referred to as the common law, the rules generally called the doctrines of equity and the rules of customary law.\(^8\) Article 11 (3) defines customary law to mean ‘rules of law which by custom are applicable to particular communities in Ghana’. The Ghanaian legal system is said to be pluralistic because it has elements of the English common law, Ghanaian traditional or customary law and Islamic law.\(^9\) To achieve uniformity and consistency in this pluralistic environment, the Constitution charges the Chieftaincy institution or traditional authorities to undertake the progressive study, interpretation and codification of rules of customary law as are applicable in their local communities.\(^10\) Additionally, the Courts are empowered and given clear guidance, not only to determine the choice of law to apply in particular instances but also to establish the existence or content of rules of customary law as the case may be.\(^11\)

Before we explore further the opportunities presented by Ghanaian customary law for designing appropriate governance frameworks for organ transplantation in that country, it is

\(^8\) Sections 14 and 19 of the Gold Coast Supreme Court Ordinance (No. 4 of 1876) made English law applicable in the Gold Coast (now Ghana) alongside Ghanaian customary law. Ghanaian law has also been influenced by Islamic law (civil) and given effect in the Marriage of Mohammedans Ordinance Cap 129 of 1951. The Ghanaian legal system is therefore pluralistic. This explains why common law as understood and employed in the Ghanaian socio-legal context includes case law, doctrines of equity and customary law rules. However, following the independence of Ghana on March 6, 1957 and its subsequent attainment of republican status in 1960, the Courts Act of 1960 repealed this reception statute and English law has since ceased to apply with binding effect in Ghana. Ghana, as a democracy currently operates the 1992 Constitution as its supreme law. As a result cases from the UK, and all other countries especially the common law countries, are now of persuasive authority only.

\(^9\) Parts of Islamic law are recognised and given effect to in Ghana; for example the 1951 Marriage of Mohammedans Ordinance Cap 129, is still valid law in Ghana.


important to explore some of the difficulties associated with settling on an appropriate regulatory framework in a pluralistic environment.

Though what constitutes regulation is undoubtedly difficult to define,\textsuperscript{12} determining what counts as good, better, or appropriate regulation\textsuperscript{13} is even more arduous because a plurality of perspectives may yield different answers ranging from maximisation of social utility through meeting the wealth aims of the regulation, to procedural justice claims.\textsuperscript{14} Yet for any regulation, particularly regulation in biotechnology and health care where plurality of values is common, to have legitimacy contextual peculiarities would necessarily have to be considered.\textsuperscript{15}

The debate about good or better regulation is often advocated to obviate the command and control approach to regulation.\textsuperscript{16} Good or better regulation from a regulatory analysis viewpoint requires the regulatory dialogue to consider the complexity and inherent tension that obtain in a pluralistic regulatory context and the adaptive capacity required of a regulatory framework under

\textsuperscript{12} Morgan, Bronwen and Yeung, Karen, \textit{An Introduction to Law and Regulation: Text and Materials} (Cambridge: Cambridge University Press, 2007), 3.


\textsuperscript{14} Lodge and Wegrich, \textit{op. cit.}, 239-253. For an exhaustive discussion of the challenging nature of regulating a moving target such as biotechnology and how a collaborative regulatory approach may help obviate claims of injustice in the context of stem cell research in the UK see Devaney, Sarah, \textit{Stem Cell Research and the Collaborative Regulation of Innovation} (London and New York: Routledge Taylor & Francis Group, 2014).

\textsuperscript{15} Lodge and Wegrich, \textit{op. cit.}, 192-253 particularly at 253.

\textsuperscript{16} Command and control as employed refers to the traditional, state-centred, coercive, hard law approach to regulation. For further details see Lodge and Wegrich, \textit{op.cit.} and Brownsword and Yeung, \textit{op.cit.}
those circumstances. This requires that policymakers and administrative institutions must be informed by the requisite expert opinion. This is because both pluralism and expertise help shape the role the law plays in legitimating regulatory regimes. Where pluralism is relied upon to inject legitimacy into the regulatory process, the law’s role is one of expressive umpire: structuring dialogue between those involved in, or affected by, regulation to ensure proper deliberation. On the other hand, where expertise is emphasised as the basis for legitimating regulatory decision, the law’s role is largely facilitative. It creates a decision-making framework that fosters expert input, fashioning a space for the relatively unfettered exercise of discretion informed by expert technical knowledge. Nonetheless, the role of law in regulatory legitimation overall centres on law’s expressive dimension in institutionalising values.

In the context of finding an appropriate regulatory framework for organ transplantation in Ghana, this implies that any pragmatic and practically effective new legislation must reflect the constitutional, cultural and social values of the Ghanaian context. After all, law’s contribution to regulation, as a potentially powerful instrument for modifying behaviour, may be seen through its expressive and facilitative roles and reflected in two distinct images: law as either a threat (proscribing conduct and threatening sanctions for violations to deter that prohibited conduct and thereby legitimating coercion) or law as umpire (reflecting the shared or agreed morality of the community players). I am persuaded that law can and should be deployed in such a way that it reflects sufficiently the shared values of the regulatory context, on the one hand whilst promoting biotechnological innovation for public good, on the other. Admittedly, conflicting views are unavoidable if the desired balance is to be achieved in Ghana’s pluralistic legal context.

17 Lodge and Wegrich, op.cit, 239.
18 Morgan and Yeung, op. cit., 299-300. For an in-depth examination of the subject see Chapter 5 ‘Regulatory accountability and legitimacy’, 221-302.
20 Ibid.
It has accordingly been argued that the law’s umpiring function may also show its expressive character arising from

the capacity of the law to institutionalise values, whether they be moral principles, community preferences chosen through democratic procedures or constitutional values. This expressive character is crucial to the legitimation of a regulatory regime.\textsuperscript{21}

Consequently, the theoretical and practical approaches to regulating biotechnology in Ghana must not be fixed. Rather, pragmatism suggests that any such approaches ought to accommodate pluralistic values, be these the pursuit of communal goals such as welfare interests (public interests), or maximising the self-interests of individuals or groups (private interests) and should emphasise the interdependence of all actors within the regulatory milieu as they pursue their interest; both private and public.\textsuperscript{22} Within the context of organ transplantation, the public interests aims may include promoting its social utility aims\textsuperscript{23} by encouraging organ donations, alleviating pain and suffering and protecting human dignity and individual autonomy while at the same time promoting the interests of the transplant surgeon (or medical community), the patient, the donor and their relatives or community and general public welfare. This means that the choice of an appropriate regulatory instrument ought to be guided by its effectiveness and legitimacy specific to the regulatory context in which it is expected to operate.\textsuperscript{24}

Ultimately, good regulation is about legitimate regulation and any debate about what is legitimate is likely to cause controversy. However, legitimate regulation is about the acceptance of the rules of the game (in terms of explicit rules and implicit understandings). Without such an acceptance or embeddedness, any regulatory regime is likely to face

\textsuperscript{21} Ibid, 341.
\textsuperscript{22} Ibid, 16-78.
\textsuperscript{23} I note how Devaney employs it in the context of stem cell research and adopt it wholly for the purposes of this research. For detailed information on how it is used in the stem cell context see Devaney, Sarah, \textit{Stem Cell Research and the Collaborative Regulation of Innovation} (London and New York: Routledge, 2014).
\textsuperscript{24} Morgan and Yeung, op. cit. Legitimacy is said to involve issues such as the institutional, cultural and political contexts in which the regulation occurs. For a fuller examination of the mechanics and choice of regulatory instruments see Chapter 3 ‘Regulatory instruments and techniques’, 79-150.
adversarial relations, the need to resort to coercive rather than cooperative approaches, and, inevitably, attempts to undermine the overall regulatory regime.  

It is my contention that in all these situations the role of the law should be both facilitative and expressive of the values of the regulatory context. Accordingly, it might prove insufficient and possibly damaging to advocate simply for a regulatory framework that is close to some universal ideal. One should not attempt to design a regulatory framework unless armed with an understanding of the institutional context of the country and its implications for regulation.

Arguably, then, for the law to play its rightful role in our pluralistic Ghanaian environment, some reflexivity is required. This may be achieved using legal foresighting.

Legal foresighting refers to

the identification and exploration of possible and desirable future legal or quasi-legal developments aimed at achieving valued social and technological ends. It is a fundamentally active and outcome-oriented reformative process; while it offers us the opportunity to subject technological trajectories, social trends, and legal conditions, ineritas, and developments to early, rational, contemplative reflection, it is its shaping capacity that makes it valuable. Legal foresighting should help us create pathways into the unknown, and part of that creation may mean (or demand) a fundamental re-visioning of the legal setting itself, its instruments, institutions, and regulatory or governance mechanisms. We must be prepared to ask whether existing systems (and their assumptions and values) are capable of responding to the demands being made of them and of delivering the future that we want.

25 Lodge and Wegrich, op. cit., 251.
The inherent dynamism of the concept of legal foresighting can be used to help us identify and explore, for example, how uncertainties arising from a biotechnologically-driven advancement in healthcare practice (such as organ transplants) can be better regulated to achieve its social utility aims. This will present us with the opportunity to subject these biotechnologies to ‘rational, contemplative reflection’ enabling us to question whether ‘existing systems (and their assumptions and values) are capable of delivering the ends we want’. 

If we are desirous of law having a relevant, significant and just role in the development of the governance frameworks for biotechnology generally, then legal foresighting becomes a vital resource for reflexive analysis. This would ensure that that law provides a ‘responsive and directive role in the management’ of the knowledge and practices associated with fast moving sectors such as health, biotechnology and biomedical sciences. I do not suggest that merely engaging the community in the regulatory dialogue will necessarily yield a regulatory framework that is trustworthy and beyond criticism; arguably criticism of regulation is unavoidable. However, what I have sought to argue thus far is that for an organ transplantation regulatory framework to be deemed sufficiently appropriate and command social legitimacy in a pluralistic regulatory environment such as Ghana, it must sufficiently reflect the political, cultural, moral, social, religious and legal (constitutional) values of the Ghanaian regulatory context. We could

29 Ibid.
30 Ibid.
31 Ibid, 7-8.
32 Ibid, 8. For a detailed discussion of the evolution and use of legal foresighting, its pitfalls, value and importance see Ibid, 4-10.
33 Harmon, Laurie and Haddow, ‘Governing risk’, op. cit.
34 Lodge and Wegrich, op. cit., 252.
achieve this through reliance on the reflexive power of legal foresighting as presented by Laurie and colleagues.\footnote{Laurie, Harmon and Arzuaga, ‘Foresighting Futures: New Technologies’, op. cit}

Having demonstrated that both customary and common law rules are constitutionally recognised and operate side by side in the Ghanaian legal context\footnote{Article 11 of the Constitution of the Republic of Ghana, 1992.}, it is apt to examine whether or not Ghanaian customary law, unlike English law, recognises property interests in (deceased) body parts and how the findings therefrom may illumine the regulation of the emerging transplants sector in Ghana particularly deceased organ donation for transplant and science research within a legal foresighting approach.

However, given the complex and controversial nature of the concepts of ownership and proprietary interests and rights, it is necessary to explore these concepts a little more with the hope that doing so will further our understanding of the context in which they are employed in the present analysis.

\textbf{8.3 Ownership and Property in Human Bodies}

Though there appears to be universal understanding about what an owner can do or non-owners cannot do with something which is a subject of ownership\footnote{Harris, J. W., ‘Who Owns My Body’ Oxford Journal of Legal Studies 16 (Spring 1996); 55-84, 57.}, what legal ownership entails is not as certain as it first appears. The liberal concept of ownership is defined as the ‘\textit{greatest possible interest in a thing which a mature system of law recognizes’}.\footnote{Honoré, A. M., ‘Ownership’ in A. G., Guest (ed.) Oxford Essays in Jurisprudence (London: Oxford University Press, 1961), 108 (emphasis in the original).} In his seminal work A. M. Honoré identifies eleven ingredients of the notion of ownership which may be collectively sufficient, though not individually necessary to establish legal ownership.\footnote{\textit{Ibid}, 112.} These
include; i) right to possess, ii) right to use, iii) right to manage, iv) the right to income, v) right to the capital, vi) right to security, vii) incident of transmissibility, viii) incident of absence of term, ix) prohibition of harmful use, x) liability to execution and xi) the incident of residuarity.\(^{41}\) It bears noting here that while some contributors argue that the list is short and have therefore added on to it, others have found it too long and have reduced it accordingly.\(^ {42}\) Honoré observed that, generally, in all the legal systems he examined, a person was deemed incapable of ‘owning his body’.\(^ {43}\) He suggests this may be attributable to the fear that the acceptance of the concept of self-ownership\(^ {44}\) might lead to interference with human freedom and to human beings or bodies being treated legally as ‘things’ capable of being owned as any other chattels.\(^ {45}\)

Other theorists such as J. W. Harris conceive property slightly differently. On his account property is defined as a ‘legal and social institution governing the use of most things and the allocation of some items of social worth’.\(^ {46}\) Harris argues that the essential features of the property institution are ‘trespassory rules and the ownership spectrum’.\(^ {47}\) By trespassory rules is meant


\(^{43}\) Honoré. ‘Ownership’, *op.cit.*, 107-147, 130 (emphasis added).

\(^{44}\) The concept of self-ownership posits that each person has full private property in his own person and powers. For a nuanced examination of the concept see Cohen, G. A., *Self-Ownership, Freedom and Equality* (Cambridge: Cambridge University Press, 1995) especially 116-117. Other theorists such as Kant argue that the concept of self-ownership is incoherent and self-contradictory. For a detailed examination of his objection see Kant, Immanuel, (with foreword by Lewis White Beck) *Lectures on Ethics* (New York: Harper & Row, Publishers, Incorporated, 1963), 165.

\(^{45}\) Honoré. ‘Ownership’, *op.cit.*, 107-147, 130. It has been argued that though people may not legally own their bodies, it is entirely appropriate to vest proprietary interests in third parties who come into lawful possession of those same samples. This is justified by reliance on the work or skill and different attributes exception. For a fuller exploration of these arguments see Skene, L., ‘Arguments Against People Legally Owning their Own Bodies, Body Parts and Tissue’ *Macquarie Law Journal* 2 (2002):165-176.

\(^{46}\) Harris, ‘Who Owns My Body’, *op.cit.*, 56. Social worth on the Harrisian account is defined to include things and services for which the potential demand outstrips supply see 56.

any social rules, whether or not embodied in law, which purport to impose obligations on all members of a society, other than an individual or group who is taken to have some form of open-ended relationship with a thing, not to make use of that thing without the consent of that individual or group.  

Harris defines the ownership spectrum to mean the ‘range of open-ended relationships presupposed and protected by trespassory rules’ and argues that the contents of ownership interests or rights are a ‘function of cultural assumptions’ which change over time and from place to place. Accordingly, ownership consists of bundles of rights on a spectrum with mere property on one end and full-blooded ownership rights on the upper end of the scale. Harris argues that the kind of ownership interests recognised in ordinary chattels by legal and societal norms is full-blooded ownership (which carries with it all the use-privileges, control and transmission powers) which is not implied by the concept of body ownership. This allows him to argue that the self-ownership argument, whether liberal or socialist (Marxist), has no validity because it commits a spectacular non sequitur pointing out (rightly) that it simply does not follow that if nobody owns me if I am not a slave then I own myself.

It is however countered that this conception is misconceived and ‘confuses potentiality with actuality’ because it defines ownership as a series, or mere collection, of proprietary rights in a particular thing which after exceeding a certain threshold delivers ownership. Consequently, while we may validly speak of a ‘property spectrum’ of which ownership is the summit,

48 Ibid.
49 Ibid, 59.
50 On Harris’s conception mere property, unlike full-blooded ownership, does not carry with it the transmission powers essential for commercial exploitation. His full arguments are set out in Harris, ‘Who Owns My Body’, op cit., particularly 82. Also see Wall, op. cit.
52 For Harris’s conception of the liberal and Marxist versions of the self-ownership argument see Ibid, 68-71.
53 Ibid, 84.
speaking of an ‘ownership spectrum’ with mere property at the lower end and full-blooded ownership at the upper end, is of dubious validity.\textsuperscript{55}

The Honoré account is not free from criticism either. It is contended that the ownership model which presents property as a bundle of rights is flawed because it fails to recognise that the competing claims inherent in proprietary rights are neither value neutral nor soluble without regulatory intervention.\textsuperscript{56} However, as pointed out by Devaney, the usefulness of Honoré’s ownership account lies in ‘its accommodation of the varying degrees of property rights over a given object which different individuals or categories of individuals can possess.’\textsuperscript{57} This is particularly apt in the Ghanaian socio-legal context where ownership or proprietary interests in deceased body parts may have to be carefully apportioned to members of the family of the decedent.

It is important to note that though ownership rights and property rights are often used interchangeably; these can be shown to be different.\textsuperscript{58} It is argued that ownership, ‘is a right of exclusive engagement with a thing because all others are under a duty not to interfere with it’ while a property right, ‘is a right of an individual to realize a particular value of a thing by engaging with it in a particular way’\textsuperscript{.59} It follows therefore that ownership may be understood to be a ‘necessary but insufficient condition of property’.\textsuperscript{60} Of course, showing that ownership and


\textsuperscript{57} Devaney, Sarah, Stem Cell Research and Collaborative Regulation of Innovation (London and New York: Routledge, 2014), 90.


\textsuperscript{59} Ibid.

\textsuperscript{60} Wall, op. cit., 801.
proprietary rights are different is not to suggest that there is an “absolute scale of ‘freedom’ of action which distinguishes the rights of an owner from that of a proprietary right holder”. Consequently, beyond affirming their conceptual difference, I use these terms interchangeably when I discuss the position of Ghanaian customary law relative to legal ownership rights in deceased bodies.

Whether or not property, liability or inalienability rules should be given priority in the regulation of the various interests and rights in human biomaterials is controversial. But before we explore this controversy it is necessary to explain the meaning of property rules, liability rules and inalienability rules as used in the extant analysis.

**8.3.1 Property or Liability Rules for Organ Transplant Regulation?**

For the purposes of this research, I adopt wholly the definition of these rules as set out by Calabresi and Melamed.

According to Calabresi and Melamed:

> an entitlement is protected by a property rule to the extent that someone who wishes to remove the entitlement from its holder must buy it from him in a voluntary transaction in which the value of the entitlement is agreed upon by the seller.\(^{62}\)

Property rules may thus be said to ‘involve a collective decision as to who is entitled to be given an initial entitlement but not as to the value of the entitlement.’\(^ {63}\) On the other hand, ‘whenever someone may destroy the initial entitlement if he is willing to pay an objectively

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\(^{61}\) Penner, *op.cit.*, 170.


\(^{63}\) Ibid, 1092.
determined value for it, the entitlement is protected by liability rules. The difference here is that while property rules permit the subsequent voluntary transfer of the initial entitlement at a value determined by the parties, liability rules require that any subsequent value determination and transfer are done by third parties such as courts or the appropriate institution of state.

Alternatively, when an entitlement is protected against sale or commercialisation then inalienability rules apply. Inalienability rules can be said to differ from both liability and property rules to the extent that they not only determine the initial entitlement-holder and the value of any subsequent transfer of the initial entitlement, they also limit or regulate the grant of the entitlement itself. It is argued that liability rules and property rules both carry risks and since we live in a world where conflicting interests cannot be costlessly resolved, the differences between these rules become important for policymaking especially in contested areas such as organ transplantation.

To say that the differences between property and liability rules are relevant in our real world especially in the context of organ transplantation is not very helpful to the policymaker in need of guidance on how to appropriately regulate organ transplantation in Ghana. The question that follows will be- granted that both cannot be co-dominant in a policy framework in that regulatory context, which shall have priority and why?

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64 Ibid.
66 Calabresi and Melamed , op. cit, 1092-1093.
67 Ibid, 1093.
68 Epstein, op. cit., 2095.
69 Ibid, 2092.
70 Epstein explains that if transaction costs were zero or all disputes were resolvable without costs then articulating the differences between liability and property rules would not be necessary. However, given that in practice the costs associated with transferring assets from one person to another are significant, a legal system must prioritise the legal rule that minimises these transactional errors. For a fuller examination of his argument see Epstein, Richard A., ‘A Clear View of The Cathedral: The Dominance of Property Rules’ The Yale Law Journal 106 (May, 1997): 2091-2120, particularly 2092-2096.
Not surprisingly, there seems to be no consensus on whether liability or property rules are preferable. This is because while some contributors argue that liability rules are superior to property rules in protecting the interests and rights in human biomaterials, others contend that property rights are more effective at protecting ownership rights in human biomaterials. For instance, while Palmer argues that liability rules are superior to property rules in dealing with the legal issues that are raised by bio-banks, Nwabueze shows that property rules are ‘most apposite for resolving some of the conflicts encountered in the context of organ donation’. Nwabueze argues that under the current no property in body parts rule, donors and recipients may encounter serious remedial problems if organs harvested but not yet transplanted are lost, maliciously damaged, stolen, misapplied or otherwise misdirected and demonstrates that only a property-based approach guarantees the needed predictability and accountability in such cases.

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71 Palmer, Larry I., ‘Should Liability Play a Role in Social Control of Biobanks?’ Journal of Law, Medicine & Ethics 33 (Spring 2005): 70-78. It is noted that this was argued in the context of biobanks. As is to be expected, liability rules as they apply in the context of biobanks will differ slightly from those engaged in solid organs such as organ transplantation. For a much nuanced examination of their applicability in transplantation see Nwabueze, Remigius N., ‘Donated Organs, Property Rights and the Remedial Quagmire’ Medical Law Review 16 (Summer 2008): 201-224. For a detailed examination of the argument that liability rules are best suited when we cannot rely on the markets to objectively value interests in property, in the context of regulation of environment pollution, see Calabresi and Melamed, op. cit. Others have proposed that, in the context of medical research, we adopt; i) enhanced regulation that better protects human subjects, and ii) the theory of trusteeship, rather than our proprietary analytic framework; see Charo, Alta R., ‘Body of Research- Ownership and Use of Human Tissue’ The New England Journal of Medicine 335 (October, 2006): 1517-1519, 1519.


73 Palmer, op. cit.,


75 Ibid.
Also, Epstein argues that given that property rules confer on property right-holders ‘sole and absolute power over the use and disposition of a given thing, it follows that its owner may hold out for as much as he pleases before selling the thing in question’.\textsuperscript{76} This holdout problem is ameliorated (when need be) by the operation of liability rules which may then compel the owner to sell the thing for a particular value determined under the appropriate institutional arrangement.\textsuperscript{77} Consequently, any choice between these two rules should be resolved in favour of property rules and that those who argue for the supremacy of liability rules fail to consider the fact that they are often adopted as a matter of necessity and require the implementation of ‘extensive procedural protections’ to ensure fairness to the parties involved.\textsuperscript{78}

It follows from the above discussions that within the context of organ transplantation, it is rewarding to explore the interests in human biomaterials using a property framework while recognising alternatives well suited to particular instances where our property analytical framework fares badly.\textsuperscript{79} Given that legal issues such as malicious damage, misapplication, misdirection or theft of donated organs destined for transplantation in a named patient are better dealt with by property rules\textsuperscript{80} and that both income and control rights of sources in their biomaterials are better protected by proprietary rights\textsuperscript{81}, continued objections to property in human bodies or their parts become increasingly and irredeemably unconvincing.

Of course, this is not to say that a property analytical framework cannot or may never be supplemented by alternatives such as liability or inalienability rules. Indeed, Nwabueze provides a model integrated analytic framework founded on property that nonetheless accommodates the

\textsuperscript{76} Epstein, \textit{op. cit.}, 2091.
\textsuperscript{77} Ibid, 2091.
\textsuperscript{78} Ibid.
\textsuperscript{79} Ibid, 2094.
\textsuperscript{80} Nwabueze, ‘Donated Organs, Property Rights and the Remedial Quagmire’, \textit{op. cit.}, 203.
\textsuperscript{81} Wall, \textit{op. cit.}
role of liability rules in deciding on the choice of legal rules to govern particular human biomaterials.\textsuperscript{82} Also, for purely prudential, pragmatic or other reasons policymakers may decline to give formal or statutory recognition to property in the body without denying the soundness of arguments in favour of a property-based approach. The difference here is that they would have done so in a much more coherent and transparent manner without the need for the extant patchwork of illogical exceptions employed by the judicial systems in common law jurisdictions.

What is clear thus far, is that whatever our jurisprudential justificatory commitment, proprietary interests are central to issues relating to the use and control of human biomaterials in biotechnology such as organ transplantation and biomedical research. I argue in section 8.5 below that though founded on the English common law tradition, Ghanaian law recognises ownership interests and rights in (at least deceased) human bodies. In order to illumine the comparative legal analysis, it is necessary to examine in the next section how well English law has coped with the changing interests and values in human biomaterials in the wake of these scientific developments before turning to the customary law of Ghana for answers.

8.4 English Law on Property in Human Bodies in a State of Flux?

English law (common law) has long established that there is no property in a dead human body.\textsuperscript{83} However, recent developments in biotechnology have put this rule under pressure leading to its refinement through the use of exceptions. Unfortunately, the law’s development has been reactionary and piecemeal in nature. As a result, though these exceptions are now part


of statutory law in England and Wales, certainty is yet to be achieved. The common law cases in the UK (England and Wales) followed the celebrated USA case of *Moore v Regents of the University of California* 793 P 2d 479 (Cal 1950) where the California Supreme Court affirmed the common law rule of no property in the human body. The Court held that Mr. Moore had no property in his excised tissues. As a consequence, an action in conversion failed since only property could be converted.

Similarly, in the UK (England and Wales) the court held in *R v Kelly and Lindsay* that once a human body or a part thereof has had some work or skill applied to it, it is capable of being property. This case was decided relying on an Australian case of *Doodeward v Spence* (1908) 6 CLR 406 at 413-444 which held that

> …when a person has by the lawful exercise of work or skills so dealt with a human body or part of a human body that it has acquired some attributes differentiating it from a mere corpse awaiting burial he requires a right to retain possession of it, at least as against any person not entitled to have delivered to him for the purposes of burial.

In fact Rose LJ argued that however questionable its historical origins, the no property in a human body rule was now part and parcel of the common law and that ‘neither a corpse nor parts of a corpse are in themselves and without more capable of being property protected by rights’. The court nonetheless held that for the purposes of section 4 of the Theft Act 1968 parts of a

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84 Section 32 (9) of HTA 2004 of the UK which appears to give statutory backing to the work or skill exception under common law.


88 [1999] QB, para 630G-631E.
corpse are capable of being property ‘if they have acquired different attributes by virtue of the
application of skill’ and ‘use or significance beyond their mere existence’. Some commentators
contend that in the decision in Moore the Court of Appeal and the minority in the Supreme Court
grounded his right to his biomaterials in natural property rights by appealing to ‘privacy, self-
ownership and creation-without-wrong’. Harris argues that while the Supreme Court majority
counteried the privacy arguments the other two were simply ignored. To cure this defect he
proposes that bodily-use freedom principle which yields mere property, ‘an ownership interest
lower on the ownership spectrum without the power of transmissibility essential for commercial
exploitation’. Harris argues that absent commerciality, such biomaterials would be unsaleable
as they possess ‘no measurable monetary value’. Since on his account there can be no natural
right to full-blooded ownership, an interference with the proprietary interest of the source in his
biomaterials should attract solatium.

However, the Court of Appeal had earlier on held, per Gibson LJ citing Williams v
Williams among others (to which the other two judges agreed), in Dobson v North Tyneside
Health Authority that an action in conversion and bailment failed because there is no property
in an unburied corpse. Curiously, Gibson LJ sought to distinguish Dobson from Doodeward by
arguing that the mere fixing or preservation of the brain tissue in paraffin wax was apparently no
sufficient skill or work to ground any property rights in the specimen.

89 [1999] QB, para 630G-631E.
91 Ibid, 82.
92 Ibid.
93 Ibid, 84.
94 (1882) 20 Ch. D. 659, 662-623.
Furthermore, in *In Re Organ Retention Group Litigation*[^96] (which followed the organ retention scandals in Alder Hey and Bristol) Gage J held that in his opinion the most appropriate starting point for legal analysis of the possessory and ownership rights in human biomaterials in English law is from the ‘firm ground of a proposition which is not disputed…that there is no property in the body of a deceased person’.[^97] However Gage J concluded that the decision in *Kelly*, establishes the exception in English law to the no property in a corpse rule and that ‘where part of the body has been subject of the application of skill such as dissection or preservation techniques’ it was capable of being property and concluded that the pathologists had lawful possession of the retained organs following post mortem.[^98] It however found one of the doctors negligent for failing to provide sufficient information during the consent process for post mortem examination. It is important to note that English law however recognises the right of relatives of the decedent to private and family life under the HRA, 1998 and European Convention on Human Rights (ECHR).[^99]

But in *Yearworth and Others v North Bristol NHS Trust*[^100], the Court of Appeal held that the men had ownership rights in their sperm and found the NHS Trust liable under the law of bailment and the law of torts. This case involved five men who were diagnosed with cancer and received treatment at Southmead Hospital in Bristol for which the defendant Trust is responsible. Prior to receiving treatment including chemotherapy, the clinicians advised that the treatment might damage their fertility and that it was possible for them to have their sperm stored in liquid

[^96]: [2004] EWHC 644 (QB); [2005] Q. B. 506. Also see the same case named differently as *AB and Ors v Leeds Hospital NHS Trust* [2004] EWHC 644.
[^98]: Ibid, para 541.
nitrogen at minus 196 degrees Celsius by the hospital for use later to the extent permissible under the Human Fertilisation and Embryology Act 1990.

Unfortunately, the hospital failed to maintain the promised optimum storage with the effect that the sperm thawed and perished as a consequence necessitating the instant action in tort and/or bailment against the Trust. More importantly, the court took a dim view of the Doodeward exception observing that the exercise of work or skill exception is ‘not entirely logical’. Unfortunately, the Court did not give sufficient legal analysis in defense of its holding about the logical inconsistency of the work or skill exception. However, some commentators have argued that the work or skill exception ‘represents a misguided application of the specification principle’ and therefore not capable, as a general principle, of explaining the creation of proprietary rights in separated biomaterials. Arguably, the decision in Yearworth may not be entirely novel since there seems to be evidence to support the proposition that some parts of the human body, generally regenerative parts, could have some property value. It is however argued, quite forcefully, that on the true and proper interpretation of the decision in Yearworth, the court did not regard itself as creating new property interests and rights in sperm, at least not as rights in rem. Ultimately, whether the court would have granted these limited property rights to the men if the parts in question were solid organs or non-renewable body parts is a matter of conjecture which would be resolved with time.

Nonetheless, Devaney argues, persuasively, that the punctuation of the no property rule with exceptions shows that the ‘common law has left the door open for recognition of the intrinsic

\[101\] [2009] EWCA Civ. 37, para 45 (d).
\[102\] Hardcastle, op. cit., 141-143.
\[103\] R v Welsh [1974] RTR 478 (urine) and R v Herbert (1961) 25 JCL 163 (hair) respectively are capable of being property in law and in R v Rothery [1976] RTR 550; a driver was found guilty of theft of a vial containing a sample of his own blood which he had provided to the police.
value of tissue for a variety of scientific purposes\textsuperscript{105} and there can be no justification for differentiating between regenerative tissues such as sperm, hairs, blood and other tissues for the purposes of property.\textsuperscript{106} As a consequence, if the law is to retain its legitimacy then it ought to recognise and acknowledge the property status in human biomaterials and that justice claims require that all those contributing to the progress of science, either as contributors of labour, skill or raw materials, be justly recompensed.\textsuperscript{107}

The evolution of the no property in a corpse rule at common law seems to reflect the socio-cultural and religious ambivalence that society attaches to dead bodies founded on the intuitive belief that somehow the human body retained its dignity even after death.\textsuperscript{108} What appears certain though is the fact that modern English law remains largely rooted in this ‘old and rather dubious’\textsuperscript{109} legal rule of uncertain origin.\textsuperscript{110}

Laurie and colleagues show the usefulness of legal foresighting in practice by examining the regulation of stem cell research in Brazil, regenerative medicine in Argentina and Biobanks in the UK (England and Wales).\textsuperscript{111} In Brazil, following the passage of a new Biosafety Act allowing the use embryos under specified conditions, the state challenged article 5 of the Act arguing that since Brazilian constitution provides that life begins at conception, article 5 of the new Act which permitted experimentation on embryos was unconstitutional. The Supreme Court then held public hearings and listened to testimonies from experts before holding that the new Biosafety Act was constitutional. Laurie and colleagues speculate that a legal foresighting

\begin{itemize}
\item \textsuperscript{105} Devaney, Sarah, Stem Cell Research and Collaborative Regulation of Innovation (Oxon: Routledge, 2014),
\item \textsuperscript{106} Ibid, 128.
\item \textsuperscript{107} Ibid, 111-112.
\item \textsuperscript{108} Mason and Laurie, ‘Consent or Property?’, \textit{op cit.}
\item \textsuperscript{109} Ibid, 710.
\item \textsuperscript{110} Quigley, Muireann, ‘Property: the Future of Human Tissue?’ \textit{Medical Law Review} 17 (Autumn, 2009): 457-466. Also, see Mason and Laurie, ‘Consent or Property?’, \textit{op. cit.} These trace the origin of the rule exposing the uncertainty that surrounded its origin and development and, to some extent, the soundness of its legal foundations.
\item \textsuperscript{111} Laurie, Harmon and Arzuaga, \textit{op.cit.} 27-32.
\end{itemize}
approach may have brought about the law reform much more quickly. In the case of Argentina, they found that stakeholders confronted with socio-legal and cultural peculiarities preferred a state-centred, top-down, hard law rather than soft law approach to regulation of regenerative medicine in that country. More importantly, they report how through legal foresighting they were able to uncover a rich collection of the values considered important in that regulatory context including solidarity, dignity, honesty, democracy and transparency among others.\textsuperscript{112} Contrasting the Argentinian situation with the UK (England and Wales) Biobank experience, Laurie and colleagues point out that though regulating the Biobank presents a number of challenges including issues with consent, security of stored biodata, access to the data, as well as property in and control over the samples, the sector is regulated by soft law rather than a specific legislation.\textsuperscript{113} Conceivably, if the UK (England and Wales) had employed legal foresighting in the promulgation of the HTA 2004 following the organ retention scandals, the adoption of the work or skill exception to the ‘no property in a corpse rule’ at common law in section 32 of that Act may have had more content and clarity.

The question that begs for further interrogation and seems to follow naturally is; if an advanced legal system like that of the UK (England and Wales) does not bring clarity to the property question how might the legal system of a developing country such as Ghana which developed from, and is founded on, the English common law tradition fare? This is particularly worrisome in the context of developing countries where there are, arguably, genuine fears that unless the property question is resolved or at least clarified the absence of adequate regulatory structures could leave many vulnerable people open to exploitation by any new biotechnologies using

\textsuperscript{112} Ibid., 29.
\textsuperscript{113} Ibid., 29-31.
human organs and tissues.\textsuperscript{114} Ghana is making strenuous efforts to establish an organ transplant programme but is Ghanaian law any illuminative? It is to this question we now turn.

\textbf{8.5 Is Ghanaian Law on (Deceased) Bodies any more Illuminative?}

The question whether a dead body or part of it was capable of being owned was hinted at in the case of \textit{Sam v The State}.\textsuperscript{115} The brief facts of the case are as follows: The Appellant was, on 23 January 1967, brought before the district magistrate grade II in Cape Coast in the Central Region of Ghana and charged together with two others on two counts; 1) conspiracy to steal and 2) stealing a human skull from the grave of one Ama Akowa. The appellant pleaded guilty and was sentenced to one day’s imprisonment and a fine of €120 or in default six months’ imprisonment with hard labour. The magistrate in reaching this decision held that ‘I am satisfied that the removal of a dead body or part of it which has been interred is a thing which has \textit{ownership} vested in it, bearing in mind the set-up of our African Society’.\textsuperscript{116}

The magistrate’s use of ‘ownership’ and ‘thing’ might be understood in a number of ways. One interpretation is that ownership must necessarily be in respect of things. To this end, having reached the conclusion that an interred body or a part of it is a thing, it was now capable of being a subject of ownership rights. Another interpretation is that, for the purposes of Ghanaian criminal law, stealing must be in respect of things. If this interpretation is correct, then having established the ‘thingness’ of an interred body part, it could then properly come under the criminal law. It is however unclear why the magistrate sought to ground a conviction for stealing


\textsuperscript{115} [1967] 1 GLR 283-290.

\textsuperscript{116} \textit{Sam v The State} [1967] 1 GLR 283-290, 285 (emphasis added).
on establishing the specific owner of the skull. This is because per section 120 subsection 2 of the Criminal Offences Act, 1960 (Act 29) (as amended) of Ghana it is not necessary to know who the owner of a thing is in order for an act to constitute a dishonest appropriation of the thing (whether dead or alive).

Furthermore, by making reference to the setup of the African (but more accurately, Ghanaian) society the Magistrate was properly arguing that a body part (at least one that has become a thing on interment) is capable of ownership rights under Ghanaian customary law. Assuming this observation to be true, the key point of our analytical interest in the context of organ transplantation, is how contextual peculiarities, influence the development of the common law in Ghana. More importantly, how these contextual peculiarities might inform the regulation of the nascent transplantation programme in Ghana. Unfortunately, the magistrate does not explain why *mere* interment confers thingness on a body part making it subject to ownership interests or why he thought the ownership vested in the very body.

Not unsurprisingly, the seeming lack of clarity resulted in the instant appeal. The legal issue for determination was whether a human skull was capable of being stolen from a grave in which the corpse was buried. The counsel for the appellant argued that at common law a dead body was not capable of being stolen and that once a human body was buried it ought to be deemed to have been abandoned and that nobody had any interest in a human skull removed from a grave. The judge, Archer J (as he then was), in dismissing the appeal, questioned how the magistrate could attribute ownership of the skull to the dead body. He held that ‘[T]here is *no doubt* that during her lifetime, Ama Akowa was the *owner of her skull* but it seems to me that on her death, her body went into the *legal possession* of her family until her burial’.117 The learned judge does not argue or justify his claim that the magistrate was wrong in holding that ownership vested in the

117 *Sam v The State* [1967] 1 GLR 283-290, 287 (emphasis added).
dead body, and that the decedent was capable of owning, and indeed, owned her skull in life but could not do so in death. Presumably, his Lordship thought that the thesis of self-ownership is self-evident and requires no justification. However, while claims of self-ownership during life might seem intuitively straightforward, the concept of self-ownership remains irredeemably disputatious.\textsuperscript{118} Indeed, the very fact that the judges in this case held different views about ownership of human bodies demonstrates the very vexed nature of the issues around ownership or property rights in human biomaterials.

The failure to establish a clear and coherent legal position on ownership of the dead bodies at custom was to haunt the judiciary a few years later in \textit{Neequaye and Another v Okoe}.\textsuperscript{119} Following the death of one Dr. Charles Robinson Neequaye, on 7 January, 1990, a dispute arose between his nuclear family (wife and children) on one hand, and the wider paternal family headed by Mr. Ashaley Okoe on the other, necessitating the instant suit. The plaintiffs (wife and children) contended that by the operation of law the persons responsible for the funeral and burial arrangements of a deceased Ga Mashie person, was his nuclear family. Relying on the common Ga proverb that ‘moni fuo kpitiyelo le le enoo etokota’ to wit ‘the one who buries the leper is the person entitled to his sandals’, the plaintiffs argued that since at customary law a corpse was regarded as property to be inherited by the persons entitled to, and under Intestate Succession Act, 1985 (PNDCL 111), the spouse and children were entitled to the lion’s share, they were those legally entitled to determine his funeral and burial arrangements and that the paternal family had no locus standi.

The respondent demurred. Lutterodt J held that under customary law, ‘the control and authority’ over a corpse vested ‘absolutely’ in the wider family and that family members were


\textsuperscript{119} [1993-94] 1 GLR 538-548.
obligated to contribute to funeral arrangements. Accordingly, since the children were part of the customary family of their deceased father they were entitled to take part in the discussions on the funeral arrangements of their father. The widow however had no role to play in the arrangements.

Furthermore, it was held that under customary law, a corpse did not form part of the self-acquired property of a deceased person, and was therefore not property capable of being inherited. His Lordship was however quick to point out that the decision did not mean that the nuclear family is of no importance in Ghana. He further clarified that though they were entitled to compassionate and sympathetic consideration under customary law and their views ought to be heard, ‘the state of the law…be it statute law or otherwise, does not vest in the spouse and children, particularly in the spouse, the rights sought for by the plaintiffs’.

The position of Ghanaian customary law as set out in Neequaye departs substantially from the position of English law. It establishes that the human body (at least a deceased body) is, or is capable of being, property. However such property, unlike ordinary chattels, is not considered to be part of the self-acquired property of the decedent. But to say that the legal right of control or possession of a dead body vests absolutely in the wider family is not exactly illuminating. This is because every Ghanaian belongs to two wider families; the paternal and maternal families. Indeed, the learned judge noted the ambiguity of ‘family’ in the Ghanaian context. He captured this in his observation that:

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The trouble is that for the Ghanaian “family” has a variety of meanings. Now when an educated top class Ga Mashie lawyer or doctor writes to his counterpart in the United States of America telling him he is going to the Caribbean Islands with his “family” for a holiday, he no doubt means (and I am sure his friend would understand him in the same vein) that he is going away with his wife and children...However, when the same Ghanaian lawyer, for example passes by his colleague’s house one Saturday afternoon and informs him that he is attending a family meeting at Bukom, his friend no doubt expects a larger group of people than those referred to above.124

Disappointingly, the court failed to take the opportunity to clarify the issues. Without saying more, it remains uncertain whether both families can in all cases make equal claims on the body of the decedent. If not, then, under what circumstances might one wider family be vested with more powers than the other? How would these competing interests and rights be balanced? These issues arose in the case of Abusuapanyin Kwaku Agyeman (Head of the Royal Agona Ntadiee Family of Akyem Manso) and Others v Bonouedee and Another [2013] unreported. The brief facts are as follows. The decedent, Wing Commander (rtd) Wisdom Yaw Ametepe of the Ghana Air Force, was of mixed traditional background. Whereas his biological father was an Ewe man (an Anlo man) who hailed from Anyako in the Volta Region his mother was of Asante-Akyem descent from the Eastern Region of Ghana.

The maternal family brought before a circuit court, an application for an order for an interlocutory injunction against the paternal family organising his funeral. They argued that in spite of the paternal origins of the deceased, his choice of personal law during his lifetime was that of his maternal family being the Akyem Manso customary law. Their claim was supported by the fact that; i) the deceased in life inherited his maternal uncle who was the occupant of the Gyaase stool of Akyem Manso and was about to be installed and outdoored as chief when he passed on, ii) he stood for and won election as an assemblyman from 2000 to 2008 by virtue of his affinity to his maternal family, iii) he had the practice of attending every family occasion

including funerals and new year meetings, and iv) the deceased named all his biological children after his maternal ancestry without a single honour to the paternal ancestry. They argued that all these events point to his choice of the Akan customary law rules as against his paternal customary law rules as his personal law rules.

The defendants demurred and countered that by Anlo custom, the body of the decedent belongs to his paternal family and that the said family has unimpeded access to the body of the decedent. Also, that the paternal family has the legal right to plan the funeral and that the maternal family had no capacity in law to initiate the instant action. Counsel for the paternal family argued that the ‘law is settled that the body of a deceased person is the property of his customary family’ and backed his point with reference to a similar claim by William E. Offei in his book *Family Law in Ghana.* Unfortunately, the action was dismissed and without the benefit of the legal arguments on the substantive matter, the property question remains unclear or, at best, unaddressed.

In the present case the wishes of the decedent were known and it appears his personal law was also easily ascertainable. However other scenarios could present practical problems for Ghanaian courts. For example, what happens where the personal law of a deceased individual was not ascertained or ascertainable, and his wishes not known, but his families who are subject to different customary law practices make claims for his body? Or where, though his personal

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125 On the evidence before court, claim (i) was found to be false while claim (iv) was contested.
126 *Abusuapanyn Kwaku Agyeman (Head of the Royal Agona Ntadiee Family of Akyem Manso) and Others v Bonouedee and Another* [2013] unreported, Defendants Statement of Case, 4.
128 Loosely, personal law is the law applicable to all matters personal or related to a specific individual and his or her family. For how to ascertain personal law in the Ghanaian legal context see section 54 (1) of the Courts Act of Ghana, 1993 (Act 459 as amended).
law is ascertainable and his wishes known, there is no precedent specific to the matter in issue? What should the courts do?

The Ghanaian legal system has an in-built mechanism aimed at adjudicating such matters. For instance, in the absence of any precedent at custom the courts have been empowered under section 54 of the Courts Act, 1993 (Act 459 as amended). The section sets out the rules to be applied in determining the choice of law under those circumstances. Rule 5 provides, in part, that where an issue arising between two or more persons who ‘are not subject to the same personal law, the court shall apply the relevant rules of their different systems of personal law to achieve a result that conforms to natural justice, equity and good conscience’. 129

Additionally, section 55 provides for the ascertainment of the existence or content of rules of customary law. In particular subsection 1 provides that ‘any question as to existence or content of a rule of customary law is a question of law for the court and not a question of fact’ and gives guidance in subsections 2, 3, 4 and 5 on how courts are to set about fulfilling that duty. Rule 5 provides that the court may request the appropriate traditional authority such as the House of Chiefs, Divisional or Traditional Councils or any other body with knowledge of customary law rules of any particular community to assist the court to ascertain its existence or content. Indeed, in the Neequaye case above the learned judge drew on the authority vested in him under section 52 subsections (1), (2) and (3) of the old Courts Act of 1971 (Act 372) and invited the Ga Mantse to help ascertain Ga customary law before reaching his conclusions.

Furthermore, it is possible to apply a known customary principle from one customary community to another where no precedent on such matter exists. The Supreme Court in Huago and Others v Djangmah II and Others held per Wiredu JSC that the proper test to apply under

those circumstances is one of the ‘reasonableness and fairness’ of the principles in issue.\textsuperscript{131} The Supreme Court per Atuguba JSC was however quick to add a proviso that in order to avoid accusations of cultural imperialism ‘all effort must be made to ascertain the particular customary law and it is only when that proves futile that resort to other customary systems can be made’.\textsuperscript{132}

Ghanaian customary law as discussed above has serious policy implications for the regulation of the control and use of human biomaterials in Ghana, especially in organ transplantation. First, it treats human bodies or parts thereof (at least deceased bodies) as property, or capable of being, property though such bodies or their parts are not part of the self-acquired property of the decedent. Second, it provides that in relation to deceased individuals, these proprietary interests and rights vest absolutely in their customary families. Third, it holds that in life, legal ownership of body parts vests in their sources. This seems to cohere with the libertarian conception of self-ownership. This is a surprising result since the Ghanaian socio-cultural setting is generally communitarian in nature. Arguably, while communitarianism recedes in life (or we see a libertarian shift), in death it is libertarianism that recedes and the customary family emerges as the proprietary right-holder (a communitarian shift).

More importantly, leaving the property question unclarified under customary law presents interesting puzzles for organ transplant regulation in Ghana. We next consider some of these regulatory puzzles.

\section*{8.6 Regulatory Puzzles for Ghana}

\textsuperscript{131} [1997-98] 1 GLR 300-336, 305.
\textsuperscript{132} [1997-98] 1 GLR 300-336, 329.
Flowing from the analysis of the Ghanaian legal position on deceased bodies thus far a number of inferences and puzzles may be highlighted for possible consideration by policymakers, legislators, lawyers, bioethicist and the public. First, in the *Sam, Neequaye* and *Abusuapanyin Kwaku Agyeman* cases the following inference may be reasonably drawn: under Ghanaian customary law recognition of self-ownership (the idea that one owns herself and her powers) is not in doubt. This seems to accord with the libertarian\textsuperscript{133} viewpoint that we are essentially self-owners. Interestingly, the Ghanaian position appears contrary to the position of English law as espoused in *R v Bentham*\textsuperscript{134}(and supported by some commentators such as Harris JW) that we legally neither possess nor own our bodies.

Furthermore, that the human body (at least, a deceased body or its parts) is, or capable of being subject to ownership interests or rights under Ghanaian customary law. Also, as established in *Neequaye*, that under Ghanaian customary law any such legal ownership (possession, control, authority, or custody, etc.) vests absolutely in the customary family of the decedent. Contrariwise, English law prioritises executors over family when legal possession\textsuperscript{135} of a corpse is at issue.\textsuperscript{136} The position of Ghanaian customary law accords, to some extent, with Scots law as set out by Lord Brodie in the case of *Mrs SC*\textsuperscript{137} that a near relative has priority because he has an ‘interest which is personal to him as an individual’.\textsuperscript{138} Nonetheless, Scots law differs from Ghanaian customary law because while in *Neequaye* the spouse was accorded no rights over the disposal of her deceased husband’s body, in *Mrs. SC* the widow and mother of the decedent soldier were granted equal rights. This might be due to the fact that in Ghana spouses

\textsuperscript{133} As defended by Locke, Nozick, Esptein and so on as discussed above.
\textsuperscript{134} [2005] UKHL 18.
\textsuperscript{135} To lawfully dispose of the body.
\textsuperscript{136} See *University Hospital Lewisham NHS Trust v Hamuth & Others* [2006] EWHC 1609 (Ch), at para 16.
\textsuperscript{137} [2011] CSOH 124.
\textsuperscript{138} [2011] CSOH 124, para 60.
are usually not part of the customary families of their partners. These differences in law therefore reflect the socio-cultural differences in the role of the family (nuclear and extended) in Ghana, England and Scotland.

It is important to point out that Ghanaian customary law rules ought to conform to the principles of ‘natural justice, equity and good conscience’.\(^{139}\) Similarly, the 1992 Constitution of Ghana accords spouses equal rights to their estates.\(^{140}\) But the customary law position that property in a (deceased) human body is not part of the self-acquired property of the decedent implies that spouses may not come under this constitutional protection. If this were so, then it will be problematic that a spouse is excluded from proprietary interests (be they income, or control rights, etc.) that accrue from the biomaterials of his or her deceased partner merely because human biomaterials are not considered as part of the self-acquired property of the decedent. We may legitimately question the legal and moral defensibility of any such claim, at least, on grounds of justice.\(^{141}\)

One way to cure this injustice may be to have statutory intervention that alters the fundamental customary law rule that there is property in a deceased human body and that such proprietary rights vest absolutely in the family. This will seem revolutionary and require acceptance by the various customary communities in Ghana in which the rule applies. Negotiating a successful outcome in the pluralistic regulatory context of Ghana will likely be impossible. Lack of acceptance will call into question the legitimacy of the rule change, suggesting that any such rule change might be a revolution too far, too soon.

\(^{139}\) Section 54 rule 5 of the Courts Act of Ghana, 1993 (Act 459 as amended); also see Abangana v Akologo [1977] GLR 382-388.


\(^{141}\) Devaney, Sarah, Stem Cell Research and Collaborative Regulation of Innovation (London and New York: Routledge, 2014).
Alternatively, one would have to establish before the Supreme Court of Ghana that the rule contravenes equal spousal rights as provided for under article 22 of the Constitution of Ghana or that it is outmoded, or injurious to a person as set out under article 26. Also, the spouse could come under the Intestate Succession Act, 1985 (PNDCL 111). But this opportunity is foreclosed by the decision in *Neequaye* that a deceased body is not part of the self-acquired property of the decedent.

Ghana could also effect the rule change through the principle of precedent through reliance on the courts to adopt the common law rule of *no property in a corpse* as is the case in England and Wales, and other common law jurisdictions.\(^{142}\) The UK experience has however shown how adopting this legal rule of dubious origin can create uncertainty and become a juridical albatross. Besides, as has been cogently argued, the existing lacunae in the common law relative to certain interferences with unburied bodies such as theft of deceased organs and tissues awaiting transplantation; or criminal damage; or recovery of possession of dead bodies among others which would otherwise be without remedial action will be filled when property rights in deceased bodies are recognised.\(^{143}\) Accordingly, recognition of proprietary rights and interests in dead bodies and their parts would provide a firm foundation upon which a regulatory framework can be enacted to bring clarity to issues such as i) the nature of these rights; ii) who the rights-holders are; iii) how the interests and rights are apportioned, and iv) the remedies that may be available when these interests and rights are unjustly interfered with.\(^{144}\) Ghanaian customary law is progressive in this respect. It is therefore my respectful contention that Ghana has no

\(^{142}\) *Moore v Regents of the University of California* 793 P 2d 479 (Cal 1950).


justifiable reason to abandon this path of progress for one of uncertain origin and dubious validity.

The more plausible, pragmatic and practically feasible approach will be to affirm the Ghanaian customary law recognition of ownership interests and rights in deceased bodies in statutory enactment. This will ensure that any such legislation (or enactment) commends itself to public support and legitimacy because it reflects the social, cultural and constitutional values of the Ghanaian regulatory context. The expressive and facilitative functions of the law can be harnessed to meet the social utility aims of biotechnology (especially organ transplantation in Ghana) if the relevant regulatory process ‘is truly collaborative’. Though the ownership rights issues raised here arose in the context of the control of deceased bodies for burial or theft of dead bodies parts, it is arguable that the customary law position will change in a fundamental way merely because parts of deceased bodies have now acquired uses beyond interment.

8.7 Concluding remarks

As shown above, the controversy around ownership rights in human biomaterials remains strong even though I agree with the claim that proponents of property in human bodies ‘appear to be on a much firmer footing’. Unsurprisingly, though Ghanaian customary law appears to be on the path of progress, some ambiguities remain and present puzzles for any legislative reform. I argue that a legislative change should tread this path of progress, affirm proprietary interests in

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148 For example, Offei states that the deceased individual is the property of his customary family under the chapter 17 ‘Funerals’ where the responsibility for the performance of customary rites and burial are discussed. For more information see Offei, W. E., *Family Law in Ghana* [3rd edition] (Accra: Optimum Design & Publishing Services, 2007), 377-378.
149 Devaney, *Stem Cell Research and Collaborative Regulation of Innovation, op cit.*, 97.
(deceased) human bodies and ensure that these are fairly and justly apportioned. This seems to coincide with the viewpoint of other commentators that the HTA 2004 of England and Wales be amended to ‘allow property in tissues’ as that will not only reflect the reasonable position of the law but incentivise tissue donation.\textsuperscript{150} Ghana has no justifiable reason to abandon its path of progress for one of uncertainty and dubious validity.

\textsuperscript{150} Devaney, \textit{Stem Cell Research and Collaborative Regulation of Innovation}, op. cit., 105.
PART III: CONCLUSION
CHAPTER 9

CONCLUSIONS AND SOME AREAS OF FUTURE COLLABORATIVE WORK

9.1 Conclusions, Contributions and Suggestions

In this final chapter, I restate the main purposes, motivations and questions that are central to this doctoral thesis. I then review the contributions that the study makes; suggest some tentative proposals for consideration by policymakers when regulating the permissible uses of human biomaterials (especially for organ transplant surgery) in the Ghanaian regulatory context and point to some areas for future collaborative research.

As a background to this study, I highlighted the burden of end-stage kidney disease as being of public health concern in Ghana and identified the efforts being undertaken to bring relief to patients through the establishment of a transplantation programme. I then pointed to the display of sensitivity around death and dying in the Ghanaian socio-cultural milieu and discussed how customary concepts such as PPIR and ancestorship may impact the regulation of organ transplants in that setting. Additionally, I show the legal and constitutional protections accorded family and cultural rights in the Ghanaian socio-legal context. These notwithstanding, I establish a systemic culture of retrieval, retention and use of deceased body parts with little regard to the interests of the decedent or their families. Similarly, I expose how concerns surrounding the sale of sperm and ova as well as increasing concerns about the murder of people

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1 See chapters 1.1 and 2.
2 Chapter 6.2.2 and 6.2.3.
3 See in particular chapter 7.4.2 and 7.4.3
4 See chapters 5.2.1, 6.2.1, and 7.4.1.
5 Chapter 7.2.
and the removal of certain body parts (kidneys and blood) presumably for ritual purposes have excited public commentary about regulating the permissible uses of human body parts in Ghana appropriately.\textsuperscript{6} I then make manifest Ghana’s desire to establish an organ transplantation programme by end of this year. Worryingly, this is being pursued without the necessary ethical, legal, clinical and institutional frameworks specific to the governance of the permissible uses of (deceased) human biomaterials in Ghana. Finally, I show that the Ghanaian socio-legal environment is pluralistic because though founded on the common law tradition, it has elements of some other legal systems (e.g. traditional African or customary and Islamic legal systems).\textsuperscript{7}

I set the scene by reiterating that as a former British colony, Ghana’s legal system is founded on the English common law tradition. But that unlike the UK, Ghana has a written constitution under which customary law, cultural and family rights are protected by entrenched provisions. It follows therefore that certain customs, practices and usages are of both cultural and legal significance in that context.

As discussed in chapter 1, the news of embracing biotechnological progress in Ghana produces mixed feelings. On the one hand, are expectations of the public good that organ transplants can do to patients with end stage diseases in that country; on the other hand, are the uncertainties about whether this biotechnology can be satisfactorily accommodated by extant ethico-legal systems, or whether it will worsen the existing but unresolved ethical and legal problems, or whether it raises novel ethical, legal, or clinical problems of its own that might require a new policy response.

\textsuperscript{6} Chapter 7.4.1.
\textsuperscript{7} See in particular chapters 5.2.1, 6.2.1 and 7.4.1.
Given that; i) organ transplantation is new to Ghana; ii) there are no ethical, legal and professional governance frameworks specific to the sector; iii) there are concerns about a systemic culture of inappropriate retention and use of human body parts following pathological services; iv) there is illicit trade in human body parts (ova, sperm etc.); and finally v) Ghana is undertaking test kidney transplants in the absence of specific ethical, legal and clinical guidance addressing the controversies surrounding the permissible uses of human organs and tissues, I undertook to examine some of these ethico-legal controversies in the Ghanaian socio-legal setting. The study identified some of the ethico-legal issues answers to which are necessary, even if not collectively sufficient, for effectively and appropriately regulating the emerging transplant sector in that context. As a result, the primary focus of this doctoral thesis was to examine the following questions in the Ghanaian socio-legal context: i) Death in Ghana: Sociocultural Implications for Organ Transplant Regulation?; ii) Posthumous Organ Retention and Use in Ghana: Regulating Individual, Familial and Societal Interests?; iii) Customary Law and Ownership of Deceased Bodies: Regulatory Puzzles for Ghana?; and iv) Settling on an Appropriate Regulation for Organ Transplants in Ghana’s Pluralistic Socio-legal Environment? The answers to these questions are addressed seriatim in the papers that form basis of this doctoral thesis.

I first examine the ethico-legal concerns surrounding the definition of death and its uneasy relationship with the retrieval of organs for transplantation within the Ghanaian socio-legal environment. I argue that any regulatory framework for organ transplants in Ghana ought to be forward looking and go beyond the current restricted practice of using only living related donors to a comprehensive programme that is reliant on organs and tissues from all ethically defensible sources. As a consequence, I discuss indigenous thinking around death and dying in the
Konkomba socio-cultural setting through the concept of Post-mortem Personality Identity Renegotiation (PPIR)\(^8\) and argue that depending upon how it is understood and utilised, it has the potential to either further or thwart the social utility aims of organ transplantation in that context. I then interrogate claims that the adoption of the neurological criterion of death was *solely* motivated by transplantation interests and find that these claims are not entirely borne out by historical facts.\(^9\) This leads me to argue that the (re)definition of death emerged as a result of the confluence of advances both in medicine and biotechnology. I conclude that Ghana should, like the UK, adopt the brainstem death criterion because it meets the ethical, clinical, and legal standards for human death and is well-suited for the Ghanaian context because it is less reliant on biotechnology.\(^10\) Finally, I consider the nature of the role of law in the process of defining and confirming death. I evaluate the statutory and judicial approaches adopted by the USA and UK (England and Wales) respectively. It emerges that the statutory approach lacks flexibility or malleability; is cumbersome to run (because it requires a continual revision of the parent Act or its legislative instruments); requires functional, well-coordinated and efficient public institutions; requires enormous financial resources as well as logistics and technical expertise among others.\(^11\) The pluralistic nature of Ghana’s regulatory context and the lack of functioning institutions as well as Ghana being a resource-poor country make a judicial definition of death better suited for that context. Additionally, I demonstrate that society’s uneasiness with the association of the (re)definition of death with organ retrieval for transplantation is not necessarily

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\(^8\) Chapter 6.2.2. For an interesting discussion on how funeral donations may serve as a tool for individuals to affirm and renegotiate the value of both the deceased and the donor in the Ghanaian context see Boni, Stefano, ‘‘Brothers 30, 000, Sisters 20,000; nephews 15, 000, nieces 10, 000’’: Akan funeral ledgers’ kinship and value negotiations, and their limits’ *Ethnography* **11** (2010): 381-402 especially at 402.

\(^9\) Chapter 6.3.2.

\(^10\) Chapter 6.5 above.

\(^11\) See chapter 6.4 especially 6.4.1 and 6.4.2.
ameliorated by having a statutory rather than judicial definition of death as the USA experience shows.\textsuperscript{12}

Some commentators also argue that not only is a dead person neither wronged nor harmed through the removal of their organs for transplant but that if deceased organs and tissues were automatically made available for transplants then thousands of lives could be saved.\textsuperscript{13} Proponents argue that it is to beings with the capacity to value their own existence that respect is owed.\textsuperscript{14} Therefore any ‘insistence on a conception of respect for the dead…which has as its consequence injury to or even the death of other people must be both self-defeating and morally indefensible’.\textsuperscript{15}

I locate these debates around posthumous interests and harms in the Ghanaian socio-cultural setting through the concept of ancestorship and argue that such interests can and do exist in the Konkomba (wider Ghanaian traditional) setting.\textsuperscript{16} Having established the existence of posthumous interests in that setting, I employ Joel Feinberg’s account of harms as a setback to interests and conclude that posthumous harms do exist in that setting.\textsuperscript{17} This being so, I argue that given the protections accorded customary law, cultural and family rights in Ghana any regulatory framework that violates family and cultural rights stands the risk of a constitutional challenge. As such any legislation that promotes or encourages conscription of deceased bodies for organ transplantation or science research may prove practically unworkable in that context.\textsuperscript{18}

\begin{footnotes}
\item[12] Chapter 6.4 above.
\item[14] Ibid.
\item[15] Ibid, 219-220.
\item[16] Chapter 7 above.
\item[17] Chapter 7.5.
\item[18] Chapter 7.6.
\end{footnotes}
Finally, I argue that claims that such a restrained policy will necessarily undermine our aim of maximising (deceased) organs for transplantation or science research in that setting may not be entirely accurate. I argue that given the cultural and existential significance of ancestorship in that socio-cultural environment, a regulatory framework that is context-appropriate could ride on the cultural value of ancestorship in that context to encourage (deceased) organ donation for transplantation and science research.19

Furthermore, I argue that given Ghana’s pluralistic legal milieu it is essential that any new regulatory framework reflects the constitutional, cultural and social values of the Ghanaian socio-cultural context. As a result, the regulatory approach must be both expressive of the pluralistic perspectives in Ghana and facilitative of our common goal of maximising the social utility aims of organ transplantation or science research. To this end, I argue that policymakers could overcome hurdles to agreeing an appropriate regulation in that context through reliance on the adaptive capacity of legal foresighting as espoused by Laurie and colleagues.20 This is because the concept of legal foresighting helps us to identify and explore, for example, how uncertainties arising from a biotechnologically-driven advancement in healthcare practice (such as organ transplants) can be better regulated to achieve its social utility aims.21 It also provides us the opportunity to subject these biotechnological advances to ‘rational, contemplative reflection’ enabling us to question whether ‘existing systems (and their assumptions and values) are capable of delivering the ends we want’.22 Moreover, given that professional guidance and codes of practices are in most part absent in Ghana, legal foresighting seems well-suited not only when reflecting about the optimal role of hard law in these developments but also when softer

19 Chapter 7. 6 above.
20 For a definition of legal foresighting see chapter 8.2 above.
22 Ibid.
law options including self-regulation, professional guidance and or codes of practice among others are contemplated. Though legal foresighting has its own drawbacks, it should be considered a ‘non-negotiable element of regulatory preparedness’ if we desire a just and relevant role for law in the development and use of new and emerging biotechnologies in the healthcare context in particular. This is because legal foresighting demands that we efficiently mobilise our ‘resources and expertise to craft an appropriate social response’ to any new or emergent biotechnology such as organ transplantation (in the context of Ghana).

I next consider the thorny issue of ownership interests in human biomaterials. I examine property, liability and inalienability rules and argue in support of Nwabueze and Epstein that property rules are most apposite for resolving the ethico-legal disputes in the transplant context. I then briefly evaluate the evolution of the no property in a corpse rule in English law and find that it is now punctured with exceptions that are in some cases contradictory or illogical.

Furthermore, having acknowledged that Ghana’s legal system is founded on the common law tradition, I examine whether Ghanaian law, unlike its English counterpart, recognises property in (deceased) human bodies. I find that Ghanaian customary law holds that a deceased body (or parts thereof) is, or capable of being, property. That this property is not part of the self-acquired property of the decedent and as such cannot be devised as envisaged under the Intestate Succession Act, 1985 (PNDCL 111). Furthermore, it holds that whilst the ownership rights in

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25 Ibid, 32.
26 See chapter 8.5.
27 Chapter 8.3.1.
28 Chapter 8.4.
deceased biomaterials vest absolutely in the customary or extended family in the case of deceased individuals, during life such interests vest in their sources thus endorsing the concept of self-ownership. Though it is unclear what the contents of these ownership interests are it is obvious they include control rights by the family (possession, custody, authority, etc.) and exclude transmissibility (at least as envisaged under PNCDL 111).

However under Ghanaian law, customary law rules ought to conform to principles of ‘natural justice, equity and good conscience.’ Accordingly, the exclusion of spouses from the ownership interests in the biomaterials of their deceased partners may have to be evaluated according to justice claims and those parts that do not accord with the ethical and legal principles of good conscience, equity or natural justice, must be jettisoned.

If these conclusions are right (and I think they are), then they present some puzzles for regulating the permissible uses of human biomaterials in Ghana. Since property in body parts are not part of the self-acquired property of the decedent and cannot be bequeathed to the nuclear family especially the spouse under Intestate Succession Act of Ghana, 1985 (PNDCL 111), it raises issues of justice and fairness. It might then be suggested that the spouse may alternately seek protection under the equal spousal rights granted under Article 22 of the 1992 Constitution of Ghana. However discussions as had in chapter 8 above seem to show that the classification of the proprietary interests in human body parts as falling outside the self-acquired property of the decedent forecloses this option as well.

A number of options may be available to regulators in Ghana to obviate accusations of injustice and unfairness. First, we may, for example, decide that the statutory framework should

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29 Section 54 rule 5 of the Courts Act of Ghana, 1993 (Act 459 as amended); also see Abangana v Akolo [1977] GLR 382-388.
override the customary law rule that there is property in human biomaterials. As argued in chapter 8.6 above, any such enactment may suffer problems of recognition and legitimacy. Alternately, policymakers could simply decline an invitation to clarify such matters and rather rely on the courts to do so through judicial precedent at common law. It appears to me that this option will similarly meet the problems of recognition and legitimacy. More importantly, the UK experience as discussed in chapter 8.4 above shows how such an approach has led to the evolution of a rule of doubtful legal validity.

Policymakers may also affirm the customary law recognition of property rights in a statute as that will, on the one hand, properly reflect or express the social, cultural and constitutional values of the Ghanaian socio-legal context, and at the same time facilitate the social utility aims of maximising donation of (deceased) human biomaterials for transplantation and science research, on the other. It is admitted that even under this option concerns of justice and fairness still hold valid (largely distributive justice claims) as they are unaddressed or remain unclarified. I shall attempt to flesh out in the ensuing section, albeit rather briefly, how just distribution may be achieved in the Ghanaian regulatory context.

**9.2 Contributions and Areas for Future Collaborative Research Work**

It is entirely expected that any claims of justice or injustice, fairness or unfairness may be legitimately subjected to reasoned scrutiny because different conceptions of justice and fairness may sometimes produce different, if not contradictory, outcomes. These challenges

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30 For a more nuanced examination of some different conceptions of justice see the contractarian conception of justice by Rawls, John, *A Theory of Justice* [first published 1971] [revised edition] (Massachusetts: Harvard University Press, 2003); however for a biting critique of the Rawlsian conception of justice that proposes a capabilities approach see. Nussbaum, Martha C., *Frontiers of Justice* (London: Oxford University Press, 2006); also for very informative treatment of utilitarian justice (justice as maximising welfare), justice as respecting freedom and individual rights and justice as promoting virtue and the good life see Sandel, Michael J., *Justice: *
notwithstanding, an appropriate and effective regulation will need to set out coherently how the various rights and interests in human biomaterials are allocated (distributive justice) and must be able to defend the distribution on the collective values on which such claims are founded.

One way to deal with the justice issue may be to look to some of the existing ethical and legal arrangements and find out whether the values underpinning them may be used to similar effect in the context of deceased organs. We may want to consider the property rights in human biomaterials, when their sources are deceased and there are no advanced directives, as family property. If this is agreeable then we could apply a distributive formula similar to the one employed in the Intestate Succession Act of Ghana, 1985 (PNDCL 111). The attraction of this formula is that it recognises the customary role of the Ghanaian family by making a nominal allocation to it while rightly divesting a large share of the intestate’s property to his or her nuclear family and dependents.\(^{31}\) I propose for discussion that when the decedent is survived by a spouse and children and or dependents (including parents) the allocative formula should be:

- i) 30% of the property rights should devolve to the surviving spouse,
- ii) 60% should devolve to the children and or dependents, and
- iii) 10% should devolve to the customary family (or community as the case may be).

The attraction of this system is that it recognises the changing importance of the extended and nuclear families in the Ghanaian socio-legal setting without denying the relevance of either.\(^{32}\) Of course, very complex scenarios may emerge in the Ghanaian socio-cultural setting.

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\(^{31}\) It is to be noted that PNDCL 111 has its own challenges leading to the drafting of a new Bill intended to remedy the weakness of the extant law.

\(^{32}\) See the memorandum to the Intestate Succession Bill of 2013.
For instance, what happens when the individual is without a spouse, or child or dependent, or has multiple wives (in the case of men because polygamy is practiced at custom)? Also, problems may arise as to whether the parents of the deceased should be awarded rights separate from those of dependents and the customary family, or whether an estranged spouse who at the time of death had been separated from the decedent for a period of time should be entitled to the same rights? Or when the decedent is a minor? Alternately, policymakers may hold that such rights are inalienable or not subject to commercial transactions. Obviously, the sensitive nature of the issues raised and the nuanced analysis required to bring some clarity to them make further engagement on it almost inescapable.

Another area of future research will be to collaborate with other researchers on the possibility of deploying legal foresighting in the Ghanaian regulatory context. It might aid stakeholders to reflect more sensitively and carefully about key assumptions and values surrounding emerging biotechnologies (such as transplant surgery, IVF, etc.) in Ghana with the twin objectives of assessing how the law might be deployed to both protect and promote individual, family and societal interests in that context.

Also, there is the need for support from other researchers to assist Ghana develop and build the capacity of its healthcare professional associations, their regulatory councils, policymakers as well as civil servants to better understand the ethico-legal issues that may be the subject of any regulatory dialogue.

This piece of work is pioneering to the extent that there has not been any extensive and holistic examination of how existing laws might respond to the rapid progress in medicine and biotechnology in Ghana in a coherent manner. Furthermore, though test transplants are being
undertaken, there has been no examination of how the ethico-legal issues raised by organ transplantation may impact on the social, cultural, legal and constitutional values in Ghana. In particular there has not been any comprehensive comparative analysis of the ethico-legal issues that are raised by the retention and use of deceased body parts in Ghana and the UK in any coherent manner. As such this study will not only enrich the ethico-legal literature in this respect, it is hoped that going forward it will inform the regulatory dialogue on regulating the emerging organ transplant sector in that country.

What deal-breaker issues might my preferred context-appropriate statutory regulation for organ transplantation in Ghana contain? As argued in the preceding chapters, I wish that any regulatory framework for Ghana must identify and clearly articulate the values and principles (and their assumptions) that underpin it. These values will understandably include the communitarian values of the Ghanaian traditional setting, collective solidarity and reverence for the dead (ancestors) among others. It should not include a statutory definition of death. It should be a property-based model that affirms the recognition of property in (deceased) human biomaterials as family property under customary law. It must however clarify that, contrary to the customary law position, justice demands that the veto on such matters should vest in the nuclear family rather than the extended family. However, as a matter of respect for custom the extended family should be accorded a nominal role reflective of the changing significance of the extended family in the Ghanaian socio-legal context. It is open to Ghanaian policymakers to decide whether or not this property-based model may be supplemented by liability or inalienability rules. I on my part, like Nwabueze, see no reason why these cannot be integrated into our property-based model. My preferred statutory regulation is one that is both facilitative of the uptake of biotechnology and biomedical research in Ghana and expressive of the
constitutional, cultural, social and moral values of that regulatory context. To that extent, I hope that a statutory regulation in that setting will adopt a soft opt-out system for obtaining organs from deceased individuals akin to the Welsh version.\textsuperscript{33} The statute should not however include the definition of death. For the reasons already given in chapter 6 above, that should be left to the judiciary to develop in accordance with extant medical standards.

Nonetheless, I decline the temptation to prescribe what I consider to be some universally ideal regulatory framework for Ghana for two reasons. First, as argued in chapter 8.2, it may be mistaken to simply advocate a regulatory framework that is presumed to be universally ideal in another context without effective dialogue and collaboration with the relevant stakeholders as that could create problems of social legitimacy for the regulation. Second, while I wish to develop a statutory regulation for the permissible uses of human biomaterials in Ghana (and what some of its contents ought to be) it is more important for me that the regulatory framework takes account of Ghanaian customary law and evolves through negotiation and collaboration with all the relevant stakeholders rather than to advocate the imposition of some prescribed standard.

How well all these get translated into practice in the Ghanaian socio-legal context will be essential to developing comprehensive regulatory and governance frameworks for the permissible uses of human biomaterials that are both context-appropriate and practically workable in that context. I am however hesitant venturing into making any predictions as to how the conclusions and suggestions proffered in this doctoral thesis will shape the future developments of the Ghanaian regulatory context. This is because predicting regulatory futures is notoriously unpredictable and its unreliability is aptly captured by Joseph A. Grundfest:

\textsuperscript{33} Section 4 of Human Transplantation (Wales) Act, 2013.
I have accepted an invitation to predict the regulatory future of securities markets in the United States. My acceptance is foolish for so many different reasons that I despair of counting them all. I therefore draw attention to two of the predictions I am about to offer and trust that the reader will overlook all the others. My first prediction is that my predictions will be proven wrong. My second is that having this essay appear in print is a big mistake. A printed essay creates an irrefutable record that will memorialize the stunning accuracy of my first prediction. On the brighter side, the record will then reflect that I knew that I had no chance of getting it right.\footnote{Grundfest, Joseph A., ‘The Future of United States Securities Regulation: An Essay on Regulation in an Age of Technological Uncertainty’ St. John’s Law Review 75 (2001): 83-111, 83.}

Have I therefore knowingly embarked on a mission that was stillborn from the outset? I do not think so. As Grundfest rightly points out, I did so because that is the only ‘responsible choice’\footnote{Ibid.} given the current circumstances of Ghana. As such, if, or rather when, this doctoral study provokes regulatory dialogue among the relevant stakeholders (bioethicists, clinicians, lawyers, Parliamentarians, policymakers, politicians, civil servants, professional societies, religious and traditional leaders etc.) on the governance of human biomaterials in Ghana, then I would have succeeded in this otherwise doomed enterprise.
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APPENDIX 1

Death in Ghana: Sociocultural implications for organ transplant regulation

Description of reprinted material

Death in Ghana: Sociocultural implications for organ transplant regulation

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Abstract

Within the context of organ retrieval for transplantation, death remains a controversial subject. Understandably, there are concerns about the conception of death, how it is understood, clinically defined, determined and confirmed, as well as its relationship with organ retrievals and transplantation surgery. Even though these concerns have been the subject of extensive commentary from medical, legal, ethical and social perspectives, these have been made largely in the context of the developed world. The first aim of this article is to re-examine, in the Ghanaian socio-legal context, the ethico-legal controversy around the definition, determination and confirmation of death and its relationship with obtaining organs for transplant. It is hoped that this will bring a new perspective to the debate and enrich our ethico-legal discourse on the
subject. Ghana is making strenuous efforts to make organ transplantation a routine surgical procedure by the end of this year, yet it has no ethical or legal framework to guide the process. A successful transplant programme will depend in part on the availability of organs from all ethically acceptable sources (deceased, living related and unrelated). This being so, the author discusses indigenous thinking around death (Post-mortem Personality Identity Renegotiation (PPIR)) and points policy-makers to how they could take advantage of PPIR to promote the social utility of any organ transplantation programme in Ghana. Furthermore, I consider the nature of the role of law in defining/determining death. I consider the merits of a statutory definition of death and conclude that given the circumstances of Ghana (its socio-legal environment) and the UK experience, a judicial rather than statutory definition is workable. The over aim of this article is to explore the need for an appropriate and comprehensive regulatory regime for the emerging sector of organ transplants in Ghana.
Death in Ghana: Sociocultural implications for organ transplant regulation
Divine N. Banyubala

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What is This?
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Keywords
Definition of death, Ghana, organ transplant, regulation, sociocultural

Introduction
Concern over the issue of mortality is a ‘universal feature of human societies’, but death evokes distinct sensibilities in different social, religious and cultural settings. Our knowledge and awareness of the certainty of death impacts on how we live and conduct our affairs and may inform and influence our perimortal consumption patterns. For instance, the Western conception of death posits that death signals the end of the material body as well as the social life of the deceased. In contrast, in the African traditional context, death is portrayed as a harmonious social relationship where the living and the dead meet through the ever-present world of ancestry. However, the emergence of new technologies (in the context of Africa) surrounding death such as mortuary and embalmment services is shaping funerary activities in urban parts of Africa. These services enable migrant workers to be buried at home in accordance with custom and may work to bridge differences in perimortal and funerary activities between Western and African societies.

5. The concept of ancestry posits that death does not extinguish all existence. It merely represents a transition from the realm of physical existence into that of ancestry. Life and death are seen as a continuum; ‘you are born, you die, and then you continue to exist in other realms’ (Heller and Barret, 2002 at 792). In the Ghanaian and, arguably, the broader African traditional context, the social environment is made up of the interaction of the worlds of both the living and the dead. Consequently, ‘death introduces forces of physical, spiritual and social rupture’ thereby enabling the deceased to transit from the state of physical imperfection to one of purity and spiritual perfection. ‘To qualify as an ancestor upon death, one must have led a good life, recognizing all relevant rules of justice and social interactions’ (Bonsu and Belk, 2003 at 44) and must have died a ‘good’ death. Upon attaining this state of piety ‘ancestors are believed to have the power to directly control the affairs of the living. They reward those who exhibit good behaviour and adherence to traditional laws of existence and punish those who violate social norms and rules’ (Bonsu and Belk, 2003 at 44). As a result, ancestors are often called upon by the living (commonly through the pouring of libations) for prosperity, good health, fertility, good harvest, rain and success or even have their powers invoked to grant victories or punish perceived enemies. Simply, ancestry is traditional Ghanaian sainthood.
This is understandable because it is ‘unlikely that the religious, cultural and social practices which surround death in any society are completely free-floating and unconnected to changing demographies’.\(^7\) The Western conception of death admits of some exceptions, for example, (1) posthumous organ donation as a way of rehabilitating the deceased’s social identity and (2) artists or authors whose works are discovered posthumously.\(^8\) This shows that in both settings there is some belief in the possibility of renegotiating one’s social status and/or value posthumously. This point of convergence of cultures in the conception of death is explored in this article and ways of harnessing its utility in respect of human organ/tissue donation (particularly deceased) and transplantation in the Ghanaian context are examined.

**The state of transplants in Ghana**

Kidney transplantation is in its infancy in large parts of sub-Saharan Africa with the exception of South Africa.\(^9\) In Ghana, strenuous efforts are being made to establish a human organ transplantation programme because chronic kidney disease (CKD) is now an issue of considerable public health concern there.\(^10\) Unfortunately, as in most parts of Africa, these efforts are hampered by the lack of resources (particularly logistics), technical expertise, and care support for patients with CKD.\(^11\) There is, however, great international interest in supporting resource-poor countries to make kidney transplantation a routine treatment option for patients with CKD.\(^12\) Driven by the public health concerns and buoyed by international interest, Ghana is expected to commence a routine kidney transplantation programme sometime in 2014 following successful test transplants (using living related donors) from 2008 to 2012.\(^13\) Arguably, in order to develop a successful organ transplantation programme, it is necessary to expand the donor pool to include other ethically defensible sources such as living unrelated and deceased donors.\(^14\)

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13. These tests were carried out with the support of Transplant Links Community, a UK registered charity that supports emerging countries in the management of chronic kidney disease. They offer teaching, advice and carry out living kidney transplantation with the aim of ensuring that sustainable transplant programmes become possible in the future. It was established in 2006 by a group of British doctors with vast experience in transplant surgery and desirous of sharing their knowledge and expertise. For a more detailed look at their activities, see http://www.transplantlinks.org/ (accessed 30 October 2012).
14. I assume for the purposes of this article that the availability of organs is an important part of developing a successful transplantation programme. As such, expanding the donor pool to include all ethically acceptable sources is desirable.
Furthermore, although Ghanaians exhibit a great deal of sociocultural sensitivity around their dead, there is no specific law or policy framework addressing ethico-legal concerns around death and dying, or for human organ donation and transplantation.\(^\text{15}\) There is no coherent guidance from the Ghana Medical and Dental Council, Ghana Medical Association, Ministry of Health (MoH)/Ghana Health Service (GHS) or the professional colleges (Ghana College of Physicians and Surgeons and the West African Colleges of Physicians and Surgeons). The commencement of a transplantation programme in the absence of specific legal and policy frameworks on how to clinically define, determine and confirm death, necessitates a re-examination of the concerns surrounding death in the Ghanaian sociocultural settings.

The first aim of this article is to re-examine, in the Ghanaian socio-legal context, the ethico-legal controversy around the definition, determination and confirmation of death and its relationship with obtaining organs for transplant. It is hoped that this will bring a new perspective to the debate and enrich our ethico-legal discourse on the subject. I also examine the nature of the role of law in defining/determining death. I consider the merits of a statutory definition of death and conclude that given the circumstances of Ghana (its socio-legal environment) and the UK experience, a judicial rather than statutory definition is workable. The overall aim of the article is to explore how policymakers could promote transplantation in a way which is consistent with and not in juxtaposition to sociocultural ideas about death in Ghana. Additionally, given that the current regulatory regime in Ghana does not have a legal definition of death, I explore problems that may be faced by agreeing a definition. I am acutely aware that these are just two issues from a spectrum of issues that would need resolving, but they are very important ones, as getting either of them wrong could have serious ramifications for public confidence in donation/transplantation.

This article begins by providing a brief clarification of the Ghanaian socio-legal context in ‘The Ghanaian socio-legal context section’, specifically the philosophical thinking of the indigenous people which underpins posthumous renegotiation of one’s social value and status. It points to some likely sociocultural implications of this for the regulation of the nascent transplant programme in Ghana. The article then explores the changing definitions of human death in the ‘Changing definitions of death: merely to suit transplantation purposes?’ section and demonstrates that redefinitions of death emerge as a result of a confluence of advances both in medicine and in biotechnology. It then challenges the notion that the redefinitions of death are merely aimed at procuring human organs/tissues for medical purposes, particularly transplantation surgery. In the ‘A statutory definition of death?’ section, the article explores whether or not society’s unease with redefinitions of death is better dealt with by introducing a statutory rather than common law definition of death. The article concludes by proposing that Ghana should not adopt a statutory definition, rather the definition of death should be judicially determined in accordance with prevailing medical professional standards and practices.

The Ghanaian socio-legal context

The legal context

Before examining the specific issues, it is necessary to briefly explain the general Ghanaian legal environment. Ghana’s legal system, as with most former colonies of Britain, is founded on the common law tradition. However, unlike the United Kingdom, Ghana has a written constitution. The 1992 Constitution of the Republic of Ghana provides in Article 11(1) that the laws of Ghana shall comprise (a) the Constitution, (b) Acts of Parliament, (c) Orders, Rules and Regulations made by any person or authority under a power conferred by the Constitution, (d) the existing Law and (e) the Common Law. ‘Common law’ as employed under Article 11(2) includes (i) the rules of law commonly referred to as common law (or judge-made or case law), (ii) the rules generally known as the doctrines of equity and (iii) the rules of customary law. Customary law means the rules of law which by custom are applicable to particular communities in Ghana. Further, the influence of Islam in Ghana has left its imprint on the Ghanaian legal system. Article 39 sets out a cultural objective by enjoining the State to take steps to encourage the integration of appropriate customary values into the fabric of national life, whilst Article 26 provides for cultural rights and practices. Importantly, Article 26(2) provides for the prohibition of customary practices that are dehumanizing or injurious to the physical and mental well-being of a person. Ghana’s legal system can thus be said to be pluralistic, because in addition to the common law tradition it features elements of two other traditions: the religion-based tradition (Islamic or Sharia (civil)) law and African traditional law or customary law. The recognition, relevance and application of customary law has been well established in common law which has also established that any such customary rule ought not to be repugnant to the principles of equity, good conscience and natural justice. It follows therefore that some of the practices and usages that have crystallized as custom may not merely be of cultural significance or value but of legal significance too. This explains why any regulatory regime must recognize the cultural contexts or reflect the social norms and values of the community in which the regulatory dialogue occurs.

The sociocultural context

In most parts of Ghana, death is central to much cultural and religious reflection, discourse and social practice. The proverb ‘Abusua do efunu’ (the family loves the...
corpse) aptly captures the sociocultural sensitivities that the Ghanaian generally attaches to death and perimortem and funerary activities. This proverb portrays and asserts the responsibility under custom of the family to and for the dead. The traditional conceptualization of societal harmony in Ghana derives from mutual respect for the living and the ancestors. One of the philosophical conceptions that affect one’s candidacy for ancestorship under indigenous Konkomba philosophical discourse is post-mortem personality identity renegotiation (hereinafter referred to as PPIR). I shall demonstrate presently that this customary practice could either further or thwart the development of a successful cadaveric organ donation and transplantation programme in Ghana, depending on how it is understood and utilized.

Briefly, PPIR under Konkomba custom is the understanding that an individual’s social value and status could be improved or worsened, or, more appropriately, renegotiated depending on perimortem events. These perimortem events include the type of death, the nature of the individual’s ill health, last wishes and actions, the immediate post-mortem details such as how the body has been treated (for example whether it is reasonably intact, covered with sores, etc.) and the kind of funerary activities and rituals performed. According to custom, the belief in the capacity of these pre- and post-mortem events to affect the deceased’s ascent to ancestorship has great purchase. This respect for the body being intact is founded on the presumption that the body belongs to ‘Uwumbor’ (the almighty maker of all – God) and the ancestors expect the elders to continue to uphold this cultural injunction. Failing to do so may not only jeopardize the deceased’s ascension to ancestorship, but also bring untold hardships, curses, misfortunes and calamities on the family and community. The channels of communication between the living and the dead are mediated through soothsayers and spiritualists. Wrongs may be


24. I use the Konkomba ethnic group because their beliefs mirror the beliefs of almost all other ethnic groups in Ghana, and therefore have huge potential for generalization. Further, their beliefs around death and dying are particularly illuminating for my purposes. Finally, as a Konkomba I closely identify with and understand some of these belief systems and am therefore in a position to, as far as possible, accurately examine them in a more nuanced manner.

25. The writer has been fascinated by the cultural practices surrounding death and the thinking that informs these practices particularly the idea that one’s social value and status could be renegotiated posthumously. As is expected, the ideas and values that underlie these indigenous belief systems are passed on through oral tradition. There is no written documentation about PPIR as espoused by the Konkomba that has come to the attention of the writer. This led me to seek deeper answers on the concept from my father (now deceased and to whom I owe a great debt of gratitude) and a number of elders of the Konkomba ethnic group of northern Ghana. The information presented here is as a result of four years of informal engagements of these connoisseurs of Konkomba indigenous values and the thinking that underpin them. Consequently, the views expressed here are attributable to these unnamed contributors.

remedied by performing certain specified rituals spelt out by the ancestors and lesser Gods (for example the earth God; who are all emissaries of Uwumbor) through the soothsayer or spiritualist or both. It is understood under Konkomba customary practice and usage that dissecting a dead body or burying a body with certain parts missing offends custom, denigrates the individual and lowers the social value of the deceased and his family. Conceptually, then, any such activity might affect the decedent’s PPIR and legitimacy as an ancestor.27

This is however not the full story. Firstly, under the same custom, there are certain circumstances under which cutting open a dead body actually furthers one’s chances of becoming an ancestor. For instance, when a pregnant woman dies (and quickening has occurred), elders are enjoined to disembowel the body, take out the baby and inter both separately. This is because the death of a pregnant woman counts as ‘bad’ death and as such undermines the status of the deceased to become an ancestor.29 This post-mortem act therefore serves to renegotiate the social status and value of the decedent. Similarly, post-mortem examinations (where not all body parts can be returned) are not seen or understood to be acts that are inconsistent with the indigenous thinking of becoming an ancestor. Furthermore, the Konkomba custom, and arguably, the Ghanaian traditional society more generally, is underpinned by a communitarian ethos and is founded on the principle of collective solidarity. Doing good to the individual, the family and the community, advancing communal goals and upholding communal values undergird all moral action. These find expression in the extended family system and the call to volunteerism referred to as ‘nkpawii’ in likpakpaln (the language spoken by the Konkomba). It guarantees individual rights and allows their enjoyment by emphasizing and focusing on the maximization of benefits and minimization of the burdens on all community members through collective solidarity. For example, when one is ill during the farming seasoning and unable to farm, nkpawii can be called by him or any member of his family on his behalf for the community to dedicate a whole day to work on his farm to ensure that his farm is tended and his family is not left without food.30 Sometimes, failure to participate in communal labour or nkpawii may attract legal sanctions.31 Finally, in order to

27. This is particularly important because it is believed that when one is not buried with certain vital organs (such as the brain, heart, etc.), the spirit/soul is violated and this undermines the deceased’s status as an ancestor which reflects negatively on the bereaved family. See also an exposition on the respect for ancestors by the Asante of southern Ghana by Bonsu and Belk, ‘Asante, Ghana’, pp. 41–55.

28. This is the stage in pregnancy when the foetus can be felt to move.


30. This is not to suggest that only males engage in farming but that the Konkomba are patriarchal.

enhance one’s post-mortem social value, some families in parts of Ghana go to the extent of using clay to improve the appearances of their dead by hiding bodily “imperfections such as sores on the skin”. Conceivably, these manifestations of indigenous philosophical thinking have the potential on the one hand to undermine, and on the other hand to further, efforts to facilitate organ donation (especially cadaveric organ donation) for transplantation. Which way the pendulum swings will depend in large part on how context appropriate the organ donation and transplantation governance structure is. As we are about to see, an appropriate governance structure may benefit from a community which believes that one’s social value can and, in certain cases, must be renegotiated post-mortem, is underpinned by a communitarian ethos and concerned about achieving communal goods and goals through the principle of collective solidarity.

Likely sociocultural implications for organ transplant regulation in Ghana

The success of any organ donation and transplantation governance will depend on how context-appropriate it is. It is my claim that the philosophical underpinnings of PPIR together with a communitarian ethos which ensures that communal goals and values are directed at doing good through the principle of collective solidarity or nkpawiin may be either a liability or an asset depending upon how these are understood and utilized. It is entirely plausible that if the indigenous people recognize and understand through education that transplantation and organ donation (particularly deceased donations) are ways through which social value and status can be renegotiated after one’s death, they are likely to be embraced. To this extent, PPIR can be viewed as a great window of opportunity for the development of a context-appropriate organ donation and transplantation governance structure. Furthermore, when the utility of organ transplantation is well explained to reflect the communal value of doing good through the spirit of nkpawiin, then it might be viewed by the Konkomba community as worthy of support.

A context-appropriate organ donation and transplantation framework in the Ghanaian sociocultural setting will be one which, among others, is respectful to and guided by indigenous communal values and principles. The fact that it might be seen as another way through which individuals and families can renegotiate their social value and status both in life and in death could provide key motivations in accepting the practice of donating organs for transplant. Otherwise there is a risk that transplantation surgery may be perceived as an enterprise that offends local custom and undermines one’s ascent to ancestorship. Any such perception, unfortunate as it may seem, could become a major stumbling block on the way towards making transplantation a routine surgical operation in Ghana. The discussion thus far is in respect of indigenous Konkomba sociocultural values and the thinking that belies them and, therefore, not necessarily reflective of the whole Ghanaian traditional context (even though their beliefs mirror those of most of the ethnic groups in Ghana). Consequently, any generalization of their application and utility must be approached with some circumspection and caution. Nonetheless, the points

made are relevant because they help to illustrate the importance of sociocultural issues in determining the likely success or otherwise of organ donation and transplantation programmes and the values and policy choices that ought to inform them. In the ensuing section, I examine the changing definitions of death and argue that claims that these are solely driven by transplantation interests are not entirely borne out by historical facts.33

Changing definitions of death: merely to suit transplantation purposes?

Changing methods of ascertaining death?

Arguably, of all the biotechnological advances that have impacted on medicine, none has had its ethico-legal contentions conducted, literally, in the shadow of death and with such intensity as transplantation surgery. What death is, how it is determined, as well as what purpose such determination serves, all provoke medical, legal and philosophical controversy. The determination and confirmation of death has not always been a task performed by doctors. Powner and colleagues have argued that the practice of the Hippocratic tradition was that as death approached or the dying process had begun, practitioners were typically instructed to withdraw from the care of the dying patient, thus leaving the actual confirmation of death to relatives and other lay carers.34 It was not until the 16th and 17th centuries, when societal concern about the fear of premature burial heightened, that physician involvement in the confirmation of death became a routine practice.35 These concerns led, in some cases, to the promulgation of laws requiring observation of dead bodies over time before interment.36 Lack of certainty in the definition and confirmation of death has dogged medical practice from then on and the associated fear of being buried alive as a result of this has, over the years, been both acknowledged and denied.37 Arguably, the continuing controversy in the discourse of

33. This is not to suggest that we should not worry if the redefinitions of death are partly motivated by transplant interests. I argue in the ‘Changing definitions of death: merely to suit transplantation purposes?’ section that the claim that the redefinitions are solely motivated by transplantation interests are not borne out by historical facts even though it is no denying the fact that organ transplant interests have since fuelled the urgency of determining the time of death. I wish to thank reviewer 2 for this point.
35. Great was such fear that in what could best be described as a policy decision to quell the societal uneasiness of the time, the Court of Appeal of Naples sentenced a doctor who certified the death, and the Mayor who authorized the interment of a woman who was apparently buried alive, to imprisonment; each to a term of three months for involuntary manslaughter. See The British Medical Journal 884 (08 December 1877), p. 819.
37. See ‘Remarkable Resuscitations’ The Lancet (09 April 1904), p. 1005; ‘Premature Burial’ The Lancet (16 May 1908), p. 1431. Also see ‘Buried Alive’ The British Medical Journal 1812 (21 September 1895), p. 730; for an interesting historical account of how, for example, a ‘dead man’ is alleged to have grasped the throat of a doctor who had made an
death, how it is defined, determined and confirmed, endures because the ancient fear of premature burial might have been replaced by the fear of premature procurement of human organs for transplantation purposes.\textsuperscript{38} In this section, this article offers a brief historical account of the evolution of the determination and confirmation of death and demonstrates that the definition (or redefinitions) of death has been a function of our continuing understanding of the human body, aided by innovation and advancements in medicine and biotechnology. Consequently, any claims that the motivations for the redefinition of death are solely attributable to transplantation interests are not supported by historical facts. For clarity and simplicity, drawing on the work of Gardiner and colleagues, I shall categorize these evolutionary trends into somatic, cardiorespiratory and neurological stages.\textsuperscript{39}

Historically, clinicians have relied on taking a careful history of the patient and the circumstances of his or her ill health to establish death. Central to the diagnosis of death is the responsibility not to misdiagnose. So great was the responsibility not to misdiagnose that many practitioners ‘concluded that advanced putrefaction of the entire body was the only valid single test to exclude apparent death’.\textsuperscript{40} This is understandable because there is a ‘massive difference in moral and legal status between the living and the dead’ and there is no doubt that it is better to err on the side of caution rather than to rush and treat someone who is still alive as though he or she were dead.\textsuperscript{41}

Traditionally, attempts at defining the moment of death have aimed at identifying the time that the human body has permanently or irreversibly lost its integrative functions or ceased to biologically function as a whole. We have long understood the relationship between breath and the integrative functions of the human body, the link between respiration, life and death. As such, it became customary to identify death by using a mirror or feather to assess whether there was enough breath to support life.\textsuperscript{42} However, concerns over premature burial by the late 18th and early parts of the 19th century led to the crystallization of medical opinion that the most reliable criteria for the determination of death were rigor mortis, putrefaction\textsuperscript{43} and ‘as an early and almost certain sign the glairy

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\textsuperscript{38} Powner, Ackerman and Grenvik, ‘Current Controversies’, pp. 1219–1223.
\textsuperscript{40} Powner, Ackerman and Grenvik, ‘Current Controversies’, pp. 1219–1223 (my emphasis).
\textsuperscript{42} Richards, ‘Ethics of Transplants’, p. 220.
\textsuperscript{43} E. Guernsey, \textit{Homoeopathic Domestic Practice} (New York: William Radde, 1857); available at: http://chestofbooks.com/health/materia-medica-drugs/Homoeopathic-Domestic_practice/Actual-Death (accessed 30 November 2012). It is reported by L.M. Whetstine that historically, Thracians, Romans and Greeks each waited three days for putrefaction to begin as a way of safeguarding against premature burial. For an interesting historical discussion, see L.M. Whetstine, ‘Definition(s) of Death’.
eyeball, with its papillary aperture fixed in dilatation’. This first set of criteria for the determination of death in the early part of the evolution of medical and scientific knowledge may, in a broad sense, therefore be termed somatic. Of course, keeping the body until decomposition set in was not the most convenient of circumstances for confirming death. As such, within the context of a medical system which includes the ability and intention to transplant functioning organs, any biotechnological advancement in medical knowledge which promises to retain robust checks against misdiagnosis of death but which, nonetheless, helps to make the determination of death reasonably early would seem welcome.

Conceivably, the understanding of circulatory function and its role in life and death following William Harvey’s pioneering work in 1628 may have prompted a rethought of the sufficiency and appropriateness of diagnosing death relying solely on somatic/respiratory criteria. Additionally, the invention of the stethoscope in 1816 and its subsequent use enabled medical science to include the absence of heartbeat in the criteria for establishing death. These developments in medical science deepened our understanding of the functioning of the human body. We were now in a position to link not just breath but also blood circulation and heartbeat to life and death. Death was now to be ascertained using a combination of these criteria. Thus cardiorespiratory death occurs when, after cardiopulmonary arrest, there is ‘simultaneous and irreversible onset of apnoea and unconsciousness in the absence of the circulation’.

The development of the mechanical ventilator in the 1950s and other implements like the cardiac pacemaker created serious problems for the determination of death and cast reasonable doubt on the adequacy of the cardiorespiratory criterion. This is because by the turn of the 20th century, successes in biotechnology, particularly in intensive care medicine, challenged the cardiorespiratory criterion because it became possible in certain cases to restore lost cardiopulmonary function. In some cases, cardiopulmonary resuscitation, post-mortem extracorporeal membrane oxygenation and autoresuscitation

are known to restore circulation. As a consequence, harvesting organs from individuals either too soon or when resuscitation has not been attempted and shown to have failed will be to ‘determine that someone is dead when she is not known to be dead’. Though practice guidelines are variable worldwide, there is general medical consensus in most countries that a minimum waiting time of either 2 or 5 min provides sufficient confidence that donation after circulatory death (DCD) is clinically, legally and ethically permissible.

Understandably, this led some sceptics to question the ethical and legal defensibility of transplanting hearts from DCD donors because ‘if a heart is restarted, the person from whom it was taken cannot have been dead according to cardiac criteria’. Arguably, then, obtaining organs from some DCD donors does not universally satisfy the dead donor rule (DDR) as a result the rule should be abandoned. It is however countered that

51. Shah and Miller, ‘Can We Handle the Truth?’ pp. 540–585.
55. Rady, et al., ‘Organ Donation After Circulatory Death’, pp. 166–168; Shah and Miller, ‘Can We Handle the Truth?’ pp. 540–585 and N. Fost, ‘Reconsidering the Dead Donor Rule: Is it Important that Organ Donors Be Dead?’, Kennedy Institute of Ethics Journal 14 (2004), pp. 249–260. The understanding of the DDR as presented is based on the work of Arnold and Youngner who credit Robertson as the first to have coined the term in 1988. It is an ethical rule directed at protecting vulnerable patients from being killed or exploited by doctors to further transplantation purposes. In its simplest formulation, it might be considered to have two distinct meanings. First, is the ethical injunction that patients shall not be killed by organ retrieval. This will seem to imply that patients shall not be killed for the purposes of organ retrieval, even if the organs are removed after their death has occurred. It is instructive to observe that this injunction appears consistent with most of our homicide laws (murder and manslaughter). Second is the moral proscription of taking organs from patients unless, and until, they are dead. This might be taken to mean that organs ought not to be retrieved from patients before they are actually dead even if removing the organs does not kill them. This would appear very relevant in cases of patients in penumbral states such as anencephaly, persistent or permanent vegetative and minimally conscious states. The practical implications of this prohibition may be wider than first suggested. It might in practice prohibit living donations even those involving
once circulation has ceased permanently, or ceased beyond the point that autoresuscitation occurs, then ‘whether the non-beating heart subsequently is left alone, removed and not restarted or removed and restarted in another patient is irrelevant to the circulatory status of the dead patient’ and that there is no evidence that autoresuscitation occurs after 65 s. Note that the cardiorespiratory criterion does not deny or reject the somatic criterion; rather it incorporates it into the redefinition of death.

The continuing search for a deeper understanding of the function of the human body led French neurosurgeons (Mollaret and Goulon) in 1959 to define, or rather redefine, death using cessation of brain, rather than cardiorespiratory function. But brain death or irreversible coma was to be formally defined in 1968 by the Ad Hoc Committee of the Harvard Medical School which was specifically set up to examine the definition of death. Death was defined as either the ‘irreversible cessation of circulatory and respiratory functions or the irreversible cessation of all functions of the entire brain, including the brain stem’. Critics have since mounted compelling evidence to show that patients in this state do not exhibit irreversible cessation of all functions of the entire brain and that some even continue to perform certain functions such as haemostasis, wounding healing, circulating blood, maintaining body temperature and gestating foetuses – functions not known to be performed by corpses. These criticisms led to the refinement of the whole-brain death concept to total brain failure. This notwithstanding, total brain failure is still vulnerable to the same criticisms levelled against whole-brain death.

paired organs such as kidneys or partial transplants of unpaired organs such as liver, lungs and pancreas or whole heart and lung transplants. In sum, the DDR ensures that patients are not killed by or for organ retrievals. For further details, see R.M. Arnold and S.J. Youngner, ‘The Dead Donor Rule: Should We Stretch it, Bend it, or Abandon it?’, *Kennedy Institute of Ethics Journal* 3 (1993), pp. 263–278.


Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Death, ‘A Definition of Irreversible Coma’, *Journal of the American Medical Association* 205 (1968), pp. 337–340; for details on claims that the contribution of others prior to the Harvard definition have not been properly acknowledged, see C. Machado, ‘The First Organ Transplant From a Brain-Dead Donor’, *Neurology* 64 (2005), pp. 1938–1942.


Some have accordingly argued that the concept of brain death is too flawed, does not fit into any ‘coherent biological or philosophical understanding of death’ and confuses the imminently dying with the dead. As such the Uniform Determination of Death Act (UDDA)’s requirement of ‘irreversibility’ of respiration, circulation or all functions of the entire brain are, at best, unacknowledged legal fictions. Consequently, a more credible alternative to the brain death criterion and DDR is to obtain organs based on the ethical principles of nonmaleficence and respect for persons.

Subsequently, the brain death criterion has, arguably, gained general acceptance among the medical and legal fraternities, especially in the developed world, even though some have remained sceptical about defining lifelessness without a requirement for the absence of cardiorespiratory function.

Generally, the points of departure have been around what brain death entails. Some have argued in support of the whole-brain death as the concept that provides the most satisfactory expression of our understanding of the concept of death of the human organism. Other commentators argue in support of death of higher brain functions (cognitive/personhood death) maintaining that ‘the moment of death is not a medical but a social decision that can vary as the times and technology change, and what is distinctly human about us is affect and cognition, not possible when the higher brain function has permanently vanished’. However, some contributors have shown that the loss of brainstem function is the distinctive and decisive factor in whole-brain death and that, for all intents and purposes, brainstem death is the ‘essential and sufficient component for the diagnosis of death’. In fact, the United Kingdom defines death as ‘the irreversible loss of the capacity for consciousness, combined with the irreversible loss of the capacity to breathe’ and argues that since irreversible cessation of brainstem function will produce this clinical state, the ‘irreversible cessation of the integrative functions of the brain-stem equates with death of the individual’. It is important to note here that

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67. Truog and Robinson, ‘Role of Brain Death and the dead-donor rule’, pp. 2391–2396. Interestingly, not all commentators who deny the legal and ethical coherence of the brain death criterion agree with the proposal by Truog and Robinson. For a fuller rejection of Truog and Robinson’s alternative policy, see Potts and Evans, ‘Does it matter that organ donors are not dead?’, pp. 406–409.
the new Academy of Medical Royal Colleges (AOMRC) guidelines, under certain conditions, treat the irreversible loss of circulation as a sufficient basis for determining brain death. This set of criteria used in defining death relative to the brain is referred to as neurological criteria.

To ground a diagnosis using *brainstem* criterion, the following clinical criteria must be fulfilled.

1. ‘Establishment of a specified condition which has led to irreversible brain damage.
2. Exclusion of potentially reversible causes of coma and apnoea.
3. Absence of brain-stem reflexes’.
4. Exclusion of confounding factors such as potentially reversible causes of the coma and apnoea (for example depressant drugs, electrolyte, metabolic, endocrine or circulatory abnormalities).

Diagnosing death using neurological criteria is not entirely new. It has been used internationally over the last four decades. Gardiner and colleagues demonstrate that diagnosing death using *brainstem* death is safe. They do so by arguing that an observation of the estimated 10,000 confirmed diagnoses of death using the *brainstem* criterion in the United Kingdom alone over the last decade, in addition to the numerous patients (particularly in countries like Japan) being maintained on mechanical ventilation for prolonged periods after satisfying neurological criteria for death show that none has regained brain function. Interestingly, not even the most ardent critics of brain death deny this claim.

The greatest attraction for the *brainstem* criterion for the diagnosis and confirmation of death is that it is physician-led, simple, practical and not constrained by biotechnology.

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73. AOMRCs, ‘Code of Practice’. I wish to thank reviewer 1 for this point.
74. Bosnell and Madder, ‘Brain Death’, pp. 289–294. I use this article because it captures, in my opinion, the essentials of the United Kingdom’s criteria and guidance and also because of its brevity and clarity.
77. Truog and Robinson, ‘Role of Brain Death and the Dead-Donor Rule’, pp. 2391–2396, particularly at p. 2392.
78. The clinical tests for confirmation of brainstem death are generally aimed at eliciting six cranial nerve functions. This is because the cranial nerve nuclei, with the exception of cranial nerves I, II and the spinal component of XI, are located in the brainstem. For a positive test result, the clinician must demonstrate that the following cranial nerve reflexes are absent: (1) pupils should be fixed in diameter and unresponsive to light mediated by cranial nerves II and III but the clinician must exclude certain drugs, or globe or craniofacial trauma, (2) nystagmus or any eye movement should not occur when each ear is instilled with ice cold mater mediated by cranial nerves III, IV, VI and VIII but must exclude a blocked external auditory meatus, certain drugs, pre-existing vestibular disease and base of skull fracture, (3) there should be no corneal reflex mediated by cranial
Also, a comparison of the diagnostic criteria of countries that recognize whole-brain death, such as the United States and Australia, shows that a clinical examination is also required for the diagnosis and that confirmatory tests are obligatory. This shows that whilst the differences between brainstem and whole-brain concepts may be significant in theory, these are less apparent in practice. Nonetheless, brainstem death remains an ‘emotive subject’ because lay people continue to have difficulty coming to terms with the fact that a warm, perfused body can be said to be dead.

It is worth noting that the use of neurological criteria in the determination and confirmation of death does not deny or reject the cardiorespiratory criteria. They are merely a means of diagnosing death early with precision and where any doubt remains a reversion to the older criteria is not disapproved off. Paradoxically, the monumental scientific and biotechnological advancements made over time have done little to ease our fear of misdiagnosis of death and in many ways may have actually compounded the problem. Finally, as demonstrated above, even though our understanding and the criteria we use for the diagnosis of death may have both evolved over time, ‘our duty remains the same, to make timely diagnosis of death whilst avoiding any diagnostic errors; an obligation medical professionals cannot and should not abdicate’.

Unfortunately, critics of brain death maintain that it is morally troubling to retrieve organs from individuals whose hearts and lungs might still be functioning. Tännsjö claims that it may be proper to admit a dualism in our criteria for defining death: one criterion for somatic death and another for personhood (cognitive) death. Indubitably, even though ‘irreversible loss of consciousness and the irreversible loss of spontaneous respiration are each individually necessary for death, neither is sufficient on its own.’

nerves V and VII, (4) there should be no facial or limb movement when supraorbital pressure is applied mediated by cranial nerves V and VII but must exclude certain drugs, locked-in syndrome or trauma to the cervical spine and there should be no gag reflex following stimulation to the posterior pharynx or cough reflex following suction catheter passed into the trachea mediated by cranial nerves IX and X but must exclude certain drugs, post-hyperventilation apnoea and trauma to the cervical spine. It must be noted that confirmatory or supplementary or ancillary tests are not required. The representation here adopted from the works of Gardiner and colleagues; Gardiner et al. ‘Diagnosis of Death’, p. i20, table 6 and supplemented by the work of Bosnell and Madder; Bosnell and Madder, ‘Brain Death’, p. 289–294, at 292 particularly table1.

81. Richards, ‘Ethics of Transplants’, p. 221.
Many may be apprehensive if the dualist argument were to succeed. Dualism in the definition of death might seem unwarranted. This is because admitting two separate definitions will complicate rather than clarify matters. It will most likely leave the public and health professionals confused as to what death is, when dead is dead and whether and when DDR will apply. It will make it even more difficult to defend against claims that changes in the definitions of death are solely to serve transplantation purposes and might lead to a real likelihood of public opprobrium and disapproval. These uncertainties may in combination act to undermine the whole transplantation enterprise. The point is strongly (and I think rightly) made that whatever our conception of death is, it would seem more pragmatic to consider ‘the brain, the heart and the lungs as forming a “cycle of life” which can be broken at any point; looked at in this way, there is no need to speak of two types of death . . . it is simply that different criteria, and different tests, can be used for identifying that the cycle has been broken’.86

What the above developments demonstrate is the need for a readiness to adjust our criteria or tests for establishing death in light of developments and progress in science and medicine. Conceivably, altering our diagnostic methods or criteria need not, and must not, diminish our duty not to misdiagnose death.87

As has been shown, brain death is widely accepted, but there is no unanimity as to whether it ought to be whole-brain (total brain failure) or brainstem death. Nonetheless, a critical analysis of the criteria for determination of brain death shows that despite the international divide on whole-brain and brainstem death concepts, the criteria used to determine and confirm death are identical around the world and are essentially clinical. This is crucial in the context of Ghana because biotechnology being generally expensive is not readily accessible even in tertiary healthcare institutions due to resource constraints. Under those circumstances, the utility of a brain death criterion that is less dependent on biotechnology, but nonetheless remains robust, cannot be overstated. Countries such as Ghana should therefore take a cue from the United Kingdom and adopt the brainstem death criterion. This must however be done taking cognizance of the socio-legal context of the country.88

**Are the changes merely to suit transplantation purposes?**

It has been argued that brain death does not equate to biological death and its acceptance as law, especially in the United States, was motivated by the desire to retrieve vital organs for transplantation occasioning an egregious moral wrong which is an affront to the DDR.89 Giacomini claims that neither biotechnological progress, nor the age-old uncertainty over the definition of death, constituted enough grounds to trigger the

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need for the redefinition of death.\textsuperscript{90} This, he argues, is because at the time that brain death was defined electroencephalography was still in its embryonic stage of development and was ‘neither necessary nor sufficient diagnostic evidence for redefining death’\textsuperscript{91} yet it was presented as one of the reasons informing the change in definition. Furthermore, as discussed above, it is argued, quite legitimately, that the UDDA in its current form relies on unacknowledged legal fictions for the sole purpose of advancing transplant interests and therefore lacks transparency.\textsuperscript{92}

But has the picture been accurately and fairly painted? I will argue presently that it has not. On the contrary, the brain death concept did not evolve solely to benefit organ transplantation as claimed because a careful examination of the ‘historical approach to this issue will demonstrate that both had an entirely separate origin’.\textsuperscript{93} As has been shown above, a number of advancements in biotechnology and medicine enhanced our understanding and evaluation of the functioning of the human body. At the same time, there was a parallel development in immunology which revolutionized transplantation surgery from the 1960s. Whilst organ transplantation is attributable to advances in immunology and surgery, the need for the definition (redefinition) of death is due to advancement in the use of biotechnology in intensive care medicine.\textsuperscript{94} This viewpoint is shared by some commentators opposed to the brain death criterion.\textsuperscript{95} Plausibly, then, if organ transplantation had not developed, it could not have been the basis (sole or otherwise) for the redefinition of death as opponents argue. Furthermore, it is arguable whether, if organ transplantation ceased today, concerns around the definition of death would become moot. It is claimed that if and when substitutes to the use of human organs for transplantation become a reality, the concept of brain death will disappear.\textsuperscript{96} This appears to be an interesting proposition indeed. If we admit that developments in immunology and intensive care medicine created problems for the traditional notion of death, then the leap to the conclusion that if the use of deceased organs in transplantation ceased the concept of brain death will disappear is one which is at best speculative. As argued above, historical facts show that even when the somatic and cardiorespiratory criteria were in use, uncertainty around death characterized by the fear of premature burial remained a societal concern.

Admittedly, though the influence of advances in biotechnology on the bioethical discourse around the definition, determination and confirmation of death is palpable, this is

\begin{thebibliography}{99}
\bibitem{91} Giacomini, Redefinition of Death in 1968, p. 1478.
\bibitem{94} C. Machado, ‘A Definition of Human Death Should not be Related to Organ Transplants’, \textit{Journal of Medical Ethics} 29 (2003), pp. 201–203.
\bibitem{95} Shah and Miller, ‘Can We Handle the Truth?’, pp. 540–585 at p. 569; Truog and Robinson, ‘Role of Brain Death and the Dead-Donor Rule’, pp. 2391–2396.
\bibitem{96} Truog and Robinson, ‘Role of Brain Death and the Dead-Donor Rule’, pp. 2391–239, p. 2395.
\end{thebibliography}
not because biotechnology per se has altered our traditional notion(s) of the definitions of life and death. Instead, as Bernat notes, ‘technology has generated cases that previously were impossible – cases that have made us aware of definitional ambiguities of which we had been previously unaware and have forced us to make distinctions and clarifications’. Whilst I acknowledge that developments in biotechnology and medicine made it necessary to reconsider what death is, it is equally undeniable that ‘a significant trigger to rethink our definition of death was the development of transplantation, which highlighted the need for speed in diagnosing death and removing organs from the body’.

Conceivably, different conceptions of death may ‘inflect the way that the human body becomes an object of biomedical attention and management’ not least in the context of organ donation and transplantation. However, as has been argued, the development of the diagnosis and confirmation of brainstem death evolved independently to organ transplantation. Interestingly, no motive is ascribed to the change in definition of death from the somatic to cardiorespiratory criterion. It is my contention that the advances in biotechnology and medicine are the sufficient factors that have accounted for the changes in the definition of death. Transplantation surgery however became a key beneficiary of this scientific progress and society is the better for this coincidence of developments.

**A statutory definition of death?**

Unquestionably, countries (such as Ghana) trying to establish transplantation programmes must not only deal with the definition of death as currently understood by medicine but also determine whether such a definition should be enshrined in statute or left to the courts to develop in common law jurisdictions. Capron and Kass argue in support of a statutory definition of death and claim that a statutory definition will bring uniformity and serve as the best way to balance the conflicting needs for clarity, precision, flexibility, public involvement and scientific accuracy in the definition of death. As a result, there is the need for a debate about regulation as this will provide a unique opportunity for the public to get involved and educated on the subject matter; express their views on troubling cases such as the use of anencephalic infants, Permanent Vegetative State or Minimally Conscious State patients as organ donors and discuss issues of post-mortem pregnancies. It has therefore been argued that a good statutory definition will be one that accommodates the informed preference of the public as the dominant factor in determining what, essentially, is an issue of choice for society. Arguably, all these

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factors seem to have operated to make the public ‘unwilling to surrender control of such matters lightly to the medical profession’.  

The US experience

In the United States, the statute recognizes whole-brain death as the legal standard for the determination and confirmation of death. Total brain death is now established at law in all the 50 states in the United States, but two states (New York and New Jersey) have ‘specific laws or regulations in place to accommodate persons who object to declarations of death grounded in neurological criteria on religious grounds’. The ethic-legal challenges presented by advancements in biotechnology were brought to the fore in the United States in the case of In re Quinlan. This tragic case involved 22-year-old Karen Quinlan who, under unclear circumstances, reportedly ceased breathing. Resuscitative measures proved ineffective and neurological tests conducted later by medical experts confirmed that she was in a chronic and persistent vegetative state and ventilator-dependent rather than brain dead. The case involved issues of definition of death, the prolongation of life using medical technology hitherto undreamed of and its impact on the rights of the incapacitated patient, her family and society and the bearing of these on the constitutional right and scope of judicial responsibility among others. However, for the purposes of this article, I limit the considerations to the definition of death. The father, a devout Catholic, sought the termination of the life support measures sustaining the daughter which he considered to be extraordinary measures. The medical and neurological experts were certain that, according to the Ad Hoc Committee of Harvard Medical School’s criteria, Karen was not brain dead. The case was considered to be significant because, as the court observed:

... the determination of the fact and time of death in past years of medical science was keyed to the action of heart and blood circulation, in turn dependent upon pulmonary activity, and hence cessation of these functions spelled out the reality of death. Developments in medical technology have obfuscated the use of the traditional definition of death.

The hospital treating her sought a declaratory judgment on whether using the neurological criteria developed by the Ad Hoc Committee of Harvard, as well as similar

criteria to determine the death of an individual whose cardiopulmonary functions are artificially sustained, is in accordance with ordinary and standard medical practice. The New Jersey Supreme Court upheld the decision of the trial court that Karen was not brain dead. It is instructive to note that, in reaching its decision, the court stated that medical obligation is related to the standards and practice prevailing in the profession. Further, the court stated that there was also a nondelegable judicial responsibility to settle such matters. Accordingly, the courts must respond to the challenges that these cases raise.

The Supreme Court of Washington in the case of re Bowman is one example. Here Matthew Bowman, aged 5, was hospitalized in September 1979, as a result of severe injuries inflicted on him by a nonfamily member. He was subsequently declared brain dead by the attending physician and thus medically dead. The hospital sought to withdraw his life-support, but the Department of Social and Health Services acting as his guardian (because his parents could not be traced at that time) petitioned the court of first instance, challenging the decision of the hospital. It must be noted that the state of Washington did not have a statutory definition of death at the time. The trial court held that ‘the legal definition of death ... must coincide with the prevailing medical opinion. Since the prevailing medical opinion recognizes that a person dies when irreversible loss of brain function occurs, the irreversible cessation of brain activity constitutes death under Washington law’.

The petitioners appealed to the Supreme Court of Washington. The issues that fell for determination were (1) whether law or medicine should define the standards establishing when death occurs, (2) if law is to define those standards, should the brain death standard be adopted and (3) if the standard is adopted, what role should medicine have in defining the criteria for determining whether the standard has been met. The Supreme Court asserted that as a matter of law, death could be determined using either cessation of cardiopulmonary function or irreversible cessation of total brain function including the brainstem and this ought to be determined in accordance with accepted medical standards. The Court went further to state that this standard reflects both the former common law standard and the changes in biotechnology.

Some commentators have, however, argued that the court’s adoption of dual standards in the Bowman case and its failure to articulate guidelines, or recognize either of the two criteria that had allowed death to be determined by case law, constituted substantial defects in the court’s decision. Pamela Ryan argues that judicial decisions may not bring certainty and clarity to the determination of death and provide little or no guidance for doctors acting in different contexts. Accordingly, she argues that in order ‘to achieve uniform treatments by the states, a determination of death standard

111. 94 Wn.2d 407, 617 P.2d 731 (1980) at 421.
applicable for all purposes requires statutory enactment rather than judicial adoption’, 113 and that the UDDA 1981114 passed in the United States is an effective example.

Interestingly, the problems with statutory law were made manifest in the case of Barber v. Superior Court115 where two physicians were charged with murder and conspiracy to murder after discontinuing the treatment of a severely brain damaged 55-year-old man (Clarence Herbert) at the request of the deceased’s family when there was virtually no chance for recovery. It is argued that the Barber prosecution arose as a result of the gap between statutory law (in this case criminal law) and recent developments in biotechnology.116 These unsettling events added to the urgency for legislative reforms in many States in the United States. These cases highlighted the fact that though medicine through biotechnology had developed new techniques for irreversible cessation of brain function whilst cardiopulmonary support is given, it was uncertain whether these were recognizable at law.117 The goal of the UDDA was, therefore, to extend ‘the common law to include the new techniques for the determination of death’.118

Some have remained unconvinced of the propriety of courts venturing into making clinical decisions about life-and-death which they consider to lie in the medical rather than legal realm.119 As such, it is not surprising that Section 1 of the UDDA sought to assure the medical community of its professional independence by providing that the determination of death must be made in accordance with accepted practice. Nonetheless, Ryan argues that ‘by providing that accepted medical standards regulate determinations of death, the UDDA reconciles the need for cognizable legal and medical standards with the need for adaptability to scientific changes’.120 This argument has some bite. Conceivably, biotechnology will continue to improve and by leaving the fine details of what tests to apply in diagnosing death to be determined by doctors, the UDDA contains the

114. Uniform Determination of Death Act (UDDA) adopted by all states in the United States following its recommendation by the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.
116. M.S. Lingerfeldt, ‘The Current State of Termination of Medical Treatment Case Law’, Nova Law Journal 9 (1984–1985), pp. 159–182, at 170. Mr Herbert’s death occurred on 6 September 1981 as such it was Section 7180 of the 1981 Health and Safety Code of California that was in force since the UDDA was yet to be adopted in California. This code though different from the UDDA recognized brain death. However, Mr Herbert was not brain dead; rather the issue bordered on whether intentionally withdrawing treatment from a patient in a vegetative state was unlawful or criminal under existing law.
flexibility to accommodate changes in medical knowledge and biotechnology. For example, the usefulness of having a statutory definition came to the fore in the case of Strachan and Another v. John F. Kennedy Memorial Hospital. The plaintiffs, the parents of the deceased, a suicide victim, brought an action against the hospital and its administrator and attending physicians alleging the tort of outrage and holding them responsible for inappropriate handling of a dead body after the hospital failed to release the body of their son following an assessment and a determination by the medical doctors that he was brain dead. The Supreme Court of New Jersey held that according to the UDDA, the suicide victim was dead and that the hospital negligently withheld the dead body of the victim from his parents, causing them emotional distress.

Nonetheless, a statutory definition remains vulnerable to challenge in other respects. First, since the specific criteria and tests (confirmatory or ancillary) are discretionary, it is entirely possible that doctors in different states or even different hospitals in the same state may employ different sets of tests to achieve the same ends. It is not implausible then that under such circumstances different sets of tests might produce the odd situation where a patient in the same position may be deemed brain dead in one state or hospital and not so in another, rendering the uniformity sought under the UDDA illusory. It might be countered that the medical profession will be trusted to cure any such mischief by defining uniform criteria and tests for determining that death has occurred as anticipated under Section 1 of the UDDA. But the fact that non-uniformity can happen indicates decisively that a statutory definition is not the panacea after all. This state of affairs is confirmed by research findings that policies around death in the United States are still ‘remarkably heterogeneous, even amongst some of the nation’s most vaunted medical institutions’. A similar finding was made by Eun-Kyoung Choi and colleagues who observed that though there is reasonable legal uniformity in the United States on brain death, clinical standards are various. As a result, there is the urgent need for a unified national standard for minimum clinical and procedural requirements for determining brain death. The problems inherent in a statute are exemplified by the amendment to the New Jersey Declaration of Death Act and Administrative Code. It was argued that the ‘adoption and periodic revision of regulations that dictate the clinical diagnosis of brain death are unusual, unnecessary and, in fact, impede the clinical practice of brain death declaration’. It might be countered that the concern of heterogeneity of practices

121. 538 A.2d 346 (N. J. 1988).
or the inability of statutory law to keep pace with fast moving developments in biotechnology and medicine may be ameliorated by (1) better coordination at the governmental levels (e.g. Federal level in the United States) or (2) delegated authority to make amendments by way of regulations.\textsuperscript{128} However, as experience in the United States has shown, these have had limited success. In fact, the New Jersey Law Revision Commission was persuaded by the arguments of the New Jersey Hospital Association and the State Board of Medical Examiners ‘that regulations setting forth medical standards to govern declarations of death by neurological criteria do not and cannot keep up with the clinical practice’ and may even delay brain death determination.\textsuperscript{129} More importantly, the fact that the definition of death has been modified from whole-brain death to total brain failure following further scientific evidence\textsuperscript{130} reaffirms the viewpoint that having a statutory definition may provide certainty in the short term but this may be at the expense of reflexivity and responsiveness – essential ingredients of regulating biotechnology.\textsuperscript{131}

Finally, the 2013 cases of \textit{Marlise Muñoz} and \textit{Jahi McMath}\textsuperscript{132} both in the United States where death is statutorily defined show that a statutory definition does not guarantee certainty. \textit{Marlise} was aged 33 and pregnant but was declared brain dead following a suspected pulmonary embolism. Her husband sought to honour her wishes by requesting that she be removed from the ventilator. The Texas hospital refused, arguing that under the Texas Advance Directives Act (TADA) life-sustaining treatment could not be withheld or withdrawn from a pregnant patient. The husband then sued the hospital and successfully argued that the TADA had no application to brain dead individuals. \textit{Jahi} was aged 13 when she was pronounced brain dead by a California hospital following an adeno-tonsillectomy. The hospital sought to remove the ventilator, but her family objected and won a temporary restraining order preventing the hospital from discontinuing life-support treatment. The family later negotiated her transfer to an undisclosed location presumably for further treatment. As both \textit{Jahi} and \textit{Marlise} were deceased, it ought to have been clear that neither should have been the subject of treatment. The fact that both these cases occurred in states where brain death is statutorily defined demonstrates that statutory definition does not necessarily remove the social, cultural, ethical, legal and emotional uncertainties associated with brain death.\textsuperscript{133}

\begin{footnotes}
\item[128] I wish to thank one of the reviewers of this article for this point.
\item[130] Shah and Miller, ‘Can We Handle the Truth?’, pp. 540–585.
\item[132] For more information on these two cases, see \textit{The Bioethics Program; Introducing an Online Symposium on the Munoz and McMath Cases} posted by Michelle N. Meyer, Union Graduate College – Icahn School of Medicine at Mount Sinai Bioethics Program; available at: http://thebioethicsprogram.wordpress/2014 (accessed 27 January 2014).
\end{footnotes}
The UK experience

The United Kingdom has had its fair share of the challenges in respect of the disconnect between the law and developments in medical technology. However, its approach to dealing with the ethico-legal concerns raised by biotechnology has been different. Unlike the United States, the United Kingdom has no statutory definition of death; rather the definition of death is firmly established by the courts through judicial precedent. The brainstem criterion for death is the legally accepted standard of determining death. The position of the law was laid in the case of Re A.134 The case involved a minor, A, who suffered severe head injuries which the doctors concerned with his care agreed, rendered him brainstem dead. The family was however opposed to the switching off of the ventilator, necessitating the instant suit. Johnson held that the court ‘had jurisdiction to make . . . a declaration that the child was dead’ and that turning off the ventilator would not be unlawful. This position of the law was later confirmed by the House of Lords in the case of Airedale NHS Trust v. Bland.135 Acknowledging the rapid pace of biotechnological advancements in medicine, the United Kingdom relies on policy guidance from the Academy of Medical Royal Colleges136 which publishes the professionally accepted standard criteria and tests for determining death and the courts uphold their authoritative-ness.137 The lesson, it is argued, is that ‘the normal organs of legal regulation often appear powerless in the face of new technology’.138 In respect of biotechnology, a ‘good’139 and effective regulatory tool must be inherently malleable due to its rapidly changing and unpredictable nature. As a result, this invites a move away from the traditional ‘command and control’ or rule-based regulatory approach (without discussing regulatory theories and strategies in this article) to a more sophisticated approach such as principles-based regulation which is both ‘reflective and facilitative of the process of scientific innovation’140 even though its own shortcomings and paradoxes are well acknowledged.141 The attitude of the actors in both jurisdictions is worth commenting


136. It is important to note that it is the AOMRCs, rather than the GMC, that issue guidance on these matters.
139. Even though I do not go into regulatory theory here, it is nonetheless important to point out that what amounts to and/or counts as good regulation is itself a matter of controversy. For further and better considerations of good regulation, see R. Baldwin, M. Cave and M. Lodge, Understanding Regulation: Theory, Strategy, and Practice (Oxford: Oxford University Press, 2nd edition, 2011), pp. 25–39.
141. For a very detailed account of PBR as a regulatory tool, its strengths, weaknesses, paradoxes as well as its rise, fall and fate see the works of Julia Black: ‘Forms and paradoxes of principles-based regulation’ Capital Markets Law Journal 3 (2008), pp.
on. Whilst in the United States there was, for unexplained reasons, almost an immediate
groundswell of opinion that the common law was somehow incapable of responding to
the emerging ethico-legal issues presented by new medical technology, there was no
such apprehension in the United Kingdom. Rather, the actors in the United Kingdom
were more trusting that the judges, guided by responsible medical opinion, could resolve
any concerns.

The attractiveness of the United Kingdom’s position is that it takes advantage of the
inherent flexibility in common law that enables the law to deal with novel situations
without creating a vacuum. Consequently, a proactive judiciary in the United Kingdom
has through case law ‘introduced certainty into the debate’, 142 making a case for statu-
tory intervention less compelling today. Additionally, since all doctors practising in the
United Kingdom are expected to be guided by responsible professional opinions as set
out in guidance by the medical colleges, the fear of heterogeneous criteria and tests is
ameliorated. Further, medical innovation and expertise ‘alter and do so faster than can
the law’. 143 It is, therefore, both necessary and desirable to keep the definition of death
as a clinical/judicial matter, changes in which can easily be ‘accommodated within the
law without any requirement for further legislation’. 144 The merit here is that the need to
continually change statutes and or their legislative instruments to accommodate changes
in clinical practice, which is a time-consuming and costly exercise, is removed.

In consonance with the practice in the United Kingdom, the Ghana College of Phy-
sicians and Surgeons should develop a code of practice as a guide to clinicians for diag-
nosing and confirming death and it is expected that the Ghanaian judiciary would, like
their English counterparts, uphold its authoritativeness. This approach is particularly sui-
ted for the Ghanaian context because of the absence of effective and efficient institu-
tions, expertise, logistics and resources to effect legislative changes timeously. The
mode of exercising the law-making powers of the Ghanaian Parliament is set out in Arti-
cle 106 of the Constitution of the Republic of Ghana. However, translating these into
practice can be a daunting task. For example, the author has, since 2008, been part of
a number of legislative reforms in the MoH/GHS and the practical constraints make con-
sideration of a judicial definition of death in the Ghanaian context imperative. 145 Addi-
tionally, the constitutional requirement for the recognition and adoption of customary
rules of law as part of the common law of Ghana calls for a definitional approach that

425–457; ‘The Rise, Fall and Fate of Principles Based Regulation’, LSE Law, Society Econ-
omy Working Papers 17/2010, last accessed on 05 March 2013 and ‘Making a success of
145. The repeal of a number of healthcare regulations proved to be an extremely challenging
exercise. It took at least 12 years to pass the Mental Health Act, 2012, (Act 846); about
eight years to pass the Health Institutions and Facilities Act, 2011, (Act 829) and 10
years to pass the Public Health Act, 2012 (Act 851). Furthermore, the legislative
instrument to operationalize key aspects of the Ghana Health Service and Teaching
Hospitals Act, 1998, (Act 525) has since not been passed.
is inherently flexible to accommodate the nuances of custom. A statutory definition lacks the required malleability. As demonstrated, countries with relatively well developed institutions and where statutory definition was adopted, such as the United States, acknowledge the practical challenges associated with a statutory definition. Consequently, developing countries such as Ghana must be aware of these challenges when considering the nature of the role that law ought to play in the definition of death and are thus encouraged to decline any invitation to define death through statute.

Transplantation, defining death and Ghana: concluding remarks

This article has examined efforts being made by Ghana to make organ transplantation a routine surgical procedure. Some reflections on the Ghanaian socio-legal context and how these may inform the policy dialogue going forward have been considered. If Ghana is to succeed in its efforts, then some of the issues that ought to be addressed by policymakers must necessarily include an appropriate governance structure that is fit for purpose. To this end, the following ought to engage the attention of the framers of any potential legislation. First, the policy/regulatory framework ought to be forward looking and must go beyond the current restricted practice of kidney transplantation using organs from living related donors to a comprehensive transplantation programme reliant on all other ethically defensible sources. Second, Ghana should, in addition to the cardiorespiratory criterion, formally adopt brainstem death because it meets the ethical, clinical and legal standards of defining death and is more applicable in the context of Ghana because it is less dependent on technology for its confirmation. Further, it is hoped that the definition of death and issuance of clear policy guidelines on death will help lessen any societal anxiety around death and organ retrievals. However, in so doing, the legal/policy framework must be informed by and sensitive to the relevant sociocultural considerations if the transplantation governance structures are to gain social legitimacy.

In conclusion, there is cross-cultural variation in the conception and construction of death. This might be due in part to the fact that ‘death evades an immutable objective definition and instead is understood in subjective terms that are culturally and historically regulated’.

Socially, as demonstrated, in both Western and Ghanaian sociocultural contexts, the theory of posthumous identity renegotiation has some purchase. Family members may donate the organs of a loved one in order to renegotiate or rehabilitate their identity posthumously or the artist whose artwork is discovered posthumously may have his or her identity renegotiated favourably. This culturally mediated variation in the conception of death has in the 20th century been further compounded by biotechnology. In the specific case of Ghana, I have argued that the nature of the role of the law in defining death should be through case law as in the United Kingdom. The pluralism of values in Ghana and the recognition of customary law by the Ghanaian socio-legal context make this imperative.

146. Whetstine, ‘Definition(s) of Death’.
What appears incontrovertible though is the fact that concerns over death will remain with us. After all, ‘the brutal reality may be that, however death is defined, and whether such a definition is enshrined in statute or not, diagnosing death will always be a matter of concern’\textsuperscript{148} because death remains an unsettling facet of our common humanity. It is my hope that this discussion will form the basis for constructive debate by bioethicists, legal experts, theologians, healthcare professionals and policymakers in our quest towards the development of organ donation and transplantation governance structures that are more context-appropriate, especially in emerging economies such as Ghana.

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\textsuperscript{148} Brazier and Cave, ‘Medicine, Patients and the Law’, p. 500.
APPENDIX 2

Posthumous Organ Retention and Use in Ghana: Regulating Individual, Familial and Societal Interests

Description of reprinted material

Posthumous Organ Retention and Use in Ghana: Regulating Individual, Familial and Societal Interests

Published as:


Abstract

The question of whether individuals retain interests or can be harmed after death is highly contentious, particularly within the context of deceased organ retrieval, retention and use. This paper argues that posthumous interests and/or harms can and do exist in the Konkomba (and wider Ghanaian) traditional setting through the concept of ancestorship, a reputational concept of immense cultural and existential significance in this setting. I adopt Joel Feinberg’s account of harms as a setback to interests. The paper argues that a socio-culturally sensitive regulatory framework does not necessarily exclude the donation of (deceased) human biomaterials for transplant and science research. Indeed, when customary values are explored with open-
mindedness and sensitivity it may be shown that such donation can form part of the important
customs of some communities in this jurisdiction. Accordingly, a context-appropriate
governance framework could utilise the cultural value of ancestorship as an incentive to
courage organ donation in the Ghanaian traditional setting.
Posthumous Organ Retention and Use in Ghana:
Regulating Individual, Familial and Societal Interests

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Abstract  The question of whether individuals retain interests or can be harmed after death is highly contentious, particularly within the context of deceased organ retrieval, retention and use. This paper argues that posthumous interests and/or harms can and do exist in the Konkomba (and wider Ghanaian) traditional setting through the concept of ancestorship, a reputational concept of immense cultural and existential significance in this setting. I adopt Joel Feinberg’s account of harms as a setback to interests. The paper argues that a socio-culturally sensitive regulatory framework does not necessarily exclude the donation of (deceased) human biomaterials for transplant and science research. Indeed, when customary values are explored with open-mindedness and sensitivity it may be shown that such donation can form part of the important customs of some communities in this jurisdiction. Accordingly, a context-appropriate governance framework could utilise the cultural value of ancestorship as an incentive to encourage organ donation in the Ghanaian traditional setting.

Keywords  Ancestors · Deceased organ donation · Consent · Family · Ghana · Posthumous harms · Posthumous interests · Regulation

Abbreviations
HTA Human Tissue Act
GMC General Medical Council
HRA Human Rights Act
GHS Ghana Health Service

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Introduction

This article argues through the concept of ancestorship that posthumous interests and/or harms can and do exist in the Ghanaian socio-cultural setting. It sets the scene by showing some legitimate concerns that belie the current law and practice of the retention and use of human biomaterials in Ghana. It then examines, through a brief account, the debates that followed the organ retention scandals in Bristol and Alder Hey in the UK with particular reference to the interests of the deceased, society and the family and suggests that similar organ retention ills in Ghana give rise to the need to learn from the UK experience and proactively address them.

In order to facilitate the understanding of the contextual issues, the paper provides a brief account of the Ghanaian socio-legal environment and its respect for family and cultural rights in Sect. 4. Feinberg’s account of harms as a setback to interests is then adopted in Sect. 5. This allows us to establish the contentious nature of the notion of posthumous interests and harms, and show that most protagonists in the debate do not deny the moral defensibility of respecting the reputations and wishes of dead people.

Ancestorship is a reputational issue of great cultural and existential importance in the Ghanaian socio-cultural setting. As such it imposes a unique obligation on families at custom that cannot cavalierly be dismissed as non-person affecting and may pose a challenge to conscription of deceased organs in that socio-legal context. However, crafting a socio-culturally sensitive regulatory framework does not necessarily preclude the donation of (deceased) human biomaterials for transplant and science research. Indeed, when the contextual issues are explored with open-mindedness and sensitivity it can be shown that such donation can form part of the important customs of some communities in this jurisdiction. Accordingly, the article argues that a regulatory framework which is sensitive to socio-cultural issues could utilise the value of ancestorship as an incentive to encourage organ donation in the Konkomba1 (and wider Ghanaian) traditional setting.

It is necessary first to show that the current practices surrounding the retention and use of human biomaterials in Ghana, particularly following pathological services, give rise to some legitimate concerns. These will next engage our attention.

Current Law and Practice in Organ Retrieval, Retention and Use in Ghana2

Human organs and tissues are routinely retained for varying lengths of time without the appropriate or required consent in Ghana.3 These collections comprise various

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1 The Konkomba are the second largest ethnic group in the Northern Region of Ghana. Their beliefs mirror the beliefs of almost all other ethnic groups in Ghana. As a result, the arguments, inferences and conclusions in this paper have a huge potential for generalisation.

2 These matters came to my attention when I held discussions with the head of department of pathology at the Korle bu teaching hospital in Accra. It is the premiere referral facility in Ghana. The discussions were in respect of concerns from amongst the doctors about the need to assist them develop the appropriate frameworks (ethical and legal) to guide their practice. Further, I have personal knowledge of some of these matters because I worked in Korle bu teaching hospital from 2003 to 2008 (not much has changed since then) and by virtue of my position as founding head of the medico-legal unit of the GHS.

3 See Sects. 2, 3, 4, 5 and 12 of [1].
surgical specimens, tissue samples and blocks, whole organs or various parts of the body (from both living and deceased providers). Most of these are preserved in pots and kept in the museums of medical schools for the purposes of medical education and research. Others are retained, sometimes for indefinite periods, following coronial investigations. There is no formal legal or professional framework for securing the requisite consent for the retention of organs/tissues and body parts following autopsies. According to the head of the pathology department of the premier hospital in Ghana, surgical specimens are kept for up to six (6) weeks before they are discarded while specimens of cancers are retained for much longer or indeterminate periods.4

There are two forms of post-mortems in Ghana. These are coronial autopsies and hospital or consent autopsies. Coronial autopsies are required by law to be carried out when a cause of death is unknown, unexplained, or suspicious [9].5 Though the Coroners Act [9] permits autopsies without the specific consent of either the dead or their families, it does not give express authorisation for the retention of body parts after coronial investigations have ended. Also, the Anatomy Act [1] regulates the examination and dissection of dead bodies and provides for related matters. However, it is section 9 that permits deceased organ retention by the head of a medical school or institution but subject to two conditions; (1) the retention being in the interests of science; and (2) the consent of the relevant competent authority. Section 9 (2) defines competent authority to mean;

the executor or other party having lawful possession of the body of the deceased and the surviving wife or husband of that individual and, in the absence of such wife or husband, any known relative of the deceased falling within such class of relatives of that individual as may be prescribed [1].

Unfortunately, a legislative instrument to prescribe and rank the class of relatives was never promulgated. This omission is vitally relevant within the context of obtaining deceased organs for transplantation particularly in relation to posthumous interests and rights. In Ghana, for the purposes of inheritance, there are two main systems of heritage- patrilineal and matrilineal.6 Understanding how these

4 See note 2 above.
5 Specifically Sect. 2 of [9]. For the role of other professionals such as social workers in rendering support services to bereaved families under these circumstances kindly see [13].
6 See the section 15 (First Schedule) Civil Liability Act, 1963 (Act 176). For patrilineal inheritance family member means (1) mother and father, (2) wife, son and daughter, (3) brother and sister, and (4) father’s brother. For the matrilineal system family means (1) mother and father, (2) wife, son and daughter, (3) brother and sister, (4) mother’s mother, (v) mother’s sister, and (6) sister’s son, sister’s daughter, and mother’s sister’s daughter. This will seem to suggest some hierarchy even though this is not explicitly stated in the Act. Importantly, the careful observer will note that both lists exclude the husband. The explanation might be that this reflects the customary norm where husbands are generally expected to be the breadwinners for the family. A husband could therefore not qualify as a dependent under the estate of the spouse. This state of affairs has changed quite significantly since the coming into force of the 1992 Constitution. Spousal rights are provided for under article 22 and it can be inferred with a high level of confidence that any attempt to exclude the husband this way may be unconstitutional when articles 1 (2) and 2 (1) (a) and (b) are read together. Furthermore, under Ghanaian customary law a spouse is not considered part of the customary family of his or her partner and this might have a direct consequence for decision-making around deceased organ donation. I explore Ghanaian customary law in relation to interests/rights in deceased human bodies in detail elsewhere. The Konkomba run a patrilineal system of inheritance.
inheritance systems work in the Ghanaian traditional context will inform how competing post-mortem interests and rights might be balanced in a socio-culturally sensitive legal framework governing organ retention.

Hospital autopsies, on the other hand, are only conducted with the prior consent of the deceased’s family when doctors determine that doing so will help to understand and/or explain a medical condition or advance medical knowledge, research or education. Hospital autopsies are neither regulated by a specific law nor guided by any professional code of practice in Ghana, with consent to them often being procured from relatives by the clinician (usually a junior doctor) and captured in the medical records of the deceased. There are no explicit requirements to ascertain the wishes of the deceased or their family.

In the face of the clear stipulations of the [1], (Act 280) and despite awareness of the role of the Ghanaian family in post-mortem events, human biomaterials are routinely retained on daily basis without the requisite consent. In the meantime we are reassured that despite the fact that there is no framework to guide their practice, organ/tissue retentions by pathologists are done in accordance with best practice. This would seem implausible since best practice in pathology will require clearly defined standards against which aberrant behaviours can be measured [29, 46, 48].

In the absence of specific ethical and legal frameworks to guide the organ retention process, it is conceivable that it may be subject to abuse. This state of affairs presents a number of challenges for Ghana.

The Concern

Obtaining human biomaterials (from both the living and the dead) in Ghana has become a hotly debated subject for a number of reasons. First, Ghana is making strenuous efforts to make organ transplantation a routine surgical procedure by the end of 2014. Test transplantation of kidneys (using living related donors) have been carried out since 2008 with the assistance of Transplant Links Community, a UK-based charity that helps developing countries to make kidney transplantation feasible in those countries. Second, there are increasing concerns about obtaining ova and sperms from people (young persons; mostly students) for IVF by hospitals (both public and private) in the absence of legal clarification of the permissible uses of human parts and products, whether in reproductive health or other areas of health.

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7 This practice has developed in the absence of any guidance on hospital post-mortems in Ghana.
8 There is no guidance on what the contents and formality of consent should be.
9 See note 3 above.
10 Codes of Practice will undoubtedly set clear standards for the guidance of the professionals and when these are flouted sanctions ought to be applied. For the importance of codes of practice and conduct see [29, p. 40 para 131; 46, p. 5; 48 and ss. 26 and 28 of HTA 2004].
11 Transplant Links Community (TLC), is a UK registered charity that supports emerging countries in the management of Chronic Kidney Disease. They offer teaching, advice and carry out living kidney transplantation with the aim of ensuring that sustainable transplant programmes become possible in the future. It was established in 2006 by a group of British doctors with vast experience in transplant surgery and desirous of sharing their knowledge and expertise. For a more detailed look at their activities see; http://www.transplantlinks.org/, (last accessed on 30/10/2012).
research and practice [10, 46]. Third, the illicit practice of stealing or selling body parts for the purposes of black magic popularly referred to as ‘juju’ is a recognised problem among persons working in mortuaries in Ghana [50, p. 489]. Fourth, there is a general unease from within the medical community, especially pathologists, about a long-standing culture of systematic and paternalistic retrieval, retention and use of human materials without the specific consent of the dead or their families.13

In relation to attempts to establish a transplantation system for Ghana, there is concern by policy-makers and medical professionals that any perception by the public that Ghanaian doctors are part of the illicit trade in human body parts may prove costly on a number of counts. First, the public outcry against any such practice might be irredeemably damaging to the reputation of the profession and its members.14 Second, it may heighten concerns surrounding death and organ retrievals and therefore lower public support for the nascent transplantation programme in Ghana. These could then force us into a reactionary rather than proactive search for an appropriate governance structure for human biomaterials in Ghana.

It is opportune at this stage to examine some of the arguments made in respect of our respect for the interests of the dead and the rights of families vis-à-vis societal interests through the debates that ensued in the UK following the organ retention scandals in Bristol and Alder Hey.

Posthumous Interests, Societal Interests and Family Rights

The organ retention scandals that came to light at Bristol Royal Infirmary and The Royal Liverpool Children’s NHS Trust (Alder Hey) were arguably the watershed in the governance of human biomaterials in the UK [29, 37]. Revelations of these practices arose during an investigation into the care of children receiving complex cardiac surgeries at Bristol. The evidence given at the Bristol inquiry triggered an investigation into organ retention practices in the wider NHS and Coronial Services [37]. The inquiries confirmed that there was a culture of systematic full-scale removal and retention of human biomaterials within the NHS [37]. The retention was in large part without the necessary consent of the parents and relatives of the

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12 The Komfo Anokye Teaching Hospital (KATH) in Kumasi (the second largest teaching hospital in Ghana) is in the news for failing to account for bodies of some deceased babies that have gone missing. The public speculation that the bodies may have been sold by orderlies of the hospital prompted a mob attack on the hospital and its staff. The Ministry of Health has since ordered an investigation into the matter and a review of the hospital’s standard operating procedures. The Chief Executive has also been relieved of his post. Worryingly, two of such cases involving the Tema General and Winneba Hospitals are currently before the High Court. For more details see KATH baby missing saga: Health ministry axe hospital CEO; http://www.myjoyonline.com/news/2014/March-25th/kath-baby-missing-saga-health; last accessed on 26/03/2014.

13 See note 3 above.

14 For details of the outrage that characterised the organ retention scandals in the UK and how this shaped the HTA 2004 see [29, 37].
The inquiries identified a number of failings including a culture of paternalistic attitudes towards bereaved relations; poor management practices; some confusion over the role of the coroner; and malpractices in pathology services across the NHS. These events culminated in the enactment of the HTA 2004 in England and Wales and later, the HTA 2006 in Scotland.

Ghana is currently experiencing human organ retention problems, some of which mirror the organ retention scandals experienced in the UK [29, 37]. As shown in Sect. 2 above, retention of human biomaterials in Ghana is not currently routinely undertaken in compliance with the existing legislation, which requires that retention be carried out only with the consent of the family of the deceased [1]. However, human organ retention (whether in Ghana, the UK or elsewhere) is a highly contested subject because it often engages very vexed matters including the posthumous interests and rights of the decedent and his/her family and it is these which must first be explored.

The organ retention scandals in the UK excited clinical, ethical and legal commentaries as well as policy discussions. Some commentators have argued against the appropriateness of the use of the word ‘consent’ in the context of post-mortem human material retrieval, retention and use and have proposed “authorisation” [27] as a better alternative. Others have gone further; not only do they argue that it is immoral to require consent for deceased organs but that we should consider making the dead body “the charge and responsibility of the state” [15, pp. 126–127]. It is claimed on this account that “the dead cannot be harmed” [39, p. 129]. As such our reverence for dead body parts is becoming a kind of vitalism which ought not to have veto over their use in the service of our collective good [16]. Harris [24] argues that though consent plays a primordial role in healthcare practice because it protects the autonomy and welfare of the individual, its role in posthumous organ retention and use can be problematical.

15 See section 1 (2) (b) of Human Tissue Act, 1961 of the UK (England and Wales).
16 For a very informative discussion of the effects of these failings on parents and families see [42].
17 These matters came to my attention when I held discussions with the head of department of pathology at the Korle bu teaching hospital in Accra. It is the premiere referral facility in Ghana. The discussions were in respect of concerns from amongst the doctors about the need to assist them develop the appropriate frameworks (ethical and legal) to guide their practice. Further, I have personal knowledge of some of these matters because I worked in Korle bu teaching hospital from 2003 to 2008 (not much has changed since then) and by virtue of my position as founding head of the medico-legal unit of the GHS.
19 Arguably, while consent necessarily implies the existence of an autonomous choice maker, authorisation does not. The Redfern report argues that in the case of children, the legal authority granted persons with parental responsibility is restricted to the best interests considerations of the child. It will however seem inappropriate to talk about best interests in the context of a dead child. Further, in respect of families of a deceased adult, family members may be content to allow organ donation but may not want to be burdened with the requirements of informed consent. It is to be noted that authorisation has since been adopted into law in Scotland; see sections 29, 30, 31, 32 and 33 of HTA (Scotland) 2006.
20 For an interesting legal exploration of this controversy see [31].
Autonomy involves the capacity to make choices, it involves acts of the will, and the dead have no capacities—they have no will, no preferences, wants nor desires, the dead cannot be autonomous and so cannot have their autonomy violated [24, p. 538].

As a result, he argues, conscription of dead bodies for important moral purposes is both ethically and legally defensible and should be seriously considered if people fail to authorise their use [24, p. 548].

Richards [38] also argues that apart from the right to testamentary disposition, including provisions for funerary activities and related matters, traditionally, the dead did not have a right to decent burial in the West. Consequently, any claim by the family for the control or possession of the body of their loved one for purposes of disposal is merely a “greater claim to sympathetic consideration, not a greater obligation or right to dispose of the body” [24, p. 533].

Other contributors make the argument that we have a moral obligation to donate our organs posthumously because it comes at no cost, pain or risk to us [26, 41], and that it is immoral to refuse to consent to such donation [15, pp. 126–127]. Requiring consent before obtaining deceased organs, although understandable, is “misguided” [41, p. 302] as such deceased organs should be treated as a public or societal resource [49] because ‘others have a greater need for them when we are dead’. 22

In support of this claim, Harris [24], for example, employs choice and interests conceptions of rights and casts doubt on the existence of posthumous rights in any tangible way. The argument is simple and effective. On the choice theory of rights, the dead have no autonomy and therefore no interests to protect. On the interests theory the dead have no welfare interests to protect (although some critical/persisting interests such as reputation, will and welfare concerns for loved ones may survive the decedent). He accords these a weak priority because they are non-person affecting [25, p. 131]23 and must yield to “reasonable demands of public interests” [24, pp. 535–537]:

Since the dead subject has ceased to be the subject of person affecting morality, since he or she has neither autonomy rights nor interests to protect and only some rather attenuated persisting or critical interests, if any, his or her wishes do not have the primacy that rights and person-affecting interests can claim in moral argument [24, p. 538].

This argument might seem persuasive in a society where there is an individualistic approach to autonomy. However, it will be of limited effect in a society such as that in Ghana that believes in the concept of ancestry; is communitarian in nature and is underpinned by the principle of ‘nkpawiin’ or collective solidarity. I shall argue that given that ancestry holds that the dead continue to exist in other realms, continually interacting with the living, then it is

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21 Emphasis added.
22 I thank Dr. Sarah Devaney for this point.
23 His argument is primarily that the possible large benefits to the living outweigh the small harms to the interests of the dead. I thank Prof. Søren Holm for this point.
conceivable that the interests of the dead are not necessarily attenuated upon physical death. As a consequence, the interests of the living are, in many cases, inextricably linked and sometimes subservient to, the interests of the dead. This is why the dead are commonly referred to as the ‘living-dead’ in the African traditional context [32].24 Under those conditions the primacy of the interests of the living is not as obvious as it first appears. It follows then that any assumption that the interests of ancestors and their relations will be accorded a lower priority than those of a living third party might prove problematic. Neither is it immediately apparent that these interests can be dismissed as conclusively non-person affecting.

Even in societies in which the concept of ancestry is alien, conscription has its own critics. These claim that the death of an individual does not mean that the deceased “ceases to matter at all” [33, p. 305] and that the interests of the family cannot be cavalierly dismissed [5]. It is further argued that the interests we have in what can or cannot be done with our bodies after death outweighs any right of the sick to deceased organs [21]. Furthermore, Giordano [20] argues that consent of the family matters because it is the relatives of the decedent who have the “strongest entitlement” [20, p. 473] to the body of their loved one. As a consequence, retrieving organs from those who “refuse consent” [23, p. 200] is not ethically defensible.

Similarly, Brazier [5] questions the defensibility of the claim that “neither the deceased…nor their family” have the final say in decisions touching on posthumous organ retention and use [5, p. 555]. According to her, to do so will be to fail to place sufficient weight on “deeply held religious and cultural beliefs” and the respect accorded the dead the world over [5, p. 550].

Brazier [5] argues that any policy prescription which discounts the interests of the deceased and their family is doomed because people will feel outraged and reject it [5, p. 557]. Interference with the disposal of the dead in breach of the dictates of their beliefs or values may constitute a violation of their rights under article 9 of the European Convention on Human Rights [5, pp. 559].25 Finally, she argues that claims by some commentators that we disregard family interests are not borne out by our shared values throughout the history of organ retentions [5, p. 565]. Contrariwise, evidence from the UK organ retention scandals show that non-consensual retention and use of body parts had a deleterious effect on many families including damage to family values as well as their emotional, psychological and psychiatric well-being [5, p. 565; 43]. Though this does not in any way imply that body parts may never be removed without express consent, it places a heavy onus on those making the demands for organs to show that there is “greater necessity than the respect for the deceased’s bodily integrity” [5, p. 565]. This is because while the good that deceased organs confer matters, equally the ends to achieving the good also matter [5, p. 567].

As pointed out from the outset, this paper examines the interests of the dead and their family in the Ghanaian traditional setting. In order to facilitate our

24 For a detailed philosophical exposition of the concept of the living-dead as understood in the wider African traditional context see [29] particularly pp. 24–26 and 81–89.
25 Also see Article 26 of [7] and Sect. 1 of HRA 1998 of the UK.
understanding of the contextual issues, it is necessary to provide a concise account of the Ghanaian socio-legal context relevant for our purposes.

The Ghanaian Socio-Legal Context

The Legal Context

The legal regime reflects the peculiar cultural and social circumstances in Ghana. This is not meant to be a detailed constitutional analysis. Rather, the discussion here is intended to point policy makers to issues that may be relevant to the social legitimacy of any dialogue on the choice of a regulatory framework for the governance of human biomaterials in Ghana. As a former British colony, Ghana’s legal system is founded on the common law tradition. The 1992 Constitution of the Republic of Ghana provides in article 11 (1) (e) and (2) that the laws of Ghana shall include the common law, doctrines of equity and customary law. By customary law is meant the “rules of law which by custom are applicable to particular communities in Ghana” [7, Article 11 (3)]. The legal point to be made here is that some of the practices and usages that have formed custom are of both cultural and legal significance.

Additionally, article 26 (1) provides that every person is “entitled to enjoy, practise, profess, maintain and promote any culture, language, tradition, or religion subject to the provisions of this Constitution” [7]. Also, the constitution provides for the right to “freedom of thought, conscience and belief” [7, Article 21 (1) (b)] and for the “protection and advancement of the family” [7, Article 28].

Furthermore, Article 1(2) establishes the Constitution as the supreme law of Ghana and Article 2(b) allows any person alleging that an act or omission contravenes or is inconsistent with the Constitution to bring an action for a declaration to the effect. Additionally, Article 12 provides for the protection of the fundamental human rights and freedoms as enshrined in Chapter Five (5) of the Constitution including cultural and family rights. However, an allegation that an act or omission is inconsistent with, or is in contravention of, any provision in the constitution will need to be proved before the Supreme Court which is the only court with jurisdiction to interpret such constitutional matters. The act or omission must

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26 Sections 14 and 19 of the Gold Coast Supreme Court Ordinance (No. 4 of 1876) made English Law applicable in the Gold Coast (now Ghana) alongside Ghanaian customary law. Ghanaian law has also been influenced by Islamic law (civil) and given effect in the Marriage of Mohammedans Ordinance Cap 129 of 1951. The Ghanaian legal system is therefore pluralistic. This explains why common law as understood and employed in the Ghanaian socio-legal context includes case law, doctrines of equity and customary law rules. However, following the independence of Ghana on March 6, 1957 and its subsequent attainment of republican status in 1960, the Constitution and Courts Act of 1960 repealed this reception statute and English law has since ceased to apply with binding effect in Ghana. Ghana, as a democracy currently operates the 1992 Constitution as its supreme law. As a result cases from the UK, and all other countries especially the common law countries, are now of persuasive authority only.

27 Emphasis added.
however not be caught under the exception in Article 26 (2) which prohibits customary practices that the Court may find dehumanising or injurious to the physical and mental well-being of a person. However, if it is an action alleging a violation of a protected right (cultural, family etc.) then, procedurally, per Article 33 of the Constitution of Ghana the High Court is the court of first instance with the right to appeal to the Court of Appeal and then to the Supreme Court. Similarly, if the alleged violation or contravention is in public interest or health and safety then these may be adjudged reasonable and lawful under the [9] (Act 18) or Public Health Act of Ghana, 2012 (Act 851) particularly sections 10 (2), 50, 168, 169 and 170.

Also, under the directive principles of state policy, policy-makers are encouraged to integrate appropriate customary values into the fabric of national life.\textsuperscript{28} Importantly, the Constitution guarantees traditional institutions such as Chieftaincy in article 270 and charges them to “undertake the \textit{progressive study, interpretation} and \textit{codification of customary law} with the view to evolving, in appropriate cases, a unified system of rules of customary law” [7, Article 272 (b) and (c)].\textsuperscript{29} As shown above, cultural rights [7, Article 26] are entrenched in the 1992 Constitution and policy-makers are encouraged to incorporate appropriate customary rules and values into national/public policy [7, Article 39].

The challenge, however, is whether or not in the Ghanaian traditional setting we could successfully ground our policy choices both on the pursuit of our basic goal of maximising organs\textsuperscript{30} for transplant and respecting the cultural rights of the people as guaranteed under the 1992 Constitution of the Republic of Ghana. It has been argued that this is possible if we moved away from maximising to satisficing and pre-committed ourselves to respecting the cultural rights of the communities that the policy choice is intended to benefit [43, pp. 190–192]. Acting in a way that in the short term appears to disservice our goal of obtaining organs can be a rational strategy if there are very good reasons for so acting. This is particularly important because ours is a pluralistic community and pluralism ought to be sufficiently valued. As such we should as far as practicable, avoid policy choices that may appear theoretically alluring but which nonetheless have a high likelihood of offending sensibilities and therefore more likely than not to create deep-seated public resentment. The short term gains of such policy choices might pale into insignificance when compared with the irredeemably damaging effects these are likely have on our objective of maximising human materials for the benefit of transplant patients, science and society.

As stated in Sect. 1, one such customary practice which, with the appropriate policy choice, could further the purposes of organ transplantation in the Konkomba socio-cultural setting is the concept of ancestorship.


\textsuperscript{29} Emphasis added.

\textsuperscript{30} I assume for the purposes of this paper that there is the need to maximise supply of organs and that committing ourselves to doing so is a good thing.
The Socio-Cultural Context

Indigenous Konkomba (and wider Ghanaian) philosophical thinking is that there are two distinct ends for the dead at custom which appears to follow the all or none principle—the deceased becomes either an ancestor or a non-ancestor. While ancestors are highly venerated and understood to live on and to continue to interact socially and spiritually with the living and dead worlds, the non-ancestors are ‘dead’ to both the eternal and external worlds. The basic thesis underlying the concept of ancestorship among the Konkomba of northern Ghana posits that death does not extinguish all existence. Life and death are understood as a continuum. You are sent into the physical world through birth, you live and you are recalled by the sending entity through death and you continue live in other realms [2, p. 796]. To qualify as ancestor one must have led a ‘good’ life- recognising all the relevant rules of justice and social interactions [4] and must have died a ‘good’ death. 31

There is however some conceptual flexibility that allows an otherwise unqualified person to become an ancestor. A number of interesting scenarios may obtain both in theory and practice to living a ‘good’ life and dying a ‘good’ death. The first is that when both conditions are met then the individual is a clear candidate for ancestorship. On the other extreme is when a person has lived a ‘bad’ life and died a ‘bad’ death. It will seem incontestable that this individual is a clear candidate for non-ancestor. However, it is possible to have two other scenarios that can produce hard cases at custom. It is entirely possible for a person who has otherwise lived a good life, through brute luck, to die a bad death. Under this condition the status of the decedent can be renegotiated at custom and his/her reputation as an ancestor restored. For example the death of a pregnant woman who has otherwise lived a good life counts as a bad death. This has the potential to set back her ultimate interest to be thought of as an ancestor. To avoid this, the baby is removed from the woman’s body and both interred separately. This act renegotiates her reputation as an ancestor.

Similarly, bad death occurs when an individual who has otherwise lived a good life in accordance with all the relevant customary norms and values dies under circumstances where it is not possible to perform the appropriate funerary activities.

31 This paper does not discuss the thesis of good or bad death. It only explores how a transplant regulatory framework could benefit from such a thesis and draws attention to some conceptual inconsistency inherent in the thesis in the Konkomba traditional setting and shows how this inconsistency could be harnessed for the purposes of maximising organs for transplant. It is not claimed that all non-consensual organ retrievals necessarily make a death a bad death. Suffice to say that the Konkomba believe that dying is a process as such peri-mortem (period immediately before, at and period immediately after) events may contribute to making a particular death count as either bad or good at custom. Generally, ‘bad’ death in the Konkomba (and wider Ghanaian) traditional setting includes death by suicide; death of a pregnant woman; drowning; execution; death in a place and situation where the required customary rites cannot be performed; and burial without certain vital organs such as brain and heart. These deaths have the potential to thwart the reputation of the decedent as ancestor. As a result, any post-mortem practices that offend the customs of any particular community and adjudged by the community to be a violation of their cultural or family rights, or inconsistent with a specified constitutional provision, may be challenged in the appropriate court. It follows then that not all non-consensual organ retention and use may be either unlawful or unconstitutional. For more information about what constitutes ‘good’ or ‘bad’ death see [34, 40].
as demanded by custom. Some parts of the body of the deceased (such as hair, nails and a piece of her burial clothes) may however be procured and put into the shell of a kapok fruit. This is then brought to the customary home (as the dead person) and given a fitting burial in accordance with the dictates at custom.  

There is however another scenario which has not received the needed consideration at custom. This is the situation where the deceased who lived a bad life dies a good death. I will argue that the conceptual flexibility must cover this scenario if it is to retain its internal coherence and consistency. Conceptual certainty obtains only when both criteria are either present or absent. It follows then that the presence or absence of any one of the criteria is not a sufficient condition to disqualify a deceased individual as an ancestor. If this is true then a person who lives a bad life but dies a good death should be able to have his reputation renegotiated as an ancestor. Just as removing a dead baby from the body of its deceased mother, or the bringing of parts of a dead body home are acts that are deemed appropriate at custom to rescue the reputations of individuals posthumously, so should the donation of body parts of a deceased family member for life-saving transplantation or the good of science and society. This will seem to be in accordance with the communitarian ethos that is the basis of the Konkomba traditional context and expressed in the principle of ‘nkpawiin’. Looking at the value of ancestors at custom and the desire of many to be thought of as such posthumously, it could serve as a great incentive to encourage community members who otherwise would not have donated their organs to do so.

Why Reputation as an Ancestor Matters

Within the Ghanaian traditional setting, it is possible to identify a complex network of bundles of posthumous interests and/or harms beyond emotional distress and psychological welfare. Reputation as an ancestor under indigenous Konkomba custom and usage confers the power on the decedent to intervene in the affairs of the family or community in very significant ways. Ancestors are deemed (whether real or perceived) to have power to directly control the affairs of the living. They reward those who exhibit good behaviour and adherence to traditional laws, and punish those who violate social norms and rules [4, p. 44]. As a result, families often prioritise the interests of ancestors over their individual or collective interests.

Furthermore, the bereaved family has a collective interest in their loved one being thought of as an ancestor. This is because any such reputation reflects positively on the family as well. Additionally, ancestors are known to intercede on behalf of their families/communities by granting good health, fertility, good harvest and victories in war. Also, the family has an interest in avoiding the calamities, misfortunes and harms that are known and understood to accompany non-adherence

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32 Such customary decisions are made by the traditional head of family or clan or community with the consent and concurrence of the principal elders of that family, clan or community as the case may be. Where uncertainty remains it is resolved by consulting spiritualists of traditional deities and soothsayers. A decision from this consultation is final.

33 ‘Nkpawiin’ translates as collective solidarity.
to their traditional norms and values which they consider to be significant. In fact Mbiti captures it succinctly that if ancestors are:

improperly buried...it is feared by the relatives or offenders that the living-dead would take revenge. This would be in the form of misfortune, especially illness, or disturbing frequent appearances of the living...People are, therefore, careful to follow the proper practices and customs regarding the burial or other means of disposal of dead bodies [32, p. 83].

When families have genuine fears and interests of this nature, it is not enough to say that these concerns are unscientific, irrational or weird. These are the experiences, values and real life situations of these people. We ought to give sufficient weight to “expectations that flow from the complex cultural and existential beliefs, where truth is entangled in what it means to be part of the human condition” [48, p. 448]. To dismiss these as squeamish will be to devalue, dehumanise and strip them of their dignity.

As Brazier [5] and Sque et al. [42] rightly observe, some of the bereaved families in the Alder Hey and Bristol organ retention scandals had been seriously injured by the conduct of the doctors involved such that a case could be made that bereaved families are entitled to be protected from such conduct [5, p. 567]. The fact that our sharpest scientific tools are still too blunt to measure these does not conclusively deny their existence. This might actually be indicative of the fact that there is more to be known about the human condition than science alone can currently offer. If the claim that (legal) rights [8] are social facts [44] is reasonably true, then by their very nature some rights are, and will remain, context-relative. As a result, instead of viewing the beliefs of another social context that we are not familiar with as necessarily lacking in logic or rationality, and therefore mistaken, we need to recognise the reality of our different social circumstances.

Posthumous Interests and Harms

Posthumous interests and/or harms remain irredeemably controversial partly because of the Epicurean argument of the absence of the subject and its counterintuitive conclusion that death is not “such a bad thing after all” [22, p. 358]. The issues are further complicated by the fact that harm in its customary usage is unavoidably vague [17]. Even when we have settled on the conception of harm we wish to use, contextual issues may lead to different subjects being capable of harm or being in a harmed condition. In the context of deceased organ donation, there is controversy as to whether obtaining organs without the express consent of the dead or their families could harm the interests of the dead and/or their relatives.

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34 We may talk of legal, moral, or cultural rights among others. However, it is plausible to presume that all of these rights share a common defining feature which illumines their use in conventional rule systems. For a fuller exploration of rights see [8, 14, 44, 51]. I am also mindful here of the fine line between arguing that some rights are context-relative and the likelihood of slippage into the universalism v. relativism debate. I wish to state that no such slippage is intended as such any suggestion to that effect is regrettable.
If so, what might any such harm entail? If not, might conscription of transplantable organs of the dead be a rational public policy? Though these issues have been the subject of extensive ethico-legal commentary, these have not been adequately explored in the context of developing countries such as Ghana. This paper situates the discussion in the traditional Ghanaian context and shows that the interests of the dead and or their relatives may prove weighty enough to defeat the plausibility of conscription of transplantable deceased organs as a rational public policy.

I draw on the work of Feinberg [17] on the concept of harm as a setback to interests (including posthumous interests). There is however some dispute as to whether or not the dead can ever be harmed [3, 6, 30, 35, 39, 44] on the basis that the “dead have no interests and are beyond both harm and benefit” [6, 39, 44]. Proponents argue that the absence of an interest bearer makes any talk of posthumous interests senseless [6, 35]. This claim is however rebutted by other commentators who establish, albeit from different perspectives, that posthumous interests do exist and their violation may warrant legal and ethical protection [12, 17, 18, 22, 28, 30, 36, 48, 52]. Feinberg [17] argues that for something to count as an interest certain conditions must exist these include some degree of ulteriority, stability and permanence. He states:

To say that something would be “in my interest” is to say that it would increase my ability or opportunity to satisfy those of my ulterior wants that are the bases of interests, those goals in whose advancement I have a stake [17, p. 55].

As a result, mere passing desires/wants and inclusive ends will not count as interests on this conception [17, pp. 55–56].

Having settled on the concepts of harms and interests our next task is to establish whether or not there are interests that survive the interest bearer. If so, whether or not such interests can be setback and their bearer harmed as a consequence. It is necessary to take a brief look at interests as used by Feinberg. He shows that interests to one’s well-being may be conceived in two ways: welfare interests (which by definition are the minimal nonultimate goals of a person) and ulterior interests (the ultimate goals and aspirations of the person). Feinberg categorises human actions into those that are self-interested and those that are not self-interested. The not self-interested acts are those that when done do not promote the interests of the actor and may actually be, in certain cases, against the legitimate interests of the actor. Self-interested acts are further divided into those acts that are either other-regarding or self-regarding. Other-regarding acts are those that promote the actor’s desire for the well-being of others, at least, as an end in itself. The self-regarding interests are subdivided into directly self-regarding (acts aimed at promoting the actor’s exclusive ulterior interests) and indirectly self-regarding (acts that promote the well-being of others but only as a means to promoting the ulterior interests of the actor) [17, pp. 65–95].

Welfare interests are thus those basic things (health, food, shelter, material resources etc.) that are necessary for human survival and as a precondition to

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For a very exhaustive analysis of interests as adopted here see [17, pp. 65–95] especially at p. 74.
achieving our ultimate goals. As such welfare interests may rightly be said to be typically, but not entirely, of instrumental value to the possessor [17, pp. 57–59]. Other contributors however establish that there is such thing as posthumous harms even though the means they adopt to achieving that end differ. 36

I find Feinberg’s approach much more suitable for the Ghanaian context. He argues persuasively that since the objects of a person’s interests are largely futuristic and often outside his immediate experience, “the area of a person’s good or harm is necessarily wider than his subjective experience and longer than his biological life” [17, p. 86]. The class of interests that die with a person are generally self-regarding while those that are capable of surviving him are other-regarding and/or public oriented goals such as good reputation, promoting social or political causes or the well-being of loved ones [17, p. 86]. It is significant to note that even those who dispute the existence of posthumous interests do not deny the ethical and legal defensibility of respecting the reputations and wills of dead people. 37

Indubitably, in the Ghanaian traditional context, being thought of as an ancestor is a reputational goal which is inextricably linked to the welfare of the deceased’s family. When this reputational interest is thwarted or set back the deceased can be harmed. For example, imagine a community in which the qualification at custom for ancestorship includes being buried with one’s heart. Also imagine a decedent whose ultimate goal had been to be thought of as an ancestor. To achieve this goal the decedent expresses his wish to be so buried to his family or loved ones prior to his demise. The family will have a duty imposed on it, at least at custom, not to thwart the actualisation of his ulterior interest, and may even act to promote it. Within the transplant context, this might mean a refusal to consent to the removal of his transplantable heart unless an appeal to some greater necessity can be made. A failure without reasonable cause will amount to a wrongful breach of their duty resulting in a violation of the deceased’s rights at custom and harm to his ultimate interests of being respected as an ancestor.

Furthermore, relatives may genuinely have other-regarding interests in the well-being of their loved one as an end in itself—whether or not their own interests are advanced. As shown above, in the Konkomba traditional setting, these interests may be properly conceived of as common, interrelated, interdependent and intertwined family interests directed towards the common object of making their dead relative an ancestor. Each family member has a self-regarding as well as

36 Feinberg grounds his conception in harms as setback to interests; Pitcher uses the dualistic account (ante-mortem/post-mortem) and identifies the ante-mortem person as the subject of harm; Johansson argues in support of posthumous harms using the fusion of times account; Levenbook adopts the loss account of harms to achieve the same effect while Tomasini does so from a phenomenological perspective.

37 For example, Partridge grounds the justification of respect for the reputation and wishes of the dead by appealing to moral agency, moral personality and social contract theory rather than in the concept of surviving interests; Callahan accounts for the respect for posthumous wishes by reference to intrinsic value, virtuous behaviour and wrongful failure of virtue while Taylor accounts for respect for the wills, reputations and wishes of the dead using the rule-consequentialist approach. Harris, on the other hand, accepts that some interests may survive the dead but argues they are not person-affecting and therefore can be set aside when balanced against person-affecting interests.
other-regarding interests in respecting the wishes of the dead and these interests may not be treated cavalierly nor overridden by the state for the benefit of either science or a third party or a stranger.

The view that there is a continual relationship between the living and the living-dead is not limited to belief in ancestors. According to Fisher [18] the relationship between the dead and the living is not only ongoing; it also has an ethical dimension. As a result “when the interests of the dead are promoted, not only is the ongoing connection between the living and the dead respected, but also the dead are benefited” [17].

Encouraging people to be, at least, minimally good Samaritans is a desirable thing but to demand that people be compelled against their legitimate interests to do good to strangers would seem ethically or legally dubious unless exceptional circumstances can be established. It is however not immediately clear to us that this condition of exceptionality or greater necessity is satisfied by merely claiming that a stranger to whom the now deceased owed no specific duty prior to his demise may benefit from all or some of his organs. The refusal of the family to donate organs under those circumstances cannot be said to have been done at the expense of, or without due regard to, the interests of the stranger in need of organs. In this case the cost to the family and the deceased are incalculably burdensome. Since no one is deemed morally blameworthy when they are unable to help another because their legitimate interests may be irredeemably damaged in life, it should not matter in death if it can be shown that such a setback to their surviving interests and the interests (self- and other-regarding) of their family is likely to occur. In the unavoidable situation where the interests of family and their deceased compete with the interests of nonfamily members in need of organs for transplant, it is reasonable to expect the family to act to protect family interests (whatever these interests turn out to be). It is insufficient to claim that such interests are simply emotional and squeamish.

Nonetheless, it does not follow that accommodating such customary beliefs will necessarily thwart the social utility aims of maximising human biomaterials for organ transplantation and science research. Given the cultural importance attached to ancestorship as shown above, exploring such contextual issues in a sensitive manner may not only show that such an approach can actually further the social utility aims of organ transplantation, but that it is also more likely to yield the additional benefits of engendering the trust and support of local communities in Ghana.

Conclusions

The strong protection accorded the traditional Ghanaian family coupled with the entrenched nature of cultural rights in the 1992 Constitution of Ghana mean that a regulatory system purporting to govern the retention and use of (deceased) human biomaterials must take the wishes of the deceased and their families into account. However, as has been pointed out, though a customary community may allege that non-consensual organ retention and use may be offensive to its customs and
practices, it must demonstrate before Ghanaian courts that any such act or omission contravenes some specified constitutional provision or violates some constitutionally protected rights (e.g. cultural and/or family rights) and that the retention and use is neither in the interest of public health and safety nor dehumanising or injurious to the physical and mental well-being of any person. Importantly, these constitutional protections explain why the current organ retention ills in Ghana are even more problematic.

Also, the issues explored here show that the organ retention problems in the UK are not unique to it. Countries such as Ghana where these issues are now being dealt with can learn valuable lessons from how the UK handled its challenges. Ghana can reflect on how the UK’s experiences serve as a useful guide to crafting policy choices that are appropriate for its socio-legal context.

Being an ancestor in the Konkomba traditional setting is a reputational issue of immense cultural significance. Families are obligated at custom not to interfere with such rights the violations of which carry consequences at custom. This is because “the living-dead are still ‘people’” with;

interest in what is going on in the family…They are the guardians of the family affairs, traditions, ethics and activities. Offence in these matters is ultimately an offence against the forebearers who, in that capacity, act as the invisible police of the family and communities [32, p. 82].

In consonance with the views expressed by McGuinness and Brazier [33] and Hamer and Rivlin [23] the decedent, as ancestor, has a direct moral worth in the Ghanaian traditional context. The consequences of failing to respect the wishes of the dead are such that they are capable of setting back the interests of both the decedent and his family members. It follows then that these interests may be rightly conceived to be at once both non-person affecting and persons-affecting (usually all members of the traditional family). As a result, the argument that deceased interests are necessarily non-person affecting fails in this context.

Indeed the GMC’s ethical guidance to doctors [19, para 50 p. 17] to the effect that patient confidentiality continues after death, and the exemption of a decedent’s information under section 38 (d) of Freedom of Information (Scotland) Act, 2002, appear to affirm the ethical and legal defensibility of posthumous interests or harms.

As shown above, in Ghana a disregard for the interests of the dead and their traditional family as a way of increasing deceased organs for transplant, might not only be unlawful, but also unconstitutional. If we are committed to the collective goal of increasing organs for transplantation then we need to argue for conceptual consistency. For example, if under the concept of ancestorship someone who has led a ‘good’ life but died a ‘bad’ death can have his reputation as an ancestor rehabilitated, so must someone who lived a ‘bad’ life and died a ‘good’ death. Since automatic qualification or disqualification as an ancestor only obtains when the two criteria are both present or absent, the absence of either must receive the same treatment at custom if conceptual consistency is to be maintained. So those who led ‘bad’ lives but died ‘good’ deaths should also be able to have their reputations
rehabilitated if they or their families donate their organs to save the lives of transplant patients.\footnote{This should be an incentive which will undoubtedly encourage a lot more to donate especially when understood and viewed from the Konkomba traditional principle of ‘nkpawiin’ or collective solidarity. For a similar ingenious and innovative incentive package for prisoners in the Philippines see \cite{11}.

Respecting the interests of the dead by safeguarding their reputation at custom as ancestors is a cultural right that a transplant policy that hopes to have social legitimacy in the Konkomba (wider Ghanaian) traditional setting must recognise. Though this might, on a utilitarian calculus appear less maximising, it may in fact be the better maximiser in the long run since any such policy is more likely to engender public cooperation and support. After all, a consequentialist approach “tells us that a right is genuine just in case the social policy of recognizing it in the appropriate rule system is the best means of promoting some favoured goal” \cite[p. 199]{43}.

Additionally, since one’s reputation as ancestor can be rehabilitated without the need for bringing the whole body home for burial, then conceptually organ donation generally, and deceased organ donation in particular, may not be inconsistent with ancestorship. This is another reason that a commitment to our collective goal of encouraging more people to donate their organs cannot afford to gloss over in the Ghanaian traditional context. Having the patience to understand and respect the cultural rights and values of communities by engaging them in honest discussions on their own terms is a better policy choice. To discount these as mere pre-scientific superstition or as weird beliefs lacking in logic or rationality might be itself irrational and counterproductive.

Summing, a transplant regulatory framework that is context-appropriate could ride on the cultural value of being an ancestor as an incentive in the Konkomba traditional setting to encourage organ donation for transplant and science research. Respect and recognition of such customary and family values may engender the trust and support of the people and thus serve as a workable guide for the development of law and policy for organ transplantation in Ghana where family and cultural rights are constitutionally protected.

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