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CORRESPONDENCE

Correspondents are asked to be brief

Kidney Donation and the Law

SIR,—While fully in agreement with your legal correspondent's interpretation of the Human Tissue Act 1961 (11 August, p. 360) as against the opinion put forward by the Medical Defence Union, I would like to suggest that a deceased person's request, even if it is within the terms of section 1 (1) and even though it gives legal cover to a doctor proceeding in reliance upon it, may not in fact be absolute, but subject to effective veto from the deceased's personal representatives.

At common law, as your correspondent observes, the personal representatives, even if not in lawful possession of the body, have an immediate right to possession. Section 1 (8) of the 1961 Act states: "Nothing in this section shall be construed as rendering unlawful any dealing with, or with any part of, the body of a deceased person which is lawful apart from this Act." This seems expressly to preserve the personal representatives' common law rights. What, therefore, is to prevent them from obtaining possession, either by judicial order or by physical removal of the body, before the operation is performed? There is nothing in the Act to disallow it. The situation might arise in practice where the donor's request conflicts with religious principles upheld by his relatives—for example, those of the Jewish religion.

The Act gives retrospective cover to the hospital authority and its agents once the organs have been removed, but it does not give them an unassailable right to obtain possession of the body. They can be relieved of it at any time by those with a prior right to it, even before the operation is performed. If, relying upon the deceased's consent for the purposes of section 1 (1), the hospital resists his representatives' demand for the body, it is no longer "lawfully in possession" of it. In this way the representatives can frustrate even the written request of the deceased if they are sufficiently energetic.

The Act does allow the hospital to proceed in the absence of any claim by the representatives, and might protect it if interference were avoided by secrecy, or even by fraud. The decision in R. v. Feist (1858)[1] gives some colour to this. There the master of a workhouse who disposed of inmates' remains for dissection was held to be "lawfully in possession" of their bodies for the purposes of the Anatomy Act 1832, even though he prevented their relatives from requiring interment by a fraud. Any such situation in a present-day context would be abysmal, but does the law obviously make it impossible?

The Advisory Group on Transplantation Problems[2] recommended that an individual's wishes as to the disposal of his own organs should have absolute primacy and override all others. They stated optimistically that this was "broadly" the position under the Human Tissue Act, but, with respect, this is not enough. I would suggest that this "absolute primacy" will not exist until it has been specifically laid down by statute. At present it is still both legally and ethically desirable to make sure in all cases that those entitled to possession of the body do not oppose the removal of the deceased's organs, since otherwise unseemly scrambles for possession of the body, though most unlikely, could conceivably develop. Indeed, on purely ethical grounds many will feel it improper to remove organs, even at the deceased's request, where there is the least hint of disapproval on the part of his relatives.

In this unit the experience is that most relatives gladly give consent when approached. This is why a practical way of preventing a donor's request from clashing with his relatives' wishes is to make sure that transplant donor cards are also signed, with approval, by the donor's executors or next of kin.—I am, etc.,

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1 (1858) 169 E.R. 1132.
2 *Advisory Group on Transplantation Problems.* London, H.M.S.O., 1969, Cmnd. 4106.

Active Management of Labour

SIR,—The active management of labour is a policy which has been increasingly adopted in many centres, and an account of its results from Professor Kieran O'Driscoll and his colleagues (21 July, p. 135) is therefore welcome. However, we would like to make the following comments.

The problem of pain during labour is not solved by placing it "in a different perspective"—that is, by limiting it to a duration of not more than 12 hours. It is still pain. The majority of primigravidae would prefer no pain at all to the possibility of 12 hours of pain alleviated by what is, in our experience, inadequate analgesia. In units where the safety and effectiveness of regional anaesthesia is appreciated pain relief no longer assumes an overriding importance in pursuing a policy of active management.

It follows that the main purpose of active management, maternal infection aside, is to reduce the effects of prolonged labour on the fetus. Since the rate of cervical dilatation varies in different parts of the world[1] the rate of 1 cm per hour derived from an African population in Salisbury, Rhodesia, may not be optimal for primigravidae and fetuses in Dublin. Critics of the method might argue that the morbidity and mortality of prolonged labour had in some measure been unnecessarily transferred to a group of babies suffering the effects of inappropriately vigorous uterine contractions. We