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I. INTRODUCTION

A person travelling to another country for the benefit of their health is nothing new. For centuries individuals have travelled to “take the waters”, benefit from the restorative sea air, or undertake pilgrimages across the globe each year in the hope of being healed or ‘cured’.¹ However, the scale of the numbers of those travelling abroad for treatment has accelerated over the last two decades. ‘Health tourism’ is a term frequently used today to describe travel outside of a jurisdiction to access medical services.² Such travel may facilitate patient choice and it can also alleviate strains on the health systems of individual states. At the same time health tourism poses challenges to our understandings of global justice through the potential for exploitation of vulnerable populations and negative impact on the health systems of the countries being visited.³ Individuals travelling outside of their home jurisdiction to access health services can pose a challenge to ‘a territorially bounded health system over which Parliament is sovereign’.⁴ This problem is particularly acute when individuals travel in order to avoid domestic prohibitions of certain clinical activities.

Over many years illicit organ sales have been subject to considerable international condemnation and the call for member states to take action to address the practice. But is condemnation really sufficient or is it the case that individual states need to take action? Many states criminalise commercial organ selling but the scope of criminalisation is limited by territorial boundaries. Organ tourism should today be seen not as a single transaction between “donor”(albeit paid) and “recipient” (or buyer) but as something much more involved which links to the broader question of trafficking in persons and human material. Concerns over practices in this area have led to a recent Council of Europe (CoE) proposal for a ‘Convention to combat trafficking in organs, tissues and cells’.⁵ The draft recommendations for this Convention include provisions concerning extra-territorial jurisdiction and enforcement.

This paper considers how domestic prohibitions on organ selling are being undermined by illicit transplantation tourism. Specifically we examine the case for extra-territorial jurisdiction for current UK law that criminalises organ sales.⁶ We

¹ E. F.S Roberts & N Scheper-Hughes ‘Introduction: Medical Migration’ (2011) 17 *Body and Society* 1.

² B. Bennett *Health Law’s Kaleidoscope: Health Law Rights in Global Age* (Aldershot: Ashgate, 2008), Chapter 8: Health Rights and Health Tourism.

³ Y.Y. B. Chen & C.M. Flood ‘Medical Tourism’s Impact on Health Care Equity and Access in Low- and Middle-Income Countries: Making the Case for Regulation’ (2013) 41 *Journal of Law, Medicine, and Ethics* 286-300; S. Benetar & G. Broack (eds) *Global Health and Global Health Ethics* (Cambridge, Cambridge University Press; 2011) Section II.

⁴ J. Harrington ‘Migration and access to health care in English medical law: a rhetorical critique’ (2009) 4 *International Journal of Law in Context* 315.

⁵ Towards a Council of Europe Convention to combat trafficking in organs, tissues and cells of human origin (2013) <http://assembly.coe.int/ASP/XRef/X2H-DW-XSL.asp?fileid=19236&lang=EN> (Accessed 23.01.2013)

⁶ Human Tissue Act 2004 s.32; See also J. V. McHale ‘Organ Transplantation, the Criminal Law and the Health Tourist: A Case for Extra-Territorial Jurisdiction?’ (2013) 22(1) *Cambridge Quarterly of Healthcare Ethics* 64-76.

examine this in the context of illicit organ sales forming a component of the emerging 'white collar' transnational crime of illicit organ tourism.⁷

The paper starts with an exploration of the evolution of health tourism. We move on to outline the international responses to commercial organ sales with particular reference to the CoE and the European Union (EU). Thirdly, we explore whether commercial transplant tourism can be viewed as an example of a transnational crime and the implications of such a characterisation. Fourthly, we explore the recent draft CoE Convention highlighting how it supports such a characterisation. Fifthly, we consider the practical challenges for implementation of this Convention. If it is accepted and ratified by the UK then there would have to be amendments to the Human Tissue Act 2004. Finally, we acknowledge that while such a Convention would have impact at domestic and EU level there are many broader issues that would still need to be addressed. In particular we highlight the fact that utilisation of criminal law should be seen as only one part of the approach to effective regulation of this area.

II. THE RISE OF HEALTH "TOURISM"

We frame illicit organ sales as a transnational crime. However, this does not adequately contextualise the situation in which illicit organ sales occur. Following Silke Meyer, we think it is useful to situate illicit organ sales in relation to the broader activity of illicit commercial transplant tourism. She argues that the latter activity is best understood as an emergent form of 'white collar crime'. Meyer distinguishes the organized crime of organ trafficking from the 'white collar' crime of illicit transplant tourism. The latter she describes as follows:

The criminal activity, operated by white-collar crime in the field of trafficking in organs, is the transplantation procedure itself. ...white-collar crime is considered to be a form of crime, where a legitimate business - such as organ transplantation - turns into an illegitimate one due to circumventions and violations of national transplant legislations, e.g., the prohibition of transplanting organs for financial gain. This is the case when medical and nursing staff involve themselves in transplanting unregistered and sold, respectively purchased, organs, such as kidneys.⁸

Not all instances of commercial transplant tourism involve criminality. Following Frederike Ambagtsheer *et al* we distinguish organ trafficking from transplant commercialism.⁹ We believe that criminal sanctions should attach to the former. Because of the mixing of criminal and non-criminal health delivery it is important to understand not just the criminal context within which these transplants take place

⁷ T. Foster 'Trafficking in Human Organs: An Emerging Form of White-Collar Crime?' (1997) 41 *Int J Offender Ther Comp Criminol* 139; For a discussion of the nature of transnational criminal law see N. Boister *An Introduction to Transnational Criminal Law* (Oxford University Press, Oxford; 2012) pages 4-7 and 123.

⁸ S. Meyer 'Trafficking in Human Organs in Europe A Myth or an Actual Threat?' (2006) 14 *Eur. J. Crime Crim. L. & Crim. Just* 209.

but also the rise of health tourism generally.^{10,11} Some governments publicise the lower cost of transplantation procedures in their hospitals while failing to adequately investigate or combat illicit organ sales.¹² In these circumstances although the method of organ procurement is illegal the health service provision may not be. In our paper we wish to highlight not just the criminal nature of transnational organ sales but also why people are increasingly travelling to access health services in other jurisdictions.

Individuals will have various reasons, ranging from expense to accessing expertise, for travelling abroad to access health care.¹³ Various types of such “tourism” have been identified; ‘reproductive tourism’, ‘transplantation tourism’ and even ‘death tourism’. Other terms to describe this group include ‘health migrant’ or individuals accessing ‘cross-border-care’; the latter ‘emphasises that patients do not travel for fun as a tourist but out of necessity’.¹⁴ We recognise the problems of defining such travel as ‘tourism’ but this is the term we follow given its prevalence in the literature.¹⁵

A number of related factors have undoubtedly facilitated the rise of individuals seeking care outside their home jurisdiction. Firstly, easier access to information regarding treatments abroad through the use of media such as the internet – we live in a globalised information age. Secondly, standards in private clinics in low and middle income countries (LMICs) are often comparable to standards in higher income countries.¹⁶ Thirdly, there are economic considerations - it is cheaper to have cosmetic dentistry in Poland than it is in the UK. Fourthly, an important factor may be to facilitate speedier treatment and to bypass waiting lists. Fifthly, legal provisions themselves which facilitate cross-border travel have made accessing treatment much easier. It is possible for patients to utilise EU Treaty provisions on free movement to assert rights to access services in other EU member states and claim reimbursement for such services from their home member state.¹⁷

209.
1-26.

¹² L. Turner “‘Medical Tourism’ initiatives should exclude commercial organ transplantation’ (2008) 101 *Journal of the Royal Society of Medicine* 391.

¹³ As quoted in N. Lunt et al ‘Medical Tourism: Treatments, markets and health system implications: A scoping review’ (OECD, 2011) <http://www.oecd.org/dataoecd/51/11/48723982.pdf> (Accessed 24.01.2013).

¹⁴ A. Pande ‘Transnational commercial surrogacy in India: gifts for global sisters’ (2011) 23 *Reproductive Biomedicine Online* 624 quoting F. Shenfield ‘Is cross-border reproductive care a problem and for whom?’ (2009) *Bionews online* http://www.bionews.org.uk/page_47257.asp/>

¹⁵ L. Turner “‘First World Health Care at Third World Prices’: Globalization, Bioethics and Medical Tourism’ (2007) 2 *Biosocieties* 308.

¹⁶ *Ibid*; see also Chen & Flood, above note 3.

¹⁷ Case C-372/04 *R (on the application of Watts) v Bedford Primary Care Trust, Secretary of State for Health* [2006] ECR I-4325; *Watts v UK* [2010] ECHR 793 (4 May 2010); *R (on the application of Watts) v Bedford Primary Care Trust, Secretary of State for Health* [2006] ECR I-4325; *SPUC v Grogan* Case C-159/90 Case C-159/90 http://eur-lex.europa.eu/smartapi/cgi/sga_doc?smartapi!celexplus!prod!CELEXnumdoc&numdoc=61990J0159; A. du Bois- Pedain, ‘Seeking Healthcare elsewhere’ (2007) *Cambridge Law Journal* 66; G. Davies, ‘The

Finally, people travel abroad to avoid domestic limitations/restrictions on particular medical procedures. The prohibitions being avoided and the legality of the activity in the destination country vary. For example, over many years individuals travelled to Italy to seek IVF treatment unavailable to them in the UK until the regulatory regimes in that jurisdiction tightened.¹⁸ Similarly, steady numbers of persons travel to Switzerland to end their lives in an attempt to bypass the statutory prohibition upon assisted suicide in England and Wales.¹⁹ There is also a reported rise in the use of commercial surrogacy by English couples in India.²⁰ In English law commercial surrogacy agreements are criminalized, although the commissioning couple and surrogate are not subject to criminal penalties.²¹ In contrast in India commercial surrogacy is unregulated and seems to be encouraged as a growth economy by the Indian government notwithstanding the recent imposition of limits on who is eligible to enter such arrangements.²² Travel to purchase organs is somewhat different. Sale of organs is prohibited in the UK and is usually also prohibited in the country that persons from the UK are travelling to.²³ This means that the service being provided (organ transplant) is being facilitated through procurement mechanisms (illicit sales) that are prohibited in both countries. Despite this there is evidence to suggest that such illicit transplant sales are on the rise.²⁴ Further some governments publicise the lower cost of transplantation procedures in their hospitals while failing to adequately investigate or combat illicit organ sales.²⁵

III. INTERNATIONAL RESPONSES TO ORGAN TRAFFICKING

effect of Mrs Watts Trip to France on the National Health Service' (2007) 18 *Kings Law Journal* 160; J.V. McHale 'The Right to Medical Treatment in EU law' *Medical Law Review*, 2007; 15:99; R. Lawson 'The Irish Abortion Cases: European Limits to National Sovereignty?' (1994) 1 *European Journal of Health Law* 167.

¹⁸ R. Fenton, 'Catholic Doctrine versus reproductive rights: the new Italian law on assisted reproduction' (2006) 14 *Medical Law Review*, 73.

¹⁹ See further s.2 (1) Suicide Act 1961; *A Local Authority v Z* [2005] 1 FLR 740; *R (Purdy) v DPP* (2009) UKHL 45; M. Hirst 'Assisted Suicide after Purdy: the unresolved issue' (2009) 12 *Crim Law Rev*, 870-876; R. Nobles & D.Schiff, 'Disobedience to Law - Debbie Purdy's Case' (2010) 73 *Modern Law Review* 295; K.Greasley, '*R(Purdy) v DPP* and the case for Wilful Blindness' (2010) *OJLS* 301.

²⁰ 'They queue to donate their eggs and rent out their wombs. One payment can transform their lives' *Daily Telegraph* 26.05.2012

²¹ Surrogacy Arrangements Act 1985 s.2

²² A. Gentleman 'India Nurtures Business of Surrogate Motherhood' *New York Times* 10.03.2008 <http://www.nytimes.com/2008/03/10/world/asia/10surrogate.html> (Accessed 24.01.2013). It is interesting to note that the Indian Government has recently issued guidelines limiting surrogacy only to those couples who have been married for more than two years and who are from a country where commercial surrogacy is legal, see Nancy Haxton 'India cuts off commercial surrogacy to many Australians' <http://www.abc.net.au/am/content/2013/s3669598.htm> (Accessed 24.01.2013)

²³ The only country with a regulated market in organs is Iran. It should be noted that sale of organs to foreigners is prohibited in Iran, specifically in order to prevent transplant tourism. However, foreigners can receive a transplant in Iran provided both donors and recipients are from the same country. In the latter situations the transplant must be authorized by the Ministry of Health Center for Management of Transplantation. See further J. Ahad et al 'Organ Transplantation in Iran' (2007) 18 *Saudi J Kidney Dis Transplantation* 648.

²⁴ J. A. Akoh 'Key issues in transplant tourism' (2012) 2 *World J Transplant* 9.

²⁵ L. Turner "'Medical Tourism" initiatives should exclude commercial organ transplantation' (2008) 101 *Journal of the Royal Society of Medicine* 391.

Although there are a limited number of countries where commercialism in organ transplantation is currently lawful, generally, it is an activity that has been the subject of both national and international condemnation. Sale of organs is prohibited in almost every country in the world, with the notable exception of Iran. *Illicit* organ sales have been subject to even higher levels of universal condemnation²⁶ The World Health Organisation Assembly has consistently held that the trade in human organs is inconsistent with basic values and contravenes the Universal Declaration of Human Rights.²⁷ In 2004 a resolution of the World Health Assembly, while noting the concern at the shortage of organs for transplantation, went on to urge that governments:

take measures to protect the poorest and most vulnerable groups from transplant tourism and the same of tissues and organs including attention to the wider problem of international trafficking in human tissues and organs.²⁸

While some commentators have suggested that following international statements such as the Declaration of Istanbul on Organ Trafficking the international situation has improved there is still a notable international 'black market' in organs.²⁹ For example, individuals travel from the USA, Japan, and Taiwan to China to procure organs commercially.³⁰ This happens despite the fact that the Chinese government, in a direct effort to combat illicit organ sales, introduced restrictions on the sale of organs to non-citizens in 2007.³¹ Similarly, illicit organ selling continues in India where commercial organ sales have been banned since the Human Organ Transplantation Act of 1994.³² In May 2012 the World Health Organisation (WHO) estimated that some 10,000 operations using black market purchased organs take place every year.³³

a. Europe and Organ Trafficking: The Council and The Commission

²⁶ For a discussion of the criticisms of 'commercialism' and 'trafficking' see Ambagtsheer et al, above note 9.

²⁷ Resolution WHA 40.13 on the development of guiding principles for human organ transplants adopted by the 40th World Health Assembly in May 1987. See also WHO Guiding Principles of Human Organ For Transplantation, endorsed by the World Health Assembly in 1991.

²⁸ Resolution adopted by the 57th World Health Assembly, 22nd May 2004, WHA57/18.

²⁹ N. Pfeffer 'Eggs-ploiting women: a critical feminist analysis of the different principles in transplant and fertility tourism' (2011) 23 *Reproductive Biomedicine Online* 634. Pfeffer notes that "since it was agreed upon the once thriving kidney bazaars in Pakistan have been closed and the Philippine government has introduced regulations aimed at preventing the country from becoming a destination of transplant tourism".

³⁰ See further 'Japanese flock to China for organ transplants' *Asia Times Online* (04.04.2006) <http://www.atimes.com/atimes/China/HD04Ad01.html> (Accessed 24.01.2013). See also discussion in Joint Council of Europe United Nations Study *Trafficking in organs, tissues and cells and trafficking in human beings for the purpose of the removal of organs* (Directorate General of Human Rights and Legal Affairs, Council of Europe 2009)

³¹ T. Alcorn 'China's organ transplant system in transition' (2011) 377 *The Lancet* 1905

³² http://www.medindia.net/indian_health_act/The_Transplantation_of_Human_Organs_Act_1994/li-st-of-acts.htm (Accessed 30.01.2013)

³³ D. Campbell & N. Davison 'Illegal Kidney Trade Booms as New Organ is sold every hour' *The Guardian* (28.05.2012) <http://www.guardian.co.uk/world/2012/may/27/kidney-trade-illegal-operations-who> (Accessed 24.01.2013)

The CoE Convention on Biomedicine provides that the human body and its parts shall not be the source of financial gain.³⁴ The Parliamentary Assembly of the CoE in 2003 in its report on the Trafficking of Organs in Europe recommended that Member States include specific provisions on organ trafficking in their criminal code and undertake “effective measures” to combat trafficking in organs.³⁵ This was to include brokers/intermediaries/hospital-nursing staff/ and medical lab technicians who were involved in illegal transplant procedures. In addition it was also proposed that sanctions should apply to those medical staff who encouraged or provided information about illicit transplant tourism. Sanctions were also recommended for those involved in the follow-up care of illicit transplant patients who failed to inform the authorities that such activity had taken place. No sanctions were suggested in relation to donors; instead States were invited to identify individuals in order to make provision for any necessary follow-up medical care. The Report also recommended that the CoE consider drafting an additional protocol to the Council of Europe Anti-Trafficking Convention, which was being debated at that time. The Council of Europe’s approach to non-commodification of human materials, which was echoed in their subsequent Additional Protocol to The Convention on Human Rights and Biomedicine concerning Transplantation of Organs and Tissues of Human Origin, has been reflected elsewhere in Europe and indeed across the broader international community.³⁶

The EU has also been consistent in its opposition to commercial dealing in human material in general and commercial organ transplantation in particular as recent EU legislative statements illustrate.³⁷ The EU Charter on Fundamental Rights echoes the Convention of Human Rights and Biomedicine by similarly providing in Article 3:

2. In the fields of medicine/biology the following must be respected: - . . .
The prohibition on making the human body and its parts as such a source of financial gain.³⁸

³⁴ Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, Chapter VII. <http://conventions.coe.int/Treaty/en/Treaties/Html/164.htm> (Accessed 25.07.13)

³⁵ Parliamentary Assembly Recommendation 1611 (2003) on trafficking in organs in Europe. <http://assembly.coe.int/Main.asp?link=/Documents/AdoptedText/ta03/EREC1611.htm> (Accessed 24.01.2013)

³⁶ CETS No 186. and see also Parliamentary Assembly Recommendation 1611 (2003) on trafficking in organs in Europe; Committee of Ministers Recommendation 2004; 7 to member states on organ trafficking. See also Asian Task Force on Organ Trafficking Recommendation on the Prohibition, Prevention and Elimination of Organ Trafficking in Asia, cited in Joint Council of Europe/United Nations study 2009 *supra*.

³⁷ See R. Watson “European Parliament tries to stamp out trafficking in human organs (2009) 327 *British Medical Journal* 1009; Communication from the Commission to the European Parliament and Council *Organ Donation and Transplantation: policy action at EU level*, COM (2007) 275 final, 30th May 2007;. Resolution of the European Parliament of 22nd April 2008, Resolution 2007/2210 on organ donation and transplantation. *Action plan on organ donation and transplantation: Strategic Co-operation between Member States* SEC 2008- 2956, Brussels 8th December 2008 (COM 2008, 819/3); . Directive 2010/45/EC of the European Parliament and of the Council of 7th July 2010 on Standards of Quality and Safety of Human Organs Intended for Transplantation OJ L 2007, 06/08/2010.

³⁸ This Article concerns the integrity of the person.

This document, originally non-binding soft-law, is of increasing importance in the EU post the Lisbon Treaty which makes it a binding part of EU law.³⁹ Certain member states, including the UK, have opted out of the Charter. Nonetheless, we will not be immune from its influence as broad EU health policy will be critically influenced by the provisions of the Charter in the future. Further, the EU Organ Transplant Directive contains a clear statement against commercial dealing in organs:

Unacceptable practices in organ donation and transplantation include trafficking in organs, sometimes linked to trafficking in persons for the purposes of the removal of organs which constitute a serious violation of fundamental rights and in particular of human dignity and physical integrity. This Directive although *having as its first objective the safety and quality of organs contributes indirectly to combating organ trafficking through the establishment of competent authorities the authorisation of transplant centres the establishment of conditions of procurement and systems of traceability.*⁴⁰

The Directive also makes reference in the preamble to Article 3(2) of the Charter of Fundamental Rights and Article 21 of the Convention on Human Rights and Biomedicine as well as WHO principles on transplantation.⁴¹ These articles concern exploitation of the human body for financial gain. While Article 13 of the Directive states that donation should be voluntary and unpaid, the Directive falls short of requiring extra-territorial application of domestic prohibitions.⁴² This is perhaps unsurprising given that the Directive is specifically focused upon standards of quality and safety in organ donation and any impact on organ trafficking is consequent to this primary objective. It follows from Article 168 of the EU Treaty and earlier EU Directives in this area, which address quality and safety issues in relation to blood and tissue, rather than more general questions concerning organ transplantation law and policy.⁴³ Altruism is seen as a safety question; paid donation, it is suggested, is something which could promote unsafe practices.⁴⁴

IV. WHY UTILISE THE CRIMINAL LAW TO REGULATE COMMERCIAL ORGAN TRANSPLANTATION TOURISM?

Clear harms can be identified to result from illicit transplant tourism. In order to fully appreciate the impact of the resultant harms it is important to consider not just the

³⁹ See further J McHale 'Fundamental Rights and Health Care' in E. Mossialos *et al* (eds) *Health Systems Governance in the EU* (Cambridge University Press, Cambridge; 2010)

⁴⁰ Directive 2010/45/EU of the European Parliament and of the Council of 7th July 2010 on standards of quality and safety of human organs intended for transplantation., para 7. [Emphasis added]

⁴¹ *Ibid*, para 19.

⁴² For a discussion of the the EU's approach to regulation in this area see G. Bache *et al* 'The Defining Features of the European Union's Approach to Regulating New Health Technologies' in M. Flear *et al* (eds) *European Law and New Health Technologies* (Oxford University Press, Oxford; 2013)

⁴³ See generally Blood Safety Directive, Directive 2002/98/EC. Tissue Directive (2004), Directive 2004/23/EC ; See for a discussion of the background to the Tissue and Cells directive T.K. Hervey and J.V. McHale *Health Law and the European Union* (Cambridge:CUP, 2004), pages 421-426; A.M. Farrell "Adding Value? EU governance of organ donation and transplantation" (2010) 17 *European Journal of Health Law* 51.

⁴⁴ Directive note 41 above, preamble, para 19.

home jurisdiction but also the harms in the countries where the transplants occur and from which the 'donors' originate.⁴⁵ In this section we consider both the harms that may arise from commercial transplant tourism and the harms that attach to organ trafficking in particular.

The first category of harms we consider are personal harms to the 'donor' and the recipient in illicit organ transplants.⁴⁶ Such procedures can have potentially adverse impact upon the health of these individuals both in the immediate and long term. To date there has been little sustained research on the organ purchasers.⁴⁷ More is known about the sellers and it is clear that the majority of those who sell their organs do so as a matter of financial necessity.⁴⁸ Some common themes regarding the nature of the harms these individuals face do emerge. However, given that the situations of these two groups are quite distinct we will deal with them in turn.

There is the potentially adverse impact upon the health of recipients who undergo illicit transplants. As noted above there is little information available about buyers in the illicit organ sale triad (the triad being broker, buyer, and seller). While there is limited research concerning those who travel abroad for commercial organ transplants how many of these cases also involve illicitly buying an organ is unclear.⁴⁹ It has been suggested that the main factors which seem to motivate people to travel abroad for an organ are need and culture.⁵⁰ These factors are closely intertwined as those from black and minority ethnic (BME) communities are less likely to receive an organ because the organ shortage is greatest among the BME community.⁵¹ In addition commentators suggest that people travel abroad for organ transplants because of familiarity with the health system in the country to which they are travelling something of course especially true when the country they are travelling to

⁴⁵ Laws relating to child sex abuse are a notable example of an offence that exists to protect individuals in other countries, see Sexual Offences Act 2003, s.72.

⁴⁶ For a discussion of the relationship between harm and criminal law see J Feinberg *The Moral Limits of the Criminal Law Volume 1: Harms to Others* (Oxford University Press, Oxford, 1987)

⁴⁷ An overview of the literature highlights a divide between those who focus on the purchasing power of these individuals as opposed to those who focus on the cultural factors which may cause people to travel. See for example the distinction between the representation of buyers in Ambagtsheer et al, above note 9 as opposed to N. Scheper-Hughes 'Commodity Fetishism in Organs Trafficking' (2001) 7 *Body & Society* 31-62. It could that the difference is evidence of distinct communities of buyers and the difference highlights the heterogeneity of this group.

⁴⁸ 'Black Market for Body Parts Spreads Among the Poor in Europe' *New York Times* (28.06.2012) http://www.nytimes.com/2012/06/29/world/europe/black-market-for-body-parts-spreads-in-europe.html?pagewanted=all&_r=0 (Accessed 20.06.13)

⁴⁹ A. Cronin et al 'Solving the kidney transplant crisis for Minority Ethnic Groups in the UK: Is being transplanted overseas the answer?' in W. Willem et al (eds) *Organ transplantation: Ethical, legal and psychosocial aspects. Expanding the European platform* (Vol II) (Pabst, Lengerich; 2011) 62–72; Ambagtsheer et al, above note 9, pages 15-17.

⁵⁰ Ambagtsheer et al, above note 9, pages 15-17. See also A. Cronin et al 'Solving the kidney transplant crisis for Minority Ethnic Groups in the UK: Is being transplanted overseas the answer?' in W. Willem et al (eds) *Organ transplantation: Ethical, legal and psychosocial aspects. Expanding the European platform* (Vol II) (Pabst, Lengerich; 2011) 62–72.

⁵¹ Cronin et al, *ibid.*

is their country of origin.⁵² There is mixed evidence on whether those who procure organs illicitly have poorer health outcomes although the evidence tends to suggest they do.⁵³ This is because although recipients may gain a short term advantage from the transplant there may be a negative impact on their long term health. One study in 2010 found that British Asians who travelled to countries such as Pakistan to procure an organ were more likely to die or have the organ fail than those who were transplanted in the UK.⁵⁴ Similarly studies of patients from the USA who were transplanted in China show higher rate of organ failure and post-operative infection.⁵⁵ The reasons for identified poorer outcomes for “organ tourist” recipients vary but these studies seem to suggest that poorer screening programmes, less advanced surgery techniques, and inappropriate post-operative care all contribute. However, it is important to note that the situation is changing as the standards of care in the countries where people are travelling to undergo commercial organ transplants improve.⁵⁶

There is also the prospect of harm to the organ “donor” in illicit organ transactions. ‘Donors’ are harmed through lack of appropriate care immediately following the transplant and an inability to access health services in the future should they need to. There is also evidence that individuals who sell their organs into illicit markets are subject to commercial exploitation.⁵⁷ Many are unlikely to be in a position to effectively bargain in the market place and thus they may be at considerable risk of coercion, manipulation, and financial exploitation.⁵⁸ Although the harms to individuals that we focus on in this paper are largely physical and/or financial individuals who sell their organs risk not just physical and financial injury, they also face broader societal harms through loss of sense of self and through stigmatisation by family, friends, and their community.⁵⁹ While legally it might be difficult to deal with such harms, particularly given the bias towards an assessment of harm in terms of *physical* impact, we think it is nonetheless important that such harms be acknowledged in our discussion.⁶⁰ Lawrence Cohen has used the term

⁵² Ambagtsheer *et al*, above note 9 pages 15-17; I. G. Cohen ‘Transplant Tourism: The Ethics and Regulation of International Markets for Organs’ (2013) 41 *Journal of Law, Medicine, and Ethics*, 269-285.

⁵³ See for example I. G. Cohen, *Ibid*.

⁵⁴ Kidney patients add to risk by having transplants abroad *The Independent* 22nd August 2010

⁵⁵ J. Gill *et al* ‘Transplant tourism in the United States: a single-center experience’ (2008) 3 *Clin J Am Soc Nephrol* 1820.

⁵⁶ See Cohen above note 54; Chen & Flood, above note 3.

⁵⁷ M. Goyal *et al* ‘Economic and health consequences of selling a kidney in India’ (2002) 288 *Journal of the American Medical Association* 1589; P Garwood ‘Dilemma Over Live-Donor Transplantation’ (2007) 85 *Bulletin of the World Health Organization* 5.

⁵⁸ See generally S. Wilkinson *Bodies for Sale: Ethics and Exploitation in the Human Body Trade* (Routledge, Oxford; 2003) Chapter 6, pp.126-132.

⁵⁹ See N. Scheper-Hughes, above note 32; M. Moniruzzaman “‘Living Cadavers’ in Bangladesh: Bioviolence in the Human Organ Bazaar’ (2012) 26 *Medical Anthropology Quarterly* 69-91.

⁶⁰ L. Cohen ‘Where it hurts: Indian Material for an Ethics of Organ Transplantation’ (1999) 128 *Daedalus* 135-165.

“bioavailability” to describe those who because of their poverty/powerlessness may sell kidneys.⁶¹ International reviews of this area also highlight such concerns.⁶²

Some argue that organ selling is justifiable as a practice if it has the effect of alleviating individuals from acute poverty and that such individuals should be ‘free’ to enter into commercial organ contracts.⁶³ Claims such as this are based in classic libertarian freedom to contract arguments.⁶⁴ We believe that freedom to contract arguments are most convincing at a theoretical level reliant on ideals of autonomy, voluntariness, and bargaining power that are not in fact reflective of the situation within which most illicit organ sales occur.⁶⁵ Brandon Chen & Colleen Flood reject the argument that it is up to those who propose regulation to justify government interference in this area.⁶⁶ They argue from the perspective of institutional norms and values stating that:

[i]f equity is considered a goal for health care systems and ... medical tourism in LMICs will likely have a deleterious equity impacts, then the burden should be borne by medical tourism’s proponents to demonstrate its benefits ... and justify why some degree of government regulation is inappropriate.⁶⁷

Freedom to contract can be limited on the grounds of public policy. For example, in the UK freedom to contract is in some instances constrained with the aim of safeguarding the consumer from unfair contractual terms in situations where there is a clear inequality of bargaining power.⁶⁸ Applying this commercial contract lens to transnational organ transplantation we see that many ‘donors’ have diminished bargaining power and as a result risk being financially exploited.⁶⁹ Alleviation from poverty is likely to be only temporary as research regarding organ trading from India illustrates.⁷⁰ The Declaration of Istanbul on Organ Trafficking and Transplant,

⁶¹ L. Cohen ‘The other kidney: bipolitics beyond recognition’ in N. Scheper Hughes & L. Wacquant (eds) *Commodifying Bodies* (Sage, London; 2002) pp. 9-30. Discussed in N. Pfeffer above note 27, 638.

⁶² In 2003 a report of the Council of Europe Parliamentary Assembly noted that trafficking networks targeted poorer European countries such as Estonia, Bulgaria, Georgia, Russia, Moldavia, Romania and the Ukraine and pressurise people into selling kidneys see further Council of Europe “Trafficking in Organs in Europe” (2003); see also discussion in Wilkinson, above note 60, 105.

⁶³ R Veatch ‘Why Liberals Should Accept Financial Incentives for Organ Procurement’ (2003) 13 *Kennedy Institute of Ethics Journal* 19; For a convincing rebuttal of such an argument see Lawrence Cohen ‘Where it hurts: Indian Material for an Ethics of Organ Transplantation’ (1999) 128 *Daedalus* 135.

⁶⁴ Cf Robert Nozick, *Anarchy, State, and Utopia* (Basic Books, New York; 1974) Particularly Part III

⁶⁵ See Virginia Held’s criticisms of this in ‘Non-Contractual Society: A Feminist View’ in M. Hanen et al (eds) *Science, Morality & Feminist Theory* (University of Calgary Press, 1987)

⁶⁶ Chen & Flood, above note 3, p.288.

⁶⁷ Ibid

⁶⁸ P. S. Atiyah *Essays on Contract* (Clarendon Press, Oxford; 1986) Essay 6. An example of such a restriction is the prohibition on organ sales found in the Human Tissue Act 2004. This demonstrates that we already restrict this particular freedom to contract at a domestic level. Therefore, it is hypocritical to allow transnational sales to go unpunished particularly when such sales may take place in a context with even greater propensity for harm than that domestically.

⁶⁹ M. Goyal above note 59

⁷⁰ See discussion in D Dickenson *Body Shopping Converting Body Parts to Profit One World* (Oxford University Press, Oxford; 2008) 154.

published in 2008, states that while organ brokers charged some £50,000-100,000 to facilitate a transplant the donors could receive sums as little as £500 for donating kidneys.⁷¹

Public policy reasons also provide a reason for limitation of freedom to contract where contract law principles clash with other ethical values. The Declaration of Istanbul on Organ Trafficking and Transplant similarly states that '[o]rgan trafficking and transplant tourism violate the principles of equity, justice and respect for human dignity and should be prohibited'.⁷² Arguments regarding consent and an individual's ability to contract are important but are not the over-riding value to be considered.⁷³ Analogies with human trafficking are particularly appropriate (especially given the fact that there is now evidence of a link between human trafficking and organ trafficking generally).⁷⁴ Beverley Balos argues that:

Traffickers, brothel owners, and customers trade women and girls as commodities because of their greater economic and social power. If attention is focused on the woman's consent, this embedded inequality becomes obscured. The veneer of consent conceals the exercise of the customer's power free of responsibility and reinforces the already existing economic and social hierarchies. The exercise of power by the dominant group thus becomes the "choice" of the subordinated group.⁷⁵

The next broad class of harms we discuss are what we describe as 'institutional' harms. These are harms to the health systems from which the recipient and donor originate. It has been argued that individuals who travel abroad to obtain a transplant are in fact benefitting the NHS and broader health service and other patients on the waiting list.⁷⁶ They are in effect introducing an extra organ into the system and thus freeing up a space on the transplant list for those who were behind them. However, in practice while some burdens may be reduced there is likely to be harm caused to both the NHS and also the health system in the country where transplantation takes place/ donors originate from. Some of these harms may be speculative due to the lack of empirical research in this area.⁷⁷ The harms are again financial and also involve increased public health risks.⁷⁸ Medical tourism poses an

⁷¹ Steering Committee of the Istanbul Summit 'Organ Trafficking and transplant tourism and commercialism: the Declaration of Istanbul' (2008) 372 *The Lancet* 5.

⁷² The Declaration of Istanbul on Organ Trafficking and Transplant Tourism (2008) Principle 6

⁷³ See Heather Widdows 'Rejecting the Choice Paradigm: Rethinking the ethical framework in prostitution and egg sale debates' in A Phillips *et al* (eds) *Gender, Agency and Coercion* (Palgrave, Basingstoke; 2013)

⁷⁴ A Bagheri, 'Asia in the Spotlight of the International Organ Trade: Time to Take Action' (2007) 2 *Asian Journal of WTO and International Health Law and Policy* 11.

⁷⁵ B. Batos 'The Wrong Way to Equality: Privileging Consent in the Trafficking of Women for Sexual Exploitation' (2004) 27 *Harvard Women's Law Journal* 137.

⁷⁶ M .Devereaux and J. F. Loring 'A Modest Proposal in Response to Rhodes and Schiano' (2010) 10 *The American Journal of Bioethics* 20; S. Meyer 'Trafficking in Human Organs in Europe A Myth or an Actual Threat?' (2006) 14 *Eur. J. Crime Crim. L. & Crim. Just* 209

⁷⁷ For further discussion of this possible harm see L. Turner 'Transnational Medical Travel: Ethical Dimensions of Global Healthcare' (2013) 22 *Cambridge Quarterly of Healthcare Ethics* 170.

⁷⁸ N Lunt *et al*, above note 12. Similarly the US Organisation for Transplant Professionals (NATCO)

institutional and public health risk through the possibility of transfer of microorganisms between hospitals on the bodies of patients.⁷⁹ But there is need for caution here as the evidence of this having occurred is scarce and often anecdotal. Illicit transplant tourism also has a deleterious effect on the healthcare systems within those countries where ‘donors’ originate and/or the transplants are taking place. An obvious harm is the burden of providing long term healthcare to individuals who have sold their organs if such care is needed. Although this harm does not directly affect the UK it still has normative bite and is a form of harm that international criminal law may aim to prevent.⁸⁰ The medical tourism market generally has the potential for harm by diverting funds from domestic healthcare and also through the possibility of creating an ‘internal brain drain’.⁸¹ Specifically in relation to organs there is also a danger that such tourism diverts scarce and limited resources in a way that prevents the establishment of a sound organ transplant system. To this end, in 2008 the Asian Taskforce on Organ Trafficking urged:

Asian countries to achieve national self-sufficiency in order to provide a sufficient number of organs for their residents who need transplantation...⁸²

In a recent review of the literature on the impact of medical tourism on health systems in LMICs Chen and Flood identify much potential institutional harm including internal brain drain and increased competition for scarce resources.⁸³ They also emphasise the potential that medical tourism has to divert clinicians away from areas of health care that are key to the health of the local population to more niche area of practice. They suggest that medical tourism far from benefitting LMICs is preventing the development of health systems that can adequately cater for the needs of the local population. They are sceptical of claims that medical tourism may have a beneficial ‘spill-over’ effect for local economies and say there is no evidence to support this.

The potential harms arising from commercial organs sales have already provided the basis for the domestic prohibition of such activity in the UK found in s.32 of the Human Tissue Act 2004. However despite this prohibition since the Act came into force in 2006 there has only been a single prosecution; of a salesman who advertised a kidney for sale on an internet chat-room. Nor have there been any prosecutions concerning those who have travelled outside the UK to obtain a

suggests that “In accordance with the NATCO Code of Ethics all transplant personnel must maintain the highest standard of professional conduct and act to protect the health and safety of organ donors and recipients. Organ tourism is not in harmony with these goals thus NATCO condemns this practice.”

<http://www.natco1.org/Advocacy/files/Organ%20Tourism.pdf> (Accessed 22 June 2012)

⁷⁹ Ibid

⁸⁰ M. Dixon *Textbook on International Law* (6th Edition) (Oxford University Press, Oxford; 2007)

Chapter 1; N. Boister *An Introduction to Transnational Criminal Law* (Oxford University Press, Oxford; 2012) pp.17-23.

⁸¹ N Lunt et al, above note 12.

⁸² ‘Recommendations on the Prohibition, Prevention, and Elimination of Organ Trafficking in Asia’ (Asian Center for WTO and International Health, Law, and Policy, 2008)

http://www.law.ntu.edu.tw/center/wto/04research.asp?tb_index=403 (Accessed 23.01.2010)

⁸³ Chen & Flood, above note 3, 288-291.

transplant.⁸⁴ The nature of the harms identified above illustrates the deficiency of a purely national response to illicit transplant tourism. Perhaps then it is time for the prohibition upon commercial dealing in transplantation to be extended in order that this has extra-territorial reach. Such an approach is a necessary part of combating ‘transnational crimes’; the broader category that we believe illicit transplant tourism falls into. In the next section we detail why we think that illicit organ sales constitute a form of transnational crime.

V – A TRANSNATIONAL CRIMINAL LAW RESPONSE TO ILLICIT ORGAN TOURISM

Examples abound of ‘rich westerners’ travelling to poorer countries to buy organs for transplant.⁸⁵ Organ trafficking follows established paths with ‘donors’ generally coming from lower income countries and recipient from higher-income countries. Transplants have also been known to occur in the country of the donor, the country of the recipient, or both parties travelling to a third country for transplant.⁸⁶ Foster has identified several criminogenic factors that have encouraged individuals to ignore prohibitions and regulations allowing the illicit market in organ trafficking to flourish.⁸⁷ Many of these factors are the result of increased globalisation that facilitates the movement of goods across borders. These include, first a demand for a class or products (organs); second, a limited supply; third, the interests of the transplant industry and; finally the actions of governments which sanction and even encourage the sale of human material whether explicit or implicit. The ‘global health market’, a rise in medical tourism generally, and a lack of effective regulation have all contributed to the growth of illicit organ sales. Similarly, Passas states that globalization causes transnational and cross-border crimes to flourish through the aggravation of:

‘criminogenic asymmetries’, which refers to structural discrepancies, mismatches and inequalities in the realms of the economy, law, politics, and culture.

Asymmetries can cause crime:

- (1) by fuelling the demand for illegal goods and services;
- (2) by generating incentives for people and organizations to engage in illegal practices; and
- (3) by reducing the ability of authorities to control crime.⁸⁸

⁸⁴ *R v Tuck* (2007); ‘Body Parts sale man avoids jail’ *BBC News* <http://news.bbc.co.uk/1/hi/england/west_midlands/6646467.stm (Accessed 24.01.2013)

⁸⁵ ‘Organ trafficking: Dutch to lead international inquiry’ *BBC News*, (16.12.2012) <http://www.bbc.co.uk/news/world-europe-20354401> (Accessed 24.01.2013); Geographically this is not always the case – individuals from Japan and Taiwan have long been known to travel to China to access organs – ‘Japanese flock to China for organ transplants’ *Asia Times Online* (04.04.2006) <http://www.atimes.com/atimes/China/HD04Ad01.html>; However, the socio-economic tone rings through in both cases; P. Lewis ‘The doctor at the heart of Kosovo’s organ scandal’ *The Guardian* 17.12.2010 <http://www.guardian.co.uk/world/2010/dec/17/kosovo-medicus-organ-clinic>. (Accessed 24.01.2013)

⁸⁶ M. Moniruzzaman, above note 61; ‘S African hospital group pleads guilty in organ scandal’ *BBC News* 10.11.2012 <http://www.bbc.co.uk/news/world-africa-11725536> (Accessed 24.01.2013)

⁸⁷ Foster, above note 7, p.143.

⁸⁸ N. Passas ‘Globalization, Criminogenic Asymmetries and Economic Crime’ (1999) 1 *European Journal of Law Reform* 402.

According to the 2000 UN Convention against Transnational Organized Crime (UNTOC) a 'transnational' offence is one where one of the following conditions is met:

- (a) It is committed in more than one State;
- (b) It is committed in one State but a substantial part of its preparation, planning, direction or control takes place in another State;
- (c) It is committed in one State but involves an organized criminal group that engages in criminal activities in more than one State; or
- (d) It is committed in one State but has substantial effects in another State.⁸⁹

The substantive aspect of the activities involved in illicit organ sales clearly meet the UN criteria of transnational crime. Therefore, we need a transnational criminal law approach to this activity. According to Boister transnational criminal law:

- Consist(s) of (a) horizontal treaty obligations between states and (b) the vertical application of criminal law by those states to individuals in order to meet their treaty obligations.⁹⁰

Therefore we propose that effective responses to this activity require a transnational criminal law approach. Here we follow Boister who identifies global organ trafficking as an emerging form of transnational crime.⁹¹ The recent Draft Council of Europe Organ Trafficking Convention 2012 can be seen as the first step in the creation of a transnational crime of organ trafficking. The Convention will create horizontal obligations between states to take steps to prevent illicit organ sales and take steps to prosecute organ trafficking. Our proposal to amend the Human Tissue Act 2004 is the second step. Amending the Human Tissue Act in the way we suggest will allow for the obligations contained in the Convention to be (vertically) implemented in the UK. Taken together both these steps represent the start of a transnational criminal law approach to dealing with illicit organ sales.

As we have seen above commercial transplant tourism gives rise to considerable problems and indeed discernable harms. We have also seen that there has been consistent international condemnation of illicit organ sales. It is perhaps then timely given the rise of such tourism to explore the prospect for the utilisation of a transnational criminal law approach to suppressing illicit organ sales. Kofi Annan eloquently summarises the situation as follows:

- If crime crosses borders, so must law enforcement. If the rule of law is undermined not only in one country, but in many, then those who defend it cannot limit themselves to purely national means.⁹²

⁸⁹ United Nations Convention against Transnational Organized Crime (2000) Article 2.
<https://www.unodc.org/documents/treaties/UNTOC/Publications/TOC%20Convention/TOCebook-e.pdf> (Accessed 24.01.2013)

⁹⁰ Boister, above note 7, p.14.

⁹¹ Boister, above note 7, p.123.

⁹² Foreword to 'United Nations Convention Against Transnational Organized Crime and the Protocols Thereto'

Illicit transplant tourism potentially involves actors from several States.⁹³ For example, there has recently been a case of kidney donors recruited from Brazil and Romania for transplants in South Africa to recipients from Israel.⁹⁴

Boister states that '[t]ransnational criminal law is limited to those offences where States use a convention designed to suppress a particular form of conduct – a 'suppression convention' – to provide for a mutual obligation to criminalize that conduct'.⁹⁵ A distinguishing feature of transnational criminal law and international criminal law is the mechanism of implementation. The obligations contained in a suppression convention will only be indirectly applicable and therefore, will require implementation through national criminal laws.⁹⁶ Our proposal for extra-territorial jurisdiction and enforcement of current domestic prohibitions on organ sales is in keeping with this two-pronged approach. Before going on to discuss our proposal in detail we will first discuss recent moves by the CoE that reflect the first prong – a suppression convention (the Draft Council of Europe Convention Organ Trafficking Convention 2012). We explore the nature and scope of the Convention in general terms and then how its implementation might impact upon the approach to extra-territorial enforcement of transplantation offences in English law.

a. Council of Europe Draft Organ Trafficking Convention 2012

In November 2012 the CoE adopted a Draft Organ Trafficking Convention prepared by a Committee of Experts on Trafficking in Organs.⁹⁷ This Convention, when ratified, will be the first legally binding international document concerning organ trafficking. The rationale behind the Convention as stated in the Preamble is the concern that:
trafficking in human organs violates human dignity and the right to life and constitutes a serious threat to public health.⁹⁸

The Convention is intended to help eradicate trafficking through the introduction of new criminal offences and stresses the need for close co-operation between the CoE member states and non-member states to combat this 'global threat'. The declared intention of the Convention is:

- a. to protect the rights of victims of the offences established under this Convention;
- b. to facilitate co-operation at national and international levels on action against the trafficking in human organs.⁹⁹

<https://www.unodc.org/documents/treaties/UNTOC/Publications/TOC%20Convention/TOCebook-e.pdf> (Accessed 24.01.2013)

⁹³ M. Smith et al, above note 31.

⁹⁴ M. Smith et al 'Organ Gangs Force Poor to Sell Kidneys for Desperate Israelis' *Bloomberg* (01.11.2011) <http://www.bloomberg.com/news/2011-11-01/organ-gangs-force-poor-to-sell-kidneys-for-desperate-israelis.html> (Accessed 24.01.2013)

⁹⁵ Ibid

⁹⁶ Ibid, 126.

⁹⁷ 'Towards a Council of Europe Convention to combat trafficking in organs, tissues and cells of human origin', above note 5; 'Committee of Experts on Trafficking in Human Organs, Tissues and Cells (PC-TO)' http://www.coe.int/t/DGHL/STANDARDSETTING/CDPC/PC_TO_en.asp (Accessed 23.01.2013)

⁹⁸ Ibid.

It places an obligation on states to criminalise various behaviours; Article 4.1 states:

- Each Party shall take the necessary legislative and other measures to establish as a criminal offence under its domestic law, when committed intentionally, the removal of human organs from living or deceased donors:
- a. where the removal is performed without the free, informed and specific consent of the living or deceased donor, or, in the case of the deceased donor, without the removal being authorised under its domestic law;
 - b. where, in exchange for the removal of organs, the living donor, or a third party, has been offered or has received a financial gain or comparable advantage;
 - c. where in exchange for the removal of organs from a deceased donor, a third party has been offered or has received a financial gain or comparable advantage.

The Convention aims to prevent physical harm and exploitation of vulnerable individuals. It further aims to prevent financial gain of a sort which could amount to commodification of human body parts. Although some attempt is made to distinguish transplant commercialism from illicit organ trafficking one weakness of the Convention is that it ultimately frames both activities as equally nefarious.¹⁰⁰ The Convention provides that States or the EU may reserve the right not to apply Article 4.1(a) above to the removal of human organs from living donors. This must only be in exceptional cases and there must be appropriate domestic safeguards in place. Lost earnings, other 'justifiable expenses' relating to removal of organs, medical examination, and damage caused as a result of the procedure are excluded from the definition of 'financial gain or comparable advantage'. This exclusion is to be welcomed as it allows for governments to provide appropriate expenses to those who altruistically donate their organs but have in many countries not been provided with any expenses to cover loss of earning or 'sick pay'.¹⁰¹ The exclusion could also potentially reduce illicit organ sales. Ambagtsheer *et al* argue one mechanism for reducing illicit organ sales is to reduce the need for such sales by increasing the availability of organs from other sources.¹⁰² The final sub-section of this Article states:

Each Party shall consider taking the necessary legislative or other measures to establish as a criminal offence under its domestic law the removal of human organs from living or deceased donors where the removal is performed outside of the framework of its domestic transplantation system, or where the removal is performed in breach of essential principles of national transplantation laws or rules.

⁹⁹ Council of Europe Draft Organ Trafficking Convention, Article 1. <http://assembly.coe.int/ASP/XRef/X2H-DW-XSL.asp?fileid=19236&lang=EN> (Accessed 23.01.2013)

¹⁰⁰ Ambagtsheer *et al*, above note 9.

¹⁰¹ The government of New South Wales has recently taken steps to deal with this discrepancy. See 'Cash for kidneys as organ donors set to get wage from government' <http://www.news.com.au/breaking-news/organs-a-nice-earner-as-donors-to-get-wage/story-e6frfkp9-1226613961284#ixzz2WIKXsMVu> (Accessed 20.06.13)

¹⁰² Ambagtsheer *et al*, above note 9.

This sub-section is an explicit acknowledgement of the importance of extra-territorial enforcement in tackling illicit organ sales. Furthermore, Article 5 of the Draft Convention, requires States to 'take the necessary legislative and other measures to establish as a criminal offence under its domestic law, when committed intentionally, the use of illicitly removed organs, as described in Article 4, paragraph 1, for purposes of implantation or other purposes than implantation'.¹⁰³ Article 10 of the Convention explicitly provides for the prospect of extra-territorial enforcement. It asks parties to consider taking necessary steps to establish a criminal offence of transplantation when it is undertaken outside the national transplantation system or in breach of 'essential principles of national transplantation laws or rules'. It also requires states to take action against illicit solicitation, recruitment, offering and requesting of undue advantages.¹⁰⁴ Interestingly this provision also applies explicitly to certain groups such as health care workers.¹⁰⁵ This is in keeping with understanding illicit transplant tourism as a form of 'white collar' crime, something we discuss above, and an acknowledgement of the fact that health care workers may often be complicit in this activity.¹⁰⁶ Other provisions relate to the reparation, preservation, storage, transportation, transfer, receipt, import and export of illicitly removed human organs.¹⁰⁷ Aiding, abetting, and attempting are also to be considered offences.¹⁰⁸

Critically it is envisaged that parties will utilize extensive jurisdiction in relation to offences committed under this Convention. Article 10 provides that:

- 1 Each Party shall take such legislative or other measures as may be necessary to establish jurisdiction over any offence established in accordance with this Convention, when the offence is committed:
 - a. in its territory; or
 - b. on board a ship flying the flag of that Party; or
 - c. on board an aircraft registered under the laws of that Party; or
 - d. by one of its nationals; or
 - e. by a person who has his or her habitual residence in its territory.

States may explicitly reserve the right not to apply or to apply in specific cases the rules set out in Article 10.1 (d) and (e). Provision is made for consultation between states where more than one party claims jurisdiction over the offence for the purpose of prosecution.¹⁰⁹ Liability is to apply to both individuals and to corporations.¹¹⁰ States are also required to ensure that offences are 'punishable by effective, proportionate and dissuasive sanctions'.¹¹¹ Such an approach to punishment is typical of a suppression convention; leaving scope for variation in the

¹⁰³ Council of Europe Draft Organ Trafficking Convention, above note 95, Article 5.

¹⁰⁴ Ibid, Article 7.

¹⁰⁵ Ibid, Article 7(3).

¹⁰⁶ See for example, P. Sidley 'South African doctors charged with involvement in organ trade' (2004) 329 *British Medical Journal* 190.

¹⁰⁷ Council of Europe Draft Organ Trafficking Convention, above note 95, Article 8.

¹⁰⁸ Ibid, Article 9.

¹⁰⁹ Ibid, Article 10(7).

¹¹⁰ Ibid, Article 11.

¹¹¹ Ibid, Article 12.

punishments States use while avoiding the possibility of sham punishments through a threshold of efficacy.¹¹² This also allows each State to decide who will be the main target of the prohibitions through imposition of variable sanctions to different parties. The Report by the Committee of the Parliamentary Assembly on Social Affairs, Health, and Sustainable Development highlighted that the draft Convention leaves the decision with Member States to decide whether donors and recipients may be prosecuted when they are involved in organ trafficking.¹¹³ They commented that ‘these two categories of persons, because of the specific nature of their situation, which can sometimes be summed up as a “matter of life or death”, may find themselves extremely vulnerable’.¹¹⁴

The Convention recognizes that other aggravating circumstances may be taken into account in relation to the prosecution of the offences outlined. These include offences causing death or serious damage to the victim, committed by a person abusing their position or with a ‘framework of a criminal organisation’ or where repeat offenders or offences against children or other ‘particularly vulnerable person’(s) are involved.¹¹⁵ The Convention also recognizes the need for effective international co-operation in investigating these offences and requirements of co-operation between states are also set out in the Convention.¹¹⁶ Boister suggests that acknowledging the need for international cooperation and the possibility of extraterritorial jurisdiction and enforcement is helpful as it avoids ‘controversial unilateral assertion’ of jurisdiction by an individual country.¹¹⁷ It is also recommended that the Convention ‘include a provision ... whereby the usual dual criminality rule is not applicable’ for the purposes of extradition.¹¹⁸

Other provisions concern the protection of victims, i.e. the ‘donors’.¹¹⁹ Signatories are required to commit to both the existence of a domestic transplantation system and also to equitable access to transplantation – this is similar to the Asian Taskforce recommendations mentioned above. The Convention also calls for the ‘collection, analysis and exchange of information’ concerning offences covered by the Convention.¹²⁰ Cooperation through information sharing will often be key to the successful enforcement of a suppression convention. A new CoE Committee is to be established to which signatories will be required to report data on cases of organ trafficking in their jurisdiction. In addition the Convention provides for the designation of a national contact point for exchange of information pertaining to trafficking in human organs – in the UK this could be the Human Tissue Authority - the statutory regulatory body established under the Human Tissue Act

¹¹² Boister, above note 7, p.136

¹¹³ ‘Towards a Council of Europe Convention to combat trafficking in organs, tissues and cells of human origin’, above note 93.

¹¹⁴ Ibid.

¹¹⁵ Article 13.

¹¹⁶ Article 17.

¹¹⁷ Boister, above note 7, 137.

¹¹⁸ ‘Towards a Council of Europe Convention to combat trafficking in organs, tissues and cells of human origin’, above note 93, Para 8.3.

¹¹⁹ Council of Europe Draft Organ Trafficking Convention, above note 95, Article 18.

¹²⁰ Ibid, Article 21.1.

2004. It is also recommended that health professionals are provided with relevant information and training and also highlights the need for public information campaigns. It also provides that advertising of activities regulated by the Convention be prohibited.¹²¹

The draft Convention is currently under consideration by the legislative bodies of the CoE. A Report by the Committee of the Parliamentary Assembly on Social Affairs, Health, and Sustainable Development has commented that currently certain provisions in the draft Convention, concerning prevention of organ trafficking and national/international co-operation in relation to such trafficking, are insufficiently detailed.¹²²

b. Extra-Territorial Jurisdiction and Enforcement

If the CoE adopts the Convention and if the UK is a signatory to it, neither of which are necessarily certain, then the question of extra-territorial jurisdiction and enforcement would become a live issue for the UK.¹²³ What then would be the consequences at domestic level?

Commercial dealing in organs for transplantation first became an issue of controversy in the UK following the Crockett case in the late 1980s.¹²⁴ Doctors who had been involved in bringing donors over from Turkey and paying them for transplantation were subject to disciplinary proceedings before the General Medical Council. The concerns of the medical community and the uproar over this incident provided the trigger for the UK government to introduce legislation – the Human Organ Transplants Act 1989. This legislation introduced a statutory ban on organ selling. It criminalized both donors and recipients who were involved in buying and selling organs for transplantation. The prohibition on commercial dealing in transplantation was included in the reformed Human Tissue Act passed in 2004.¹²⁵ The original Bill when introduced into Parliament contained a total prohibition upon commercial dealing in human materials following the approach taken in Article 21 of the Convention of Human Rights and Biomedicine. However, the legislation was subject to intensive lobbying by the scientific community during its passage and consequently one of the provisions related to commercial dealing in human material was amended.¹²⁶ Section 32 of the Human Tissue Act 2004 now regulates the use of ‘controlled material’- human material which is intended to be used for

¹²¹ Ibid, Article 21.2(3).

¹²² ‘Towards a Council of Europe Convention to combat trafficking in organs, tissues and cells of human origin’, above note 93.

¹²³ It should be noted that the UK is still not a signatory to the Council of Europe Convention on Human Rights and Biomedicine.

¹²⁴ See D. Brahams, ‘Kidneys for Sale by Living Donors’ (1989) *The Lancet* 285 and ‘Kidneys for Sale’ (1989) *New LJ* 159.

¹²⁵ Human Tissue Act 2004, s.32.

¹²⁶ K. Liddell and A. Hall “Beyond Bristol and Alder Hey: The Future Regulation of Human Tissue” (2005) 13 *Medical Law Review* 170; During the debates the government minister Rosie Winterton stated that it was: “never our intention to interfere with commercial activities that had been lawfully and ethically carried on for many years. We therefore propose to amend the Bill to confine the offences connected with advertising and supply of human tissue for reward to transplantable tissue only”. (House of Commons Hansard Debates, 28th June 2004, column 115)

transplantation, subject to limited exceptions.¹²⁷ It excludes gametes, embryos and also “material which is the subject of property because of an application of human skill.”¹²⁸ It is much broader than the provisions of the 1989 Act and extends to cover all cellular material for transplantation. Section 32(1) provides that:

- (1) A person commits an offence if he:
 - (a) gives or receives a reward for the supply of, or for an offer to supply, any controlled material;
 - (b) seeks to find a person willing to supply any controlled material for reward;
 - (c) offers to supply any controlled material for reward;
 - (d) initiates or negotiates any arrangement involving the giving of a reward for the supply of or for an offer to supply any controlled material;
 - (e) takes part in the management or control of a body of persons corporate or unincorporated whose activities consist of or include the initiation of negotiation of such arrangements.¹²⁹

Advertising is also caught by the legislation. Section 32(2) makes it an offence to publish or to cause to be published advertisements inviting persons to supply or offer to supply controlled material for transplantation. The Human Tissue Authority, the regulatory body for human material established under the 2004 Act, has the power to designate individuals to exercise powers which would be otherwise prohibited under section 32. The Act does not extend to payment for the transport and preparation of such material nor to the provision of expenses and recompense for loss of earnings.¹³⁰ The only prosecution to date under the section occurred in 2007. Daniel Tuck was successfully prosecuted for offering to sell a kidney for transplantation on an internet chatroom website for £24,000 and was given a 12 months suspended jail sentence.¹³¹

Neither the 1989 nor the 2004 Act made specific provision for their application outside the jurisdiction. This may have been because paid cross-border transplantation was not thought to be a problem at the time of its enactment; certainly this issue does not seem to have been the subject of parliamentary consideration during the passage of the legislation. Debates in the lead-up to the 2004 Act focused largely on consent and retention and use of materials for scientific purposes. This is unsurprising given the trigger for the legislation was the major scandal concerning the widespread national unauthorised retention of human material in hospitals and medical schools all over England and Wales.¹³² However,

¹²⁷ Human Tissue Act 2004 s. 32(8), (9).

¹²⁸ Human Tissue Act 2004, s.32(9).

¹²⁹ Criminal penalties: summary- max 1 year prison or fine; on indictment- max 3 years prison- or fine.

¹³⁰ Respectively, Human Tissue Act 2004 S3.2(6) & S.32(7)

¹³¹ *R v Tuck* (2007); ‘Body Parts sale man avoids jail’ *BBC News* <http://news.bbc.co.uk/1/hi/england/west_midlands/6646467.stm (Accessed 24.01.2013)

¹³² See the two principal reports into organ retention: Bristol Inquiry Report Removal and Retention of Human Material hereafter referred to as the Bristol Inquiry (Department of Health, 2000); The Royal Liverpool Children’s Inquiry Report hereafter referred to as the Redfern Report (London, The Stationery Office, 2001). For a discussion of the impact of the findings of these Inquiries see J.K.

only a short time after the Act came into force the potential problems of the issue was highlighted in the media.¹³³ As evidence grows of persons from England and Wales travelling to participate in illicit transplant tourism the absence of extra-territorial jurisdiction in our domestic prohibitions becomes a more pressing concern.¹³⁴

i. How far should extra-territorial enforcement extend?

The Draft Convention provides considerable flexibility to member states in terms of implementation and would inevitably lead to debate as to how far extra-territorial enforcement of criminal prohibitions should extend. In relation to initial implementation we suggest that debate should center upon the “brokers” and those involved in organised organ trafficking activities. Lunt *et al* define the role of brokers in medical tourism as a key feature of the coordinating and accessing services.¹³⁵ There is also some evidence to suggest a link between illicit organ markets and human trafficking more generally:

As with human trafficking for other exploitative purposes, victims of trafficking for the purpose of organ removal are often recruited from vulnerable groups (for instance, those who live in extreme poverty) and traffickers are often part of transnational organised crime groups. Organized crime groups lure people abroad under false promises and convince or force them to sell their organs. Recipients of the organs must pay a much higher price than donors receive, part of which benefits brokers, surgeons and hospital directors, who have been reported to be involved in the organized criminal network.¹³⁶

Brokers, therefore, can be seen as a lynchpin of the illicit organ trade. Brokers may act in concert with physicians or indeed physicians themselves may act as brokers. The potential for links between brokers involved in illicit organ sales and broader problems of human trafficking justify this group being the main target of the criminal prohibitions through more severe sanctions.

In order to effectively address the problem of organ trafficking we suggest that health professionals involved should also be subject to criminal prosecution. The point at which physicians may become involved in the transnational transaction will

Mason and G.T. Laurie ‘Consent or property: Dealing with the Body and Its Parts in the Shadow of Bristol and Alder Hey’ (2001) 64 *Modern Law Review* 710.

¹³³ ‘Warning over UK’s ‘organ tourists’’ (15.08.2008)

<http://www.politics.co.uk/news/2008/08/15/warning-over-uk-s-organ-tourists> (Accessed 24.01.2013)

In this article Adrian McNeil, then Chief Executive of the Human Tissue Authority, commented that “It is not an offence for a person in the UK to seek medical treatment abroad, but patients seeking this route might find it difficult to assure themselves both of the quality and safety of the transplant and whether the donor has given fully informed consent”. He went on to say that the international transplant community condemned such travel.

¹³⁴ Y. Shimazono *The State of the International Organ Trade: a provisional picture based on integration of available information* (2009). WHO <http://www.who.int/bulletin/volumes/85/12/06-039370/en/#R28#R28> (Accessed 24.01.2013)

¹³⁵ N. Lunt et al, above note 12.

¹³⁶ The Vienna Forum to fight Human Trafficking 13-15 February 2008, Austria Center Vienna Background Paper

depend on the context. Devereaux and Loring distinguish two categories of illicit transplant tourism:

“the before” and “the afters”: presurgical patients “who announce their intention” of purchasing an organ transplant in China, and postsurgical patients returning from transplants acquired abroad.¹³⁷

This is a distinction acknowledged in the Convention between those who facilitate the travel and those who provide after-care and fail to inform the authorities.¹³⁸ An example of a law that has physicians as the target of regulation is Taiwan’s ‘Transplantation Act’ which states that doctors or hospitals involved in organ brokering can be fined up to 1 Million NTD.¹³⁹ We propose a similar model of fines together with the potential for the GMC to impose professional sanctions would be appropriate. Those who receive the organs could also receive fines.¹⁴⁰ It might also be appropriate that they forfeit their position on the organ transplant waiting list should a future transplant be necessary. The latter is already a sanction on those who display other forms of non-compliance with treatment such as continued consumption of alcohol.¹⁴¹ However, the main target for sanction under our models would be those that facilitate and encourage illicit organ sales, this is because as Silke argues:

[P]unishment for those exploiting the vulnerable position of both, donor and recipient, and gaining the main financial profits in this business, should definitely be harsher than for those that should actually be protected by legislations against trafficking in organs. Therefore, organized criminals, e.g., brokers, and white-collar criminals, e.g., medical staff participating in illicit transplantations ... should receive higher sentences than donors and recipients.¹⁴²

ii. *The Mechanics of Enforcement*

As discussed above, there are currently no express provisions within the legislation that the offence of trade in organs is capable of extra-territorial enforcement. This poses a problem for the implementation of the Draft Convention. So could jurisdiction in relation to such offences extend outside England and Wales? International law provides that all States have the right to exercise criminal jurisdiction over events and persons (whether these are national or residents) within

¹³⁷ M. Devereaux and J. F. Loring, above note 77, p.20.

¹³⁸ Parliamentary Assembly Recommendation 1611 (2003) on trafficking in organs in Europe. <http://assembly.coe.int/Main.asp?link=/Documents/AdoptedText/ta03/EREC1611.htm> (Accessed 24.01.2013)

¹³⁹ Fu Chang Tsai ‘Transplant Tourism From Taiwan to China: Some Reflection on Professional Ethics and Regulation’ (2010) 10 *The American Journal of Bioethics* 22.

¹⁴⁰ We are ambivalent about this as an absolute rule given the diversity of the situations that can lead someone to travel for a transplant.

¹⁴¹ ‘Liver Advisory Group Alcohol Guidelines: November 2005’

http://www.organdonation.nhs.uk/about_transplants/organ_allocation/pdf/liver_advisory_group_alcohol_guidelines-november_2005.pdf (Accessed 24.01.2013)

¹⁴² S. Meyer ‘Trafficking in Human Organs in Europe A Myth or an Actual Threat?’ (2006) 14 *Eur. J. Crime Crim. L. & Crim. Just* 229

their borders under the principle of territoriality.¹⁴³ States are also entitled under international law to exercise criminal law jurisdiction in respect of events and persons where this is outside their territory. The active personality principle/active nationality principle enables states to prosecute nationals for crimes which were committed elsewhere in the world.¹⁴⁴ But while international law would sanction extra-territorial enforcement currently English criminal law does not generally extend to cover behaviour of UK citizens outside the jurisdiction unless this is explicitly stated in legislation.¹⁴⁵ In *Cox v Army Council* Viscount Simmonds summarised the situation as follows:

Apart from those exceptional cases in which specific provision is made in respect of acts committed abroad the whole body of the criminal law of England deals only with acts committed in England.¹⁴⁶

A number of offences apply outside the territory of the United Kingdom.¹⁴⁷ However, the only offence which relates to medical procedures is the Female Genital Mutilation Act 2003. This Act, which replaced the Female Circumcision Act 1985, was explicitly amended to extend extra-territorial jurisdiction under section 4 of the legislation.¹⁴⁸ It should be noted that there have yet to be any prosecutions under this section.

In a situation in which some elements or consequences of the offence have occurred abroad but the last part of the offence occurs in the UK the courts have stated that the offence is within the UK as long as the offence is completed in the UK.¹⁴⁹ However where some elements of the crime are undertaken in the UK but the offence is completed abroad and there is no express statutory provision then the legal position as to whether the offence can extend outside the jurisdiction is somewhat less certain. In *Manning* the Court of Appeal took the approach that there is a 'clear preponderance of authority that in the absence of specific statutory jurisdiction' the Courts do not have jurisdiction when the crime is completed abroad.¹⁵⁰ This follows the "terminatory" or "last act" requirement; a crime is deemed to be committed only where it is completed.¹⁵¹ It has been suggested that this is amenable to exceptions and that crimes could be committed within the

¹⁴³ See further V. Lowe *International Law* (Clarendon Law Series, Oxford; 2007) Chapter 5; M. Shaw *International Law* (Cambridge University Press, Cambridge; 2008) Chapter 12

¹⁴⁴ Boister, above note 7, pp.142-147.

¹⁴⁵ *Harden* [1963] 1 QB 8; M. Hurst *Jurisdiction and the Ambit of the Criminal Law* (Oxford University Press, Oxford; 2003)

¹⁴⁶ [1963] AC 48 at 67

¹⁴⁷ The offence of murder by a British subject and conspiracy to commit murder apply wherever they take place; see Offences Against the Person Act 1861 s.9 & s.4. Other offences include the Bribery Act 2010 s.7; Sexual Offences Act 2003, s.72.

¹⁴⁸ Health professionals have monitoring role to identify those that may be at risk of FGM either in the UK or risk being taken overseas for this procedure, see further J. Simpson et al 'Female genital mutilation: the role of health professionals in prevention, assessment, and management' (2012) 344 *British Medical Journal* 37-41.

¹⁴⁹ *Harden* (1963) 1 QB 8 and *Treacy v DPP* [1971] AC 537

¹⁵⁰ (1998) Court of Appeal 2 Cr Appl R 461

¹⁵¹ *Blackstones Criminal Practice* (Oxford University Press, Oxford; 2009) pp.155-156.

jurisdiction in a situation in which the last consistent element takes place abroad.¹⁵² Were this approach to be taken it could be argued that if a donor was paid in cash by a recipient from England while in another jurisdiction then the recipient could be prosecuted on his return to the UK under the Human Tissue Act 2004. However in *Manning* the Court of Appeal rejected this and followed the earlier case of *R v Harden* where it was held that ‘last act’ jurisdictional approach is the most appropriate.¹⁵³ In *Wallace Duncan (No 4)* the more flexible approach was taken by the Court of Appeal.¹⁵⁴ Lord Woolf CJ suggested that to take the approach of the terminatory requirement ‘leads to a wholly unsatisfactory situation in contemporary circumstances’.¹⁵⁵

Blackstones Criminal Practice notes that while *Smith (Wallace Duncan) (No 4)* is binding on trial courts in view of its conflict with earlier authorities it could be open to challenge on appeal.¹⁵⁶ It notes the question of liability in relation to cross-border commission of an offence was discussed by two members of the Supreme Court in *DPP v Purdy* in relation to the extra-territorial application of the law concerning assisted suicide in relation to assisted dying. In this case Lord Phillips left open as to whether the offence applied outside the jurisdiction.¹⁵⁷ He did note that s 3(3) of the Suicide Act 1961 stated ‘[t]his Act shall extend to England and Wales only’. Lord Hope engaged with the writing of Michael Hirst and rejected Hirst’s argument that section 2(1) of the Suicide Act did not extend to extra-territorial suicide. Lord Hope instead stated that:

[S]ection 2(1) applies to any act of the kind it describes that are performed within this jurisdiction irrespective of where the final act of suicide is to be committed.

He followed the approach in *Wallace Duncan*; namely that there was no hard and fast rule that the last act had to be in the UK. Lord Neuberger took the view that the fact that it did not explicitly apply abroad did not mean that the provisions were not applicable, he emphasised that this was a 40-year-old statute and it needed to be applied in context. *Smith (Wallace Duncan)* has been subsequently applied by the Court of Appeal in *Sheppard*.¹⁵⁸ Nonetheless, the controversy regarding the case law in this area implies that if extra-territorial applicability of the provisions of the Human Tissue Act 2004 is necessary then it is not sufficient to rely on existing common law principles. Rather specific new legislative provisions would need to be put in place addressing this issue. This has happened in relation to health related crime in other jurisdictions.¹⁵⁹

¹⁵² In *Smith (Wallace Duncan)* [1996] 2 Cr App R 1 and *Smith (Wallace Duncan) (No 4)* [2004] QB 418

¹⁵³ *R v Harden* [1963] 1 QB 8.

¹⁵⁴ [2004] QB 418.

¹⁵⁵ *Ibid.*

¹⁵⁶ Blackstones, above note 146, para A 8.4.

¹⁵⁷ *R (Purdy) v DPP* (2009) UKHL 45

¹⁵⁸ [2010] 1 WLR 2779.

¹⁵⁹ For example a Turkish law bans cross border reproductive care where this involves gamete donation. Item 231 of the Turkish Penal Code provides that it is illegal to “change or obscure a child’s ancestry” and sets a penalty of 1-3 years imprisonment. See W. Van Hoof and G. Pennings ‘Extraterritoriality for cross-border reproductive care: should states act against citizens travelling

iii. *Investigation of the Crime*

The decision to extend criminal liability to where the crime is committed outside the jurisdiction is however only one part of the story. For the offence to be effective it must be capable of investigation and punishment and in the context of crimes related to health this element too may be very problematic. Certain health activities may be difficult to detect in an acceptable manner. An example of the problem of inappropriate investigation and detention is evidenced in 1990s German practice where women who were returning from the Netherlands were required to undergo gynaecological examinations to check whether they had had an abortion.¹⁶⁰ In contrast illicit transplant tourism falls into a different category. Most instances of illicit transplant tourism involve 'dual criminality', i.e. commercial organ sale is prohibited not just in England and Wales but also usually in the country where the transaction takes place.¹⁶¹ In relation to transplantation there will probably be some knowledge by the state health services as patients need follow-up care and immunosuppressant medication for the rest of their life. They would almost certainly return to a clinician for further treatment, whether on the NHS or otherwise. The barrier to detecting the crime is therefore not visibility but rather domestic laws regarding patient confidentiality, data protection, and professional guidance from regulatory bodies such as the General Medical Council. This means that in conjunction with the introduction of extra-territorial jurisdiction it may also be necessary to engage with the medical profession in order to uncover illegal activities. Identification of a transplant crime would probably require the involvement of a health worker to notify the appropriate authority as recognised by the Council of Europe Assembly.¹⁶² It should be noted that the Council of Europe Convention also envisages that health professionals will be amongst those groups given training/education in this area as they will have a pro-active role in the enforcement process.

This may lead to conflicts with notions of health care professional-patient confidentiality.¹⁶³ In both health care professional ethical codes and in English law it has long been recognized that health care professionals owe a duty of confidentiality to their patients.¹⁶⁴ Today the obligation of confidentiality under the equitable

abroad for illegal infertility treatment' (2011) 23 *Reproductive Biomedicine Online* 546-544; Storrow suggests that this could be upheld because first, it is an expression of nationality principle and second, unlikely to give rise to jurisdictional dispute between states, R.F Storrow 'Assisted reproduction on treacherous terrain the legal hazards of cross-border reproductive travel' (2011) 23 *Reproductive Biomedicine Online* 541. However, such extra-territorial jurisdiction could be the subject of a European Human Rights claim. In the case of *SH v Austria* the Grand Chamber took in to account, in finding that a prohibition on gamete donation was not a breach of the European Convention on Human Rights, that individuals effected by the domestic prohibition could travel, see *S.H. and Others v Austria*, no. 57813/00, (Grand Chamber, 3 November 2011).

¹⁶⁰ Van Hoof & Pennings, above note 155.

¹⁶¹ Boister notes that this is a key feature of transnational criminal law, above note 7, p.14.

¹⁶² Parliamentary Assembly Recommendation 1611, above note 134.

¹⁶³ See the discussion of physician attitudes in Ambagtsheer et al, above note 9, 11-13.

¹⁶⁴ See e.g. *X v Y* [1988] 2 All ER 648; General Medical Council, *Confidentiality* (GMC, London;2009); NMC *The Code: Standards of conduct, performance and ethics for nurses and midwives* (NMC, London; 2008).

remedy of breach of confidence is underpinned by the right to privacy which is safeguarded under Article 8 of the ECHR.¹⁶⁵ This obligation can be outweighed both at common law and under Article 8 of the ECHR by public interest considerations such as the prevention of crime and this is emphasised in professional guidance.¹⁶⁶ Nonetheless there is a considerable difference in safeguarding clinicians if they break confidentiality and imposition of a specific duty. A statutory duty could be imposed to require persons to report to the police or the Human Tissue Authority when they have knowledge/reasonable suspicion that a person had contravened the prohibition e.g. by buying an organ in another jurisdiction and consequently needing remedial surgery where the transplant had been rejected. This by itself would not be a total aberration given that there are already situations in which patient confidentiality is compromised by statutes requiring disclosure of crimes or attempted crime.¹⁶⁷ Therefore, such a duty would not be wholly out of line with existing criminal justice policy. Nonetheless, we acknowledge, that it is likely that the imposition of any such statutory duty to assist/facilitate the investigation of a crime will be exceedingly controversial given the ethical and policy debates around the legitimacy of the use of criminal sanctions in this area in the first place.

Further challenges of enforcement would also remain. Where crimes are committed extra-territorially this will necessarily involve practical problems of investigation of such crimes outside the jurisdiction. Extra-territorial investigation would require the co-operation of the law enforcement agencies of the country where the offence was alleged to have been committed by a UK national. Interestingly this issue was floated in relation to earlier CoE discussions and the need for engagement of e.g. Interpol.¹⁶⁸ The investigation itself would raise the need for consequent new resources being employed. This would be the case in relation to any crime and thus is not an exceptional hurdle to be overcome. The draft Council of Europe Convention if implemented would facilitate the development of a collaborative cross-European approach here. A final issue would be that of sentencing. While cross-jurisdictional criminal enforcement may be appropriate the sentence to be imposed in relation to cross-jurisdictional offences would require careful consideration.

VI. CONCLUSIONS

The global health market creates new challenges for our understanding of health care provision. Many of these challenges require appropriate legal responses. It is perhaps only by framing the specific challenges of illicit organ sales today within a transnational law framework, that states will possess effective legal mechanisms

¹⁶⁵ *Campbell v. Mirror Group Newspapers* [2004] 2 All ER 99.

¹⁶⁶ *W v Egdell* [1990] 1 All ER 835; J.V. McHale 'Confidentiality: an absolute obligation?' (1989) 52 *Modern Law Review* 715; J.K. Mason 'The Legal Aspects and the Implications of Risk Assessment' (2000) 7 *Medical Law Review* 69; [Confidentiality: NHS Code of Practice](#). Supplementary Guidance: Public Interest Disclosures (National Health Service, 2010) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/152224/dh_12203_1.pdf.pdf (Accessed 20.06.13)

¹⁶⁷ S.19 Terrorism Act 2000, also see s.172 of Road Traffic Act where on request a doctor must provide any evidence which may lead to the identification of a car driver involved in an accident.

¹⁶⁸ Parliamentary Assembly Recommendation 1611 above note 134.

necessary to deal with this activity. Today the axis of debate around this issue needs to move from a discussion as to whether commercialism is appropriate within the organ transplant sphere to consider illicit organ sales as more akin to a form of trafficking.

Of course, extra territorial jurisdiction and enforcement may not be the only response and there are other strategies which could be additionally employed to highlight state disapproval of illicit transplant tourism. So for example, in the early 2000's the Parliamentary Assembly of the Council of Europe recommended in relation to demand countries that national medical insurance schemes denied reimbursement for illegal transplants abroad and follow up care of unlawful transplants. In addition it also noted that there needed to be tight control concerning organ registers and waiting lists. A further approach could be the imposition of some limitations upon access to subsequent health care services if the patient had travelled abroad and received a transplant. While initially it would appear that seeking a paid transplant in another jurisdiction might reduce the strain on NHS resources, as we outlined above this may not necessarily be the case if such organs have been subject to fungal infections.¹⁶⁹ Where such instances occur then this would lead to costs for remedial surgery and after care. It also appears that some patients have received transplants abroad when they would not have been eligible under the NHS waiting list at that time.¹⁷⁰ Such limitations are akin to those suggested in the past concerning persons who for example participate in dangerous sports.¹⁷¹ This type of response is likely also to be extremely controversial. Not least given that the UK General Medical Council Guidelines have in the past stated that '[y]ou must not refuse or delay treatment because you believe that patients' actions have contributed to their condition'.¹⁷²

Roberts and Schepers-Hughes suggest that medical tourism 'can both alter and reinforce borders and consequently the nation-states on either sides'.¹⁷³ Essentially transplantation can be seen as not simply a global health market but an area where there is global injustice and where power and finance may result in real exploitation of vulnerable individuals. The Council of Europe draft Convention represents a timely opportunity to move beyond a traditional choice model and instead for states to commit to a stronger normative statement regarding the permissibility of travelling abroad to engage in activities that are prohibited in the home jurisdiction. If values such as the prevention of exploitation of those who are financially worse off or institutional health values such as equality in accessing healthcare are important in society, then the use of extra-territorial jurisdiction is surely necessary to protect those values. As Gostin and Taylor state:

¹⁶⁹ S. Shoham et al. "Invasive Filamentous Fungal Infections associated with renal transplant tourism" (2010) 123 *Transplant Infectious Diseases* 71.

¹⁷⁰ <http://www.who.int/bulletin/volumes/85/12/06-039370/en/#R33#R33> (Accessed 24.01.2013)

¹⁷¹ 'Press release: MHRA warns public of potentially dangerous sports supplements'

<http://www.mhra.gov.uk/NewsCentre/Pressreleases/CON174842> (Accessed 29.01.2013)

¹⁷² GMC *Good Medical Practice: Decisions about access to medical care* (London: General Medical Council, 2007).

¹⁷³ Roberts & Schepers-Hughes, above note 1.

Amelioration of the enduring and complex problems of global health is virtually impossible without a collective response. The creation of international legal norms, processes and institutions provides an ongoing and structured forum for states to develop a shared humanitarian instinct on global health.¹⁷⁴

The draft Council of Europe Convention provides us with a timely opportunity to re-evaluate the law concerning commercial dealing in organs in the light of an increasingly globalised forum for the delivery of health care and for health lawyers and health professionals alike to re-evaluate the scope and application of the criminal law in this area.

¹⁷⁴ L. O. Gostin & A. Taylor 'Global Health Law: A Definition and Grand Challenges' (2008) 1 *Public Health Ethics* 61.