Lincoln Douglas Topic Analysis

Organ Consent

September / October 2014
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September / October 2014
by Dr. Travis Cram

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P.O. Box 14924
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Organ Procurement: Introduction

Resolved: A just society ought to presume consent for organ procurement from the deceased.

Greetings!

The summer has passed quickly and now it is time to get the ball rolling on the first Lincoln-Douglas topic of the year. The September-October topic is simultaneously expansive, timely, and incredibly important, promising a variety of good debates. In this introduction, I will give you some background concerning the break-down of the topic and then briefly discuss the affirmative and negative positions.

This topic asks whether or not a “just society ought to presume consent for organ procurement from the deceased.” The affirmative must defend that it should while the negative is responsible for either defending an opt-in system (where people must register as organ donors prior to death), contesting whether or not presumed consent is just (regardless of whether it is desirable) or articulating a superior alternative than presumed consent. Organ donation is a huge issue with extensive social, legal, and ethical implications. The world has suffered from an organ deficit for years, despite transplanting technologies and risks declining. Living donations are limited because people are usually not willing to donate live organs and procurement from the deceased is often low due to the existing opt-in system that is used in several parts of the world. “Presumed consent” is a very specific term of art in the organ donation literature. Chouhan and Draper provide a useful definition for such a regime:

P. Chouhan and H. Draper, Centre for Biomedical Ethics, Department of Primary Care and General Practice, The Medical School, University of Birmingham, JOURNAL OF MEDICAL ETHICS, “Modified mandated choice for organ procurement,” vol. 29, no. 3, pp. 157-162, June 2003, accessed 8.15.2014:asp.

Presumed consent (sometimes referred to as opting out) is a system that allows staff to presume that a person wants to be an organ donor unless they have registered a view to the contrary. Although the BMA would still like relatives to be given the opportunity to object (though not to consent), the presumption is that an unregistered person is a willing donor, thus permitting organs to be removed without further ado.

As they indicate, a central question in presumed consent systems is the role that the family should play in the decision to obtain organs from the deceased. A great deal of literature indicates that family members are often asked permission to donate organs, even if the deceased is a registered organ donor. Given that family members are often in bereavement and usually unclear about the specific wishes or opinions of the departed (how many families routinely discuss where they stand on the issue of organ donation?), familial requests contribute to the growing organ shortage that has plagued the western world. Thus, many debates will center on how much involvement (if any) the family should have. A second issue that sits at the core of the topic is the boundary between life and death, and Hartogh explains:

Govert den Hartogh, Department of Philosophy, University of Amsterdam, JOURNAL OF MEDICAL ETHICS, “Tacitly consenting to donate one's organs,” vol. 37, no. 8, August 2011, accessed 8.15.2014: academic search premiere.

It is true that in some cases special reasons may exist for insisting on explicit consent. In some countries for such reasons formal written consent is required for any invasive medical procedure to be undertaken. (Note, however, that ‘invasive’ in this context refers to the living body.) For similar reasons we would not be content with tacit consent for allowing the donation of living organs. In such cases the dangers of erring on the unsafe side appear to loom very large, either because of the probability or of the catastrophic consequences of error, or both. On some other issues it may be controversial whether for such reasons explicit consent is or should be required. The
Post mortem removal of organs is not one of those issues. If, for example, people have religious reasons for being very much opposed to having their organs removed, a system such as the one I described gives them all the opportunity they need for acting on such reasons.

While the wording of the topic is clearly limited to procurement from deceased persons, it is not so straightforward in practice. In order for organs to be transplantable, they have to be removed from a body with a beating heart and working lungs. Thus, determining when a body is legally and ethically deceased while still being able to keep its systems functioning is a question that is fraught with many implications. It is possible that some teams may push the topic in a very narrow direction and limit their interpretation to total death, which would only implicate a small number of organs, such as corneas. While this possibility is always present, I have set this file up to deal with broader questions.

The first affirmative position in the file argues that presumed consent is required in order to close the donation gap. So long as people are not able to access healthy organs for transplantations, unnecessary pain, suffering, and death will persist, impacting tens of thousands of people in this country alone. A related issue this position covers is the problem of illicit organ markets. The current system creates overwhelming incentives to turn to unregulated jurisdictions in order to buy live organs. This raises organ trafficking and also directly impacts impoverished and marginalized populations who often are coerced into selling their organs for a paltry sum (despite then suffering from numerous diseases afterwards). The second position argues that families should not be consulted. While this may seem like a hardline stance, families are the chief barrier to donation and are often consulted in the status quo. It is very difficult to win that presumed consent is a just solution if it cannot yield higher procurement rates. Sidestepping families is thus unavoidable. The final affirmative position argues that providing the choice to opt-out is sufficient to respect individual autonomy, thus preserving the central tenet of a liberal order: individual liberty.

The first negative position argues presumed consent amounts to nothing more than the exploitation of the dead. Given the blurry boundaries between death and life when it comes to organ harvesting, doctors would have incentives to take people off life support even if their families objected. This danger is especially pronounced with those who are poor, homeless, or unidentified, should they be found in an unconscious state. The second argument contends that the risk of physician abuse would lead to overwhelming public backlash and a loss of confidence in the system. Should that happen, it is highly likely that people would opt-out of organ donation at a very high rate, rolling back the only reason to have a presumed consent system in the first place. The third and finally argument defends alternatives to presumed consent, such as a mandatory choice regime (wherein individuals would have to choose regularly whether they want to donate or explicitly opt-out).

All things considered, this promises to be an intriguing topic. While this file is fairly comprehensive, I strongly recommend you roll in your own research and strategic thinking in order to keep up with the competition and win as many debates as possible. Good luck!
**Organ Procurement: Strategic Tips**

1. Always try to keep a clear view over who should have the advantage of presumption depending on the issues of the topic. It can be incredibly helpful in a closely contested debate.

2. This year’s topic has several different proposals in the literature for resolving shortages. You’ll be on the high ground in most debates if you can capture which system best resolves illegal transplantation markets, given how abhorrent they often are.

3. The rights and mindset of the family is key issue on this topic. This block is strategic because it turns negative claims that taking organs increases suffering for the bereaved.

4. This card is very effective at circumventing the core of the negative’s case because it challenges the premise that families or the dying are in the right state of mind to provide actual consent.

5. Cognitive biases are a fascinating and crucial part of this year’s topic. There is excellent affirmative evidence that indicates people do not object to donation after death on any principled ground, but simply because people have a natural tendency not change the status quo.

6. Try to incorporate evidence that directly refutes claims of totalitarianism because it is a place where negatives can really appeal to the judge’s biases.

7. Public opinion is not usually relevant to value debates, but this year’s topic is an exception. Given that the debate turns on the question of whether opting in or out is superior, whether or not there is public backlash or support affects the efficacy of the entire system.

8. This file does not include a lot of negative arguments about the need to promote altruism because it seems somewhat unpersuasive to say people should die in order for those who opt in to feel good about themselves. However, it is a very common argument in the literature so I have include a few blocks that cover the question.

9. It can sometimes be difficult to get some judges (especially younger ones) to buy into impacts such as ‘respecting the dead’. The best way to tie these questions to an impact is to argue that blurring the lines between life and death risks the sacrifice of people who are not yet entirely deceased.

10. The best negative arguments hinge on public perception. Again, while perception does not normally play a large role in value debating, backlash is the best negative argument because the evidence that it would effectively undermine more organ procurement is rather strong (closing the donation gap is also the affirmative’s best argument).

11. Family involvement is a tricky issue on this topic. Affirmatives will likely try to eliminate family consent after death because that is the biggest barrier to donation presently. This block tries to short-circuit those arguments by saying that family members would likely challenge presumed consent, tying up organs in a legal battle.

12. The distinction between tacit and presumed consent is a very narrow one and it may not prove to be a large issue on this year’s topic. However, I have provided a few pieces of evidence to allow the negative to be prepared.

13. When you are negative, keep in mind that the more you can do to remove the affirmative’s ability to claim that they achieve greater organ donation, the far more difficult it is to persuasively justify presumed consent.
**Affirmative Position One: Organ Shortages Demand Presumed Consent**

1. **There is an ethical imperative to close the organ shortage gap. Cadaveric organ donation is the only viable way to do so.**

   P. Chouhan and H. Draper, Centre for Biomedical Ethics, Department of Primary Care and General Practice, The Medical School, University of Birmingham, JOURNAL OF MEDICAL ETHICS, “Modified mandated choice for organ procurement,” vol. 29, no. 3, pp. 157-162, June 2003, accessed 8.15.2014: academic search premiere.

   The need for organs for transplantation continues to be greater than the number donated. Other methods for increasing the availability of organs for transplantation being explored. Of these, advances in stem cell technology seem promising, but there are considerable obstacles yet to be overcome, as is the case with xenografting. Financial incentives for donation have also been considered, but the sale of any human tissue is likely to fall foul the Council of Europe's Convention on Human Rights and Biomedicine. Given the present limitations on such alternatives, the failure to secure sufficient numbers of cadaveric organ donations has led to a noticeable increase in live donation of certain organs such as kidneys, as well as lung and liver lobes. Even if the risks and harms to live donors are statistically acceptable however, and this is not always the case, it would still be ethically preferable to use cadaveric organs, if only there were sufficient of these available, since no risk or harm to a living person is better than even a small risk or harm. There is, therefore, an ethical imperative to increase the number of cadaveric organs available before pursuing other options for saving life (and quality of life) that aim at increasing the number of donations from living persons. This remains the case, even if it is unlikely that there will ever be sufficient numbers of cadaveric donations to completely negate the need for live donation. Furthermore, some organs or tissues, such as hearts and corneas, can, at the present time, only be obtained through cadaveric donation.

2. **Presumption should rest with the affirmative because the benefits of increasing the organ supply are overwhelmingly clear.**


   Is there a moral case for changing the law regulating organ donation from a system of ‘contracting in’ to ‘contracting out’ or “presumed consent” in those countries that have not yet done so? Contracting in refers to a system in which the law requires that donors and/or relatives must positively indicate their willingness for organs to be removed for transplantation. In a contracting out system, organs may be removed after death unless individuals positively indicate during their lifetimes that they did not wish this to be done, a system also known as presumed consent. We start with the premise that any measure that increases the supply of organs for transplantation is a good thing. If the contracting out system were to achieve this, the onus would then be on those who oppose it to demonstrate that the benefit that flows from it is outweighed by the harm.

3. **Maximization of organ donation rates must take primacy. It trumps consent issues.**


   I assume that increasing the supply of organs is, uncontroversially, a morally laudable aim -- the issue is simply to show that the means of doing so are not morally objectionable. It is sometimes suggested that some measures designed to increase the supply of donor organs undermine the expressive value of altruism in their donation. The primary value of organ donation, however, is instrumental, rather than expressive, and this value is not threatened by the donor's motives. We can appeal here to the values of choice identified by Scanlon. He argues that being able to choose is valuable in at least three ways. First, choosing may be instrumentally useful to getting what you want. If we are in a restaurant, for example, then you are probably best placed to know what you like, both in general and on that occasion, so you would ordinarily be best satisfied if you choose your own dish from the menu. Second, there may be expressive or representative value in making the choice. Your partner may be able to satisfy his desires better with his own money than you can, but there is value in you choosing a gift for him, and this would be lost if you simply gave him the money or vouchers to spend for himself. Third, there is symbolic value in being recognised as someone capable of choosing for yourself, rather than being treated like a child. Instrumentally, what matters is getting what you want, almost regardless of how you get it (at least, unless the means itself has instrumental effects). If I need an organ transplant, then what matters to me is getting the organ. It makes no difference to me, from the purely instrumental perspective, whether I do so as a result of altruism on the part of the donor, or whether they only part with the organ in exchange for money, or even if they donated under duress (say, at gunpoint). From an instrumental perspective, we should simply choose whichever of these methods maximises organ donation. Of course, we care about more than merely maximising the supply of organs. We think it would be wrong to extract organs forcibly from people against their wishes, because people have rights -- expressible as 'side constraints' or 'trumps' -- that restrict what we can do to them, even for the social good. I shall argue, in the latter part of this paper, that opt-out systems do not violate such rights.
**Affirmative Position One: Organ Shortages Demand Presumed Consent [cont’d]**

4. **Donation should be a default. The consequences of overriding autonomy pale in comparison to the moral obligation to provide healthy organs to those in need.**

Goverd den Hartogh, Department of Philosophy, University of Amsterdam, JOURNAL OF MEDICAL ETHICS, “Tacitly consenting to donate one's organs,” vol. 37, no. 8, August 2011, accessed 8.15.2014; academic search premiere.

One way of dealing with the objection would be to grant it. Yes, maybe there is some moral cost involved in choosing organ removal as the default, even in a tacit consent system. That moral cost can, however, be outweighed by the benefits of the greater number of organs becoming available for transplantation. I believe that a stronger reply is available. We may welcome that greater number of organs without considering it to be the justifying ground for our choice of the default. The possible bad consequences of having one's organs removed are normally very limited, both for the deceased (although I do not deny that such consequences may exist) and for his relatives, and this means that one normally has a strong moral reason to make one's organs available for transplantation to people with organ failure. That is enough for taking removal to be the default. The manipulation objection fails, because such a system presents no hindrance at all for people to be clearly and fully aware of the existence of that moral reason, and act on it by consenting, explicitly or tacitly. Even if they are only dimly aware of it, it is to be preferred that they act on it. If patients with organ failure have a moral claim on us to make our organs available to them after our death, but a conscription system, for reasons of principle or practicality, is not an option, we should at the very least adopt organ removal as the default. That need not even be a restriction or limitation of people's authority-right to decide about their own dead bodies.

5. **Encouraged voluntarism is ineffective at getting consent for donation. Presumed consent is necessary.**


By the mid-1980's, it had become clear that the policy of encouraged voluntarism embodied in the UAGA was not producing enough donors. Few persons signed donor cards. Even when potential donors with signed cards were identified, hospitals refused to harvest their organs without familial consent, and doctors were reluctant to approach families to ask for permission. The supply of cadaver organs remained limited at the same time that advances in transplant technique and immunosuppressive therapy improved the success rate of transplants, thereby increasing demand. The continued shortage of donor organs prompted the search for an alternative to the principles of encouraged voluntarism. One proposal was presumed consent. Under the name of "routine salvage," Dukeminier and Sanders had advocated this approach back in 1968 when transplantation successes first began to stimulate interest in increasing the supply of donor organs. As envisioned by Dukeminier and Sanders, presumed consent would eliminate the need for donors to carry donor cards, and for physicians to intrude on the family's grief just when they had learned of the death of a loved one. In essence, the burden of taking action would shift from the surgeon wishing to remove the organs to the donor and his family. There would be no need for the doctor to obtain explicit consent to donation; instead, it would be up to the family, or to the decedent while still alive, to assert an objection. In the absence of an objection, the doctor would be entitled to assume that he had permission to retrieve any organs that were needed, and he could remove the organs without fear of legal liability.

6. **Presumed consent results in greater levels of organ procurement and transplant rates.**


Interest in presumed consent stems chiefly from the expectation that it would significantly increase the supply of transplant organs. European experience with presumed consent is frequently cited in support. Benoit and his colleagues report that transplantation has increased since the introduction of presumed consent in France -from 551 to 1808 kidneys; from 15 to 622 hearts and hearts/lungs; from 7 to 409 livers; and from 2 to 43 pancreas. Roels and his colleagues state that the adoption of presumed consent in Belgium resulted in an 86 percent increase in cadaveric kidney procurement, and a 183 percent increase in the total number of organs available for transplant. They also report much higher transplantation rates in three countries that they claim have presumed consent systems -- Belgium, France and Austria -- compared with three other countries that do not -- the United Kingdom, the Federal Republic of Germany, and the Netherlands. In a paper reporting more recent data from 1989, Roels and his colleagues state flatly that "data presented show that, at least in Europe, the problem of chronic organ shortage can adequately be solved in the setting of an [sic] opting-out legislation."
**Affirmative Position One: Organ Shortages Demand Presumed Consent [cont’d]**

7. There is a moral obligation to use presumed consent to increase organ supply in order to bring illicit trafficking to an end.


The current paradigm presents the worst-case scenario. Due to an insurmountable organ shortage, a black market exploits the socially invisible and helpless. To continue on the current course is to allow unacceptable exploitation. International collaboration is required to develop a common strategy to stop the trafficking of human organs. This Comment examines international and U.S. attitudes towards organ harvesting with the objectives of achieving a more unified front to increase organ availability and curb exploitation in third world countries. Part I describes the various organ harvesting policies in third world countries, using Thailand, Singapore, and the Philippines as concrete examples of a much broader problem. Part III discusses the history and law of organ procurement in the United States, which construes organs as gifts which may be freely given or withheld. This Comment questions the sufficiency of this scheme in light of alternatives, such as a system of presumed consent, which are arguably more effective in increasing organ supply. For a number of reasons, presumed consent does not have public support in the United States, which may be rooted in notions of privacy and property law. Next, Part IV examines the development of property and privacy law as it pertains to the human body. Finally, Part V concludes that presumed consent is not only a preferable system of donation which is constitutionally sound, but it is much less intrusive than many laws enacted in comparable situations. On an international level, there needs to be a concerted effort to increase supply of organs and apply rules evenhandedly. One solution may be presumed consent, a policy in line with national and international laws.

8. Presumed consent resolves the chief ethical criterion for organ donation systems.


In the first place, they doubt that presumed consent would increase the supply of donor organs. Citing the experience in France, critics assert that health professionals in the United States would behave no differently than their French counterparts, and would refuse to harvest organs without express permission. This is an empirical question, and underscores the need for definitive data from Austria and other countries demonstrating the impact of presumed consent on organ availability. Critics of presumed consent do not rest on this point, however. They take the position that, contrary to those who argue that presumed consent would yield the secondary benefits described above, such a system would be so inhumane, manipulative and unpopular that it must be rejected for those reasons alone. In other words, the end does not justify the means. The question then is, assuming that presumed consent would significantly increase the supply of donor organs, must it be rejected for other reasons? A. Ethical Objections. The ethical objections to presumed consent can best be summarized by referring to the five ethical values that the Task Force on Organ Transplantation of the Department of Health and Human Services in 1986 identified as necessary for any organ procurement system to promote: "saving lives and improving quality of life"; "promoting a sense of community through acts of generosity"; "respecting individual autonomy"; "showing respect for the decedent"; and "showing respect for the wishes of the family." There would seem to be little disagreement that, assuming that presumed consent significantly increased the supply of cadaveric organs, it would promote the first value of saving lives and improving the quality of life.

9. Presumed consent is necessary to avoid massive amounts of easily preventable deaths.


The current organ crisis in the United States suggests that NOTA and UAGA result in market failure. The shortage of organs for transplantation results in a tragic number of potentially preventable deaths. Organs are retrieved from only 15-20% of the 15,000 to 20,000 eligible donors each year and increased efforts to encourage organ donation would save many more lives. n This Comment argues that an organ procurement system based on presumed consent would help to eliminate the gap between organ supply and demand. The nations with the highest per capita organ donation rates in the world all operate under presumed consent laws. Commentators have warned that the political prospect for enacting presumed consent laws in the U.S. is bleak. In addition, the public’s lack of support for presumed consent is grounded in legal concepts of privacy and property as they relate to the human body. This Part discusses individual autonomy and the freedom from government intervention as it relates to the human body and questions the underlying premise that we own our bodies.
1. The status quo policy of opting in drives up an artificial organ shortage, fueling illicit harvesting and organ tourism around the globe.

Consequence: Shortages sustain illicit organ markets


In stark contrast to the systems in place in Thailand, Singapore, and the Philippines, the U.S. approach to organ harvesting is highly restrictive. Despite their differences, however, all of these systems present problems that may be equally problematic on an ethical level. In third world countries, the problem is the presence of systems that lead to unethical harvesting of organs. In the United Systems, the problem is the presence of a system that discourages any organ harvesting whatsoever. In December 2003, there were 83,686 people on the organ waiting list in the United States. Last year, 6,187 Americans died while waiting for organs. This Comment argues that rather than creating a situation in which the need for organs is being met, the system in the United States actually creates critical levels of organ shortages. Furthermore, the situation will worsen before it improves. As medical science continues to advance, the demand for organs will increase because organ transplantation is the best treatment and only hope for many people suffering from end-stage disease. "The lifesaving potential of organ transplantation is limited only by a shortage of organ donors," which is perpetuated by the inefficiency of national law and policy in organ transplantation.

2. Presumed consent is the best way to close the organ gap without having to resort to mechanisms like markets or sales that drive illicit trading in organs.

Consequence: Presumed consent can help close down illicit markets in organ trade


The biggest obstacle for the transplant community is scarcity of organs. A number of options for increasing supply exist. Recognizing that the creation of an organ market is one such option, some members of the legal and medical community are attacking NOTA’s prohibition on the sale or purchase of human organs. Their approach is to advocate alternatives to the prohibition, such as providing an ethically acceptable financial incentive to the beneficiaries of a decedent that may motivate an individual to formally express his intentions about donation prior to his or her death. The sale of human organs, however, whether from a living person or a cadaver, is against the law in virtually every country and has been condemned by all of the world’s medical associations. So, while some medical professionals and ethicists are currently debating the possibility of compensation for organ donors, a market in body parts is a highly controversial shift in policy that violates current U.S. law and International Protocols. Another option for increasing organ supply includes policy changes involving mandated choice or presumed consent. These policy changes offer a more viable, unified, and accepted way of increasing available organs, especially when compared to the creation of an organ market. Increasing consent rate among potential donors would significantly increase the number of organs available. "In fact, if all potential donors became actual donors, there would be enough hearts and kidneys available to transplant each person added to the list in 2002."

3. Presumed consent can help close down illicit markets in organ trade.

Consequence: Presumed consent can help close down illicit markets in organ trade


NOTA and UAGA are insufficient to replenish organ demand in the U.S. and, therefore, prompt would-be recipients to take matters into their own hands. Unfortunately, self-help measures result in the exploitation of impoverished inhabitants of third world countries, in the manner described in Part II above. The only way to solve the crisis is through international collaboration to increase organ supply. A market in which the impoverished sell their organs to the rich is not an ethical solution. The WMA and the European Community have taken steps to denounce the black market for organs. Accordingly, there is international support for a movement towards presumed consent. A. The Convention on Human Rights and Biomedicine In recognition of the human rights abuses occurring in impoverished countries, many European countries are passing laws to protect the exploited from selling organs for a pittance. In 1997, the Council of Europe signed a treaty to protect living donors. The Council agreed that "donor consent was necessary for any organ procurement law and that financial gain in the organ market was highly unethical." In 2001, the Council of Europe enacted the Additional Protocol to the Convention on Human Rights and Biomedicine, Concerning Transplantation of Organs and Tissues of Human Origin (the Protocol). Parties to the Protocol use their own internal laws to effectuate the measures enunciated by the Convention. The Protocol distinguishes between: (1) living donors capable of giving consent, (2) incompetent living donors, and (3) deceased donors.
4. **Organ trafficking is a demand based problem. Only resolving the shortage and creating new regulatory conditions can put an end to it.**


The Council of Europe criticized the "recent trends in some western European countries towards less restrictive laws, which would allow greater scope of unrelated living donation." Calling for universal action, the Council stated, "trafficking in organs, like trafficking in human beings or drugs, is demand driven." Combating this type of crime should not remain the sole responsibility of countries in Eastern Europe. The Council listed examples of measures that should be taken by all member states to minimize the risk of organ trafficking in Europe such as: reducing demand, promoting organ donation more effectively, maintaining strict regulation with regard to living unrelated donors, guaranteeing transparency of national registers and waiting lists and establishing the legal responsibility of the medical profession for tracking irregularities and sharing information. The Council once again denounced the idea of a market-based distribution of organs. "The principal according to which the human body and its parts shall not, as such, give rise to financial gain is part of the legal acquis of the Council of Europe." While those in favor of an organ market cite the inevitable sale of organs as a call for legalization and regulation, the Council called for prohibition by strengthening existing laws. While the prohibition of organ trafficking is legally established in the Council of Europe member states, most countries still have legislative loopholes in this domain. Criminal responsibility for organ trafficking is rarely specified in national criminal codes. "Criminal responsibility should include brokers, intermediaries, hospital/nursing staff and medical laboratory technicians involved in the illegal transplant procedure.” Medical staff who even encourage transplant should also be eligible for prosecution. Furthermore, "the medical staff involved in follow-up care of patients who have purchased organs should be accountable if they fail to alert the health authorities of the situation."

5. **Presumed consent laws are essential to prevent the suffering and injustice of economically coercive organ donations.**


As a "demand country," the United States is in a position to reduce the burden on the impoverished inhabitants of eastern Europe who sell their body parts for the health of the rich, by increasing the supply of organs available within the United States. Primarily, the United States could help relieve the burden by taking appropriate measures to increase the number of available organs obtained postmortem by enacting presumed consent laws. International collaboration is the only effective way to stop the flourishing black market. While some commentators argue for regulation of an organ market, it is clear that the World Medical Association, the Council of Europe, the United States, and a majority of ethicists are repulsed by the idea. Presumed consent is a viable alternative. Presumed consent is not only a morally and legally justified course of action, it also falls in line with the principles enunciated by international organizations. A major fallacy of the "opt in" system of organ procurement is the assumption that people who have not registered to donate their organs have expressed their refusal to donate. People who fail to sign donor cards would say that organ donations are desirable and noble when asked. Arguably, presuming consent allows us to meet the wishes of most people. Furthermore, the "opt out" registry protects the individual autonomy of those who do not want to donate their organs. Unless it can be shown that presumed consent is ethically unacceptable, society has a duty to pursue the option that would save thousands of lives.
1. The giant gap needed for supplying organs incentivizes unethical harvesting through illicit markets.


Thailand, Singapore, and the Philippines serve as useful illustrations of the varied approaches taken by third world countries to Organ Harvesting. The following discussion of the economic and structural conditions affecting organ harvesting in these countries illustrates the ways in which these factors, present in most third world countries, contribute to situations in which organs are being harvested unethically. A. Financial Corruption in Thailand Even in countries where organ harvesting is illegal, incentives to profit from organ transplantation corrupt hospital policy. For religious or merely superstitious reasons, Thai families are averse to organ donation and will not allow surgeons to remove organs before cremation. Therefore, the waiting list for a transplant is long. Due to a fairly wealthy population, hospitals and surgeons are in a position to make large profits if they can find available organs. Thailand has two health care systems. One is characterized by dirty and overcrowded public hospitals; the other is comprised of lavish, state of the art, private hospitals. The private profit-seeking hospitals are centers for medical tourism and maintain some of the best facilities in the world. Some private hospitals are unwilling to help accident victims because they are too poor to pay the bill. Other private hospitals engage in a more aggressive cost-benefit analysis: "If they admit traffic victims who then die, and if their families are willing to donate their organs, the hospital would then have two kidneys available for transplant into two patients able to afford the $ 10,000 cost of an operation that would cost about $ 100,000 in the United States." Bangkok's Vachiraprakarn General Hospital (VGH) adopted this policy. In spring of 2002, a transplant surgeon persuaded the family of a comatose pregnant woman to transfer her from a rural hospital to VGH, after promising to provide "free" medical care. The family then signed a consent form, which authorized the removal of the woman's kidneys if she died. Following her death, the family received a $ 2,500 payment for "funeral expenses." The surgeon removed the woman's kidneys, transplanted them into two patients, and charged each patient for the full amount of the surgery and their “gifts.” As calculated, for an expenditure of $ 2,500, the surgeon made $ 25,000. VGH was investigated when rumors emerged that the woman had not been brain dead upon the removal of her organs. The Thai Medical Council investigated the allegations and found that VGH has consistently violated laws prohibiting the sale of organs. The hospital had a longstanding practice of transplanting kidneys from living donors who are not related to the recipient, making substantial payments to families agreeing to a donation, and then charging the recipients of the organs the full costs of the payment. As a general practice, VGH bribed people in other hospitals to transfer patients near death to VGH and paid ambulance drivers to bring near critically injured patients to its emergency room. Though Thailand has active medical and legal authorities, they only respond to complaints; they do not initiate investigations. Surgeons and administrators remain free to cut their own deals in the organ market.

2. The illicit market dramatically impacts those who are poor or marginalized, forcing the world's most vulnerable to bear the burden of the global organ shortage entirely. 2


Poverty oppresses the rural inhabitants of many third world countries, and the resulting desperation sometimes leads young men and women in these countries to sell their body parts. A saber-like scar marks the abdomens of as many as 14 out of 40 young people in the rural towns of India and South East Asia. It is a symbol of either ultimate liberty or devastating exploitation. Generally, the donor is a young man between the age of 18 and 28 who sells his kidney for $ 2,000-$ 3,000. The recipient pays $ 250,000 per transplant. The surplus goes to international organized crime and the doctors who make the transplants. In a thriving underground market, "the circulation of kidneys follows established routes of capital from South to North, from East to West, from poorer to more affluent bodies, from black and brown bodies to white ones, and from female to male or from poor, low status men to more affluent men." Despite its illegality in almost every country, organ trafficking persists because the poverty of potential donors, endless waitlists, and better quality of organs harvested from live donors make organ commerce an irresistible trade. The coordinator of kidney transplantation at Hadassah University Hospital in Jerusalem estimates that "60 of the 244 patients currently receiving post-transplant care purchased their new kidney from a stranger - just short of 25% of the patients at one of Israel's largest medical centers participating in the organ business." Although organ trade is prohibited by national and international transplant societies as well as by the World Medical Association (WMA), their rules are rarely enforced. The WMA formally espouses that, "payment for organs and tissues for donation and transplantation should be prohibited. A financial incentive compromises the voluntariness of the choice .... Organs suspected to have been obtained though commercial transaction should not be accepted for transplantation." The WMA, however, neither has nor seeks the authority to discipline. It merely provides "guidance to medical associations, physicians, and other health care providers." Desperate buyers and sellers who are dealing in life and death transactions rarely follow such guidance. As a result, there is no effective international regulation.
3. Leaving organ supply up to markets, illicit or otherwise, results in using economic necessity to coerce people into giving up their organs.


Bioethical arguments about the right to buy or sell an organ are based on Western notions of contract and individual choice. Yet, in the United States, organs are construed as gifts for social policy reasons. The United States does not believe people should have the choice to sell their organs. "We may freely withhold or freely give them, but we may not sell them, nor claim them for others as a matter of right." Since demand will continue to escalate, the only way to close the gap between organ need and availability is to increase supply. Proponents of a legal market argue that people respond to monetary incentives. Based on market incentives, people will sell their kidneys, increase the supply of the scarce and highly valuable resource, and create a "win-win" situation for the donor and recipient. The Philippines is one region where the freedom of contract hypothesis is tested in reality. In the Philippines, kidneys are legally purchased on an open market. Medical teams go into the poor areas, perform blood and tissue tests on the inhabitants, and store the results. When a recipient arrives for a transplant, an organ broker reviews the stored results, finds a donor based on these results, arranges a pairing, and a surgeon performs the transplant. The practice is defended as a matter of free choice. A group of American physicians and bioethicists concur, arguing that since we cannot rid the world of poverty, the choice to sell a kidney is the "best option poverty has left." Empirical evidence, however, weakens this theoretical argument. When asked about their health and economic condition, Filipinos who had sold their kidneys complained of pains and disabilities for which they could not afford medical treatment. They were also further in debt. Before the surgery, many had worked at loading ships on the docks. After the surgery, they were no longer able to do heavy lifting or had been fired due to the stigma associated with infirmity. "Decisions to sell a kidney appear to have less to do with raising cash toward some current or future goal than with paying off a high interest debt to local moneylenders." It has even been suggested that once a region is reputed to be a source for kidneys, "brokers intensify their search for sellers there; creditors then become more aggressive in calling in debts, and relatives of patients become still more reluctant to donate a kidney when they can buy one." Some ethicists have concluded that this freedom of contract is really a "false liberty." "The choice to sell a kidney in an urban slum of Calcutta or in a Brazilian favela, or a Philippine shantytown is often anything but a free and autonomous one."

4. The organ shortage is a travesty for justice because it shifts the burden for the rich’s health onto the very poor.


At the June 2003 Parliamentary Assembly, the Council addressed the problem of "transplant tourism," which has prospered hand in hand with the rapid progress in medical science and technology that has made organ transplantation a routine medical procedure practiced in hospitals across the world. The Council reiterated: The supply of organs from cadaveric, but particularly from living, donors is very limited and strictly controlled in Europe. There are currently 120,000 patients on chronic dialysis treatment and nearly 40,000 patients waiting for a kidney transplant in Western Europe alone. Some 15% to 30% of patients die on waiting lists, as a result of chronic shortage of organs. The waiting time for transplantation, currently about three years, will reach almost ten years by the year 2010. The Council then noted, "international criminal organizations have identified this lucrative opportunity caused by the "gap" between organ supply and demand, putting more pressure on people in extreme poverty to resort to selling their organs." Organ trafficking has reached a level of international concern since "it is very likely that further progress in medical science will continue to increase the gap between the supply of, and demand for, organs." The Council noted that poverty was the main incentive for selling kidneys. "As a result of poverty, young people in some parts of eastern Europe have sold one of their kidneys for sums of $ 2,500 to $ 3,000, while recipients are said to pay between $ 100,000 and $ 200,000 per transplant." The Council voiced the "grave concern that following illegal transplants the donor's state of health generally worsens in the medium term, due to the absence of any kind of medical follow-up, hard physical work, and an unhealthy lifestyle connected to inadequate nutrition and a high consumption of alcohol." In a twist of fate, "most illegal donors will thus be forced in time to live on dialysis treatment or await, in turn, a kidney transplant." The situation presents difficult questions: "Should the poor provide for the health of the rich? Should the price of alleviating poverty be human health? Should poverty compromise human dignity and health? And in terms of medical ethics, should help to recipients be counterbalanced by neglect of, and harm to, donors?" Almost everyone agrees that it is a tragedy for the poor to sell their bodies for the health of the rich.
5. Opting in causes needless suffering and drives illicit organ transactions.


Internationally, organ transplantation has been established as a feasible solution to the problem of end-stage organ failure. As medical technology and surgical techniques improve, the capability for successful organ transplantation grows, which in turn, allows people who were once classified as terminally ill to dramatically extend their lives. As organ transplantation becomes a more available therapy, the demand for transplantable organs increases. Unfortunately, not all countries have taken measures to increase domestic supplies of transplantable organs in order to meet the rising demand. Part of the cause of some countries’ organ shortages is the mixed goals of their organ procurement laws; in others, society’s moral or cultural biases against organ harvesting prevents effective organ procurement. Some countries have not developed a comprehensive system of organ procurement, leaving those in need of an organ to find one for themselves. Obviously, a shortage of transplantable organs results in death when potential recipients do not receive a transplant in time. However, other problems are developing due to the worldwide organ deficit. Internationally, one of the most pronounced problems is the human rights violations occurring as a result of the highly questionable, if not illegal, methods of satisfying organ demands. The current shortage of legally collected organs is due to the lack of efficacy of most domestic laws, the lack of legislative consistency from nation to nation, and the lack of consistent and aggressive enforcement of such laws. The variation between legal systems has allowed abuse of the simplest method of organ procurement -- organ sales from live donors. This system is generally poorly regulated and fraught with health risks to both the donor and recipient. Often, it is the poorer citizens of developing countries who are supplying organs for the members of the upper class who can afford them, either directly or through organ brokers. However, when the organ, like any other valuable commodity, cannot be bought, it is stolen resulting in flagrant violations of human rights. Since organ demand generally is not met through legal methods of collection, there are a significant number of people suffering and dying in hospitals who could not only be living normal lives, but expending fewer hospital resources. An organ deficit forces doctors to decide which patient receives an organ and which one does not. Desperate patients who feel they can no longer wait for an organ to be legally supplied, and who can afford the high cost, look to the black market for organs. If the demand for human organs was met legally and cheaply, there would be little incentive to seek organs illegally. A legal high organ procurement rate would, therefore, lead to the eventual elimination of the human rights violations inherent in the human organ black market.

6. There needs to be a global opt-out system for organ procurement. That is the quickest, most effective way to stop suffering and end coercive transplantations.


Assuming that saving lives is the goal of any organ procurement and transplantation program, each nation should enact uniform legislation allowing for the procurement of as many organs as possible from the potential pool of adequate cadavers and willing living donors. However, there are numerous restraints that differ greatly from region to region, country to country, and religion to religion, which prevent the thorough collection of organs. These factors include, but are not limited to, the education of the public concerning the benefits of organ donation; the attitude of the public toward organ donation; the attitude of the government and health professionals toward organ collection; moral or ethical objections to organ donations resulting from religious or cultural traditions or enacted laws; the possible property rights the donor or his family might have in the organs; the civil or privacy rights the donor may have in the disposition of the body; the cost of the transplant operation; hospital resources for transplants; organ resources for transplants; political or social motives to be accomplished with organ donation; and the determination of time of death in relation to the usefulness of the cadaveric organs. The ideal legal philosophy should attempt to promote prodigious collection while retaining flexibility, so as to accommodate local objections to certain practices. Section II of this Note addresses the existence of international forces of supply and demand for transplantable human organs, and discusses why domestic organ demand is not limited to national borders. Section III documents the crimes being committed by individuals and states as a result of the worldwide inadequacy of organ procurement legislation. Section IV examines the current patchwork of domestic laws in an effort to determine what states can do to maximize the safe, effective, and socially equitable collection of human organs for transplantation. Section V addresses the principles of international law under which one country can prosecute another country, or its nationals’ for the absence of human rights abuses. Section VI concludes that the worldwide harmonization of domestic legislation, which would enact an organ procurement system, presuming the consent of the individual to donate organs while maintaining the option to withdraw consent, will best alleviate the demand for transplantable organs. This system should also provide a framework for the extraterritorial prosecution of human rights violators, thereby eliminating the existence of the black market.
**Underview: Presumed Consent Resolves Shortages**

1. Presumed consent empirically results in much higher increases in cadaveric organ donation.

   P. Chouhan and H. Draper, Centre for Biomedical Ethics, Department of Primary Care and General Practice, The Medical School, University of Birmingham, JOURNAL OF MEDICAL ETHICS, “Modified mandated choice for organ procurement,” vol. 29, no. 3, pp. 157-162, June 2003, accessed 8.15.2014: academic search premiere.

   This is a system that has found favour in some other countries. After the passing of a presumed consent law in Belgium, the number of kidneys available for transplantation increased by 114 per cent over the ensuing five years. There was no similar increase experienced in other countries without presumed consent laws in the same geographical region. Interestingly, donation rates in Denmark fell by almost half after the introduction of an expressed consent law in 1986, even though Denmark previously had one of the highest cadaveric organ procurement rates under the presumed consent system that was operated prior to 1986. Singapore also experienced a sharp rise in donation rates after instituting presumed consent. Incidentally, the publicity campaign before the introduction of the presumed consent law in 1987 had the added effect of causing an increase in the number of donations under the pre-existing expressed consent system. In Belgium too the implementation of presumed consent was supported by a strong publicity campaign, which may have influenced donation rates.

2. Presumed consent has enough empirical support for its ability to shrink the supply gap that it is immoral not to switch to it as the most efficient method of procuring organs.


   Since 1990 in those countries that have a contracting in system in place the number of cadaver organs available for transplantation has not kept up with demand; indeed the gap is widening. Nonetheless, many people believe that the law should not be changed, arguing that a significant improvement in supply could result from public and professional education and measures to simplify the process of donation and retrieval of organs. Although not discounting this possibility, we believe that a contracting out system would achieve the same effect with greater certainty, as has been shown in countries that have changed to this option. Therefore we believe that it is morally unjustified to perpetuate a system that falls short of increasing the availability of organs to people who might benefit from transplantation.

3. Austria is a country with both de jure and de facto presumed consent and the data shows that it can increase procurement rates in several areas.


   One true presumed consent system in Europe is found in Austria. A patient who does not wish to donate organs must state his objection in writing. Donation is not discussed with families unless they raise the issue. The only exceptions are cases involving pediatric patients and foreigners. It is therefore noteworthy that the latest data from Eurotransplant on the availability of kidneys for transplantation show that Austria not only has a significantly higher rate than the Federal Republic of Germany, Luxembourg and the Netherlands, all of which have voluntary donation systems, but also a rate more than 11 percent higher than Belgium, which, despite its de jure presumed consent system, operates de facto on the basis of encouraged voluntarism or routine request. The Austrian data on heart and liver donation are not as clear. If presumed consent provided more organs than other donation approaches, it would be expected that, as a percentage of the population, more hearts and livers would be donated in Austria not only in comparison with countries that have de jure and de facto voluntary systems, like the United Kingdom, Germany and The Netherlands, but also in comparison with Belgium and France. According to Roels and his colleagues, Austria, Belgium and France all have much higher numbers of hearts and livers available for transplantation per million inhabitants than the United Kingdom, the Federal Republic of Germany and The Netherlands. But while Austria has a somewhat higher rate for livers than either France or Belgium, it has a lower rate for hearts. The Austrian experience therefore provides some support for the notion that adopting presumed consent increases the supply of donor organs over other donation approaches, but the data are incomplete, and a number of questions remain unanswered.
4. Empirical evidence shows that presumed consent can elevate procurement rates.


There are some interesting approaches to organ donation in the international arena which are worth considering. The most well-known system of presumed consent is that of Belgium, which was enacted in 1986 and updated in 2007. Their laws, which have been used as an example in many other countries, state that organs and tissues may be removed from the body of any person who is a Belgian National, or has lived in Belgium for six months, and who is recorded in the Register of the Population, unless it is established that an objection to such a removal has been expressed by the patient. This can be done through sending a formal objection to the local authority. In Belgium in the late 1980’s, the number of donors rose from 15 to 40 per year over a 3-year period. Nationally, organ donation rose by 55% within 5 years despite a decrease in the number of organs available from road-traffic accidents. Individuals who wished to opt out of the scheme were able to register their objection at any Town Hall, but since 1986 less than 2% of the population have done so. A computerised register was able to store all of the objections easily. There are clearly stark differences between the current provisions in the U.K. and Belgium. Firstly, in the Belgian legislation it is clear that both organs and tissues are eligible for donation under the presumed consent program, and it takes little to qualify as a ‘Belgium National’ for the purposes of organ donation. Secondly, children are allowed to object to donation in Belgium, meaning that they are included in the presumed consent program. Thirdly, the donor may express his objection to donation directly to the doctor, but the doctor does not have to take any account of the relatives’ views, thus preserving the autonomy of the patient. Belgium operates a considerably strict policy; relatives of the deceased have no power to veto the presumed consent of the patient. A much stricter policy applies in Austria, where organs can be removed from the patient provided that in his or her lifetime, he or she expressed no objection. The relatives of the deceased are allowed to object, but the doctors are under no obligation to seek their views. Other ‘softer’ schemes in France and Spain allow organ donation on the premise that the relatives are consulted in order to establish the views of the deceased. If the deceased has objected at any time in any way, the donation will not go ahead. Interestingly, a program in Singapore allows for the automatic exclusion of certain groups of people, such as non-citizens and Muslims.

5. While opting in is not necessarily an unjust system, the need to yield organs indicates that presumed consent would be morally preferable.


The Protocol declined to adopt either an “opt in” or “opt out” system, explaining that, "without anticipating the system to be introduced, the Article accordingly provides that if the deceased person's wishes are at all in doubt, it must be possible to rely on national law for guidance as to the appropriate procedure." The Protocol acknowledged the validity of both systems. In some countries, "the law permits that if there is not explicit or implicit objection to donation, removal can be carried out." In that case, the law provides a means of expressing intention, such as drawing up a register of objections. In other countries, "the law does not preclude the wishes of those concerned and prescribes inquiries among relatives and friends to establish whether or not the deceased person was in favour of organ donation." Unless national law provides otherwise, the Article states that "such authorization should not depend on the preferences of the close relatives themselves for or against organ donation." "It is the expressed views of the potential donor which are paramount in deciding whether organs or tissue may be retrieved." While not explicitly stating a preference for a system of presumed consent, the Protocol's preference can be inferred by Article 19, which advocates the promotion of donation. "Because of the shortage of available organs, this article makes a provision for Parties to take all appropriate measures to promote the donation of organs and tissues." The Article states, "it is also appropriate to remember that organ and tissue removal from deceased persons has to be given priority if living donation is to be minimized." In contrast, the Protocol condemns the sale of organs by stating that “the human body and its parts shall not, as such, give rise to financial gain.” Any trade in organs for financial gain is prohibited. The rationale is that, "organ or tissue traffickers may also use coercion either in addition to or as an alternative to offering inducements ... [and] such practices cause particular concern because they exploit vulnerable people and may undermine people's faith in the transplant system.” Since an organ market is strictly prohibited, donation from deceased persons is favored, and steps to increase donation are championed. The Protocol undoubtedly supports a presumed consent system of organ donation.
Affirmative Position Two: Families Should Not be Consulted

1. Family input must be overridden in order to prevent them from having total veto power over organ donation.


Section 1(1)(a) stipulates that a doctor must be satisfied that the information provided by the deceased’s spouse, partner, parent or child correctly represents the deceased’s objection to donation. This is a difficult policy to implement when one considers the importance of patient autonomy. Concerns about overriding familial views have already been canvassed in relation to consenting to organ donation, but the crux of the 2009 Bill was to give respect to a patient’s decision to partake (or, rather, not to partake) in a particular medical procedure. The only way in which a doctor can be satisfied that the deceased’s objection is truly his own, is to check on the relevant register to see if the deceased has expressly objected to the donation of his organs upon his death. Unless a stricter provision is in place, any similar Bill will simply allow the views of the deceased’s relatives to exert the same absolute power over organ donation that we see today. This discussion also presents the question: is the listed group of potential relatives in the 2009 Bill wide enough? What of those deceased patients who have no such relatives? Will consent in these cases simply be presumed without searching for distant relatives or close friends who could speak on the deceased’s behalf? Inevitably, Section 1(1)(b) also provides the same named relatives — spouse, partner, parent or child — with the power to object to organ donation if they were to experience ‘distress’ as a result of the procedure. This ‘soft’ provision may be frustrating to some. The U.K. has been apprehensive in earlier decades to draft Bills or reforms regarding presumed consent programs in organ donation. This apprehension may be a response to the public concern that relatives will feel shocked that their deceased spouses and children will be “harvested” — without any familial consent — for their hearts, lungs, livers, and kidneys before their bodies have even turned cold. It may be this overhanging threat of unethical behaviour on the part of medical professionals that is responsible for the rather ‘soft’ approach under Section 1(1)(b). Through allowing them to veto the deceased’s wish to donate, Parliament appear to want to include the deceased’s relatives in the whole donation process because, in their time of grief, they may not be able to bear the idea of their relative’s organs being taken away. It depends on the approach that Parliament wish to take, and the impact on donation the wish to make, as to whether the provision under Section 1(1)(b) is acceptable or damaging to the ultimate goal of a presumed consent Bill.

2. Presumed consent is empirically effective at raising organ supply while alleviating family members of the psychological pain of having to make a choice.


In three western countries there is evidence that changing to a contracting out system resulted in an increase in organs-Austria, and Belgium-but the change in legislation has not achieved this rise on its own. In Spain, for example, additional measures included the appointment of more co-ordinators and provision of financial incentives. In the case of Belgium there is well documented and convincing evidence that a change in the law from contracting in to contracting out in 1986 led to an increase in organ supply. Staff at the organ-transplantation centre in Antwerp were strongly opposed to the new law and retained a contracting in policy accompanied by enhanced public and professional education; by contrast, at Leuven the new law was adopted. In Antwerp, organ donation rates remained unchanged; in Leuven they rose from 15 to 40 donors per year over a 3-year period. In the whole country organ donation rose by 55% within 5 years despite a concurrent decrease in the number of organs available from road-traffic accidents. Citizens who wish to opt out of the scheme may register their objection at any Town Hall; since 1986 less than 2% of the population have done so. Use of a computerised register has simplified ascertaining the existence of any objection. In Belgium, despite the existence of this law, doctors are encouraged to approach the relatives in all cases and practitioners may decide against removing the organs if in their opinion this would cause undue distress or for any other valid reason. Less than 10% of families do object compared with 20-30% elsewhere in Europe. Another benefit has been an increase in the number of referrals of cadaver donors from collaborating centres, suggesting that the intensivists have found the new law favourable to donation. It would seem from the Belgian experience that relatives may be reluctant to take a personal decision about the removal of organs, but they find it easier to agree if they are simply confirming the intention of the dead person. If this is so, a contracting out system has a moral benefit of relieving grieving relatives of the burden of deciding about donation at a time of great psychological stress. A change in the law thus achieves the dual effect of increasing the supply of organs and lessening the distress of relatives. Those who have moral objections to it must produce convincing evidence that the harm that would follow such a change would outweigh these clear benefits.
Affirmative Position Two: Families Should Not be Consulted [cont’d]

4. Presumed consent is preferable for resolving family issues because its informed consent procedures guarantee that the deceased person speaks and consults their family prior to death over whether they’d like to donate.


Since state, federal, and international laws forbid the exchange of organs for direct compensation, such indirect measures should satisfy the constitutional requirement of “just compensation.” Presumed consent laws should also ensure that the public as a whole receives notice of the eventual taking through public education measures that would need to be in place. Although presumed consent might not allow the next-of-kin to be heard or object to the removal of organs, due process does not require notice and a hearing in every situation. Several reasons exist for excusing the hearing and objection requirements in this scenario. First, allowing the next-of-kin with the opportunity to be heard and object will defeat the purpose of presumed consent laws. Second, the Supreme Court has explained that procedural Due Process guarantees are directed primarily at adjudicative action and are rarely applicable to rulemaking. “Where a rule of conduct applies to more than a few people, it is impracticable that every one should have a direct voice in its adoption.” Third, presumed consent laws give the decedent the ultimate choice over his or her organs and intend to facilitate family discussion on organ donation while all parties are alive. When the decedent's organs are removed, family members may argue that the state is taking their property interest in the deceased's body. If so, there has been adequate process. The family discussion that took place during the decedent's life should be construed as a "hearing" and a chance to "object." The next-of-kin, who will hold the quasi property interest in the decedent's body, can speak to family members about organ donation and will have their say during the decedent's lifetime. When the courts "couple [the] rather minimal [property] interest with the exigent circumstances surrounding and accompanying the organ donation decision and the State's legitimate and compelling interest in providing for and securing a future for the living ... it becomes highly doubtful that [any significant] process is due [to the] plaintiff." Therefore, even if a constitutionally protected property right exists, presumed consent laws survive the constitutional challenge.

5. Presumed consent removes an enormous psychological burden from the bereaved and gives doctors more control to do the right thing.


The brave move by Parliament to draft such a detailed presumed consent organ donation Bill provides a ray of hope for the many transplant candidates awaiting an organ transplant in the U.K. There will always be ethical difficulties when a piece of legislation proposes to operate on the presumption that every member of society holds the same moral ideals and aspires to live by the same altruistic values, but if carefully drafted, a new Bill founded upon the provisions of the 2009 Bill could initiate a major shift in the way our society views organ donation. The 2009 Bill offered a somewhat ‘soft’ approach to presumed consent, giving the majority of the power to object to the organ donation to the relatives of the deceased. The doctor must simply be ‘satisfied’ that the relatives have witnessed the deceased objecting to such a procedure, or the relatives must expressly state to the doctor that they would suffer distress as a result of the procedure. The suggested amendments (above) offer a slightly stricter approach, placing more power into the hands of the doctor when no objection has been registered. Parliament may have intended to start ‘soft’ in this area in order to lessen the potential backlash from the general public. After all, it is a controversial idea. However, plenty of support can be found, including from the British Medical Association, which, back in 2000, offered their views in support of a presumed consent organ donation program: It is reasonable and appropriate to assume that most people would wish to act in an altruistic manner and to help others by donating their organs after death. Studies show that the majority of people would be willing to donate but only a small number of these are on the NHS Organ Donor Register or carry a donor card. Given that the majority of people would be willing to donate, there are good reasons for presuming consent and requiring those who object to donation to register their views. It is more efficient and cost effective to maintain a register of the small number who wish to opt out of donation than of the majority who are willing to be donors. This represents a more positive view of organ donation which is to be encouraged. It may be true that many people are willing to donate, but perhaps this could be proven with a nation-wide Governmental survey? One advantage to a presumed consent organ donation program which cannot be denied is the easing of the burden upon the shoulders of grieving relatives to consent to donation only moments after they are faced with the untimely death of their loved one. To presume consent allows for the relatives of the deceased to simply ‘confirm’ that donation can go ahead, as opposed to undertaking the decision alone. It is a difficult decision to make only moments after losing a spouse, partner, parent or child, but knowing that the deceased has not formally registered an objection to donation could make the whole experience of donation for the grieving relatives much easier to cope with. The presumed consent program also gives objecting individuals a formal mechanism for registering their views. The only potential issues we may still have to contend with are the ways in which it is appropriate to treat both dead and dying patients. Hopefully, the former will be treated in a way which the relatives are satisfied, and the latter will not be seen as ‘organ resources’ by a profession which is in desperate need for scarce organs.
Affirmative Position Two: Families Should Not be Consulted [cont’d]

6. The issues with presumed consent are that physicians aren’t willing to follow up on presumption, instead deferring to asking relatives. This appeal to altruism is the root cause of organ problems.


France was the first country to legislate on these matters. In this country, as soon as it became apparent that human organs could be used for therapeutic purposes, the Legislator instituted a legislative framework aimed at facilitating their procurement but no special status was conferred on the wishes of the deceased concerning the posthumous fate of his/her organs or those of relatives. Historically, obtaining consent from the harvested individual has never been considered a fundamental prerequisite to organ removal. In effect, the French Decree of 30th October 1947, instituted to facilitate corneal grafts (organ transplants not being practiced at the time), stipulated that ‘organ removal for scientific or therapeutic purposes may be practised without familial consent’... Practitioners, however, began to doubt that organ appropriation without consent was totally justified. If the first French transplantations were effectuated with organs harvested in accordance with this decree, physicians’ unease with regard to the families concerned rapidly led them to consult the next of kin to obtain their consent to ‘donate’ a deceased member’s organs. It was, however, without concern for the family status of the person from whom they sought permission, or a family’s right to donate another person’s organs, even if that person was a relative. Thereafter, within all countries willing to develop transplantation, the concept of ‘donation’, that undeniably facilitated the first organ transplantations whether from living or deceased donors, rapidly became the only conceivable means of procuring the organs necessary for this new branch of medicine; a method that has subsequently never been challenged. This standpoint, incessantly reiterated since the 1960’s, has largely determined the orientation of transplantation practices and the difficulties with which they are currently confronted.

Yet, as is the case in numerous Western countries, the French legislative framework is based on presumed consent, a ‘legal fiction’ (Hermitte 1993) authorising organ removal in the absence of proven opposition from the deceased during his/her lifetime. Can the inherent ambiguity of this legal fiction be circumvented by appealing to donors’ altruism? In a context of growing pressure to increase organ retrieval, what moral foundations of the practice of organ removal will remain? This appeal to citizens’ altruism, incessantly reformulated over the years, is presented as virtually the only answer to what is apprehended everywhere as a ‘shortage’ of organs, though it would be more accurate to describe it as a gap between the number of persons needing a transplant and the number of organs available for transplant. After a brief review of the different means of procuring organs for transplantation whether from living or deceased individuals, we will examine the notion of altruism and its limits in this domain. We will show that the only morally acceptable response to the organ shortage rhetoric is to be found in the strict application of legislation regarding the fate of human body parts after death. In view of this, we propose an original system of application that could be implemented immediately within the current French institutional framework. We will subsequently outline conditions under which the social acceptance of systematic post-mortem organ removal could be envisaged and how it can be reconciled with current European legislations in their strictest application.

7. The costs of donating the deceased’s organs pales in comparison to the harm it alleviates.


Arguably, a paternalistic approach that would place such obstacles in the way of making a decision to donate organs might be justifiable if there were clear grounds for thinking that those who decide to donate organs under the status quo often make a terrible mistake. But there are no good grounds for holding this. Cadaveric organ donation indisputably saves many lives; it is permitted and even encouraged by the mainstream interpretations of all major religions; and although we may certainly fear encroachments upon the bodily integrity of our corpses or those of our loved ones, such fears seem more to be based on an irrational imagining of our living selves experiencing the disintegration of our dead bodies than on sound, justifying reasons. There are genuine costs to the donor and the donor’s family of organ donation, such as the mutilation of the donor’s body, and the impact on the grieving relatives of not being able to stay with their loved one during and after circulatory cessation. But because these costs pale into insignificance in comparison to the interests of those who desperately need organs, it cannot be plausibly claimed that many of those who have decided to donate were seriously irrational or mistaken in doing so. I have not examined all possible means of increasing the relative difficulty of donating versus not donating here. It might be argued that there is some other means available that would place burdens on donors, but not on non-donors, yet does not invite the kind of deontological objections raised here. But we can respond that while it is true that not all means of increasing burdens on would-be donors would necessarily be equally bad, any possible means would infringe on autonomy to some degree, by moving us further away from the state in which people are maximally able to put into effect their considered preferences either to donate or not to donate.

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8. Problems with presumed consent are due to their application- they are overly deferential to the family.


A major difficulty however persists in this domain. The legal framework concerning organ donation in most countries using so-called “presumed consent” legislation constitutes one of the rare examples of National Law that is neither bypassed nor infringed, but simply not applied. It is a unique example in the field of bioethics. In these countries, custom and practice are the standard references in contemporary methods of organ procurement rather than the law. In order to bypass this pitfall, we propose an innovative solution to organ procurement which consists in rendering the current legislative frameworks applicable and providing a possible solution to the social need for organs. Most of the “presumed consent” laws make no reference to consent. The notion of presumed consent is a ‘legal fiction’ that, as such, constitutes an exception in law.10 Usually, practices confirm this status, as in France where 60% of the population has never broached the question of organ donation law within the family (Annual Report, French Biomedicine Agency 2006). To remedy the absence of explicitly expressed individual will but without introducing the registration of explicit consent in favour of organ donation, Legislators have stipulated that the retrieval of organs from a deceased person’s body for therapeutic or scientific purposes are authorised if during the said person’s lifetime no explicit opposition to organ removal has been recorded. Legally, the idea of presumed consent is thus never specifically iterated. Nevertheless most legislation reiterates the necessity of attempting by all possible means to find a document or witness testifying to the deceased’s possible refusal. The French so-called Bioethics Law of July 29th 1994, stipulates that ‘organ retrieval from cadaveric donors is authorized if the deceased did not make known his refusal during his lifetime’, and: ‘A physician that has no direct information concerning the deceased’s wishes, must make every attempt to consult the next of kin’. It is generally accepted that refusal may have been expressed by any means, notably via a National Register of Organ Donation Refusal. However, a physician that has no direct knowledge of the deceased’s wishes, must endeavour to consult the next of kin regarding his possible opposition to posthumous organ removal, expressed by any means during his lifetime, and must inform them about the organs and tissues removed. Organ removal is thus authorised if close relations cannot testify whether the deceased expressed opposition. We make the assumption that the non-application of such laws is not simply due to their ambiguities, but also to imprecise formulation as to their application. In time and practice, and motivated by the latter, the wishes of close relations have progressively come to prevail over those of the deceased, notably in cases where no explicit request has been recorded. In many countries, these practices have contributed to an interpretative flexibility of the Law and the terms of its application. The Law solely expects the family to express the wishes of the deceased. In practice, however, and in virtue of these medical practices, the family’s wishes have progressively supplanted those of the deceased that remain unknown. This interpretative flexibility is even more apparent in the fact that these contemporary practices no longer consist in discovering whether the deceased had expressed opposition to organ donation during his/her lifetime, or at least not exclusively, but in ascertaining whether the family consents to donating a relative’s organs (Paterson 1997; Thouvenin 2004). There has been a progressive misappropriation of ‘a rule of evidence’ that has been transformed into a ‘per se rule’ (Thouvenin 2004).

9. The current system creates a double-veto opportunity between the individual and their family after death- presuming the ability to take organs is a better option.


The current policy of the American Medical Association regarding the use of organs from the recently deceased is to act only when 1) the deceased is known to have no objections to the use of his or her organs, and 2) no member of the immediate family, upon consultation, vetoes the use of the deceased's organs. This policy has been called the 'double veto' either the deceased's wishes concerning his or her remains, or the wishes of the family members surviving the deceased, is sufficient to stop the procurement of organs from the deceased. If either party vetoes the decision to use the deceased's organs for transplant, the procurement, as a matter of policy, will not take place. In what follows, I will argue that this policy ought to be abandoned. I will not, however, argue that the autonomy of the patient should trump all else. Rather, I will argue that there is sufficient reason to take, without consent on the part of the deceased, the deceased's organs. As I hope to show, this position is entirely compatible with the view that we have a prima facie obligation to respect the wishes of the deceased.
1. **The harm that people suffer as a result of organ shortages overwhelms the injustice of denying family members a veto over organs.**

   P. Chouhan and H. Draper, Centre for Biomedical Ethics, Department of Primary Care and General Practice, The Medical School, University of Birmingham, JOURNAL OF MEDICAL ETHICS, “Modified mandated choice for organ procurement,” vol. 29, no. 3, pp. 157-162, June 2003, accessed 8.15.2014: academic search premiere.

   Spital's position only addresses obliquely the question of why the relatives ought not to have the final say. If we are correct, self-ownership of the body and in some respects individual autonomy do not apply after death. If, however, claims to ownership over bodies result from vested interests, surely the relatives can claim some ownership over the body simply because they have the greatest interest in determining how it is to be disposed of? Here we return to the legal parallel of the disposal of one's assets after death. The needs of living relatives can be used to put aside the deceased's own wishes where it is thought that the deceased's wishes are unjust. The corresponding question is whether not allowing relatives to have the final say is unjust. It could be unjust, because the relatives can come to significant psychological harm if their wishes about the disposal of the body are frustrated. But on the other hand, it could be considered unjust to those who desperately need organs, for these organs to be buried or cremated, and it could be argued that serious though the relatives' psychological damage might be, the loss of life is more severe still. This line of thought seems, however, to be returning us yet again to the second criticism of mandated choice, namely that there should be no choice in the matter of organ donation, but all organs (from the deceased) should be available for transplantation.

2. **Failings of presumed consent are due to legal ambiguity and being overly deferential to the family, not the principles of the system itself.**


   Firstly, we will briefly review the existing means of procuring organs for transplantation. Today, donation or consent to donate is the most frequent and best tolerated means of obtaining a deceased person’s organs for transplantation. It equally applies to living donors having given their consent under specific and explicit conditions. In what follows, however, we will only take post mortem organ removal into consideration. In many countries, legislation on organ donation is based on the principle of ‘presumed consent’ contrary to other countries where consent must be explicitly expressed. Post-mortem organ procurement systems in Europe are based either on explicit consent (opt-in system) or presumed consent (opt-out system) where consent to donate is presumed whenever the will of the deceased person is unknown at the time of death. France was actually the first country to pass presumed consent legislation. Today, however, there are at least seventeen European countries whose current legislation on organ donation is based on the principle of ‘presumed consent’ (Austria, Belgium, Spain, France, Portugal, Finland, Norway, Switzerland, Sweden, Italy, Greece, Czech Rep., Hungary, Poland, Slovakia, Baltic states, and Romania). In the majority of these countries whenever the will of the deceased is unknown at the time of death, the “donor(s)” is (are) the relative(s) and the deceased person simply the source of organs to be donated. Only seven countries have an explicit consent form of legislation (UK, Ireland, Netherlands, Switzerland (part), Germany, Denmark, Bulgaria, and Slovenia). In countries that require explicit consent, individuals must expressly declare their willingness to become a donor after death without which, post mortem organ removal is proscribed. The ambiguity inherent in the notion of presumed consent generates major difficulties in applying current laws stricto sensu. In practice, the medical profession does not authorise itself to remove a deceased person’s organs without obtaining prior consent from the family (Boileau 1997). Therefore, we think that our proposal could be of interest for a large number of European countries. Healthy organs or tissues, removed for the needs of a patient and therefore suitable for transplantation, may equally be obtained through abandonment. For a number of years, these organs were regarded as res nullus and thus useable without restriction. This was the case for so-called ‘free-kidneys’ used from the 1950s to the 1970s, and the first ‘domino’ heart transplants. In most countries, the current legal framework has abolished this notion and today no human tissue or organ can be used without having obtained, prior to death, the informed consent of the person from which it will be taken. Organ commercialism is also a means of procurement but its authorization remains highly restricted. The prevailing trend is a broad consensus proscribing this form of organ procurement as confirmed by the Declaration of Istanbul on May 2nd 2008. The ultimate means of organ procurement is the institution of systematic, obligatory organ removal on the death of individuals assessed as being suitable organ sources (Dukeminier and David 1968). We will come back to this in more detail later. The prevailing mode of organ procurement in the West is, on the contrary, essentially reliant on altruistic donation, the limitations of which will presently be examined in detail.
Underview: Organ Shortages Trump Family Choice [cont’d]

3. Absolute integrity of the dead is an absurd standard— it would bar any post-mortem procedures such as autopsies.


The most basic version of the view that the loss of bodily integrity is a harm (where I will begin) would have it that any and all loss of bodily integrity constitutes a harm against the deceased and/or the deceased’s family simply in virtue of the fact that it is a loss. An amputation would constitute a loss, on this view, even if it was required for health (it is a loss in the sense that, all things considered, it would be better if the amputation had not been necessary). Likewise, the removal of a ruptured appendix would count as a loss (on the same grounds as above). Let us call this view BI1: The Intrinsically Valuable View. Now, as is I hope clear, BI1 has a smell of the absurd about it. If the dead are harmed, or have their interests thwarted, when any loss of bodily integrity occurs, it would follow that any autopsy would go against the interests of the dead. This would be so even if said autopsy were necessary in bringing about justice for the deceased, perhaps by uncovering evidence that would lead to the capture of the deceased’s murderer. Presuming that the dead have interests, it would seem then that some loss of bodily integrity (an autopsy) would be in the interest of the deceased, but also against the interests of the deceased, as, ex hypothesi, all disruption of bodily integrity constitutes a violation of the interests of the deceased. Because this is absurd, we have sufficient reason to reject the (rather banal) view that bodily integrity is itself of intrinsic value. Moreover, if bodily integrity is intrinsically valuable (if BI1 is true), it would follow that decomposition itself would constitute a harm and/or a thwarting of the interests of the deceased. Decomposition, as we now know, is inevitable. It thus follows that there is no way to avoid the destruction of what (on the banal view) is posited as having an intrinsic value. The refusal to donate organs on the basis of wanting to preserve the integrity of the body here seems simply misguided: one cannot preserve the integrity of the body. Dust will indeed return to dust. It seems pointless to insist on the bodily integrity of a corpse when that corpse might be of some use, but to ignore the integrity of the same corpse once it is in the ground. This consequence of the banal view, I think, reveals that few persons actually endorse this view. If one’s aim is to prevent loss of bodily integrity, then we are not doing nearly enough to preserve the corpse. Even after embalming, a corpse will normally begin to decompose within a week. If we really cared about preserving the integrity of the corpse, there would be as much resistance to grave decomposition as there is to organ donation. Because the movement for infinite preservation is limited to very few, eccentric individuals (like philosophy’s beloved Jeremy Bentham), we have good reason to think that the more common objections to mandatory organ donation is a subtler view than the one we have been considering.
1. **Family members do not have property rights to the deceased’s organs and presumed consent alleviates them of their burden of choice.**


In most legal systems, relatives have no property claim over the body of the deceased. Furthermore, any claim they may seek to assert seems rather weak when set against the claims of the person in need of a transplant. This is not to argue that relatives’ interests should be ignored, and indeed the Belgian model takes them into account. This version of the contracting out system, as opposed to one in which the wishes of the relatives are ignored, is consistent with the recommendations of the Conference of European Health Ministers and WHO. The primary role of relatives is thus to corroborate that the dead person did not actually register an objection. They are not put into the position of having to make the decision themselves, but simply to confirm the facts. As a result the refusal rate is much lower.

2. **Presumed consent provides enough due process to satisfy quasi-property rights that the family has to the deceased.**


If the court finds a property interest in a deceased relative’s body, the question then becomes how much weight is given to that interest? The court began to measure the quantitative significance of the constitutional property interest in a deceased relative’s body in Mansaw v. Midwest Organ Bank. In Mansaw, a father challenged the constitutionality of a Missouri statute that allowed his dead son's organs to be harvested, based solely upon the consent of the boy's mother, without securing his consent. The court stated that "the only constitutionally protectable interest that a person may have in a deceased relative's body should be characterized as a property interest." The court called the property interest "minimal," however, visualizing it as a "low right on the constitutional totem pole" when compared to other rights such as privacy. The father's right was further diminished because it was a joint interest shared equally with the boy's mother. Therefore, the court held that half of an interest in this property right did not outweigh the state's interest in providing organs to the living. "Plaintiff's interest must yield to the greater rights of the state - and our society - in carrying out its public policy, when the co-owner has consented and the hospital is unaware of [the] plaintiff's objections." While the lower courts disagree as to the existence of constitutional property rights in corpses, where a property right is recognized, the requirement of proper due process does not exclude the possibility of presumed consent laws. After holding that a constitutionally protected property right existed, the Brotherton court suggested that the right would not be violated if a proper pre-deprivation procedure existed. The court did not suggest an appropriate procedure but mentioned the need for the next-of-kin to be notified and given an opportunity to be heard. Additionally, the dissent in Georgia Lions suggested the need for minimum due process requirements of notice to the next-of-kin and a chance for the next-of-kin to object. Where the next-of-kin has a property interest in a deceased relative's body, presumed consent laws provide the necessary due process. A presumed consent law can provide appropriate pre-deprivation procedures so that the government can take the deceased's organs and lawfully take the property from the next-of-kin. For example, a Pennsylvania statute provides indirect "compensation" to the next-of-kin, allowing money from the trust fund to be used for things such as the decedent's hospital and funeral expenses. It is interesting to note that Pennsylvania is also the only state that acknowledges its "taking" of the incompetent pregnant woman's body by providing "just compensation" by paying the expenses associated with continued medical care.
Affirmative Position Three: Opting Out Respects Autonomy

1. An organ donation scheme that presumes consent unless there is explicit opting-out preserves autonomy of choice sufficiently

Ben Saunders, Professor in the Department of Psychiatry and Behavioral Sciences at the Medical University of South Carolina, JOURNAL OF MEDICAL ETHICS, vol. 38, no. 2, pp. 75-76, February 2012, accessed 8.15.2014: academic search premiere. This consideration goes some way to addressing De Wispelaere’s worries as to the robustness of the consent involved. If an opt-out system allows an individual to veto the use of their organs, then this provides a clear statement of their wishes. Where someone has not opted-out, it is reasonable to assume that they do not have strong objections to the use of their organs. Our present system, conversely, often leaves families unsure whether a loved one objected to the use of their organs or simply did not get round to registering. This brings us to De Wispelaere's main contention: that acts of consent ought to be 'minimally approval-tracking'. The claim is not that an act of consent is valid only if it coincides with what the actor in question actually wants, but rather that it must be probable that it is what they want. I am not clear what kind of probability he has in mind here. Should we assume that, if 60% of people are in favour of donation, then a given individual has a 60% probability of wanting to donate? That seems absurd. Presumably we should focus on the likelihood that the individual in question wishes to donate given that they have performed a specified action. Someone is unlikely to sign a consent form unless they approve of donation, so an opt-in procedure generally tracks approval. But someone may fail to opt-out, though they do not approve of having their organs used. Hence, De Wispelaere argues, an opt-out system may fail to be approval-tracking. It is not clear why probabilistic approval-tracking should matter. What if someone has signed a consent form, but then claims that they never approved of the procedure in question? My claim was that they have consented, by signing a form, whatever their intentions were. For De Wispelaere, however, the answer is unclear: it all depends on how likely it was that they approved. But it seems that, if the procedure were sufficiently approval-tracking, then De Wispelaere would agree that the person consented, though they did not in fact approve. If this is right, it means that approval is not necessary, provided that the act of consenting meets certain conditions. De Wispelaere claims that minimal approval-tracking should be one of these. I do not endorse this condition, though something like it follows from my conditions of publicity and relative costlessness. Suppose someone knows that their silence will be taken as consent, but it is not costly for them to object. If they nonetheless fail to object, this undermines their claim that they did not approve of the procedure in question. So, even if minimal approval-tracking is necessary, it is not clear that an opt-out scheme fails to be minimally approval-tracking. If we think it equally important to track refusal and refusals of approval, then opt-in and opt-out appear symmetrical, neither worse than the other. If it is more important to track refusals of consent, then an opt-out scheme may actually be better, since refusals can be made explicit. (This leaves open what to say of those who neither approve nor refuse.)

2. Presumed consent is better able to achieve autonomous and informed choice than opting in because it ensures any decision is not made under duress or bereavement.

Maxwell J. Mehlman, Professor of Law and Director, The Law-Medicine Center, Case Western Reserve University School of Law, HEALTH MATRIX: JOURNAL OF LAW-MEDICINE, “Presumed consent to organ donation: A reevaluation,” vol. 1, no. 1, pp. 31-67, Spring 1991, accessed 8.15.2014: academic search premiere. Presumed consent may increase the likelihood that decisions about donation are voluntary and informed. Since the decision to object to donation would be made voluntarily by the patient or the family (depending on how the presumed consent system were designed), the decision could be made at a time when the decisionmakers were not confronting their own or their loved one's death. It therefore might be more deliberative and dispassionate than a decision under required request. Presumed consent also may enhance patient autonomy. Under required request, the ultimate decision to donate typically is made by the patient's family, rather than by the patient. Even in the infrequent case in which the patient had signed a donor card or otherwise expressed a desire to donate, surgeons are unlikely to remove organs unless the family has given permission. When the family disagrees with the patient's disposition, required request therefore may frustrate the patient's actual wishes. Depending on how it was implemented, presumed consent might reduce the ability of the family to override the decedent. The family might be given no right to object when the patient, assuming he or she was competent, had not refused donation. More likely, the role of the family might be limited, at least nominally, to expressing what they believed to be the patient's desires rather than their own.
3. The rights of individual autonomy are not absolute. Organ harvesting from the deceased imposes no major cost, making a failure to act a violation of the duty to rescue.


There is an intuitive and constitutional difference between extracting an organ from a living human being and taking an organ from a dead body. Most people are repulsed by the idea of forced organ removal during life. An intuitive response would be, "Not my body," which belies a sense of ownership as well as privacy. This part describes the general legal consensus that an individual is protected by privacy rights during life. Even during an individual's life, however, the right to live free from government intrusion is not absolute, and there are clear exceptions to individual autonomy. Discussing several ways in which government interests override individual autonomy, this portion of the Comment argues that organ extraction during life is conceivable. This section does not argue that living organ extraction is preferable. The goal is to acknowledge that such a system is possible under existing law, especially in light of abortion law. 1. No Duty Rule In McFall v. Shrimp, the Pennsylvania court posed the following question, "In order to save the life of one of its members by the only means available, may society infringe upon one's absolute right to his "bodily security"?" In this case, the plaintiff, McFall, suffered a rare bone marrow disease and faced certain death without a bone marrow transplant. McFall sought an injunction to require Shrimp, his cousin, to donate his bone marrow, a procedure which would have imposed little risk but a great deal of pain. The court refused to grant the injunction, citing the common law rule, which provides that "one human being is under no legal compulsion to give aid or to take action to save another human being or to rescue." Similarly, in Curran v. Bosze, the court denied a father's request for an injunction to order a mother to produce her twin children for blood testing and possible bone marrow harvesting in order to save the life of their half-brother, who would die without a bone marrow transplant. How does this analysis change upon death? One could argue that, morally, it is the duty of every able person to donate his or her organs upon death. Opponents would assert the classic "no duty" principle of American tort law, which protects individual autonomy. Yet, our notions of morality test this "no duty" rule with hypothetical "stories about children tripping, hitting their heads, and falling insensate into shallow ponds." In these cases, most people conclude that failure to rescue, absent any personal risk to the hypothetical rescuer, is morally wrong. Some states even impose criminal penalties in "duty of easy rescue" cases where assistance can be given without personal risk to the rescuer. Arguably, organ donation falls within this same category of "duty of easy rescue." One could argue that there is "a presumptive duty to provide others with organs that may be vital to them but are useless to us."

4. The true public preference is for organ donation. Presumed consent removes the psychological barriers to yielding one's organs after death.


Although it is commonly believed that the public is opposed to presumed consent, some commentators argue that most people in fact are favorable or indifferent and simply cannot admit it or act upon it. In support, these commentators cite the fact that far more people state that they are willing to donate their organs than fill out donor cards. This suggests that people are in favor of donation in the abstract, but that psychological factors involved in contemplating their own deaths, or those of their loved ones, make them unable to articulate their true wishes. By eliminating the need to confront donation actively in order to donate, presumed consent might overcome these psychological impediments and allow individuals to give effect to their true beliefs. Before leaving the subject of why presumed consent might be beneficial, it is worth pointing out that, while it is important to attempt to create a donation system that is more humane, in which decision-making is more autonomous and informed, and that is more consistent with underlying personal beliefs, the chief purpose of presumed consent is to increase the supply of donor organs. Therefore, even if presumed consent did not provide any of these secondary benefits, it still might be preferred to existing approaches so long as it yielded a significantly greater number of transplant organs.
**Affirmative Position Three: Opting Out Respects Autonomy [cont’d]**

5. The rights of self-determination may be absolute, but the encumbrance of having people opt-out is not so extreme as to constitute a violation of liberty.

Govert den Hartogh, Department of Philosophy, University of Amsterdam, JOURNAL OF MEDICAL ETHICS, “Tacitly consenting to donate one's organs,” vol. 37, no. 8, August 2011, accessed 8.15.2014: academic search premiere.

Another common objection to the choice of organ removal as the default is that it violates your right to self-determination because you are obligated by this choice to spend some minutes of your valuable time on filling out a donation form. It is, however, an inflation of the notion of ‘rights’ to use it in this context. What the objection refers to is a presumption of liberty: there should be good reasons for restricting the liberty of citizens. This presumption should be clearly distinguished from the right to make decisions concerning one’s body, dead or alive. It is quite common for citizens to be burdened by chores in the general interest; to fill out a form and return it post-free or online must be one of the least burdensome. Surely the interests of patients with organ failure provide ample justification for such a requirement. The mere fact that registering dissent is not altogether cost free does not amount to a form of coercion or pressure that might possibly invalidate the consent given by abstaining from it.

6. The intuitive response to condemn presumptive consent because it is a form of crass utilitarianism is simply a gut-level reaction due to status quo bias. 5


One cannot make the case for an opt-out system on the basis of its practical effectiveness alone: we must also take into account any potential ethical objections to it. It might be objected that an opt-out system would be morally undesirable because it threatens an important aspect of individual autonomy. We have an important interest, it might be supposed, in not having our body parts removed and distributed to others after our deaths whenever we have not explicitly consented to this. The choice of an opt-out system for its public health effects might appear to be a good one on the basis of a certain kind of utilitarian judgment, but arguably only because such a judgment is a crass one that leaves out consideration of some of the important moral implications of the choice. When seen in its true light, perhaps an opt-out system should be rejected because it would violate important human rights or otherwise produce great harms to some of those whose organs would be taken. This sort of objection is not, I think, as compelling as it may at first appear. In fact, I will argue that it only appears compelling because of a further manifestation of status quo bias. Those of us living in opt-in countries view the opt-in system as the status quo. And because changing to an opt-out system would produce both gains and losses, the preceding argument has already indicated why we might hold an irrational bias against switching. But how are we to tell whether our objections to a proposal are based on a sound rational evaluation of its merits and demerits, or rather are fuelled merely by our irrational status quo bias? I will focus on two proposals for detecting and eliminating our status quo biases that have been offered. Confusingly, both proposals have been called the ‘Reversal Test’ by their proponents, although they are in fact quite different. I will first consider a proposal found in some of the medical ethics literature which, to disambiguate, I will call the ‘Switching Test’. I will argue that we have no good reason to believe that the Switching Test is effective. Then I will introduce by way of alternative a test proposed by Nick Bostrom and Toby Ord that I shall refer to as the ‘Reversal Test’. I will argue that employing the Reversal Test as a reflective exercise can help us detect and eliminate status quo bias that may be implicit in our intuitive objections to opt-out systems of organ donation.
Affirmative Position Three: Opting Out Respects Autonomy [cont’d]

7. Presumed consent flips the operation of status quo bias by placing consent in the seat of protecting the status quo, thus preventing opt-outs.


Status quo bias, then, may exacerbate organ shortage under an opt-in system. Even if relatives were still provided with an absolute option to veto the decision to donate under an opt-out system, moving to that system could address some of the negative effects of status quo bias by altering the built-in default of an opt-in system. Given that there is status quo bias, fewer relatives should be expected to choose what might then be called an option to ‘veto donation’ than to exercise what is now called their option ‘not to donate’; likewise, fewer relatives should be expected to choose the option of nondonation if they recognise that had they done nothing at all (i.e. had they not opted out), donation would have occurred. Moreover, a move to an opt-out system could address negative effects of status quo bias among donors themselves, as well as relatives. Our evidence of status quo bias shows that, all things being equal, people are less likely to sign up to any register that would alter our treatment of them irrespective of the options offered simply because doing so alters what would otherwise happen by default. The choice between an opt-in system and an opt-out system should be made with this factor in mind, since status quo bias would produce a reduction in the availability of organs and cost to public health if an opt-in policy is chosen, whereas it would produce an increase in organ availability and a benefit to public health if an opt-out policy is chosen. These points about the likely effects of the direction of the opt-in/opt-out default and status quo bias remain true even if there are some respects in which it is unclear what ‘the’ status quo is in cases of potential organ donation (these cases do, after all, often arise in extraordinary circumstances, after a very unexpected death of a healthy individual). They also remain true even if there are certain respects in which aspects of the status quo in the organ donation process are unalterable. For example, the fact that the organs are situated in the body of the donor at the time of death makes it natural for us to think that, in one respect, the status quo persists whenever the donor’s organs are not surgically removed. This ‘natural’ default cannot be altered simply by changing the policy about what we do with the bodies of those who die without explicitly choosing whether or not they wish to be donors: indeed, it cannot be altered at all. As a result, status quo bias might still discourage donation to some extent, even under an opt-out system. The point here is just that the difference between an opt-in and opt-out system provides us with one important respect in which the status quo is manipulable, and manipulating it could reverse the direction of status quo bias in one context, turning it to the general advantage.

8. Presumed consent should also entail programs to educate the public and achieve informed consent. Doing so resolves the problems with patient autonomy and coercion.


A better approach would be to educate patients and their families about how presumed consent worked and to construct an effective opting-out method by which they can express their objections to donation. In this way, a presumed consent system can be consistent with the ethical objectives of achieving individual autonomy and respecting the decedent and the wishes of the family, at the same time that it increased the supply of transplant organs by avoiding the need for express consent. Constructing an effective educational program and opting-out system would not be easy. Experience with encouraged voluntarism and required request shows that educating the public and providers about organ donation is expensive and difficult. Furthermore, little attention has been given to how to design an opting-out system for the United States. The experience of European countries with presumed consent legislation is of little value. In Austria, a patient's objections must be made by written document, and there does not appear to be any method by which a family's objections can be asserted. France allows objections to be recorded by individual hospitals, but makes no provision for coordinating this information so that the objection will be honored if the patient is treated at another institution. Belgium employs a computerized central registry where objections may be recorded and which may be accessed by transplant centers. However, there is considerable opposition in the United States to the use of centralized computer registries. In any event, the practice of physicians in France and Belgium of requesting permission to remove organs suggests that neither country has established an opting-out system that is satisfactory.
Affirmative Position Three: Opting Out Respects Autonomy [cont’d]

9. Presumed consent removes bureaucratic red tape that prevents timely donations that are necessary for successful transplants to occur.


Another benefit of a presumed consent system is that it would be an easier system to manage than the traditional voluntary consent. If there was no registered objection to organ removal, the physician removing the organ could proceed without contacting the deceased's next of kin for consent. If doctors were assured they were on solid legal ground, they could proceed with the organ removal without the hesitation that plagues French doctors. Shortening the time between death and determination of consent also insures that the organ is as fresh as possible, increasing the transplant's chance for success. But, perhaps the biggest advantage to doctors is that they would not feel inhibited in initiating the donor process, since they would not have to "bother" a grieving family when the family is arguably not prepared to make decisions concerning organ donation. While it is not hard to envision a family perhaps becoming upset because they did not get to participate in this critical choice, this problem can be overcome by (1) educating the public about the presumed consent law; (2) telling the family that if the deceased had wished to give or withdraw consent for organ removal, the deceased would have done so during life; and (3) assuring the family that the organ will be used to save another person's life. Complete public education is not only imperative in gaining the support of the next of kin, but also in insuring that each individual is aware of their own right to opt-out if they choose. While harmonizing legislation around a presumed consent model would help to insure that each nation's procurement system was working effectively, it is also imperative that effective prohibitions on organ sales, especially those that sink to the level of human rights violations, are passed and enforced. While many nations have passed prohibitions on organ sales, few have written their statutes such that extraterritorial jurisdiction can be obtained. Illegal organ sales directly harm nations operating under a presumed consent system because such sales only serve to undermine the low-cost, safe, equitable, and efficient alternative offered by presumed consent. Using the protective principle of extraterritorial jurisdiction, it would not be difficult for nations with statutes prohibiting organ sales to prosecute those that engage in such commerce extraterritorially.

VII. Conclusion

An international system as complex and interactive as the one proposed cannot occur immediately. States must act domestically to enact legislation that aims to maximize organ procurement while minimizing rights violations. States acting to strengthen domestic markets will in effect strengthen the international market by limiting the incentive for abuse to their organ supply through sloppy, illegal sales to foreigners. Presumed consent is the most efficient and least violative of the procurement methods currently in existence, and should be adopted by nations worldwide in conjunction with a ban on all organ sales.
Underview: Consent Is Not Absolute

1. Death weakens the power of consent. There is no longer an abiding interest in total autonomy.

P. Chouhan and H. Draper, Centre for Biomedical Ethics, Department of Primary Care and General Practice, The Medical School, University of Birmingham, JOURNAL OF MEDICAL ETHICS, “Modified mandated choice for organ procurement,” vol. 29, no. 3, pp. 157-162, June 2003, accessed 8.15.2014: academic search premiere.

What is more controversial is the extent to which the dead can still be thought to own their bodies. Arguably, when one dies, one ceases to have an interest in what happens to one's body in the same sense that one has when one is alive and things that are done to one's body are done to oneself. Since the sense of “ownership” of the body derives from this interest, rather than, say, some financial transaction, it is doubtful that one could be thought of as owning one's body after death. This is not of course to say that one ceases to have any interests after one dies. One's interest in medical confidentiality, for instance, continues after death. Interestingly, whilst making or executing a will is often cited as a useful parallel to organ donation, wills are sometimes contested after death, and relatives may be successful in overriding the wishes of the deceased. All this seems to suggest that whilst one's autonomous decisions about one's body may have to be respected during one's life, they do not command the same respect after one's death. Translating this into policy would mean that individuals are entitled to make decisions about what happens to their dead body whilst they are alive, but once they are dead anything that they decided whilst alive can be ignored (if there is some imperative for doing so, such as the preservation of some vital interest of another--living--person). This is reminiscent of the argument for mandated donation since it is clearly in the interests of those who are living but dying for want of an organ to override the wishes of those who wanted to be buried or cremated whole. We will return to this contention shortly. For now, what we have established is that it could be inappropriate to be concerned about self ownership and autonomous choice after death. In fact, however, it can be argued that mandated choice enhances the autonomous wishes of those who have died.

2. There is no overarching right to privacy or autonomy after death- property law governs how dead bodies are dealt with.


The future of organ transplantation is uncertain. While competing scholars arrive at different answers, the question remains clear, "Do we own our bodies, and do they, if ever, belong to someone else who needs them?" Imagine, for instance, a hypothetical lawsuit where a person needs a new kidney in order to live. The most suitable donor declines to contribute the kidney. While alive, the donor defends under the Fourteenth Amendment right to privacy. Privacy law guarantees a zone of freedom under the Fourteenth Amendment that protects certain liberties so fundamental and intimate to individual autonomy that government intrusion is unwarranted. Framed as a privacy issue, government invasions of the body are unconstitutional unless narrowly tailored to serve a compelling interest. In the hypothetical presented, the Fourteenth Amendment would almost certainly protect the donor's right to refuse the invasive medical operation even if it means the loss of a life that could have been saved. How does the foregoing analysis change when the donor is dead and property law replaces privacy law? Conceptually, property is a bundle of rights, including the right to "possess, use, exclude, profit and dispose." Under the Due Process Clause of the Fourteenth Amendment, deprivations of property are constitutional if rationally related to a legitimate state interest. Furthermore, property can be taken from one person and reassigned to another upon payment of compensation; privacy cannot. U.S. law has evolved so that privacy protects life and property law applies in death. When the subject is invasion of the human body, under property theory, the state possesses the power to extract the decedent's organs for any public purpose, so long as it provides him or her with just compensation.
Underview: Consent Is Not Absolute [cont'd]

3. **Society has numerous infringements on autonomy for the sake of a well-functioning just society- conscription and vaccines prove.**

   The rights to possess, use, and exclude others from one's body while one is alive are established by constitutional law. When the United States abolished slavery with the Thirteenth Amendment, a person could no longer be the property of another. This right is not absolute, however, as illustrated by the military draft. In Arver v. United States, the Supreme Court held that raising an army by means of a selective draft does not impose involuntary servitude in violation of the Thirteenth Amendment. In its ruling, the Court held "it may not be doubted that the very conception of a just government and its duty to the citizen includes the reciprocal obligation of the citizen to render military service in case of need, and the right to compel it." Accordingly, "people can be conscripted into the military against their will and be made to put their bodies to the service of the common good." Similarly, compulsory vaccinations have been upheld as necessary for the common good. These cases illustrate the exceptions to individual autonomy. In some circumstances, individuals are compelled by law to sacrifice their bodies for the public good. This Comment does not intend to argue that living people should be taken by the state as chattel and required to donate expendable organs. Rather, the purpose is to illustrate that there is not, nor has there ever been, an absolute right to bodily privacy in life, much less in death.

4. **So long as individuals retain the final right to opt out the system is not coercive or totalitarian.**

   One of the conditions underlying the acceptability of societal programmes in contemporary liberal democracies, particularly in the medical field, lies in the respect for the principle of individual autonomy and the obtainment of individual consent. Any socially legitimate reason for calling this principle into question would suppose a minima that a vital benefit will be gained and result from it. It remains to be determined whether the fact of declaring organ donation a national priority, as in France, constitutes a vital necessity justifying a societal measure of this kind. Therefore two requirements must be taken into consideration; on the one hand, respect for the principle of individual autonomy and on the other the collective need for cadaveric organs to treat vital organ dysfunctions in other individuals. This poses the question of the implementation of this normative principle in the public domain, via legislation, in a context of social pressure aimed at maximising organ procurement. This dual requirement thus calls for a compromise solution whereby the availability of cadaveric organs for the benefit of society would be acceptable. The moral requisite of respect for individual autonomy with regard to the fate of the body and its organs after death would justify instituting a specific individual right to determine that fate; a right that would neither institute nor infer any type of proprietary relationship between an individual and his or her own body.
**Underview: Status Quo Bias Is Not Rational**

1. **Status quo bias is a serious distortion of deliberation and choice making- studies support its impact.**


   Status quo bias was first demonstrated by William Samuelson and Richard Zeckhauser. In their early experiments, they gave questionnaires in which similar options were presented to different subjects with differing ways of describing, or framing, the status quo. In the neutral framing condition, the options were presented without a default. Under the status quo framing conditions, in contrast, one of the choices was presented as the status quo. For example, in one of the questions, subjects were told that they were serious readers of the financial pages who had inherited from their great uncle either (in the neutral condition) a sum of cash, or (in the various status quo framings) a portfolio of cash and securities in which a significant portion of the portfolio is already invested in one of the options. Subjects were then asked to choose from a set of up to four investment options, such as: ‘Invest in [Retain the investment in] moderate-risk Company A. Over a year’s time, the stock has .5 chance of increasing 30% in value, a .2 chance of being unchanged, and a .3 chance of declining 20% in value’, and, ‘Invest in [Retain the investment in] municipal bonds. Over a year’s time, they will yield a tax-free return of 6%.’ The prompt also specified that the transaction costs of any switches would be negligible. It was found that, in general, each option was chosen much more frequently when framed as the status quo, less frequently when the choice was framed neutrally, and much less frequently when the option was framed as a change from the default. But given the negligibility of transaction costs, and the concrete information provided about the relative risks and rewards of the investment options, it is difficult to see how the default status of an option in this context could provide any reason at all to choose it. Samuelson and Zeckhauser also noted that in the real world, status quo bias appears to similarly affect people’s decisions, including very important decisions such as those respecting asset allocations in their pension plans, or choice of health insurance plans. This occurs even in cases where free transfers are possible and would be advantageous in various respects (for example, in the case of moving pension plan allocations into safer securities to reduce risk as one nears retirement age). The vast majority of people tend to stick with the default option or with what they started with, even when they admit to having had no particular reason for the initial choice they made.

2. **Status quo bias is triggered by a desire to avert loss, even if there is no tangible loss one faces.**


   Status quo bias seems to have a number of different psychological sources, including simple inattention, but one of the more interesting sources of status quo bias is loss aversion. This term is Daniel Kahneman and Amos Tversky’s name for a seemingly pervasive phenomenon in which losses loom larger than gains when people assess their options. Some irrational instances of loss aversion can be demonstrated just by framing the exact same set of options differently, either in terms of potential losses or potential gains, and showing that this changes people’s preferences between them. One real world example is in credit card marketing. Credit card companies would prefer retailers not to charge higher prices to credit card users, thereby discouraging credit card use. But when required by law to permit this, they have lobbied for the right to demand that any difference in price is labelled as a ‘cash discount’ rather than a ‘credit card surcharge’. They recognise that people are more willing to forego what they think of as a cash discount than to pay what they think of as a credit card surcharge, even when the final price either way would be equivalent. Perhaps a more striking example of loss aversion comes from a Kahneman and Tversky study in which respondents were asked to choose between two potential programs for combating what was described as a disease that is expected to kill 600 people. Some respondents received two options framed in positive terms: If program A is adopted, 200 people will be saved. If program B is adopted, there is 1/3 probability that 600 people will be saved, and 2/3 probability that no people will be saved. Others respondents received two options framed in negative terms: If program C is adopted 400 people will die. If program D is adopted there is 1/3 probability that nobody will die, and 2/3 probability that 600 people will die. It is easy to see that options A and C, and options B and D, are numerically equivalent. But the researchers demonstrated that people become substantially more risk-seeking when attempting to avoid what they perceived as unacceptable losses under the negative framing: support of 72% in favour of program A in the first condition became support of 78% in favour of program D in the second! Similar loss aversion effects have been demonstrated across a wide range of contexts, and even experts (such as doctors choosing between treatment options) have been shown to be subject to it when they make decisions. Because significant changes from the status quo often involve both gains and losses, and because loss aversion leads to irrational emphasis of potential losses over potential gains, loss aversion can help explain pervasive status quo bias.
Underview: Status Quo Bias Is Not Rational [cont’d]

3. Opt-out regimes yield more organs, respect personal autonomy better than any other alternative, and are not subject to status-quo bias.

Simon Rippon, Oxford Uehiro Centre for Practical Ethics, University of Oxford, JOURNAL OF APPLIED PHILOSOPHY, “How to Reverse the Organ Shortage,” vol. 29, no. 4, pp. 344-358, 2012, accessed 8.15.2014: academic search premiere. Our second policy alternative is the opt-out system. It would shift the slight burden of explicitly registering their choices from those who wish to donate to those who wish not to. It should be coupled with the provision of simple means of opting out, such as a toll free telephone number, a web site, and a freepost mail-in system, in order to prevent imposing a significant burden on those who may wish to opt out. It might be objected that we can nevertheless predict that a number of people who would prefer not to donate their organs after their deaths, will not express an official preference, and so will not opt out and will become donors by default. But given that the relative number of people who are against organ donation is small, this number is likely to be much smaller than the number of people whose preferences are similarly contravened under the present opt-in system. We could further reduce this number by heavily publicising the opt-out register. In contrast to the presumptive approach, a properly implemented opt-out system would tend to enhance rather than reduce our adherence to people’s personal views and to clearly define and protect our respect for their autonomous choices. Reflection prompted by the Reversal Test thus indicates that we hold an irrational status quo bias toward our opt-in organ donation system, and that the introduction of an opt-out system of organ donation would actually do better than the presumptive approach, and indeed better than the current system does, to protect the autonomous choices of donors and next of kin. Even if the introduction of an opt-out system were to generate opposition that produces a paradoxical short-term fall in donation rates, as has been feared, we can safely predict that in the long run its popularity would recover as it became accepted as the status quo.
**Answers to: “Altruism is a Core Value”**

1. **Altruism should not be uncritically accepted as a value premise- if the motivations for the act are simply protecting the self from violation the act is morally questionable on altruistic grounds.**


   Donation, based on a spontaneous, voluntary individual act, has been widely promoted by public authorities in countries where it constitutes the only means of organ procurement. It is achieved by the systematized call for individual generosity, altruism and civic-mindedness. The legitimacy of this exclusive approach should nevertheless be questioned. Is it pertinent to refer to altruism and ‘civic-minded altruism’ in particular, where organ procurement for therapeutic purposes is concerned? Altruism is the selfless concern for the welfare of others but, in the strict acceptance of the term, it concerns the motivation behind the act and its expected outcome rather than its effective outcome. An analysis of motivation permits the differentiation between pure universal altruism, the concern for the good of others as fellow human beings, and more specific forms of ‘self-referential’ altruism, so called by C. D. Broad (1952). Universal altruism may occasionally call for the repression of personal emotional bonds and specific moral obligations whereas self-referential altruism (particularism) inherently implies a compromise between different possible outcomes. One of the factors used to measure the value of an altruistic act is the extent to which it contributes to another person’s welfare and its effective positive utility, which in the case of organ transplantation is measured by the increased life expectancy and improved quality of life of organ receivers. Altruistic motivation is generated (albeit secondarily) by a prior knowledge or understanding of what constitutes the welfare of others, although the two may be dissociated at the time the act is performed. An interventionist interpretation of altruism would consider that the act is motivated by the desire to intervene for the good of others whereas in another form of altruism, the act would consist in inciting others to take the necessary steps to ensure their own welfare or alternatively, rendering them capable of ensuring their own welfare (thereby privileging autonomy). Altruism relies on the concern for the well-being of others (or indeed an understanding of this ‘well-being’) that distinguishes it from selflessness that describes individual acts motivated by no concern for the self or the desire to increase one’s positive utility. In the debate on organ donation, altruism is put forward, without further discussion, as an eminently moral attitude whilst those who refuse to ‘donate’ often earn themselves widespread opprobrium. Yet the moral value of an altruistic act depends on one’s definition of altruism. An altruistic act based on the repression or negation of self (that one discerns in certain living donors) cannot be accorded the same moral value as one involving an active concern for the welfare of others. Certain authors in the philosophical tradition, such as Schopenhauer, place altruism at the centre of morality, which in this case would constitute an excessive or even illegitimate demand on citizens since all would be expected to behave ‘morally’.

2. **Altruism is an ineffective value because it does not govern any other aspect of society.**


   Invoking altruism in the specific domain of organ donation is neither coherent nor maybe even legitimate. In the case of living organ donors, it should be reminded that devotion may be an indirect way of satisfying one’s personal interests. Hoping to increase the number of organ donations, whether from the living or the deceased, on the sole basis of altruism is inherently precarious in that one cannot rely on the altruistic nature of humanity. A. Smith echoes a predominant current in philosophical thought when he underlines that ‘every man… is much more deeply interested in whatever immediately concerns himself, than in what concerns any other man’ (Smith 1790). The social contract, from which the organisation of organ donations has emanated, is based on this intuition and by no means based on individual altruism. ‘Beneficence… is the ornament which embellishes, not the foundation which supports the building’ (Smith 1790). Organ donation rhetoric is in contradiction with the principles governing macrosocial interaction. If society is not founded on the principle of benevolence and altruism, it is nevertheless the fundamental, exclusive motivation to which the nation appeals for the procurement of human organs. Yet, in all social and political interaction in general ‘it is not from the benevolence of the butcher, the brewer or the baker that we expect our dinner, but from their regard to their own interest. We address ourselves not to their humanity, but to their self-love, and never talk to them of our own necessities, but of their advantages’ (Smith 1776). One can therefore doubt that the dichotomy between altruism vs. selfishness is the most pertinent standpoint in matters of organ donation (see Berthoud 1993).
Answers to: “Altruism is a Core Value” [cont’d]

3. **Altruistic systems that attempt to recruit people into organ donation rest on a flawed view of justice.**


Fostering altruism as a moral obligation in the discourses promoting organ donation contains an underlying presupposition; it assumes that the persuasiveness and pedagogy of its arguments demonstrating the validity of the practices concerned (i.e. the social utility of organ donation or the possible savings on public health expenditures) will inevitably win citizens’ adherence. This rationalistic presupposition, inherited from the philosophy of the ‘Siècle des Lumières’ omits the social, individual and anthropological context in which the question of organ donation is posed but on which the outcome nevertheless depends. This rationalistic presupposition takes no account of anti-social reactions (that are unquestionably individualistic) though some can be understood. A frequent expression of this type of reaction is: ‘no-one has ever done anything for me, why should I donate my organs?’ Though certainly objectively false, the subjective validity and significance of this opinion cannot be denied or doubted (see Bateman 1997). In short, it would be presumptuous (and false) to imagine that voluntary organ donation is beyond question and that the only possibly outcome is necessarily strictly rationalistic. This rationalistic presupposition expresses a form of universalism that ignores moral or spiritual inhibitions concerning organ removal practices and imposes an abstract concept of universality. It equally assumes that the underlying contribution of communication is to reduce public reticence. However, ‘one can be informed but resolutely against organ donations. One’s attitude when confronted with organ donation is not a question of information or rationality, but of personal signification and values’ (Le Breton 2008).
**Answers to: “Exception Are Needed for Children”**

1. **Presumed consent should especially apply to children because there is an exceptionally high need for youth organs.**


   Sections 2(2) & (3) of the 2009 Bill state that the intention to remove an organ can only be acted upon after the objection register has been consulted; if the patient has registered his objection, the donation cannot go ahead. These provisions are, of course, to be read in conjunction with Sections 1(1)(a) & (b). It appears that a combination of the deceased’s wishes and the views of the relatives will be considered by the doctor before a decision is to be made. Therefore, if the deceased objected to donation in the required way, the deceased’s view stands. If the deceased consented (or was presumed to have consented), the relatives can veto this. There is no provision in the 2009 Bill which stipulates that the views of the relatives are not to be considered by the doctor in any circumstances. As a result, Parliament give the impression that the provisions and the relatives of the deceased are to work in harmony to reach an agreement on donation. The Organ Donation Taskforce presented an interesting view in this regard. After questioning the public about presumed consent and opt out systems, there was a feeling that a system of presumed consent would relieve families of the burden of making a decision in the absence of any indication as to the deceased’s wishes. However, the Taskforce found: this a somewhat paternalistic view, at odds with the ethos of today’s NHS. Further, our evidence from donor families was that they stressed the importance to them of being involved in the decision to donate and of being allowed to make the decision that was right for them at the time. direction for a new Bill to take? There are significant shortages of infant and child organs, and in instances where a child is tragically taken at such a young age, it is difficult to approach the grieving parents to request an organ donation. Perhaps of all groups, children should be the most eligible for strict presumed consent donation programs? The most controversial part of this provision is not related to what is included, but what is excluded. Parliament does not appear to mention any particular groups of society who could be automatically exempt from presumed donation. Both Belgium and Singapore take the opportunity to exclude certain vulnerable donors from their presumed consent programs, such as mentally disabled adults, non-citizens, and Muslims. In addition, the 1969 Renal Transplantation Bill in the U.K. provided exclusions for persons who, at the time of death, were suffering from mental illness or mental handicap, minors, those over 65, prisoners, and permanent residents in institutions for the aged, disabled or handicapped. What about adults in the U.K. with strong religious preferences or mental and physical disabilities? Is it correct that they are to be ‘presumed’ to be consenting when ordinarily they would be deemed reluctant or incapable to consent to such medical procedures? The provisions of the 2009 Bill may take advantage of such individuals.

2. **Organ donation should be all or nothing. Exceptions undermine justice.**


   The question of organ donation can be formulated in terms of interindividual justice, certain conditions of which duplicate those regarding global justice in that the individuals benefitting from the allocation of the goods in question have no immediate relationship with the resource suppliers. In the first place, and by analogy, if an individual accepts the principle of post mortem organ donation and is prepared to donate to next of kin for example (although current legislation is not formulated in those terms), then from a moral standpoint, there is no legitimate or moral justification in objecting to having the same duty towards individuals that are emotionally, socially or geographically distant. The moral responsibility is identical in both cases, independently of the nature of the good in question. This transitivity could further be justified by the fact that, when questioned, the vast majority of citizens in western democracies admit to being in favour of organ donation. Secondly, individual moral responsibility is equally engaged with respect to these distant, anonymous individuals in the same terms that apply to global justice. This attribution of responsibility is essentially founded on the distinction between ‘contributing to’ and ‘failure to prevent’ (or ‘having failed to avoid that…’). Although deceased potential donors are not effectively responsible for the receivers’ deteriorated states of health, their responsibility is nevertheless engaged in that they ‘failed to prevent’ a deterioration or ‘did not permit’ an improvement in health status to occur, especially in a case where the donor’s positive utility is not diminished by the gesture. The configuration underlying post mortem donation and potential resource allocation is asymmetrical and reinforces this moral responsibility. It opposes two situations in such a way that for one party the resource is lacking and constitutes a need that in the majority of cases is vital, whereas for the other party in possession of the resource (the deceased) it will no longer be used or exploited. These reasons create a moral responsibility concerning the quality of life of another human being, whoever the other may be, inasmuch as it is in one’s power to improve another human being’s quality of life.
Answers to: “Families Know the Deceased’s Wishes Best”

1. Familial refusal to donate organs is not due to thinking the deceased opposed donation but is due to status-quo bias, a cognitive distortion.


An opt-out system promises to increase the supply of organs for transplantation partly because even though a large majority of people support the practice of organ donation, many supporters fail to ever register to become donors under opt-in systems. In these cases the decision usually falls on the decedent’s family, who quite often refuse to donate organs because they are not sure what the deceased themselves would want. But this behaviour itself raises a question: why do families often choose refusal rather than donation because of a lack of information about the decedent’s wishes? After all, families in this position are generally just as unsure that the deceased would not want to donate as they are that the decedent would want to donate, so families risk choosing against the decedent’s wishes either way. And even most people not on the organ donor register would, it seems, prefer to donate. Why not, then, consent to organ donation in these circumstances? The high rate of such refusals appears to be influenced by an irrational cognitive bias known as ‘status quo bias’. Status Quo Bias and its Significance I use the term ‘status quo bias’ to refer to an irrational cognitive bias which tends to produce a preference for the status quo, or default. It is not, of course, always irrational to prefer the status quo: it might simply be better than any of the alternatives. Even when it is not, one may have some reason to prefer to stick with the status quo. It might be risky to attempt any changes to the status quo, or the transaction costs of making changes might be high. There might also be other kinds of reasons to prefer the status quo. For example, if I promise to stay where I am until you arrive, it would not generally be irrational for me to prefer to stay, even if being somewhere else would be more pleasant. But a large number of observational and experimental studies in the social sciences literature provide strong evidence that we have a pervasive bias toward the status quo even when no such reasons for preferring the status quo exist.

2. The opt in regime is overly cautious because it seeks consent from the patient and also their family after death- that is the chief cause of the organ shortage.


The primary defense of (at least part) of the current policy (known as the “Pittsburgh Protocol”) relies on the view that we have a moral obligation to respect the autonomy of patients, even after these patients die. This view can be defended in several ways, some more controversial than others. What the patient would want is thus regarded as one of the deciding-features in determining whether or not said patient's organs might be used. The current policy in American and British medical practice is to presume that a patient would not consent to organ donation. Thus, given this policy, removing the organs of a deceased patient - even if such a removal would save multiple lives - cannot be carried out unless the medical staff has explicit consent on the part of the patient (when he or she was living), or, that failing, on the part of the patient-surrogate (if the patient did not specify one way or the other), as well as explicit consent from the family of the patient. This policy reflects some rather intuitive views, albeit while ignoring the philosophical difficulties surrounding them: 1) it is thought that the loss of bodily integrity is against the interests of the deceased, the deceased's family, or both, and 2) consent to the loss of said integrity is "morally transformative" (to use Alan Wertheimer’s phrase). It is the consent of all involved that transforms a (perceived) harm into a non-harm. Consent, in the case of organ donation, marks the difference between a violation of one's interests and a generous act. By requiring the consent of both parties (the patient and the patient's family), it is presumed that we avoid engaging in morally questionable action. As I suggested above, these views are perfectly intuitive, so long as we ignore some of the philosophical difficulties surrounding them when we consider the case of the dead. I want to take a closer look at each of these presuppositions, and bring out some of the philosophical difficulties in more detail. My aim in doing this is to begin to consider what the double veto leaves wanting as a policy for organ procurement. In considering the limitations of the double veto by examining its problematic philosophical underpinnings, I also want to prepare the ground for an alternative view: namely, that organs should be harvested regardless of whether or not consent is obtained from the deceased or the deceased's family. 2.1 Bodily Integrity First, consider the view that the loss of bodily integrity is against the interests of the deceased, the deceased's family, or both. Rather than dive into the vast literature on the question of whether or not the dead have interests, let us simply assume that the dead do, in fact, have some stake in what happens after their death. If it can be shown that this interest in bodily integrity is not sufficient to avoid organ donation, the case for a policy of double veto will be virtually annihilated.
3. Requesting the families donate the deceased’s organs triggers loss aversion reasoning.

Under an opt-in system for organ donation, there is a built in default of the following kind: if donors and their families do nothing, the organs will not be used for transplantation. On the plausible assumption that status quo bias is genuine and is as pervasive as the social science literature indicates, it is likely that this default adversely affects the availability of organs. Loss aversion may underlie status quo bias in this kind of case, because a decision to donate organs involves both gains and losses compared to the default. Organ donation and organ donors save lives, but the practice also comes with costs, such as that of surgical mutilation and loss of organs from the body of the decedent, and the fact that the family cannot stay with a brain dead donor to say goodbye as circulation finally ceases (the donor needs to be in surgery before the tissues are starved of oxygen). Because donors and families are subject to loss aversion, and these negative aspects of donating may tend to loom larger than the positives, we can predict that status quo bias will probably influence people’s decisions, resulting in irrational reluctance to consent.

4. Family autonomy does not respect the wishes of the deceased. There is no reason they should be included.

Notice, however, that this does not address the issue of whether the double veto policy itself is based on respect for autonomy. Indeed, if Wilkinson's marriage analogy is a good one, the double veto would seem to be based more on respect for a surgeon's desire not to cause offense. While this is not objectionable per se, it does point to a limitation in the view that the double veto is designed to protect the autonomy of a patient. While it might not necessarily violate said autonomy, neither does it do much by way of insuring that the autonomous wishes of the deceased are carried out. Thus, any defense of the double veto cannot rely on the claim that the policy is justified as a means of protecting autonomy, for even though the policy might not necessarily violate autonomy, neither does it hold autonomy in particularly high regard. This point can perhaps be made more clearly when we notice two senses in which one might respect another's autonomy, one strong, the other weak. Respecting someone's autonomy in the weak sense can be accomplished through a policy of non-interference. I respect your autonomy just insofar as I do not do anything to prevent you from carrying out your wishes. The stronger sense of respecting autonomy involves the actual promotion of the autonomously chosen ends of others. In respecting someone's autonomy in this sense, one is required, as Kant claims, to make one's ends my own. To truly respect your ends involves not merely non-interference, but actually contributing, where possible, to the attainment of your morally permissible, autonomously chosen goals. Wilkinson's marriage analogy, it seems, demonstrates forcefully that the double veto is compatible with respect for autonomy in its weaker sense. A doctor is not interfering with my autonomously chosen end of donating my organs by allowing a family veto. Her non-interference is thus a form of respect. But this is a far cry from the stronger form of respect for my autonomy, which would require the doctor to actively attempt to carry out my wishes once I have died.
1. Viewing an intact corpse is not necessary for familial closure to occur.


First, it is not at all obvious that a viewing of the dead provides the therapeutic effect that it is often claimed to have. It is perhaps revealing to notice that the viewing of the deceased is anything but a universal cultural practice. This suggests, at a minimum, that there are many ways to achieve healthy closure after the loss of a loved one, as it is unreasonable to suggest that only cultures that have viewing are adequately dealing with the fact of death. So, even if it is true that viewing an intact corpse can aid in the mourning process, allowing survivors to achieve closure, it is not the only way to find such closure - nor even demonstrably the best. Indeed, it might even be the case that our attitudes about viewing the body are in fact an instance of our inability to deal with the fact of death. Consider Kamm's remarks on this point: [I]t seems important that the last contact of the living with the dead should be with what seems to be an intact body; anything else may take away a continuing illusion of life. People may prefer that the undeniable evidence of death and radical change that a dismembered surface or decaying body presents come to exist beyond sight. As Kamm goes on to (correctly) point out, even if such viewing is crucially important for the benefit of the survivors, it has almost no relevance to the issue of internal organ removal. Any loss of bodily integrity can be disguised for the benefit of the family. Even if it is true that grievers have the right to experience an intact body, it does not follow that the body must actually remain intact. All that follows is that we have a duty to make the body appear to be intact - and this can be accomplished in conjunction with the removal of organs. Of course, if this were a general policy, families might well demand knowing whether or not organs were used. As a workable policy, then, this one would be highly unsatisfactory. To counter the demands of those with a strong interest in the integrity of the corpse, we thus need to show that the interests of those surviving the deceased (or even of the deceased himself) can be trumped. This, I think, can be shown quite easily (I will return to this below).

2. Excluding the family from the decision not only respects the autonomy of the deceased, but also prevents the family from having to get their hands dirty with the decision.


Let us now turn to the "dirty hands" objection: the view that consenting to organ removal makes the grieving part of the violation of the deceased, implicating them in a wrong-doing. There is indeed an important difference between allowing the body to lose integrity in the grave, and consenting to the immediate loss of that body's integrity. The difference between removing organs and letting them rot is analogous to the difference between killing and letting die. Even if we cannot stop decomposition, we need not have a hand in it. Thus, while the rot of the grave might well be lamentable, it is not the result of a direct action on the part of the family of the deceased (in normal cases). Allowing organ transplant, however, would involve the action of the family, and hence would implicate them in the destruction of the body. But notice that what we are to conclude from this point is anything but clear. One might conclude, as it seems the double veto does, that the family should have veto power when it comes to organ donation. This enables the family to prevent themselves from having a hand in the loss of bodily integrity, even though that loss is inevitable. But another perfectly plausible response is to simply take the choice out of the hands of the family. Giving the family no say whatsoever would serve two functions. First, it would actually serve as a means of respecting patient autonomy in a way that the current policy does not (because the family could no longer override the wishes of the deceased when the deceased wished to donate organs). Second, it would prevent forcing a family to dirty their hands with a decision they are perhaps ill-equipped to make (emotionally, morally, or intellectually). On this view, then, the objection to organ donation actually works against BI2: by removing the power of the family to veto, we effectively eliminate the double threat of dirty hands (that they violate the integrity of the body, and so save a life; or that they preserve the sanctity of the body, but thereby let someone die).
**Answers to: “Illicit Trafficking Isn’t a Concern”**

1. It is particularly unjust to allow people to die from organ failure because there is no technological or health barrier to transplants. It is simply a procurement failure.


   Modern techniques of organ transplantation have so substantially increased the viability of organ transplantation as a worldwide therapy that 300,000 people annually receive an organ transplant. The medical advances in transplantation techniques, incredible for their growing success rate, have resulted in increased need for transplantable organs. The advent of immunosuppressant drugs that increase compatibility between donors, preservation techniques that allow for increased organ life outside of the body, increased effectiveness of recipient registries, greater numbers of transplant teams that can transport organs, and more skilled surgeons who can perform the surgery has changed organ transplantation from an experimental scientific phenomenon to an accepted solution to organ failure. Unfortunately, there have not been similar advances in creating laws that facilitate increasing the supply of organs to meet the demand. The initial effect of the demand for transplantable organs was a deficit on the domestic level, with the effect on particular states determined by distinct supply and demand factors. Local demand for transplantable organs is determined by the number of patients diagnosed as potential organ transplant recipients. With the increased availability of medical technology making organ transplantation more of a therapy, as opposed to an experimental option, the number of patients who could be saved, but die due to a lack of transplantable organs, also increases. However, according to current classifications of patients who need a transplantable organ, a sufficient supply of potentially transplantable organs exists to meet the demand for almost every type of organ. The problem is that these potential donor organs are not being adequately collected by the states. This means that, on any given day, for each patient who dies for lack of a transplantable organ, an equal or greater number of viable organs are buried in the ground. While some may look at this as merely a social problem, the forces of supply and demand in this allocation system have created a market, albeit a black market, for human organs. It is obvious that in its current condition, most state allocation schemes are failing as effective suppliers of donor organs.

2. Organ shortages drive those in need to tour to the least regulated jurisdictions in order to harvest organs from the vulnerable.


   These problems are not only domestic, but increasingly, they take on an international dimension due to the failure of domestic allocation schemes and the increasing relative ease of organ transplantation. There are many reports of nationals of a particular country traveling to a foreign country in search of a transplantable organ. The result is that patients are traveling to the countries with the fewest restrictions on the sources of organs and the methods of procuring these organs. In the current international market, this is reflected by the fact that organs are being bought and traded, virtually unregulated, in some countries. States that cannot meet their domestic demand are, in effect, forcing their citizens to travel elsewhere for life-saving treatment, encouraging an international market that survives on violations of basic human rights and organ sales by the poor. Such an international procurement scheme is ineffective and undesirable. The challenge is to identify the form the international market should take, and the domestic policies that would best encourage such an international market. States need to determine what rights they have under international law in creating minimum standards to be adhered to by other states. This challenge should be met, not only because it can have a positive impact on other states' markets, but because better organ procurement methods elsewhere will positively affect their own domestic market. It is important for states to realize that the illegal trafficking of human organs cannot be categorized as just a violation of basic human rights. Such a crime is motivated, not by politics or religion, but by greed for the potentially great profit available to unscrupulous organ brokers dealing with both donors in dire need of money, and recipients in dire need of organs. Therefore, laws that deal with such criminals should not be organized around policies that address primarily religious taboos and cultural mores; rather these laws should seek to avoid the victimization and exploitation of people, both domestically and internationally. Ideally, every domestic system would operate in a similar, efficient fashion, such that international problems and abuses could be averted. Of course, this is quite unrealistic, if only because of the disparate medical resources that exist between countries. Domestic concerns have naturally been preeminent in formulating a national policy toward organ procurement. However, it is not enough to limit policy decisions to immediate domestic concerns. States must be aware that failure to satisfy demand locally will have international ramifications. Similar to other international markets, repercussions of the ill effects created by some domestic markets in organ procurement will be felt by similar markets in other nations. For example, consider the spread of disease through foreign organ transplantation and the higher percentage of unnecessary organ recipient deaths due to the lax medical standards which often accompany lax legal standards. These are two of the many growing international problems, as demonstrated in the following section.
3. Gaps in jurisdiction and regulations create incentives to exploit those with organs to sell in poorly regulated jurisdictions.


Few nations are meeting organ demand locally and as a result, more people are traveling abroad hoping to acquire an organ. Transnational travel for transplantable organs provides the basis for the assertion that organ procurement must be examined as not just a collection of domestic allocation systems, but as an international market. The domestic allocation systems that are producing the fewest organs are essentially forcing their citizens in need of an organ to obtain a transplant in a state that does not have a shortage. In our current international market, the nations that procure the greatest number of organs are those that allow their residents to sell their organs and have them removed while they are still alive. Unfortunately, empirical evidence suggests that this type of system "starts with unregulated organ removal and ends with a vicious traffic whereby the poor and uneducated are exploited in the interest of the wealthy." Further, such systems allow for human rights violations to occur, and fail to meet medical standards that protect against the spread of disease and infection. While one can argue that these are problems endemic to a particular nation, and not the international market, careful examination reveals this to be false for two reasons. First, if domestic supply met domestic demand, people would not feel the need to travel to risky, abusive markets to obtain organs. Second, patients who do travel abroad to receive an organ sometimes return with a diseased or infected organ that needs immediate emergency treatment in the patient's home state.

4. Illicit organ donation subjects the poor to exploitation, disease, and suffering as they sell their organs.


Despite the large number of countries which have developed regulated jurisdictions, the problem of organ trafficking remains significant. Few nations are meeting organ demand locally and as a result, more people are traveling abroad hoping to acquire an organ. Transnational travel for transplantable organs provides the basis for the assertion that organ procurement must be examined as not just a collection of domestic allocation systems, but as an international market. The domestic allocation systems that are producing the fewest organs are essentially forcing their citizens in need of an organ to obtain a transplant in a state that does not have a shortage. In our current international market, the nations that procure the greatest number of organs are those that allow their residents to sell their organs and have them removed while they are still alive. Unfortunately, empirical evidence suggests that this type of system "starts with unregulated organ removal and ends with a vicious traffic whereby the poor and uneducated are exploited in the interest of the wealthy." Further, such systems allow for human rights violations to occur, and fail to meet medical standards that protect against the spread of disease and infection. While one can argue that these are problems endemic to a particular nation, and not the international market, careful examination reveals this to be false for two reasons. First, if domestic supply met domestic demand, people would not feel the need to travel to risky, abusive markets to obtain organs. Second, patients who do travel abroad to receive an organ sometimes return with a diseased or infected organ that needs immediate emergency treatment in the patient's home state.
1. Recruiting for organs and pushing people to opt-in is net worse for individual autonomy than a default option.


Proponents of the presumptive approach may protest that it could be instituted without infringing on people’s ability to make autonomous choices. Perhaps they will renounce unfair browbeating methods and high-pressure sales tactics. Perhaps they would even require the counsellors to provide, on request, the sort of factual information that might lead someone not to donate. Departures from neutrality of the sort the presumptive approach demands might be more morally defensible, and might indeed be more effective at encouraging assent, if they are subtle. Indeed, the subtle type of presumptive approach is the one that seems to have been attempted in practice. Counsellors might not be explicitly presented as advocates for those waiting on the transplant list, but rather simply as ‘members of the medical team’. Instead of a counsellor offering to provide ‘information about organ donation’, he or she might offer ‘the opportunity’ to donate and make the donor a ‘hero’. Instead of concluding by offering time to make a decision, the counsellor might instead presumptively offer to ‘lead’ the patient or next of kin ‘through the process’ of providing consent. The difficulty for this attempted defence of the presumptive approach is that in order for it to continue to be defined as presumptive, the way that counsellors approach donors and next of kin must be slanted towards encouraging their donations. This inevitably places some burden on those who would choose not to donate, and may threaten their ability to make their own autonomous choices altogether. Arguably, the lack of explicit presentation of advocacy that the subtle approach engenders is an even greater threat to autonomous choice than a less subtle approach would be; donors and families might justifiably feel ‘tricked’ into donating by an apparently neutral party. Moreover, the presumptive approach is premised on counsellors approaching donors or next of kin either at or around the time of death of the donor—inevitably a highly stressful context, and one in which the individuals concerned are particularly unlikely to be able to make appropriately reflective and rational decisions. It is easy see how counsellors in these circumstances might unduly influence choices and violate individual autonomy. Even if the behaviour of counsellors were to be carefully and tightly regulated so as to avert this likely possibility, the risk of a slippery slope to violations of autonomy would remain ever-present, because the counsellor must be motivated to increase donation rates beyond what they would be on the neutral approach. The presumptive approach thus turns out to be subject to similar objections to the policies imagined under the Reversal Test that would make opting in more burdensome, and in some ways the objections are even more serious in the present case.

2. Requiring that people opt in to donation and also allowing the family to give consent creates situations where the patients explicit consent is overridden.


The other class of arguments in support of the preservation of bodily integrity I called “deceased-regarding” above. In essence, these arguments are concerned to respect the wishes of the deceased. At this point, however, I want to limit my concerns to whether or not the current policy of double veto actually does respect the autonomy of the deceased. I do this as a means of further exploring (and criticizing) our current policy for organ procurement. In defending an organ conscription policy, which I will do in sections 3 through 5, I will return to the question of autonomy, providing a more sustained treatment of the question. As mentioned above, the double veto requires the deceased as well as the deceased's immediate family give consent to the removal of organs from the deceased. On the face of it, this policy seems to conflict with the autonomy of the patient: if my wishes to be an organ donor can be overridden by the wishes of my family to preserve my bodily integrity, it seems that, prima facie, my autonomous wishes can be trumped by the wishes of my family. Thus, it appears that the double veto policy is not in fact compatible with a true respect for the autonomy of the patient. But this incompatibility, it might be argued, is only a prima facie one. T. M. Wilkinson provides the following analogy: If my parents refuse to allow me to be married, they have indeed violated my autonomy. If, however, the woman I intend to marry refuses to marry me unless my parents approve, my autonomy has not been violated. Likewise, if a doctor will only remove organs from a patient on the condition that both the patient and the patient's family give consent, the doctor has not violated anyone's autonomy. This, I think, is a powerful counterexample to the claim that the double veto does not respect the autonomy of the deceased. But it is important not to exaggerate the force of this argument. It does not show that autonomy is never violated in the double veto. It merely shows that it is logically possible to refrain from acting on someone's rational wishes without thereby failing to respect those wishes.
Answers to” “Opting-in Necessary to Respect Autonomy” [cont’d]

3. Opt-in systems are just as susceptible to overrunning individual autonomy because family members can still consent.

Govert den Hartogh, Department of Philosophy, University of Amsterdam, JOURNAL OF MEDICAL ETHICS, “Tacitly consenting to donate one's organs,” vol. 37, no. 8, August 2011, accessed 8.15.2014: academic search premiere.

It is generally assumed that people have the authority to decide, with respect to their own bodies, what other people are allowed to do. This authority does not only concern their living, but also their dead bodies, although it may be mistaken to take the second authority to be implied by the same basic right to bodily integrity as the first one. If this authority is granted, it follows that organs should not be removed post mortem for transplantation ends without the consent of the deceased. Opt-out systems of postmortal organ procurement, however, do not seem to respect this requirement, for they allow the removal of the organs unless the deceased (or his family) has explicitly objected. This is the main reason why countries such as the USA, the UK, Germany and The Netherlands still hold on to an opt-in system, even though, according to the majority opinion of experts, opt-out systems have better results in terms of organs becoming available for transplantation. It is remarkable that the actual opt-in systems adopted by those countries are vulnerable to the very same objection, because in cases in which the deceased has neither registered his consent nor his refusal they allow his relatives to make the decision. The fact that opt-in systems are also open to it, however, by itself does not invalidate the objection to opt-out systems.

4. Opt-in systems force people to try and recruit or solicit organ donations, leading to skewed information during consent procedures and destroying individual autonomy.


Because the opponents of an opt-out organ donation policy cannot meet the burden of explaining why the current opt-in system is the best one, we should look for an alternative. Let’s consider, then, our two competing policy alternatives for improving the rates of organ donation. The first is the presumptive approach. Under this system, explicit consent is necessary, but the choice of whether or not to donate would be presented to still-living donors, or to their next of kin, by counsellors who would present the options in a non-neutral way, with the aim of encouraging assent to donation. Our reflection in accordance with the Reversal Test has already highlighted a number of serious objections to the mirror image of the presumptive approach, which I called the ‘aversive approach’. Now all we need to do is to see whether they would also apply here. Is there a danger that the presumptive approach could threaten a person’s ability to make a properly informed autonomous choice about the matter at hand? It is rather clear that it could, since the counsellors used under the presumptive approach are charged with encouraging assent to donate, and their subjects, exposed to a unidirectional persuasive influence (without having chosen to be so exposed), are consequently vulnerable to making decisions that are less likely to reflect their own fully-informed reflective preferences.
Answers to: “Opt-in Systems Effective”

1. The policy of the status quo has to change- humans lack the cognitive capacity to imagine their way out of status-quo bias.


First, then, consider the Switching Test, which has been advocated by Dominic Wilkinson in connection with opt-out systems of medical testing and organ donation, and by Scott Abereeg et al. in connection with decisions made by doctors in critical care and other medical practice. According to proponents of the Switching Test, in order to eliminate status quo bias in our objections to a proposal, we should simply imagine the option under consideration as if it were the status quo and consider whether, from that perspective, we would then think that there is sufficient reason to change to what is in reality the status quo. For example, a doctor finding herself opposed to the release of a patient from the Intensive Care Unit to the medical floor because of his elevated blood glucose level should imagine whether, if the patient were now on the medical floor, she would consider the patient’s blood glucose level a sufficient indication for transfer to the ICU. Similarly, if we find ourselves opposed to an opt-out policy for organ donation, we should imagine that we already have an opt-out policy, and ask whether the reasons to move to an opt-in system seem strong enough to make the switch to it. It should be noted that if there are significant costs involved in making the switch itself, they could make it irrational to switch in either direction, even if one option is clearly superior to the other. For example, the costs involved in making changes to which side of the road people are required to drive on may provide decisive reason not to switch. To simplify the presentation here, I shall assume for the time being that there are no such costs involved in the cases we are considering. The main problem with the Switching Test is that it is highly doubtful that we human beings can perform the kind of imaginative feat it demands in order to free ourselves from the undue influence of our existing beliefs and biases. To see why this matters, it is important to understand that the collected evidence of status quo bias has not been gleaned by presenting the same group of individuals with a set of options twice over while varying the status quo slant that they are presented with, but rather by randomly sorting a set of individuals into two different groups who each receive the options presented with only one status quo slant. Once a customer has rejected the idea of paying your ‘credit card surcharge’ on a particular transaction, it would be an impressive feat of salesmanship indeed to get the same customer to change his mind and to forgo what you only then start calling your ‘cash discount’ on a higher price! Unless an individual can be made to either forget the judgment already made, or to imaginatively enter into the perspective of having never made any judgment at all, there can be little hope of expunging the status quo bias that has already been manifested in reaching a decision. A relevant analogy here is to be found in the observed behaviour of juries who are told by the judge that they must disregard some piece of evidence that has already been exposed to them in court. Research shows that even when jurors are motivated to comply, they still tend to be influenced by the inadmissible evidence in rendering their verdicts. These considerations should lead us to doubt that the Switching Test is likely to produce a change of mind, even if status quo bias is present. Of course, if performing the Switching Test did in fact produce a change of mind, it would be good evidence of status quo bias having distorted our initial judgment. But the Switching Test seems likely to produce a large proportion of false negatives (i.e. undetected instances of status quo bias) and thus to falsely appear to vindicate many judgments that are in fact irrational.

2. An opt-out system of presumed consent is critical to stop organ deaths and achieve justice.


Thousands of lives are lost each year because of a lack of organs available for transplant, but currently, in the UK and many other countries, organs cannot be taken from a deceased donor without explicit consent from the donor or his or her relatives. Switching to an ‘opt-out’ (or ‘presumed consent’) system for organ donation could substantially increase the supply of organs, and save many lives. However, it has been argued in some quarters that there are serious ethical objections to an opt-out policy, and that it would be better to adopt a different policy known as the ‘presumptive approach’, that requires explicit consent while also attempting to sway the choices of potential donors and family in the direction of donating, using various persuasive techniques. This article shows how reflection on the impact of a well-known cognitive bias known as ‘status quo bias’ can explain (i) why moving from the status quo to an opt-out policy might be effective in increasing organ availability, even without impinging on anyone’s autonomous choices, (ii) why we might have overestimated the strength of the objections to an opt-out policy, and (iii) why the presumptive approach is morally objectionable, while an opt-out policy is not.
Answers to: “Opt-in Systems Effective” [cont’d]

3. Opt-in systems are ethically suspect because they engage in presumptuous recruiting and a lack of complete, informed consent.


An alternative policy for increasing donation rates, which has been used in parts of the United States, is known as the ‘presumptive approach’. This approach might at first appear to offer a milder, less coercive ‘nudge’ in order to improve organ donation rates than the introduction of an opt-out scheme would. Under the presumptive approach, explicit consent from the donor or, more usually, next of kin is required in order for organ donation to take place, but this consent is not requested in a wholly neutral way. Instead, counsellors who are charged with increasing donation rates emphasise the benefits of organ donation to dying patients or their next of kin, and present the option to donate as the ‘normal’ choice made, and as a morally good choice to make. Because the presumptive approach requires that those who donate explicitly provide their consent, it might be thought to provide additional protection for individual autonomy, and thus represent a morally preferable alternative to an opt-out policy. These first appearances are, however, misleading: I will show that the presumptive approach actually raises serious ethical difficulties, whereas an opt-out policy, properly implemented, would protect the value of respect for autonomy that we hold dear. While recent studies show that opt-out legislation has already been practically efficacious (in particular, a recent ten-year study of donation rates in twenty two countries concluded that it has a ‘positive and sizeable effect’ on organ donation rates), the public acceptance of the legitimacy of an opt-out system, and thus its potential effectiveness, would only be enhanced by a better understanding of the ethical issues at stake. Therefore, setting out the relevant ethical issues is of practical as well as moral and philosophical importance.

4. The reversal test reveals that maintaining an opt-in system is irrational and ethics demands a switch.


Bostrom and Ord’s Reversal Test uses a different method, which (as I will show) produces rather more useful results. If you find yourself opposed to a proposal to change a certain parameter in one direction, Bostrom and Ord suggest, consider the option of changing it in the opposite direction instead. If you think that that change too would be a bad thing, then this could be true either because there is some good reason that counts against changing the parameter at all (such as transition costs, or significant risks involved in meddling with the parameter), or else because the value of the parameter as it is currently set is optimal. If you cannot provide good reasons in support of either of these grounds for rejecting the proposed changes, then it is not your rational assessment of the reasons but your irrational status quo bias that underlies your opposition to changing the parameter. In this section of the article, I will indicate how Bostrom and Ord’s Reversal Test prompts us to re-examine our reasons for having an opt-in system from a more neutral perspective, and leads to the conclusion that opposition to an opt-out system for organ donation is produced by irrational status quo bias rather than recognition of good reasons. In the case at hand, the relevant parameter that could be moved in either direction would be the relative ease of donating organs versus not donating them. Under the status quo opt-in system, there is the slight burden on donors (or next of kin) of having to register their preference to donate, whereas non-donors need not register any preference. An opt-out system would make it slightly easier to donate and slightly more burdensome not to donate your organs after your death than the current opt-in system does. If you find yourself opposing this idea, the Reversal Test asks that you consider the following question: should we instead make it relatively more burdensome to donate and easier not to donate your organs after your death than it is under the present, opt-in system? We might accomplish this, for example, by introducing bureaucratic hurdles such as requiring valid opt-in statements to be witnessed by a lawyer or minister of religion, or by instituting mandatory counselling sessions that would be directed toward discouraging opting in (this might be called the ‘aversive approach’, in contrast with the presumptive approach). We could legally require explicit consent from next of kin as well as that from donors themselves before donation can take place, and we could additionally require that the aversive approach and various bureaucratic hurdles be applied to next of kin before their consent can be accepted as valid.
Answers to: “Opt-outs Occur too Frequently”

1. Experimental evidence supports the argument that presumptive consent resolves opt-out problems and family vetoes.

Simon Rippon, Oxford Uehiro Centre for Practical Ethics, University of Oxford, JOURNAL OF APPLIED PHILOSOPHY, “How to Reverse the Organ Shortage,” vol. 29, no. 4, pp. 344-358, 2012, accessed 8.15.2014: academic search premiere. The theory that changing the default from opt-in to opt-out could change organ donation rates is supported by some direct experimental evidence, as well as the kind of real-world data mentioned earlier. Eric J. Johnson and Daniel Goldstein ran an online experiment in which respondents were asked whether they would be organ donors on the basis of questions that provided a varying presentation of the default. For example, the opt-in condition asked respondents to imagine that they had just moved to a new state where the default was not to be a donor, and they were given the choice of either confirming their status as a non-donor or changing it with a simple mouse click. The researchers found that the form of the question had a ‘dramatic impact’, with consent rates jumping from 42% to 82% between the opt-in and opt-out conditions.

2. Presumed consent does not trigger backlash or lessen altruism.

Christian Williams, J.D. Candidate, Case Western Reserve University School of Law, CASE WESTERN RESERVE JOURNAL OF INTERNATIONAL LAW, “Combatting the Problems of Human Rights Abuses and Inadequate Organ Supply Through Presumed Donative Consent,” 26 Case W. Res. J. Int'l L. 315, Spring/Summer 1994, accessed 8.15.2014: lexis-nexis. Others are more concerned that the presumption itself is a problem, in that it restricts or in some way takes away an individual's freedom, and could somehow lead to a cheapening of human life. It would seem that this can be true only if society in general was opposed to the idea of organ transplantation donation. However, polls in Singapore, Canada, Great Britain, and the United States, as well as other countries, have shown that as a society we do not oppose organ donation, but support it as a therapy for organ failure. General support for organ donation, coupled with the fact that presumed consent allows for an individual to opt-out, would seem to counter such an argument. If anything, presumed consent with the ability to opt-out affirms an individual's freedom by expressly ensuring that a donor's wishes are respected, instead of allowing the next of kin to either donate, or forbid donation, of an individual's organs after death. Other critics claim that eliminating altruistic feelings that the positive act of donation provides would be a loss that even increased organ numbers could not justify. Such a belief indicates that (1) a person cannot experience any sort of altruistic feelings by simply remaining within the donation system, and (2) the state has no right to enact a law that will reflect the altruistic nature of society. Many countries, in times of war, enact civilian draft laws to increase military enlistment. These individuals, though drafted, often experience altruistic feelings of patriotism, as does the rest of society. Assuming society is in favor of organ donation, why would similar patriotic feelings not develop? An even more basic argument for supporting the altruistic nature of a presumed consent system is that it would be consistent with traditional humanist values on the presumption that one favors life and life-saving: putting the burden on the individual who would deny someone life by withdrawing consent for organ removal.
Answers to: “People Backlash to Presumed Consent”

1. There is no empirical support that people will backlash to a presumed consent system by opting out at a higher rate.

I. Kennedy, et. al, School of Public Policy, University College, London University, LANCET, “The case for ‘presumed consent’ in organ donation,” vol. 351, no. 9116, pp. 1650-1653, May 30, 1998, accessed 8.15.2014: academic search premiere. It may be argued that this change in public policy would invoke such social unease and disquiet that people would turn away from the whole concept of transplantation. This has not been the experience in countries that have changed, where, if anything, the general population and medical professionals are happier with the new law than with the old. In Belgium and Spain an increase in organ supply has been achieved despite a fall in the number of potential donors. Another objection is that the state already has a big enough stake in our lives—eg, through the tax law, and further incursion into our affairs by assuming possession of our body parts and the right to distribute them to others by law would be a step too far. A study by the King's Fund Institute in 1994 concluded that, in the UK, the medical professions, the transplantation community, and the public were split over the ethics of the contracting out law and it would be inappropriate to recommend a change in the law because this might provoke an acrimonious debate that could damage confidence in transplantation technology as a whole. Others may argue that people would feel pressure not to contract out because this would be socially unacceptable. Both arguments are rebutted by the ready acceptance of the law in Belgium and elsewhere, and the immediate benefit it achieved in increasing the supply of organs. Clearly, from a moral standpoint, the social context in which any law is to operate and any medical action that arises from it must be a significant consideration in determining policy. Before any such law is promulgated, there will have to be an informed public debate and a clear demonstration that it would be morally acceptable to most people. Much of the objection to change would be mitigated by appropriate public education.

2. Presumed consent has low barriers to opting out and doctors are free to desist if they think it would better fit the deceased’s wishes.

I. Kennedy, et. al, School of Public Policy, University College, London University, LANCET, “The case for ‘presumed consent’ in organ donation,” vol. 351, no. 9116, pp. 1650-1653, May 30, 1998, accessed 8.15.2014: academic search premiere. This right is allowed for both in principle and in practice by the Belgian model, in which objection can be registered by law and doctors have the discretion to desist if they feel that removal of organs will better reflect the individual's wishes to avoid undue distress to the relatives. It is essential to ensure that simple mechanisms for registering an objection are easily available. In developed countries it should not be difficult to ensure that an opportunity is provided whenever any official business is transacted—eg, when applying for a passport or driving licence. The safety mechanism of checking the decision with the relatives should minimise the possibility of erroneous interpretation of the dead person's wishes. We conclude that a sensitive, secure, and robust system could be introduced, preceded by a reasonable period of notice and publicity to give time to those who wish to register their objection. Whether this approach recommends itself to developing countries, where other priorities compete, is a separate matter.

3. Empirically, opting out levels are incredibly low.

Erica Teagarden, Associate with Hinshaw & Culbertson LLP in Chicago, NORTH CAROLINA JOURNAL OF INTERNATIONAL LAW AND COMMERCIAL REGULATION, “Human Trafficking: Legal Issues In Presumed Consent Laws,” 30 N.C.J. Int'l L. & Com. Reg. 685, Spring 2005, accessed 8.15.2014: lexis-nexis. Presumed consent offers an alternative where citizens are presumed to consent to donation unless they explicitly state they do not want to be donors. The current donor system in the U.S. is an "opt-in" system which depends on "a patchwork of organ donor card, driver's licenses, advanced directives, and durable power of attorney for healthcare statements as vehicles for citizens to state their wishes." The opt-in system depends on the referral of all potentially medically eligible donors to the local OPO. The OPO then initiates contact with the patient's family regarding donation. The OPO tries to determine the "patient's wishes from documentation and discussions with family." Yet, even if the potential donor indicated his or her wish to donate, the family must also consent. In contrast to what normally happens, 82% of Americans believe that the individual, rather than his or her family should make the decision regarding organ donation. Fifty-eight percent of Americans were unsure about their own plans to donate. Only 38% had discussed their plans with their families. Most of the time, families are making the organ donation decision under stressful circumstances and do not know whether the decedent intended to donate. The natural inclination is to use the default rule. The default rule in the U.S. is not to donate organs. In contrast, many European countries operate a presumed consent system. In Belgium, for example, a national database tracks those who have opted out, and presumed consent has led to an increase in the number of available organs. In Belgium, less than 2% of the population opts out of the system.
Answers to: “Presumed Consent Destroys Altruism”

1. Even if it is a social good to be able to make altruistic decisions, the suffering and death that accompanies organ shortages trumps.


   It has often been thought desirable that people donate their organs altruistically, as a gift. I do not deny that it is. A society in which people need no inducement to help each other, because all are virtuous, is morally preferable to one in which inducements are necessary. I deny, however, that this should be our primary concern. People are not suffering or dying simply as a result of a lack of charity or altruism in society, but because of the shortage of donor organs. We may be able to do little about the former, but we can address the latter problem, so we should do so. Concerns about expressive value are all very well, but they must be appropriately balanced against our other needs, and in this case the need for organs seems more urgent. It may be that introducing the mechanisms necessary to increase the supply of organs would suggest a lack of virtuous donors, but that is clearly already the case or we would not be facing such a shortfall. Moreover, there is no reason to assume that institutions designed to increase organ supply -- such as incentive schemes or an opt-out system of donation -- will in any way worsen the problem of moral motivation. While these schemes are generally designed to make the moral course of action (donation) less costly, that need not undermine its morality.

2. Presumed consent is the best way to enable altruistic behavior. Moreover, it is absurd to claim that people should die on the chance that others won’t get the opportunity to be altruistic.


   Ethical objections to presumed consent therefore must be based on its inability to meet one or more of the other four objectives. The second objective is a restatement of Ramsey's defense of voluntary behavior, which was mentioned earlier: the more the state takes away the opportunity to act voluntarily, the less of an opportunity individuals have to be altruistic, and therefore the less virtuous our community will be. Since presumed consent laws eliminate the need to express our willingness to donate organs, they arguably reduce our ability to act generously. One response to this objection is that presumed consent laws facilitate rather than reduce altruistic behavior. This follows from the argument, described earlier, that people really want to donate their organs, or those of their loved ones, but for psychological reasons cannot bring themselves to do so. According to this argument, presumed consent allows people to fulfill their altruistic impulses by refraining from objecting, which is psychologically easier for them than having to give their express consent. While altruistic action ideally might be preferred to altruistic inaction, altruistic behavior, even of an inactive sort, is better than nonaltruistic behavior. In addition, Ramsey's position seems to lead to an absurd result. Imagine telling a patient waiting for a life-saving transplant that he will be allowed to die just in case someone decides at the last minute to be benevolent and to donate the needed organ. Given the fact that people have not been willing to donate enough organs under encouraged voluntarism and required request, it is hard to accept the idea that we should avoid saving lives and improving quality of life on the off-chance that people's behavior suddenly will change.

3. There is still altruistic value in organ donation even if it is done out of presumption rather than the costly act of opting in.


   Some, following a line of thought in Kant, seem to think that morally worthy action ought to be difficult. If you only do something because it is easy, then it is unclear whether your action is really morally good or merely resulted from inclination. It should not, however, be assumed that it cannot be morally good. The problem here is merely an epistemic one: it is difficult to know whether you would have done the right thing had it been harder or more costly for you. Many people find helping the needy intrinsically rewarding, rather than a chore, but this does not diminish the worth of their action, even aside from its instrumental value. What matters is the counter-factual -- whether they would still have done the right thing even had it been costly to do so. This does not mean that an action must actually be costly to have moral worth.
Answers to: “Presumed Consent Destroys Altruism” [cont’d]

4. **Weighting altruism as a core value justifies policies that would make organ donation exceptionally difficult in order to maximize altruistic effort.**


   One way to challenge the intuition that donating ought to be costly, in order to ensure that donors are properly motivated, is to ask whether we should take measures to make organ donation more difficult or costly? We could make organ donation more burdensome in a variety of ways. For instance, we could require would-be organ donors to pay a fee, increase the bureaucracy involved in registering as a donor, or mandate any would-be donors to go through a series of invasive health checks, in order to determine the fitness of their gift. These measures would, of course, lead to a predictable decline in donation rates, but they would serve to ensure that donations came only from those really motivated by duty. If we care more about moral worth, or expressive value, than increasing the supply of organs then we should be willing to consider such proposals, in order to ensure that donors really are acting for moral reasons. I take it that proposals to make donation more difficult are absurd. We would not want to reduce the supply of organs in order to ensure that the supply we had was donated for unimpeachable moral reasons. Why, then, should we resist making donation easier? Someone willing to defend the status quo would need to adduce reasons to believe that we currently have exactly the right balance between the instrumental concern to increase organ supply and the expressive concern with people's moral character. I think that there are powerful reasons to say that we ought to prioritise the former. Offsetting the costs attached to morally desirable actions will not, I grant, increase the amount of moral virtue exhibited. Those who only donate when it is easy for them to do so do not show moral worth. Nonetheless, that donation is made easier does not diminish the moral worth of those who would have donated, even if it had been more costly. There is no loss of moral worth. Moreover, there is an increase in the supply of organs, which is itself morally desirable, even if it has not come about in a virtuous manner. What matters is simply that it has not come about in a morally objectionable way -- that is, that no one's rights have been violated. This will be the focus of the remaining section of the paper.

5. **Relying on altruism in the context of organ donation systems is paradoxical- one cannot incentivize or coach altruism.**


   Referring to altruism is equally problematic from a moral standpoint since organ donation falls within a framework that does not coincide with the ordinary moral configuration in which selflessness is more likely to intervene; here it not only involves an act but a decision that has implications on an individual’s corporal integrity. Organ donation cannot therefore be treated as a typical case of moral behaviour based on altruism or selflessness in that one is donating oneself, in this case a part of oneself. This configuration denotes ‘particularistic altruism’; it is not the expression of pure selfless action since several outcomes are in competition, particularly in the case of live donors for whom the cost of donation may be expressed as a loss of health potential and may occasionally put their own lives at risk. In the general case of organ donation, the act of giving is therefore not only a moral act but, in the strictest sense of the term, the gift of self (i.e. intrinsically). The appeal to altruism is therefore inherently problematical; ‘inciting altruistic behaviour’ as well as ‘educating altruistic conduct’, though to a lesser extent, is paradoxical. In addition, the question of organ donation raises the specific case of justice towards distant persons, i.e. unrelated individuals for whom one does not feel personally concerned (Follesdal and Pogge 2005) by virtue of the total anonymity under which donations are effectuated. In the case of post mortem donations (and anonymous live donations), we are confronted with the problem of solidarity towards unrelated individuals that are and will always remain strangers. Yet anthropologists continuously emphasize the fact that ‘organ donation is not common practice between strangers’ (Fixot 2010).
Answers to: “Presumed Consent Is Unconstitutional”

1. There is no constitutional or legal barrier to a presumed consent law.


Legal concerns raised by presumed consent fall into two general categories -- constitutional issues, and criminal and civil liability. Neither area presents any serious impediments to adopting a presumed consent approach. 1. Constitutional Concerns Constitutional issues arise because of the need for government involvement in implementing and operating a presumed consent system. Since presumed consent would alter the existing legal rules regarding organ donation, it would have to be adopted by state legislative action. In particular, states would have to replace or amend the UAGA. In addition, the opting-out system might be supervised or sanctioned by the government. The presence of governmental or "state" action means that presumed consent would have to meet constitutional requirements. Two major constitutional principles are involved -- the first amendment prohibition against government interference with the free exercise of religion, and the fifth amendment, which prohibits the government from depriving persons of liberty or property without due process, or taking private property for public use without just compensation. It is extremely unlikely that a court would declare a presumed consent law with an effective opting-out system unconstitutional on the basis that it deprived persons of substantive property rights in violation of the fifth amendment. Most courts have not regarded donor organs as property within the terms of the amendment. Historically, English law conferred jurisdiction over the disposition of corpses on ecclesiastical courts rather than on the secular authorities and their common law courts. As a consequence, English common law, which was the source of the legal principles governing property rights in the United States, never included dead bodies or their constituent parts within its rules. American courts followed suit, holding that neither the decedent nor the next of kin have a property right in the body in the usual sense. Instead, family members at most have a right to dispose of the deceased's remains, consistent with laws and government regulations on the subject. While this right is often referred to as a "quasi-property" right, most courts have held that it does not confer upon the family the type of property rights that are protected by fifth amendment. However, the Court of Appeals for the Sixth Circuit recently held that families had a "substantial interest in the dead body" that was protected by due process.

2. Presumed consent easily resolved due process concern through the opting out provision.


Another approach would be for the Ohio legislature to state that the family possesses no property rights in the deceased other than those fights expressly granted under state law, or that the family has no property fight that triggers due process requirements. Since Brotherton involves the imposition of due process requirements on state action through the fourteenth amendment, and since fourteenth amendment fights are contingent on state law, the impact of Brotherton could be avoided if the legislature clarified that it did not intend to create property-type rights when it passed the UAGA, or that whatever rights had inadvertently been created were extinguished. Finally, even if the decision in Brotherton were allowed to stand, it need not be read to preclude the adoption of a presumed consent approach so long as the system incorporated an effective opting-out mechanism. In Mathews v. Eldridge, the Supreme Court set forth the following balancing test to determine what process was required by the fifth amendment: First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute requirement would entail. Given the limited nature of the private interest in donor organs and the public interest in increasing the supply of transplant organs, an opting-out system that reasonably reduced the risk of an unintended donation would be likely to satisfy the requirements of due process. Under such a system, the family would be deemed to have waived its rights to a "hearing" unless it objected to donation. Nor would a heating be required in the event the family did not waive its right to one, since this would mean that the family had asserted an objection, that the organs would not be removed, and that therefore the family would not have its property rights diminished. In order for the opting-out system to satisfy due process in this fashion, however, it might be necessary to show that the family had received notice of the existence of the presumed consent system and had understood how it operated. This would entail a comprehensive educational program, and would probably require some sort of actual notification of the family, such as by posting a notice in hospitals and providing the family with written information.
Answers to: “Presumed Consent Is Unconstitutional” [cont’d]

3. Case law upholds the view that there is no constitutional barrier to presumed consent.


Even if organs were accorded the status of constitutionally protected property, a presumed consent system would not necessarily constitute a "taking" under the due process clause of the fifth amendment. Assuming that the body were returned to the family in a condition suitable for burial following removal of organs for transplantation, the family would not be deprived of its right to dispose of the body or of any of its value. Furthermore, the opting-out system would allow the family to prevent removal of organs (assuming no contrary indication by the decedent), so that the family's failure to exercise its opting-out rights could be deemed to be acquiescence, rather than a taking without permission. In any event, in view of the legal prohibition against the sale of organs, it is hard to imagine how donors or their families could receive "just compensation" under the takings clause of the fifth amendment. The constitutionality of a presumed consent law under the property clauses of the fifth amendment is supported by recent state court decisions upholding the constitutionality of state statutes authorizing nonconsensual removal of corneal tissue. In State v. Powell, the Florida Supreme Court, by a vote of six to one, held that the removal of corneal tissue for transplantation during statutorily required autopsies was not a constitutionally protected taking of private property. It is noteworthy that the Florida law does not establish an explicit opting-out system; the coroner is permitted to remove corneal tissue so long as he does not know of an objection by the next of kin. The Georgia Supreme Court reached the same result in a case involving a similar statute.

4. Case law favors presumed consent and regime design remedies potential constitutional problems.


Apart from questions arising under the property clauses, the presumed consent law might be challenged on the ground that it deprived persons of liberty without due process as required by the fifth amendment. In State v. Powell, the Florida Supreme Court rejected the argument that the right of the next of kin to dispose of the body of a loved one amounted to the type of fundamental right protected under either the federal or state constitution. Similarly, an appellate court in Michigan rejected a fifth amendment argument against that state's cornea removal statute, holding that constitutional rights concerning the integrity of the body ended with death. The recent decision in the Cruzan case, in which the U.S. Supreme Court upheld a state court's requirement of clear and convincing evidence before a person in a persistent vegetative state could be deprived of nutrition and hydration, is further evidence that liberty interests will be narrowly construed in cases involving the rights of persons who are no longer competent to make their own decisions, and perhaps in cases involving the rights of their families as well. Constitutional objections to presumed consent laws also might be asserted on first amendment grounds. The court in State v. Powell expressly noted that the plaintiffs had not alleged that their objection to the removal of corneal tissues was based on religious convictions, suggesting that the case might have come out differently if they had. As discussed earlier, however, a well-designed opting-out system that permitted religious objections to block organ retrieval ought to avoid the first amendment's ban on laws prohibiting the free exercise of religion.

5. There is no compelling privacy interest in preventing presumed consent from operating.


Several states have enacted presumed consent statutes that permit the removal of organs from a dead body without prior consent. The constitutionality of presumed consent laws has been questioned on two fronts: (1) as an invasion of privacy and (2) as a "taking" of property. The privacy challenge fails because privacy rights end when the individual is brain dead. The "taking" challenge has met with mixed reviews in the lower courts. 1. Extracting Organs from Corpses is not an Invasion of Privacy In Tillman v. Detroit Receiving Hospital, the Michigan Court of Appeals upheld a statute that permitted a dead daughter's corneas to be harvested without her mother's consent. The court explained that: the privacy right encompasses the right to make decisions concerning the integrity of one's body ... However, this right is a personal one. It ends with the death of the person to whom it has value. It may not be claimed by his estate or his next of kin. Therefore, if there is any shield to guard against organ extraction, it takes the form of property, not privacy rights in death.
Answers to: “Presumed Consent Too Difficult in Practice

1. Presumed consent requires several safeguards and regulatory decisions but none of them are insurmountable with effective planning.


Furthermore, the opting-out system would have to address a number of thorny issues. What should the role of the family be in relation to the patient? Should objections by the family be able to override a patient's wishes to donate? Under the current system, the decedent's instructions are controlling, so long as the decedent complies with the requirements of the UAGA. Effectuating the decedent's wishes under a presumed consent system would be more difficult, however. If the decedent wanted to donate his organs, he merely could refrain from registering an objection under whatever opting-out system was adopted. However, the same lack of objection would occur in the case of a decedent who did not want to donate but who was unaware of the need to object. In either case, there would be no binding instructions left by the decedent, and therefore no way to determine if an objection from family members was consistent with or contradicted the decedent's wishes. A presumed consent system also would need special rules to govern removal of organs from minors, from patients who had never been competent, and from patients who died without family members being available. Under the UAGA, for example, a minor cannot make a binding disposition of his organs; only the family can grant permission for organs to be removed. A similar approach might be taken under presumed consent, in which case organs could be removed unless the family objected. Alternatively, the minor's inability to make binding decisions may justify an exception to the usual rule of presumed consent and necessitate adopting a requirement that the family give express permission to donation. Finally, the opting-out system would need an effective means by which a decedent who had objected to donation could change his mind. While it would be difficult to design an acceptable opting-out system, the problems might not be insurmountable. With adequate research, it is possible that an opting-out system could be constructed that, on the one hand, was not so burdensome for decedents, families or health providers that it unduly discouraged organ retrieval, and on the other hand, satisfied ethical concerns by giving adequate consideration to the participants' wishes and sensibilities.

2. There is widespread empirical success of presumed consent regimes- Europe proves.


Recognizing a growing shortage of kidneys for transplantation, France passed its presumed consent law in 1976. The French Loi de Cavailllet provides: An organ to be used for therapeutic or scientific purposes may be removed from the cadaver of a person who has not during his lifetime made known his refusal of such procedure. If, however, the cadaver is that of a minor or a mentally defective person, organ removal for transplantation must be authorized by his legal representative. The law did not outline the procedure for objecting to organ donation. In 1978, the Council of State, France's highest advisory and dispute resolving body, issued a decree that specified the law's procedural requirements. The decree provided for the right of the potential donor to object to the donation of his or her organs "by any means" and at any time. Any objection would be registered in a hospital register maintained for that purpose. The decree also allows anyone hearing witness to a patient's objection to register the patient's refusal in the register. Any physician who is responsible for removing organs from a patient must check the register to ensure that no objection has been made. Therefore, reasonable efforts to determine whether any objections have been made are required, while consent from family members is not. Austria's Hospital Law states that "it shall be permissible to remove organs ... from deceased persons" for the purpose of transplantation and that "such removal shall be prohibited if the physicians are in possession of declaration in which the deceased person, or prior to his death, his legal representative, has expressly refused his consent to organ donation." Austria is the only country with a pure presumed consent system, as it does not offer the next-of-kin an opportunity to object to donation of the deceased's organs. Austrian physicians do not discuss donation with the family unless the family raises the issue that the deceased is a minor. In order to avoid the organ procurement, the individual must have objected to donation, and this objection must be known to the physician at the relevant hour. The physician has no affirmative duty to search for documents indicating consent or non-consent even if there is doubt regarding the decedent's wishes. Spain is the world leader in organ donation. Organ donations have increased by 142% since 1989. Spain operates under a presumed consent system. While presumed consent is standard, families are still asked if their loved ones will be organ donors. Another factor that makes the Spanish system unique is "active detection." Active detection means "having transplant coordinators visit emergency rooms and the ICU on a daily basis, checking the roster of patients and their status." Spain created the Organizacion Nacional de Trasplantes (ONT), a network of transplant coordinators in 139 intensive care units across the country. ONT professionals identify potential organ donors by closely monitoring the emergency departments and tactfully discussing the donation process with families of the deceased. A survey by Spanish researchers found that out of 200 families that declined to have their relatives' organs donated, 78% changed their mind after the process was explained in detail. The success of the Spanish system can be attributed to the combination of presumed consent and its efficient procurement system that educates the families of potential donors.
Answers to: “Presumed Consent Too Difficult in Practice [cont’d]

3. Opt-out systems are the most effective way to yield more organs, respect religious autonomy, and achieve justice.


Relying on the present international market to provide a sufficient number of transplantable organs is clearly unacceptable. The practice of problematic inter-vivos organ sales, coupled with generally inefficient and unfollowed voluntary procurement systems, has proven ineffective at meeting the goal of obtaining the maximum number of organs while violating the fewest number of rights possible. What is needed is a general system that can be adapted to fit an individual state's cultural, ethical, and religious standards or constraints. Presumed consent of the individual, coupled with an option to withdraw consent and a priority incentive for those who do not withdraw consent, will provide the best, safest, and least violative method of increasing organ supply. Additionally, these factors provide a working model for uniform legislation regarding extraterritorial jurisdiction, and also help decrease human rights transgressions. However, before an argument recommending presumed consent can be made, it must be established that a state should have an organ procurement system. Aside from the abuses that occur as a result of ineffective or nonexistent legislation outlined in Section III, there is also the to health care does not fall within the traditional notions of human rights, argument that people have a right to health care. Although the right human body. This does not mean that a country cannot; at a mimit does fall under a generalized notion of a right to life. The right to health care will always be constrained by practical considerations, such as the strength of a country's health care system and the frailties of the mum, insure safe, sanitary organ transplantation; and, at most, insure that a sufficient number of organs are procured so that most people can obtain a life-saving organ for transplantation. Harmonizing organ procurement legislation around the most effective and ethical means acceptable, while simultaneously prohibiting activities such as organ commerce, will best attain this right to a safe transplant.

4. Presumed consent is the most effective and efficient way of increasing organ procurement.


The law that Singapore has enacted is an excellent example to consider. Singapore's law is based upon the presumed consent of all citizens to have their organs removed for transplantation in the event of accidental death, except those who have opted-out; those who are below the age of twenty-one, those who are above the age of sixty, those who are incompetent, or who are Muslim. For those whose consent is not presumed, it may either be given by a legal guardian -- in the case of minors and incompetents -- or by opting-in -- for Muslims and those who had previously opted-out. One lesson Singapore's legislature has learned from the sale of organs, and which is incorporated into this law, is that the lack of incentive to donate generates fewer donations. Therefore, this Act gives priority to those who do not withdraw their consent to posthumously donate their organs over those that do withdraw their consent to donate organs in the event that two such people were in need of the same organ. As discussed previously, presumed consent, when strictly adhered to, is the most efficient method of procuring organs. Not only does such a system provide more organs for transplantation, thereby saving more lives, but it also eliminates other problems. For instance, an increase in the supply of cadaveric organs would lead to improvements in tissue matching between donor organs and recipients, as well as allowing surgeons to be more selective about which organs are procured. Contrary to some criticisms, presumed consent allows for more careful application of brain-death criteria, since the increased supply of donor organs eliminates any temptation to obtain organs through “inappropriate” methods. In countries like the United States, which has a federally funded dialysis program which has climbed in cost to taxpayers from $ 228.5 million in 1974 to almost $ 2 billion in 1982 to close to $ 4 billion a year as of 1992, a presumed consent system would result in lower costs to the government. It currently costs $ 32,000 per year for dialysis for one patient, as compared to $ 56,000 for the first year of a kidney transplant, and $ 6,000 per year thereafter. Additionally, as kidney transplantation becomes a more practiced therapy, one can expect costs to fall even further. Increased cadaveric procurement numbers would also reduce the current reliance on the living donor. There are other advantages to a presumed consent system that proponents of procurement systems -- such as altruism and organ sales -- try to obscure by criticizing as unethical. For example, many critics charge the presumed consent system takes advantage of “reluctant” or “procrastinating” dissenters, in that those who delay opting-out for whatever reason end up not truly expressing their desire to opt-out. This, however, is not an ethical problem that should concern the state any more than the state should be concerned about someone who, after having federal taxes withheld by the government, does not actively pursue their right to a refund of any overpayment.
Answers to: “Presumed Consent Violates Privacy Values”

1. There is no absolute right to privacy that would override the compelling state interest in increasing the organ procurement rate.


Rather than focusing on abortion as a fundamental liberty, a different reading of Roe suggests the right of women to be on equal footing with men. Men can walk away from pregnancy so that the pregnancy has minimal impact on the man's life, career, and self-development. This option is not available to women. Applying this rationale, Roe stands for “a prohibition of discriminatory taking of women's bodies for the alleged common good, and not a prohibition of universal, non discriminatory appropriations for that purpose.” Based on this rationale, a statute that makes kidneys available to those who need them based on universal appropriation, even during life, may be valid in the face of severe public need. Furthermore, when looking at the government's competing interest, we are now dealing with a human being, rather than a fetus, whose life depends on the donation. This would seem to present an even more compelling interest in supporting legislation to mandate living organ donation. In consideration of such a law, the McFall court opined: for a society which respects the rights of one individual, to sink its teeth into the jugular vein or neck of one of its members and suck from it sustenance for another member, is revolting to our hard-wrought concepts of jurisprudence. Forcible extraction of living body tissue causes revulsion to the judicial mind. Such would raise the specter of the swastika and the Inquisition, reminiscent of the horrors this portends. Yet, even after Roe, courts have sometimes required pregnant women to undergo dangerous procedures for the protection of their fetuses. One court permitted a hospital to perform a caesarian section over the objections of a terminally ill woman who was 26 weeks pregnant, when the surgery posed substantial risks to the woman's health but was necessary for the fetus to live. In sum, Roe stands at the intersection of two lines of cases. The first line operates on "liberty" principles, as they relate to intimate relationships, family, and decisions about whether to bear a child. The second line of cases puts recognizable limits on governmental power to mandate medical treatment or to bar its rejection. The foregoing discussion of Roe and Casey shows that freedom from government intervention is not an absolute right. On occasion, state interests trump privacy as illustrated by abortion law. The same rationale could extend to organ procurement.

2. Presumed consent is not in violation of privacy or property considerations.


As this Comment has discussed, property and privacy rights guide the legal analysis of organ donation under U.S. law. While the individual does not have a right of privacy in death, it appears that courts are moving towards recognizing the next-of-kin's right to possess the decedent's body as a constitutionally protected property right. The recognition of this right, however, does not preclude presumed consent. It merely requires that the government provide due process. Since the Supreme Court has said that the states have an "unqualified interest" in the preservation of human life, it does not appear that a significant amount of due process is required. Thus, presumed consent laws would allow the government to interfere with the property interests of the next-of-kin and procure organs for the benefit the public. There are substantial parallels between organ transplantation and abortion law. When an individual is alive, the Fourteenth Amendment protects that person from government intrusion whether in the form of forced pregnancy or organ extraction. This privacy right terminates, however, when the individual is brain dead. Thirty-three states have laws that prevent the removal of life-sustaining medical care from an incompetent pregnant woman even when doing so denies the woman's express wishes stated in her living will. Anti-abortion law is much more intrusive than presumed consent because the latter explicitly provides for the possibility that the individual can easily choose to opt out of organ donation. Presumed consent is merely the default rule, whereas the anti-abortion law overrides the expressed wishes of the individual and her family. Furthermore, when you balance the competing interests at stake, organ donation saves the lives of living human beings, whereas the anti-abortion law protects the potential life of the fetus. A comparison of the two laws leads to the irrational conclusion that Americans value the potential of life more than life itself. With over 79,000 U.S. patients waiting for an organ transplant and 3,000 new patients being added to the waiting list each month, there is no time like the present to consider a more rational result.
Answers to: “Presumed Consent Violates Religious/Cultural Taboos”

1. No organized religious doctrine opposes organ donation as a formal principle.


In addition to the objection that presumed consent would not be sufficiently sensitive to the feelings of decedents and their next-of-kin in general, some of its opponents are particularly concerned that it would conflict with religious views against donation and transplantation. This could make enactment of presumed consent laws extremely difficult politically, and could lead courts to declare them unconstitutional on first amendment grounds. There is considerable confusion over the extent of valid religious objections to donation and transplantation. Despite its rejection of presumed consent, for example, the HHS Task Force on Organ Transplantation in 1986 asserted that "no major religious group in the United States opposes organ donation as a matter of formal doctrine."

2. Jewish doctrine isn’t entirely opposed to organ donation- it is in flux and opting out would solve their concerns.


One source of religious opposition, however, is believed to be orthodox Judaism. An Israeli rabbi, Mordechai Halperin, was quoted in 1985 as saying that “Jewish law would treat as 'murder' the removal of organs from a body whose heart was beating but whose EEG record was flat,” voicing a traditional Jewish objection to accepting brain death as a definition of death. On the other hand, a leading orthodox Jewish ethicist, Fred Rosner, explains that opinion is shifting on the brain death issue and that "[w]hether or not total, irreversible brain stem death, as evidenced by sophisticated medical testing, is the Jewish legal equivalent of decapitation [and therefore qualifies as a criterion of death] is presently a matter of intense debate in rabbinic circles.” Aside from the issue of the determination of death, which relates to the availability of suitable cadaveric organs, Jewish doctrine is unclear on the issue of donation itself. Halperin, for example, believes that “[t]he removal of livers for transplantation would be permissible because artificial organs are not available, but kidney transplants are not always justifiable because kidney dialysis is possible.” Rosner states however that “[a]ll rabbinic authorities would agree that such a case [kidney transplantation] constitutes piku'ach nefesh, or danger to life, and, therefore, the prohibitions revolving around the dead donor would all be set aside for the overriding consideration of saving a life."

3. Religious freedom considerations do not conflict with presumed consent.


How does this approach play out with presumed consent to organ donation? Is it worse to take organs when the patient would not have wanted them taken, or is it worse to leave organs when the patient would have wanted them taken? At first glance, there is no harm or benefit either way. Taking or leaving organs has no effect on the welfare of a dead person. However, we believe it matters whether we respect the previously expressed wishes of a dead person because of the importance of such respect for people when they are still alive. That is, people want to know that they will be treated after their death as they wish to be treated. Thus, for example, we assure people that they can direct the disposition of their property after they die by writing a will, and we assure people they can direct the disposition of their bodies after they die by expressing a preference for burial or cremation. There are two important reasons why we might view the harm from an erroneous donation under presumed consent as worse than an erroneous non-donation under actual consent. First, religious beliefs may be more important in decisions not to donate than in decisions to donate. Some people may have strong religious objections to being an organ donor, but other people may not have a strong religious desire to be an organ donor. On the other hand, the religious argument may not be insurmountable. While it is commonly believed that orthodox religious doctrine rejects organ donation, this is not actually the case. Indeed, organ donation is permitted by many mainstream religious denominations. Orthodox Judaism, for example, permits organ retrieval after death, as long as physicians can demonstrate that a specific person stands to lose his or her life or an entire physical ability (e.g., the ability to see) without the donation. At the same time, religious doctrine may even impose a duty to donate one's organs. In short, it does not appear that religious considerations should doom presumed consent, but other considerations might.
Answers to: “Presumed Consent Violates Religious/Cultural Taboos” [cont’d]

1. Cultural and religious barriers to organ donation are relatively low or going away naturally.


Persons of Asian descent are also thought to object to donation and transplantation for religious reasons. In Japan, an attempted heart transplant in 1968 and a simultaneous kidney/liver transplant in 1984, using organs obtained from brain dead patients, triggered criticism and, in the former incident, prompted an investigation by the prosecutor. Moreover, Japanese lawmakers continue to resist establishing any legal definition of death, much less a brain death criterion. However, legislation in 1979 allows kidneys and corneas to be removed upon the donor's written request or with the permission of the family, and one commentator observes that, "in the future Japan will become as active in organ transplantation as most nations in the West.” Religious concerns are believed to be in part responsible for the lower donation and transplant rates for African-Americans. A recent Gallup poll found that, while 29 percent of white respondents stated that they are very likely to want to donate their organs and 80 percent stated that they would give permission for the organs of a loved one to be donated, the figures for African-Americans dropped to 17 and 71 percent respectively. Yet the effect of religious opposition in this population may be small in comparison with other factors, such as lack of information, financial constraints and distrust of the white medical establishment.

2. Education procedures that accompany presumed consent can be tweaked in order to resolve religious objections and ensure that they are accommodated.


In summary, although the extent of religious opposition may be uncertain, and although some religious groups may be moving toward a more favorable attitude toward donation and transplantation generally, religious concerns cannot be ignored in designing a presumed consent program. For one thing, both the orthodox Jewish and Japanese Shinto religions seem to be dead set against any approach that would deny the family the right to object to donation. Educational efforts that accompanied the adoption of presumed consent therefore would have to pay particular attention to religious groups with known objections, and the methods for opting-out would have to be highly effective and "user-friendly." It might even be necessary for the opting-out system to include special mechanisms for ensuring that religious objections were identified and respected. Given an adequate opting-out system, however, religious concerns need not preclude the adoption of presumed consent.

3. Safeguards are easily put in place to prevent hasty decisions by physicians to declare people dead.


Removal of organs for transplantation does raise one particular concern in the minds of some members of the public that might be exacerbated by a presumed consent approach. There are people who are afraid that "over-zealous" organ procurers might pronounce them dead prematurely or even hasten their deaths to obtain their organs. For example, the 1985 Gallup poll found that 20 percent of respondents who did not want to give permission for their organs to be removed rated as a very important reason the fear that "doctors might hasten my death if they needed my organs," while 23 percent rated as very important the possibility that "they might do something to me before I am really dead." This is a fear created by organ donation programs in general. However, a presumed consent system might be especially suspect because eliminating the need to get permission from the family might be seen as reducing the ability of the family to protect patients from unscrupulous physicians. The UAGA deals with this concern by prohibiting either the attending physician at the time of death or the physician who determines the time of death from participating in the removal or transplantation of organs. Additional safeguards might be needed under a presumed consent approach if these protections were regarded as insufficient.
**Answers to: “Presumption Favors Keeping Opt-in”**

1. **There is no transitory cost of moving to an opt-out system for organ donation. The burden of proof rests with the negative.**


   The Reversal Test sets a challenge to the opponents of an opt-out system who would agree about the badness of making donation more difficult, then, to either offer some good reason for why changes to the organ donor system would be bad things in themselves, or else explain why the current level of relative ease of donation and difficulty of not donating should be thought to be the optimal level. It is difficult to see how the first claim could be supported. There would be some one-off transition costs associated with making and implementing any new legislation, but we are concerned here with goods (saving lives of potential transplant patients; avoiding violations of autonomy) that are of such enormous significance that they could easily outweigh such costs, especially when the stakes over the longer term are considered. There are no other reasons obvious to me for thinking that changes to the status quo organ donation system would be bad in themselves. If the first claim cannot be supported, then the opponent of an opt-out system has only one rational option left to defend the status quo. It is to explain why we should think that the relative ease of donation and difficulty of not donating is already set at exactly the optimal level.

2. **Having a default option is unavoidable because there must always be an outcome of inaction. That means we should err on the side of that default yielding higher organ donations.**


   We think that the practice of cadaverous organ donation in general has good consequences, and we also care about allowing people to make free and effective choices about the disposal of their bodily organs. These concerns inform our argument for not making it more burdensome than it already is to donate them. But then it is hard to see how an argument for the status quo, under which it is slightly easier not to donate than to donate, can be made — at least in societies where a majority of people support organ donation and would choose it for themselves, as in the UK. Under the current system many people who, if they had to make a choice, would choose to donate their organs after their deaths, do not register and, as a result, do not donate. Because of status quo bias, we can predict that there are many others who irrationally will not choose to donate, but who would choose to donate under a different system that made donation the default option. And many people on transplant waiting lists die as a result of the unavailability of all of these organs. If there is going to be a default option at all, all these reasons weigh in favour of making donation rather than non-donation the default.

3. **The status quo is no longer tenable. The time is now to change to a presumed consent system.**


   UK’s Organ Donation (Presumed Consent and Safeguards) Bill of 2004 proposed a sweeping change in the law in the form of an opt-out system for the donation of cadaver organs. The Organ Donation Taskforce in 2008 later examined the idea of presumed consent at length, before concluding that our current organ procurement system needs a radical overhaul. Most recently, the Organ Donation (Presumed Consent) Bill of 2009 (“the 2009 Bill”) provided the most comprehensive proposal yet for an opt-out organ donation system in the United Kingdom. Is it now time to take this controversial issue seriously? If the 2009 Bill provides a window into the future, what practical and ethical difficulties will this new presumed consent legislation impart upon our current organ procurement system? This article will provide an overview of the previous attempts in the U.K. to implement an opt-out system for organ donation, before examining in detail the content of the 2009 Bill as a potential template for a new presumed consent law. Finally, some sweeping amendments to the 2009 Bill will be suggested, and it will be concluded that a new piece of legislation may change our national and international views of organ donation for the better.
Answers to: “Presumption Favors Keeping Opt-in” [cont’d]

4. There is no reason why tradition or custom should govern organ policy simply because opting-in happens to be the status quo. There is equal probability that the system is unjust and suboptimal.


Note that there are two distinct kinds of argument available in support of the claim that the status quo is optimal. A normative argument would cite justifying reasons for the status quo state of affairs, thereby explaining directly why the status quo ought to be maintained. But we could also examine the explanatory reasons for why the status quo happens to be as it is. Some possible explanations of the status quo might be justifying explanations; that is, on learning the explanation, we would have reason to believe that the status quo is optimal in virtue of the way in which it has been brought about. We need not be able to cite any specific justifying reasons for why the status quo ought to be as it is in order to recognize a good justifying explanation. For example, suppose I learn that the mathematical proof I see in a notebook was written by a famous, brilliant mathematician. Then, all other things being equal, I will have some reason to believe that the proof is correct, even if I am unable to understand and assess the mathematics that justifies each of its steps. A more pertinent example here is the following: according to Condorcet’s jury theorem, if a public policy has come about by a majority vote between two options, if each voter is more likely than not to vote correctly, and if each voter comes to his decision independently of the others, then the probability that the group as a whole will reach the correct decision approaches 1 as the group size increases. So if we learned that these idealizations were approximately true of the way in which the organ donation system actually came about, we might have found good reason to believe that the status quo system is the best one. Having said this, there are several reasons to doubt the existence of a satisfying justifying explanation of the opt-in organ donation system as it exists in the major English-speaking countries. Condorcet’s assumptions are unrealistic as descriptions of the way in which the policy for the current organ donation system in opt-in countries has come about. Since there were in fact more than two options available (e.g. the various options which would make donation particularly burdensome), we would need to assume that voters individually performed much better than random to each have probability greater than 0.5 of choosing the correct option, and we have no good grounds for this strong assumption. Perhaps more importantly, it seems prima facie likely that whatever the best explanation of the opt-in systems in these countries is, much the same explanation will also account for the existence of opt-out systems in other developed countries. If the optimal answer to the choice between opt-in and opt-out is not relative to the particular country it is in (and we have been offered no reason to believe that it is), this indicates that the explanation could just as easily have produced a sub-optimal system as the optimal one, and so is not a justifying explanation at all. Finally, we must note that even the best justifying explanations of the status quo system would only produce a prima facie presumption of its optimality (going back to the example, we should recognize that even the most brilliant mathematician could have made a mistake). So the claim that an explanation is justifying can always be overridden by our direct consideration of the normative reasons for having one system or another. At this point, then, let us turn to consideration of the normative argument for the status quo.

5. Opt in systems undermine justice by characterizing the social problem of organ shortages as an individualist issue.


The appeal to altruism equally contains an inherent bias that calls into question its legitimacy and pertinence. Putting citizens under the obligation to behave generously to counteract the said organ shortage prioritizes individual responsibility over social responsibility in an issue that is eminently social. It betrays an erroneous interpretation of the letter of the law that consists in ‘presenting organ removal, a violation of corporal integrity, as a donation and the absence of refusal from an individual as the equivalent of consent’ (Thouvenin 2004 - unpublished). There is a highly significant trend that currently consists in reporting and reformulating certain social problems in terms of individual responsibility: that is to say attributing responsibility to the individual. This trend is clearly apparent in the public and political treatment of current health problems in France. It constitutes a salient characteristic of liberal ideology prevalent in current public policy. That the question of organ procurement should first, foremost and above all be formulated in terms of individual responsibility rather than social and collective responsibility is debatable. In effect, organ shortage could be explained by the inadequate census of potential donors (Guibet Lafaye and Paybasset 2010) and, as in France, by the significant regional disparities in organ harvesting that cannot be solely explained by demographical variations in population density or the age of donors (Antoine 2010 – unpublished). In conclusion, it would be an error to convert the problem of quantitative organ shortage to one of individual responsibility when it is above all a collective dysfunction in organ resources management. Finally, if one assumes the utilitarian logic underlying the current rhetoric on organ shortage, relying on donations is ineffective since not all individuals will consent. The ineffectiveness equally lies in the time spent negotiating with families to obtain consent for the donation of a next of kin’s organs. Thus, relying on altruism and individual generosity for organ donation cannot be a satisfactory response to the question of organ procurement in the terms currently used to justify it; that is organ shortage. The appropriation of organs is presented as a more effective solution but provokes an undeniable moral prejudice or even social aversion. Is it however possible to determine the moral conditions under which its implementation would be acceptable?
Answers to “Public Opinion Doesn’t Support Presumed Consent”

1. Public opinion of presumed consent is not clear because the terminologies have been used imprecisely.


An additional factor may have been that the presumed consent concept was being confused with an entirely different approach, that of "required request." In 1983, Arthur Caplan had called for a shift from encouraged voluntarism to a system in which hospitals would be required by law to ask potential donors or their families if they had any objection to the removal of organs following death. Since people would be asked if they objected to donation rather than if they consented, Caplan felt that this amounted to creating a presumption in favor of removing organs. His proposal differed from Sanders' and Dukeminier's original presumed consent scheme in the key respect that, under Caplan's approach, organs could be harvested only if the donor or family expressly stated that they had no objection, while according to Sanders and Dukeminier, organs could be removed without any action by the donor or the family, so long as neither the donor nor the family had voiced an objection. Caplan's position thus in fact occupied a middle ground between encouraged voluntarism and presumed consent, as Matas and his colleagues pointed out in 1985. Nevertheless, Caplan termed his approach "presumed consent." Eventually, the distinction between asking donors and families if they consented to donation and asking them if they objected, which had formed the basis for Caplan calling his scheme "presumed consent" in the first place, disappeared. All hospitals would simply be required to ask donors or their families for permission to remove organs. Caplan advocated this middle-ground approach as the solution to the failure of encouraged voluntarism. Although he now used the more accurate term "required request," his original use of the term "presumed consent" may have led some who had favored Sanders' and Dukeminier's proposal to believe that the two approaches were substantially the same.

2. Polling data that the public opposes presumed consent is weak and ambiguous.


As noted earlier, public opposition was cited by the HHS Task Force on Organ Transplantation in 1986 as the sole basis for rejecting the presumed consent approach. An article in the Journal of The American Medical Association in 1985 reported, for example, that presumed consent "would not be very popular among the American public." This conclusion was based on a survey finding that "an overwhelming majority of Americans (86.5 percent of all respondents surveyed) believe that physicians should not have the power to remove organs from people who have died and who have not signed an organ donor card without consulting the next of kin." In fact, the survey reported in JAMA is the only opinion poll to report that the public is opposed to presumed consent. It is widely believed that the Gallup organization, which routinely conducts public opinion surveys on public attitudes toward organ donation, has reported similar results. However, the closest that the Gallup poll has come to inquiring about attitudes toward presumed consent is when it asked respondents in its 1985 and 1986 surveys if they agreed or disagreed with the statement: "Even if I have never given anyone permission, I wouldn't mind if my organs were donated upon my death." The question used by Gallup does not make it clear whether or not organs would be donated only if the family had been asked, and therefore the responses cannot be said to bear directly on the respondent's attitudes toward presumed consent. Nevertheless, the fact that 62 percent of respondents in 1985 and 61 percent in 1986 stated that they would want their organs donated even without their ever having given permission can hardly be construed as opposition to presumed consent.
Answers to” “Public Opinion Doesn’t Support Presumed Consent” [cont’d]

3. Survey data that there is public opposition to presumed consent is highly questionable.


This leaves the report in JAMA as the only survey that claims to demonstrate public opposition to presumed consent. Yet the validity of its findings is questionable. The question that was asked about attitudes toward presumed consent apparently was: "Should doctors have the power to remove organs from people who have died but have not signed an organ donor card without consulting the next of kin?” The question made no mention of the possibility of opting-out. Respondents may have assumed that no objection could be made to donation. The question therefore may have elicited negative attitudes toward a system of mandatory harvesting without a right of refusal, rather than toward a system of presumed consent. In addition, it appears that the survey asked the "presumed consent” question after it had asked respondents about their willingness to donate their own organs, and that the question about donating one's own organs was asked after a question about willingness to donate the organs of a relative. It is well-known that people report a greater willingness to donate someone else's organs than their own. Therefore, the questions appear to have been asked in an order that was likely to produce a decreasing percentage of positive responses, which may well have biased the results.

4. Public attitudes are not strongly against presumed consent. Rather, polling data reflects the public’s overall discomfort with death.


In short, public attitudes toward presumed consent presently are unknown. It is conceivable that an unbiased survey that explained the operation of an opting-out system and then asked if respondents would agree that organs could be removed if neither the decedent nor the next of kin had registered an objection would reveal a large degree of support. Depending on how the question were asked, support for presumed consent might well come close to the level of strong support for donating one's own organs, which, according to Gallup polls, has hovered around only 30 percent over the last five years. In fact, if public opinion polls reveal anything, it is that the public by and large seems to be upset by the notion of death and the prospect of removal of organs for transplantation, and would rather not be confronted with having to think about it. A presumed consent program that did not force people to consider these issues might be relatively noncontroversial, as appears to be the case with state statutes permitting medical examiners to remove corneas and pituitaries without consent. Most people are probably unaware, for example, that after a man dies, string is tied around his penis, cotton is stuffed up his rectum and his body is exsanguinated before burial. If told about it, people might well be uncomfortable about being told, rather than about what was done.

5. More recent opinion polling shows that a majority of people approve of opt-out systems- Britain proves.


As recently as 2004, the Organ Donation (Presumed Consent and Safeguards) Bill was put before the Commons. Its opening paragraph stated as follows: A Bill to provide for the removal of organs for transplantation purposes, after death has been confirmed in a person aged 16 or over, except where a potential donor previously registered an objection or where a close relative objects. Although the 2004 Bill did not proceed much further in the legislative process, it presented the opportunity for Parliament to discuss this controversial and important matter in depth. The 2009 Bill was presented to Parliament in March 2009 with the same objective in mind. The Department of Health also set up the Organ Donation Taskforce, which, in 2008, published an independent report into the implications of a presumed consent system in the UK. The Taskforce came to the conclusion that the current opt in system may simply need a radical overhaul, as it was found that only a small proportion of the general public were aware of the existence of the Organ Donor Register. However, the Report found that approximately 60% of the population ‘would support a change to an opt out system, as long as it was properly implemented to ensure that the rights of vulnerable groups were protected’. Below is a detailed examination of the 2009 Bill as a template for a new presumed consent system, and the procedural and ethical difficulties that it would present.
Answers to: “Required Consent is Superior Alternative”

1. The evidence that changing request procedures would alleviate organ shortages is mixed at best.


Although required request has been in operation for only a few years, there seems to be a growing sense that it has failed to solve the organ shortage problem. The data on whether or not required request has increased the rate of donation are mixed. Burris and his colleagues report that monthly collections of eyes in Oregon increased 135 percent during the first year of routine request. The President of the Eye Bank Association of America claims that hospital donations of eyes increased 66 percent following the switch to required request. The New York State Department of Health reports that, in the year after the legislature passed a required request law in New York State, heart donations increased by 94 percent, livers by 96 percent, kidneys by 23 percent, and eyes by 58 percent. Other data present a less favorable picture. Kittur and his colleagues in Baltimore attribute a phenomenal 400 percent increase in donor referrals and a 500 percent increase in tissue donations to a vigorous “donor advocacy” program, but while their data show that more people were being asked to consent, the consent rate remained at only 39 percent of those asked, and the ratio of donations to requests increased only 3 percent compared to the year immediately preceding the inception of the program. Andersen and Fox state that, while eye, bone and skin donations in Oregon increased, kidney donations decreased the first year after required request was enacted. They also report no increase in the number of organ donors in Los Angeles and San Francisco following adoption of required request in California. Caplan, who is perhaps most closely associated with the required request concept, admits that, while donations have increased in many places, “these numbers ought to be even greater given the large number of persons who could donate tissue upon their deaths.” Finally, even if required request laws have increased the availability of donor organs, it is clear that the number of organs still falls substantially short of the need.

2. Required request regimes are unproven and difficult to get compliance with- presumed consent is superior.


Caplan cites two problems that procurement officials and state health department representatives believe to be responsible for the lack of success of required request laws. First, health professionals who must make the requests are not adequately trained to be effective, and second, physicians, regarding required request laws as a bureaucratic intrusion into the practice of medicine, refuse to comply. The design of many state required request laws is also partly responsible: the laws often contain major loopholes allowing the requirements to be circumvented and in many cases no penalties are established for failure to comply. It might not yet be time to write off required request. Better efforts to educate those who must deal with families of potential donors, perhaps coupled with more stringent legal requirements, might increase the frequency and effectiveness of donation requests. Greater monitoring of hospital compliance with Medicare required request requirements also could help. Nevertheless, disappointment with required request has sparked renewed interest in other approaches, including presumed consent.
**Answers to: “Threshold For Taking Organs Should Be Very High”**

1. **Justifying barriers to donation makes it more difficult for autonomous agents to express their will.**


   Increasing the difficulty of donating, however, would impinge on such capacities in respect of organ donation. For example: (i) Legally requiring the explicit consent of next of kin as well as that of donors themselves (as is already the case in practice in many countries) in effect prioritises a next of kin preference not to donate above a personal preference to do so. But, given some plausible assumptions, our autonomous personal preferences before death concerning what will happen to our bodies posthumously should have more weight than those of others. These assumptions are: first, that living people have a right to autonomous control over a self-regarding sphere of interest; second, that this self-regarding sphere extends to posthumous matters, when these are sufficiently well connected to how well the person’s life turns out (for example, matters such as whether one’s reasonable preferences concerning the disposal of one’s body or possessions are met); third, that whether or not a person’s organs are donated posthumously according to their preference is sufficiently well connected to how well their life turns out; and fourth, that no other person has other-regarding rights that trump these self-regarding rights. In any case, it is also worth remembering, in connection with this proposal, that not everyone enjoys a relationship of respect and trust with their next of kin, and that the legal requirement in question might inflict significant harm on those who do not. (ii) Legally requiring witness by a minister or lawyer would place a significant practical, and possibly financial, burden on an individual’s freedom to choose to donate. This burden cannot be justified (in the way that we might justify some similar burdens on other choices, e.g. on making a valid will) by pointing to some potential harm to other people that might result from one’s choice being incorrectly made or unreliably recorded. (iii) Adoption of the ‘aversive approach’ would not only place a practical burden on any individual wishing to donate, but would additionally threaten to undermine entirely a person’s capacity to make a properly informed autonomous choice about the matter at hand. There is an important distinction between: on the one hand, providing someone with information that would assist them in making informed, autonomous choices; and on the other hand, influencing the autonomous choices that a person would make by browbeating or using other non-rational methods. Even if the counsellors employed under the aversive approach were banned from engaging in high-pressure sales tactics, and even if they were strictly limited to providing factual information, they would necessarily focus on the partial information that speaks against donation. Individuals confronted with only one-sided, partial information are vulnerable to making decisions that are less rather than more expressive of their fully-informed subjective preferences, since the relative vividness of the case on one side can easily exert an irrational influence on one’s decision making.

2. **There is a consequential and deontological consensus that we should not erect barriers to donation, making it difficult.**


   Most people will agree that making it more burdensome to donate in such ways would be clearly bad, for both consequentialist and deontological reasons. In terms of consequences, the burdensome procedures proposed would reduce the availability of donor organs, and thereby produce negative public health consequences. Additional burdens would also reduce the ability of donors to satisfy their preferences, and could lead to painful experiences of frustration for many of those who try to do so. Note also that this consequentialist objection need not depend on features of the particular examples I have used to illustrate how donating could be made relatively more burdensome. Since non-donation is the default option, there is no real burden on non-donors which could be reduced—so the only way to make donating relatively more burdensome than not donating would be to increase burdens on would-be donors. But any significant additional burden on donors can be expected to produce the negative consequences of reducing the supply of organs, and making it more troublesome for would-be donors to satisfy their considered preference to donate. In terms of deontology, increasing the difficulty of donating threatens to infringe on people’s autonomy by hindering their ability to put into effect their own, meaningful choices. Although I have indicated some ways in which people may be subject to pervasive irrational biases, these do not, of course, constitute a complete story about anyone’s choices — I have only described an irrational influence on otherwise rational decisions. While admitting the possibility of biases, we can still consistently hold that protection of individual autonomy is important, for example because it enables individuals — as far as possible — to express and enact their deepest preferences about their own lives, or their judgments about what matters.
1. **Presumed consent is not just because it violates numerous taboos and cultural norms against desecrating the dead and politicizing the legal definition of death.**


Accordingly, many Asian countries do not recognize brain death as the legal standard of death. In fact, in many world religious and cultural traditions, “brain death” does not conclusively establish death, and an individual whose lungs and heart still function is considered a live human being. For followers of these traditions, extraction of organs from a "brain dead" individual constitutes live dismemberment or murder. As noted by the Bellagio Task Force Report on Transplantation, Bodily Integrity, and the International Traffic in Organs, In the Middle East, religious precepts discourage and in places prohibit cadaveric organ donation. Islamic teachings emphasize the need to maintain the integrity of the body at burial, and although many religious leaders have sanctioned organ donation as a gift of life, others continue to object to the practice. So, too, some Orthodox Jewish rabbis sanction cadaveric donation on the grounds of "pekuaḥ nefesh," the need to save a life. However, others reject the principle of brain death (equating it with murder), thereby making organ retrieval almost impossible... Cultural barriers are no less significant in western countries. In the United States, for example, 53% of families (in one recent study) refused to allow their dead kin to become organ donors. Taboos against dismembering a dead body are far more widely shared than commonly appreciated. While the state must, as a practical matter, establish a reliable standard for classifying the dead, defining the rights of individuals and grieving families by modern technological theories alone when third parties stand to gain from such definitions is troubling. Modern and ever-changing science should not be the final arbiter of rights in a constitutional democracy. As explained by one court, "the law, equity and justice must not themselves quail and be helpless in the face of modern technological marvels presenting questions hitherto unthought of.” Even if the state continues to recognize both cardiopulmonary and brain death for other purposes, utilization of the brain death standard in the context of organ harvesting without explicit consent is extremely invasive and should be reconsidered.

2. **Presumed consent creates absurd situations wherein bodies are moved from ward to ward and kept ‘alive’ only for the sake of grabbing their organs.**


When the heartbeat of a patient is maintained artificially because he or she has no chance of recovery, this is known as elective ventilation, and it would enable doctors to remove ‘living’ organs from ‘deceased’ patients. The 2009 Bill, by allowing for deceased patients to include electrively ventilated patients, was promoting the idea that elective ventilation could be used as a means of acquiring human organs. There may be a great danger here. Normally, patients are placed on life support machines in order for doctors to carry out tests. Once it is established that the patient is dead, the ventilation is no longer necessary. Parliament was suggesting, in essence, that since all individuals are presumed to be consenting to organ donation, it would be appropriate and correct to maintain brain-stem dead patients on a life support machine solely to acquire his or her organs for transplantation. Moving brain-dead individuals with no hope of recovery from one ward/department to another with attached ventilator equipment solely to attain their organs could be viewed as deeply undignified. There is also a concern that the patient may only be in a persistent vegetative state rather than brain stem dead, which would mean that when the organs are taken, and the machine is switched off, the patient was still alive. This ‘maintaining of cadavers’ for the purposes of organ donation will be difficult for some to accept. There are concerns that this controversial procedure will: a) lead to a cruel delaying of death; b) persistent vegetative state (PVS) patients may be mistakenly diagnosed as brain-stem dead; c) a person close to natural death may develop PVS; d) it is distressing for relatives to see their loved one’s body being kept ‘alive’ for ‘salvaging’ purposes; and e) unless it can be proved that such a procedure is in the best interests of the patient, it is currently illegal. In the words of Lord Browne-Wilkinson in Airedale NHS Trust v Bland: If there comes a stage where the responsible doctor comes to the reasonable conclusion that further continuance of an intrusive life support system is not in the best interests of the patient, he can no longer lawfully continue that life support system: to do so would constitute the crime of battery and the tort of trespass to the person. If elective ventilation is simply deemed to be illegal because of the lack of consent, Parliament may be able to manoeuvre around this conundrum as a result of Brown, which implies that a patient, when ‘consenting’ to his organ donation under the 2009 Bill, can also consent to the battery which takes place on his body when his organs are taken from him in his ventilated state. Although it is almost impossible to argue that the process of electively ventilating a braindead patient for the purposes of gleaning his organs for transplantation is in his best interests, if both brain-stem tests have been carried out, technically the patient is already dead, and so the ‘best interests’ test becomes obsolete.
Negative Position One: Presumed Consent Exploits the Dead [cont’d]

3. Presumed consent creates an ethical mine-field. Even if patients are not ‘murdered’ for their organs their families face the prospect of constant harassment to end their loved one’s life.


Since the 2009 Bill required that the patient be brain-stem dead, this does rule out the possibility of persistent vegetative state patients being accidentally ‘murdered’ for their organs. However, PVS and other patients do seem vulnerable under the provisions of the 2009 Bill. At the slightest hint of brain death, relatives of the patient may find themselves fending off vulture-like practitioners, preparing the nearby life support machine in morbidity anticipation. The Organ Donation Taskforce made their concerns about this issue very clear when publishing the worries of the members of the public: The fear that you might not actually be dead, with doctors ‘jumping in too quickly’ before ‘someone is definitely gone’, was one that was widely expressed. A system of decision making which is based on respecting the known wishes of the patient is the one that is most likely to maintain the integrity of the relationship between doctors and patients and trust in the donation system. The notion of ‘presumed consent’ can clearly spill over into the area of elective ventilation, and this is an ethical minefield that no one can cross safely. There may be room for medical personnel to take advantage of this controversial provision if it were to be re-submitted in a new Bill, and a re-drafting may be necessary to prevent any unethical practices. Ideally, elective ventilation and organ procurement should never cross paths, but some support has been found for such a combination. After all, the only way in which a dead patient can provide efficient organs is if he or she were to be kept alive. Solomon states that an electively ventilated patient is quite clearly a means of saving lives and reducing suffering. It has also been stated that while it would be difficult to argue that treatment which prolonged the process of dying was in the best interests of the patient, it might be possible to establish that the patient was so strongly committed to being an organ donor during her lifetime that elective ventilation would allow her final wishes about the fate of her body to be fulfilled.

4. The rights to opt-out under presumed consent are illusory. It is a covert system of organ conscription.


What if the price of living in a civil society was not just money, but a piece of your body? Imagine for a moment that a stranger you have never met demands the right to your organs after your death, or the organs of a loved one who has just passed away. Does this stranger have a right to your body? Could the state legally redistribute body parts according to its vision of the greater good? Imagine further that your religion forbade organ harvesting after death. Could the state still exact this corporeal death tax even if it violated your religious law and traditional right to bury your loved ones intact? The affirmative answer to these questions might surprise you. The average American, having heard pleas to give the "gift of life," generally assumes that organ donation is a personal and voluntary choice belonging to individuals and their families. Yet this is not necessarily the case. Under presumed consent laws, the state assumes that all of its citizens wish to donate their organs after death. One must affirmatively "opt-out" in order to avoid organ harvesting. Initially, presumed consent sounds appealing as a means of curing organ shortage while simultaneously respecting the rights of those who object to post-mortem organ extraction. Yet closer examination reveals that "opt-out" rights are illusory. Those who object to organ transplantation face enormous difficulty and uncertainty in attempting to ensure that their organs or those of their family members are not harvested against their will, provided that they even know "presumed consent” laws exist. Grieving families seeking relief upon discovering that the corpses of their loved ones were dismembered without their consent under color of law are often denied recovery because of liability shields and a body of case law that is reluctant to acknowledge legal interests in the dead. The reality of presumed consent is far closer to organ conscription than philanthropic choice. State invasion of the human body or its remains for utilitarian ends is an affront to liberty, privacy, and family rights. In addition, for the various Jews, Christians, Muslims, Buddhists, Confucians, and others who oppose organ donation on religious grounds, presumed consent severely burdens their free exercise of religion by precluding quintessentially religious burial rites. Freedom of religion would be quite farcical if it did not include the right of families to bury their dead whole, without the state picking over the remains of their loved ones. This article focuses on presumed consent laws in the State of Texas. Part I analyzes the scope and implications of current Texas nonconsensual organ harvesting statutes. Part II examines the constitutionality of Texas’ presumed consent laws under the Texas Religious Freedom Restoration Act, the Texas Constitution, and the Constitution of the United States. Part III explores international norms concerning human rights and organ harvesting. State, federal, and international law strongly suggest that presumed consent is both unconstitutional and immoral. An anatomical gift should be just that - a gift, rather than conscription under the guise of a voluntary contribution.
5. Socializing the dead’s organs destroys their personal autonomy and unravels a just society.


The acceptability and significance of societal appropriation as a means of organ procurement largely depends on the way it is presented. This form of appropriation appears a priori and intuitively unacceptable leading, even those authors likely to promote it to back down on the question of its implementation, even if it would provide a solution to the so called ‘organ shortage’. S. Giordano who believes that after death the human body, not being subject to property right, could be considered as a ‘public thing’ (res publica) nevertheless acknowledges that ultimately, it belongs to the deceased’s family and that the importance it confers to the deceased’s body and its disposition cannot be underestimated. Similarly, Truog considers that whilst a deceased human body should be considered as a societal resource, the State (represented by UNOS in the case of the United States) must nevertheless take into account an individual’s explicit will to become a donor after death. Respect for an individual’s consent, including postmortem consent, structures both medical practice and social interaction. It was explicitly introduced into legislation (see the 1994 Bioethics Laws and its revised version in 2004; Law n 2004–800 of August 6th 2004 relative to bioethics) as a witness to and condition of the quality of medical practices. Societal organ appropriation in western democracies cannot thus be envisaged or implemented without respecting individual consent. The scepticism emanating from this kind of proposal stems from the reluctance to accept any form of societal appropriation of the body based exclusively on social utilitarianism and without regard for individual consent. The reason behind this aversion is normative in that it recognises an individual’s interests after death that can be shown not to necessarily disappear with individual consciousness. The badness of events that harm persons is independent of their existing bodies and minds and of the direct experience the person concerned has of them as bad events. Undermining a person’s reputation and the non-respect of an individual’s will after death are examples. Respect for an individual’s interests engages and describes the only moral link justifying our responsibility for any actions involving past or future beings. In an environmental context for example, it motivates the avoidance of actions that would damage future generations and justifies implementing the principle of precaution. Concerning deceased individuals, Joel Feinberg (1977) has argued that although death is the total and final end of the person, one may still be ‘harmed’ or have one’s ‘interests’ infringed on after death. Some interests might persist beyond the annihilation of their bearer and remain detached from the life of him. These are ‘posthumous interests’ (Feinberg, 1977).

6. Presumed consent laws are arbitrary and give too much power to physicians to rob bodies of their organs.


Section 693.003 of the Texas Health and Safety Code pertains to the disposition of bodies under the control of the medical examiner. The statute, which authorizes presumed consent, differentiates among harvesting procedures based on the distinction between visceral and non-visceral organs and tissues. Visceral organs are defined as "the heart, kidney, liver, or other organ or tissue that requires a patient support system to maintain the viability of the organ or tissue." Section 693.003 initially states that visceral organs may not be harvested without the consent of a family member from the priority scheme detailed in Section 693.004. For non-visceral organs and tissues, however, the medical examiner is authorized to harvest them if "no reasonable likelihood exists" that family members can be identified or contacted within a four-hour period. Quite peculiarly, however, Section 521.405 of the Texas Transportation Code authorizes "the removal of the heart, lung, kidney, liver, or other organ or tissue that requires a patient support system to maintain the viability of the organ or tissue" if a family member "is not contacted within four hours after death is pronounced." This statute expressly permits liberal unauthorized removal of visceral organs, which would seem to be precluded under the Texas Health & Safety Code. The statute grants broad immunity, providing that one "who performs an action authorized by this section is not civilly or criminally liable because of that action. Each medical examiner is encouraged to permit organ and tissue removal at the earliest possible time." Corneas may be extracted under similar circumstances. Section 693.012 of the Texas Health & Safety Code permits cornea extraction upon request from an authorized official of an eye bank if the decedent died under circumstances requiring an inquest, no objection from family members is known, and the removal will not interfere with autopsy or post-mortem facial appearance. In summary, the statutes pertaining to organ and tissue extraction broadly authorize the medical examiner to remove body parts from individuals not known to be donors, limited only by vague and arbitrary discretion concerning the likelihood that a family member of the decedent might be contacted. Even if family members subsequently discover the nonconsensual harvesting and pursue legal remedy, civil or criminal liability of the medical examiner is precluded. In fact, medical examiners are explicitly encouraged to facilitate speedy harvesting. For corneas, the possibility of contacting a family member is irrelevant. Extraction is limited only when it might interfere with the public's interest in ascertaining the cause of death or when cosmetic considerations are relevant. These minimal restraints leave medical examiners relatively free to harvest the tissues of decedents under their control without ever obtaining consent.
7. Presumed consent is incapable of achieving justice because it creates absurd outcomes—prisoners of war would have greater rights than the average citizen.


As our history and legal culture are so inextricably linked to our European counterparts, the law of the Council of Europe should serve as a useful reference. The Council's Charter of Fundamental Rights states in Article 3 that "(1) everyone has the right to respect for his or her private and mental and physical integrity. (2) In the fields of medicine and biology, the following must be respected in particular: - the free and informed consent of the person concerned, according to the procedures laid down by law..." The Council's Convention on Human Rights and Biomedicine Concerning Transplantation of Organs and Tissues of Human Origin did not directly address post-mortem organ harvesting, but the 2001 Additional Protocol, which has been adopted by ten member nations, specifies that "organs or tissues shall not be removed from the body of a deceased person unless consent or authorisation required by law has been obtained." The Explanatory Report to the Additional Protocol explained that nations should inform their public about organ procurement laws. Furthermore, even in European nations employing presumed consent with centralized opt-out mechanisms, a medical team in charge of removal of the organs of the deceased must attempt to reach his close relatives to try to ascertain information concerning his wishes, rather than those of his next-of-kin. It is intriguing to note that the Geneva Convention specifically addresses the harvesting of organs from prisoners of war. A 1977 Protocol Additional states that "it is, in particular, prohibited to carry out on [prisoners of war], even with their consent: ... (c) removal of tissue or organs for transplantation." Commentaries to the Protocol explain that prisoners of war and other detainees of an enemy power are vulnerable, and it is necessary to observe strict ethical rules when the danger of abuse is so great. Hence, even harvesting pursuant to consent is prohibited because the authenticity of such consent is suspect. In this sense, international law acknowledges that organ harvesting may only be conducted pursuant to genuine consent. It is peculiar that citizens of the State of Texas and other states that have adopted presumed consent laws appear to have fewer legal rights over their remains than international prisoners of war.

8. There must be absolute consent when it comes to bodies and organs and the state’s ability to control them. Otherwise, the only natural alternative is tyranny.


Nonetheless, the United States has repeatedly criticized other nations for unethical practices in the procurement of organs for transplantation. Congress has been particularly troubled by reports of the extraction and sale of the organs of Chinese prisoners, without their consent, for the benefit of wealthy transplant recipients, and has held numerous hearings on the subject in recent years. Ironically, some introspection might be in order, as Chinese laws pertaining to organ harvesting from prisoners are, at least facially, less audacious than American presumed consent statutes, including those of the State of Texas. Chinese provisions provide that the bodies and organs of executed prisoners may be extracted only when the prisoner's family does not collect his body or when the prisoner or his family consent to harvesting. Even then, "the dead bodies or organs from the condemned criminals of minority nationalities are not to be used," as "respect should be shown to the mourning and funeral customs in the implementation of the Regulations." Even the severely criticized Chinese government at least outwardly recognizes that the harvesting of human organs without consent is immoral, particularly when such harvesting interferes with religious beliefs. Experts in the field of international organ transplantation have made poignant remarks concerning the moral devolution of this seemingly philanthropic pursuit. One prominent Japanese sociologist who has studied the repercussions of organ transplantation in Asia describes the emerging international social phenomenon as "life-utilitarianism." This sociologist, Dr. Awaya, testified before Congress concerning "kidney tours" during which wealthy foreigners are brought to China to tour the country on non-dialysis days while they wait for a transplant from an executed prisoner. Having noticed that many desperate individuals in need of tissues do not care from whom their transplant comes or under what conditions, Dr. Awaya "warns that we are beginning to look at each others' bodies greedily, as a way of getting new parts to make our own lives longer. He calls it "social or friendly cannibalism." These international norms and observations remind us that whenever the needs of some are placed above the rights and dignities of others, oppression is the natural result. When those needs involve human body parts, the potential for tyranny reaches dramatic new proportions. The new "life-utilitarianism" suggests that unrestrained demands for others' organs in the name of preserving life may do so at the expense of humanity. The natural desperation of those needing transplants implies that legal safeguards are needed to protect the rights of others. The United States and the State of Texas should ensure that our own organ procurement methods are ethical, and that they adhere to international standards requiring genuine consent.
**Underview: When Death Occurs Is Not Clear**

1. **Presumed consent enables the sacrifice of people for the greater good, even if they are not fully deceased yet.**


Nonetheless, brain dead patients are deemed deceased and are thus subject to presumed consent statutes. One victim of expedient presumed consent laws as applied to the brain dead was Arthur Forge, Jr. of Fort Worth, Texas. When police found him in a field, unconscious and without identification, he was brought to John Peter Smith Hospital. After he was declared brain dead, he was maintained on artificial life support for two days until his heart, liver, pancreas, intestines, kidneys, and one lung were harvested; at that point, he was disconnected from life support. Four days later, a simple fingerprint check revealed Mr. Forge's identity and the fact that his nephew had filed a missing persons report with the Fort Worth Police Department two full days before he was discovered in his unconscious state. Mr. Forge's story raises a number of concerns inherent to presumed consent in general, and the use of the brain death standard for nonconsensual organ harvesting in particular. First, his story demonstrates the unreliability of administrative procedures and the vulnerability of individuals in such unfortunate circumstances. Second, sustained artificial life support is itself controversial because many individuals would not wish to have their lives forcibly preserved in such a debilitated state. Most acutely disturbing is the fact that Mr. Forge, then an unidentified man, was sustained as "John Doe," a human being viewed predominantly as a vessel for organs needed by others. Only after he yielded his bodily harvest was he laid to rest. For many individuals of faith who oppose transplantation on religious grounds, stories like Mr. Forge's are terrifying and gruesome. While modern natural death statutes equate human life with registered functioning of the brain, religions often define life and death in terms of the relationship of the soul to the body. For example, in Asian cultures, "for the traditional-minded, death does not take place at a specific moment. The process of dying ... involves not only heart and brain but soul."

2. **The vast majority of organ donations occur before complete, official death. This means that either the affirmative would coerce those who are still alive or not being able to solve organ shortages.**

Michael Potts, Methodist University, Joseph L. Verheijde, Departments of Biomedical Ethics, Physical Medicine, and Rehabilitation, Mayo Clinic, Mohamed Y. Rady, Center for Biology and Society, School of Life Sciences, Arizona State University, and David W. Evans, Queens College, JOURNAL OF MEDICAL ETHICS, “Normative consent and presumed consent for organ donation: a critique,” vol. 36, no. 8, pp. 498-499, August 2010, accessed 8.15.2014: academic search premiere.

Saunders' premise 'that it is wrong for (most) people to withhold their consent to postmortem organ donation' is also challenged at an empirical level, that is to say, are donors truly post-mortem at the time of procurement? There is growing moral and scientific agreement that the organ donors in heart-beating and non-heart-beating procurement protocols are not dead when their organs are surgically removed. ~~ If the procurement of organs is not a postmortem but a premortem intervention, this current practice not only raises legal issues, but it effectively qualifies organ donation as a supererogatory act. The latter implies that the presumed duty to donate must be considered too onerous and, therefore, under the assumption of normative consent, it would be morally permissible to refuse organ donation. The scientific facts about death determination within the context of organ procurement nullify Saunders' argument that 'it seems that the burden demanded is small'. Saunders' threshold of the duty to donate implies that even if donors are not dead, they are so close to death that their organs can nevertheless be taken because their very short remaining lives are not of comparable moral importance to the lives of those who need organs. This line of argument raises the question of how moral judgements are to be made on whose life can be sacrificed (donor) and whose life should be saved (recipient). Saunders' argument also ignores the potential for postmortem harm to surviving relatives and other close associates of those who have their organs removed. The existential absence in death and the physical mutilation can have profound psychosocial consequences on the grief and bereavement reactions of family members.
3. Presumed consent puts pressure on physicians to declare those who are brain-dead eligible for organ harvesting even if they are not yet deceased.


Modern technology has dramatically altered the legal definition of death. Traditional legal standards for determination of death focused on permanent cessation of respiration and circulation. Advances in artificial life support and the demand for organ transplantation led to the acceptance of brain death as a standard for determining death. In Texas, both cardiac and brain death are recognized. Specifically, if artificial means of support preclude a determination that a person's spontaneous respiratory and circulatory functions have ceased, the person is dead when, in the announced opinion of a physician, according to ordinary standards of medical practice, there is irreversible cessation of all spontaneous brain function. Death occurs when the relevant functions cease.

Determination of death is relevant to presumed consent because the majority of solid organs are harvested from patients whose respiration and circulation are maintained through artificial life support, but whose brain functions have perceptively ceased. Acceptance of brain death as legal death is convenient for transplantation purposes, because “once a donor’s breathing and heartbeat cease ... the solid organs are damaged and quickly become nonviable for transplantation.” Yet, even in the scientific community, brain death is not uncontroversial. Troubling evidence demonstrates that as many as twenty percent of allegedly brain dead individuals nonetheless register electrical brain activity on electroencephalograms. The “brain dead” patient's heart rate and blood pressure have been known to rise upon incision and organ harvesting, suggesting response to stimuli.

4. Presumed consent does not have an effective way to determine when death has occurred while still maintaining viability for organs.


The second provision to cause a great moral problem is embedded in Section 3, which states that no organs may be removed from a cadaver unless two registered medical practitioners have satisfied themselves that the person is dead. Section 4 proceeds to explain the definition of “death” as the irreversible loss of the capacity for consciousness and the capacity to breathe, determined by permanent cessation of the heartbeat. Brain stem tests are then to be carried out in accordance with the criteria set out by the Conference of Royal Colleges. There have been several calls in the past for Parliament to provide a statutory definition of “death”, and Parliament appear to have “borrowed” a definition for the purposes of the 2009 Bill, but there are long-known controversies concerning the true time of brain-stem death. It has been submitted that since actual death occurs before the brain-stem tests, there is an urgent need for some criterion to establish the moment of death. By leaving such criteria to be ascertained by the Conference of Royal Colleges, Parliament may be expressing their desire to detach themselves from this thorny issue, leaving the uncertainties in medicine to continue. Because patients are deemed to be ‘alive’ right up until two brain stem tests have been performed, no procedures are allowed to be carried out on the patient that would not be in his or her best interests, and this includes life support to simply ‘maintain’ organs. An even more complex moral dilemma appears under Section 4: ‘[brain stem death can be] determined by permanent cessation of heartbeat or, where the heartbeat is maintained artificially, by brain stem tests. . . .

5. The lack of trust created by presumed consent is devastating. The system cannot function without a high degree of legitimacy.


Transplant professionals place a high priority on reassuring the public and building trust in the organ transplant system. Indeed, in the wake of two recent organ donation controversies, experts emphasized concerns about maintaining public trust. In July 2007, prosecutors filed felony charges against a transplant surgeon in California, alleging that he hastened the death of a patient whose family had agreed to donation. In discussing the charges, an organ donation advocate observed that “we spend an inordinate amount of time telling people [that these kinds of abuses] won’t happen.” In a second controversy in August 2008, transplant surgeons in Colorado provoked a major debate after reporting a practice of retrieving hearts from infants who were declared dead because their hearts had stopped beating for seventy-five seconds. The organs were then transplanted into other infants and the heartbeats restored. Critics observed that the first infants were not actually dead when their hearts were removed because the cessation of their heartbeats was not irreversible, and one leading expert predicted that the transplant community would reject the seventy-five-second standard. Dr. James Bernat stated that “there is a primal fear people have of being declared dead wrongly.” He went on to say that “physicians and transplant enterprises need to be mindful to reassure skeptical people that there will be no instance in which surgeons will procure organs from someone before they are dead.” Academic debates over specific organ procurement or allocation policies make the same point - the impact of those policies on public trust plays a critical role in assessing their acceptability.
Underview: Abuse of the System is Likely

1. Presumed consent is highly likely to be abused or gamed by the medical system because there are enormous profits at stake.

Carrie Parsons O’Keeffe, no qualifications available, TEXAS FORUM ON CIVIL LIBERTIES AND CIVIL RIGHTS, “When

Presumed consent laws pertaining to decedents under the control of the medical examiner are even more disconcerting when one considers recent revelations of profiteering by medical examiners and the tissue industry. In a recent congressional hearing evaluating the need for federal oversight of tissue banks, Senator Collins noted that "a single tissue donor can yield over $200,000 in revenue to tissue banks. Tissue banks make this money not by selling human tissue, which is illegal, but by charging processing fees to the recipients of this material." Tissue is processed by private, for-profit companies, which reportedly give money to non-profit tissue banks in return for exclusive rights to the tissue they collect. Indeed, human tissues are a lucrative trade, with revenues expected to reach $1 billion by 2003. One official noted that "the field is becoming more entrepreneurial." Cosmetic use of human cadaver tissue is particularly profitable, with such tissues being used for lip enhancement, penile implants, and face lifts. With such enormous profit potential and the absence of any regulations pertaining to tissue usage, medical examiners enjoy prospects of significant pecuniary gain for the tissues they release under Texas law. A startling expose by The Chicago Tribune reveals just such a situation in San Antonio, Texas: County supervisors even take bids from tissue banks on the right to bodies collected by the medical examiner. Last year, the winning contract went to South Texas Blood and Tissue Center, which agreed to pay $180,000 annually. "This is a business," said Vincent DiMaio, the Bexar County medical examiner. "People make a lot of money selling tissue." Since 1983, DiMaio has moonlighted as a tissue harvester, cutting bones and other parts from the bodies that passed through his office. Always, DiMaio insists, permission was given by the family of the deceased. The county, though, has spent more than $100,000 settling claims that he did not have permission. DiMaio has received up to $47,000 a year from tissue banks, according to county purchasing records. Several DiMaio assistants also received $50 from the tissue bank each time they obtained a family's consent to harvest tissue. Current presumed consent laws permit scandalous profiteering via the taking and selling of body parts without authorization under color of state law. Statutes preventing the sale of body parts for "consideration" leave significant loopholes that still allow the human body to serve as a commodity. Under the guise of philanthropy, presumed consent enriches both medical examiners and private, for-profit corporations.

2. Presumed consent debases human life, reducing the corpse to nothing other than a source of value to feed others.

Carrie Parsons O’Keeffe, no qualifications available, TEXAS FORUM ON CIVIL LIBERTIES AND CIVIL RIGHTS, “When

Presumed consent is not itself immune from establishment. It reflects a majoritarian view that the human corpse is valueless, save the utility of its spare parts to others. Those who suggest that some should sacrifice their religion and privacy to save the lives of others would be hard pressed to explain why they are permitted to bequeath their wealth to their families while others remain hungry, or why copyright laws monopolize life-saving drugs for the profit of large corporations. How can some individuals be forced to forsake body parts for harms they took no part in creating while the law recognizes the right of a woman to affirmatively abort her fetus and the right of individuals to deliberately refuse medical treatment at the cost of their own lives? The reason for these contradictions is that, embedded in presumed consent is the distinctively secular and modern view that the human corpse is not sacred. For those who view it as worthless, it is easy to demand such an "infinitesimally small intrusion" from others, but were their wealth or bodily autonomy on the line, the intrusion would assume far greater significance. This is because presumed consent is not religiously neutral - it reflects the state establishment of secular humanism applied to our very bodies. Beyond issues of religion, even the most adamant proponents of organ transplantation in all situations should question laws that endow the government with the authority to conscript and redistribute the human body. In this nation founded upon mistrust of broad-based and far-reaching government power, permitting the government to seize the very flesh and innards of its citizens suggests that the police power is indeed quite limitless. Subjecting the disposition of the human body itself to the whims of the majority inflicts a most humiliating and invasive tyranny. Presumed consent offends state, national, and international values as they are stated in our federal Constitution, the Texas State Constitution and statutes, and international human rights standards. American laws and ethics demand that Texas must ensure that an "anatomical gift" is, indeed, a gift.
3. **Presumed consent raises the prospect of hidden regimes for governing organ procurement.** Such regimes are grossly unethical and would lead to massive backlash by the medical community.


As suggested earlier, the objection that presumed consent would interfere with patient autonomy may be misplaced if presumed consent is being compared with required request, since required request as a practical matter allows the family to override the patient's wishes with regard to donation. Nevertheless, there is such an inescapable, underlying unease created by the prospect that health care providers will be permitted to perform acts on dead bodies regardless of the wishes of the patient and the family that a presumed consent system must address these concerns in order to be a viable policy option. One alternative would be to adopt a presumed consent system but to conceal it from public knowledge. After all, if patients and their families were unaware that organs were being removed, they would have no occasion to be upset. Assuming families retained the option of viewing the dead relative at the funeral, this would not only entail harvesting organs in such a way that the absence of the organs would not be noticeable, which would be desirable anyway to spare the family, but refraining from conducting any public information programs about the donation system. This approach would be both unethical and impractical. By attempting to hide the truth, it would deprive patients and their families of a meaningful opportunity to object to donation. The result would not be a system of presumed consent, but of mandatory organ removal. Physicians are unlikely to accept such an approach. Nor could such a system be kept secret for long. For one thing, the press would be sure to find out and to seize upon it. The resulting public backlash would almost certainly lead to legal action against providers and force the repeal of any presumed consent legislation that had been passed.

4. **Presumed consent ends in totalitarianism.**

Michael Potts, Methodist University, Joseph L. Verheijde, Departments of Biomedical Ethics, Physical Medicine, and Rehabilitation, Mayo Clinic, Mohamed Y. Rady, Center for Biology and Society, School of Life Sciences, Arizona State University, and David W. Evans, Queens College, JOURNAL OF MEDICAL ETHICS, “Normative consent and presumed consent for organ donation: a critique,” vol. 36, no. 8, pp. 498-499, August 2010, accessed 8.15.2014: academic search premiere.

If a presumed consent policy were thus adopted, it would be morally legitimate to remove organs from individuals whose wishes concerning donation are not known. This paper disputes Saunders' arguments. First, if death caused by the absence of organ transplant is the operational premise, then, there is nothing of comparable moral precedence under which a person is not obligated to donate. Saunders' use of Singer's principle produces a duty to donate in almost all circumstances. However, this premise is based on a flawed interpretation of cause and effect between organ availability and death. Second, given growing moral and scientific agreement that the organ donors in heart-beating and non-heart-beating procurement protocols are not dead when their organs are surgically removed, it is not at all clear that people have a duty to consent to their lives being taken for their organs. Third, Saunders' claim that there can be good reasons for refusing consent clashes with his claim that there is a moral obligation for everyone to donate their organs. Saunders' argument is more consistent with a conclusion of 'mandatory consent'. Finally, it is argued that Saunders' policy, if put into place, would be totalitarian in scope and would therefore be inconsistent with the freedom required for a democratic society.

5. **Giving physicians the authority to bypass the family raises the risk of fraud.**


Organ transplantation policy is regularly influenced by the need to maintain public trust in the system of organ procurement and allocation. Given the serious shortage of organs, people worry that transplant personnel will act wrongly in procuring organs or in allocating them. Employing presumed consent and also excluding families from the donation decision may increase public concerns about the transplant system. Indeed, for centuries, people have worried that the pursuit of medical and scientific interests will lead doctors to engage in misconduct when it comes to securing body parts, and for centuries, there have been dishonest physicians who validated those concerns. There are two aspects to the concern about unscrupulous behavior by doctors or others. First, coroners or physicians may take organs and other body parts after death against the known wishes of the dead person (or of the decedent's family members). In other words, erroneous donations may occur, not only because mistakes will be made, but also because of intentional misconduct. Second, and more worrisome, coroners or doctors may not wait until death to take the organs - the great need for organs may result in practices that shorten patients' lives. Indeed, even under our current system of actual consent, people worry that doctors may declare death prematurely to free up organs for transplantation. Or they worry that doctors may not treat diseases aggressively enough in order to hasten the availability of organs for transplantation.
Negative Position Two: Public Backlash Destroys Presumed Consent

1. Presumed consent risks dramatically undermining public faith in the medical establishment because they do not want their organs to become collective property.


Many legal scholars argue that implementing a system of presumed consent would be contrary to the precepts of autonomy held by American citizens, and that the institution of such a system would "insidiously exploit the citizen's regrettable reluctance to dissent" to organ donation. Moreover, such a system, which equates silence with donation, "is antithetical to American culture," and "because this system disregards the high level of autonomy embraced by American culture and society, it should not be adopted." Presumed consent could "lead to a situation where the poor, the uneducated, and the legally disenfranchised might bear a disadvantageous burden, and only the more advantaged groups would exercise autonomy,' since only the more advantaged groups would be aware of their right to opt-out" of the system. The second obstacle to implementing a system of presumed consent is the fact that presumed consent may not be entirely effective. Many European countries that have implemented presumed consent still face significant organ shortages. The implementation of presumed consent laws also presents a legal challenge, as several American courts have struck down presumed consent statutes. For example, in Brotherton v. Cleveland, the court addressed the legality of Ohio Revised Code section 2108.60, which authorized Ohio county coroners to remove the corneas of autopsy subjects without first obtaining the consent of the next-of-kin, provided that the next-of-kin had made no objection to the removal. In Brotherton, where the wife of the deceased had objected to the removal of her husband's corneas, but the coroner removed them anyway, the court held that the Ohio statute violated the next-of-kin's "claim of entitlement' in [her husband's] body, including his corneas, [which was] protected by the due process clause of the fourteenth amendment." A final criticism of the presumed consent model is that such a system may weaken faith in the American health care system. According to scholars, "The secrecy of the system challenges the family's belief that all appropriate efforts were made to save the life of the organ donor." Moreover, Even under the best of circumstances, where the family is fully informed about the patient's condition, treatment, and prognosis, when the patient dies and the family is asked to consent to organ donation, family members may wonder whether the patient was allowed to die in order to make organs available for others who could make "better' use of them. When organs are taken in secret, suspicions will intensify. Secrecy implies that there is a need to hide something, and the family could easily conclude that the something being hidden is less than adequate care for the deceased. The concept of presumed consent assumes that all Americans who do not sign organ donation cards would want their organs donated upon death. However, contrary to this assumption, statistics show that some Americans do not wish to become organ donors for a variety of social, religious, and personal reasons. Accordingly, reason dictates that adopting a presumed consent system would be unjust because it would not be ethical to presume the consent of many Americans who would not wish to be organ donors.

2. Perception is everything with organ donation. If the public doesn’t trust the system to be just, opt-outs will increase dramatically. 10


The chronic shortage of organs available for transplantation in developed countries results in tens of thousands of deaths of patients on waiting lists each year. Rates of cadaveric organ donation could be increased in many of them, including all of the major English-speaking countries, by instituting an ‘opt-out’ (or ‘presumed consent’) system for organ donation. In an opt-out system, which is already in place in many European countries and planned in Wales, people do not have to opt in as organ donors by providing explicit consent, but must rather place their name on an opt-out register before their deaths if they prefer not to donate their organs. Various moral, legal and practical objections have been raised to the opt-out system. It has been argued that it is an intrusive policy that would violate the rights of individuals to refuse to donate their organs, and the rights of relatives over the body of the deceased. It has been claimed that it makes an illicit presumption that there is a state right to distribute our body parts as the state sees fit. It has further been argued that because of these questionable moral implications of opt-out policies, the introduction of an opt-out policy may undermine public confidence in the transplant system as a whole, thereby producing a paradoxical decline in organ availability. The latter might occur even if the public were mistaken in their moral objections to the policy.
3. Public education efforts are necessary to avoid backlash.


A final misconception shared by many Americans is that celebrities or famous citizens will receive organs over more needy "ordinary" patients. This misconception is based on high-profile cases such as Pennsylvania Governor Robert Casey and baseball legend Mickey Mantle. Governor Casey waited only one day for his heart-liver transplant at a time when the average wait-list was over six months for a heart, and two months for a liver. Similarly, Mantle, suffering from alcohol-induced liver failure, waited less than two days before receiving his liver transplant and died less than two months later. In response to the concerns of potential donors regarding the allocation of their organs to high-profile persons, both UNOS and the OPTN attempted to assure potential donors that the system is not based on fame or wealth and that the allocation of organs is structured to fairly distribute organs. Both scholars and the medical community have proposed ways in which to better inform the American public and to dispel myths associated with organ donation. For example, in the proposed Cadaveric Organ Donor Act ("CODA"), the drafters mandated that "a significant public educational program will need to be waged to advise citizens and residents of the opportunity to register as donors .... The Secretary [of Health and Human Services] has a duty to inform the public regarding organ donation and to make Donor Forms available." A "significant public educational program" could employ the mass-media in the form of advertising. Although costly, such a system, similar to the anti-smoking and anti-drunk driving campaigns of the last two decades, would be effective in reaching a vast number of Americans. Another feasible alternative would be for states to require that informational sessions about organ donation be incorporated into driver's education classes. Under such a system, future drivers would be educated about organ donation and would make a better informed decision regarding whether to opt into the system when asked to choose at the license registry.

4. Presumed consent empirically results in individuals being accidentally sacrificed by the state.


On the morning of July 22, 1999, Fort Worth, Texas police found an unconscious, unidentified man lying in a field in the far southeastern corner of the city. Upon examination at John Peter Smith Hospital, doctors discovered that "John Doe" was suffering from bleeding and swelling on the brain, though his body showed no signs of trauma. He also tested positive for cocaine use. Although doctors declared John Doe brain dead at 5:30 p.m. that evening, they maintained him on a ventilator for an additional thirty-two hours while the Life Gift Organ Donation Center sought a court order authorizing the coroner to release all organs from the man's body. In its petition, LifeGift cited a Texas law allowing organs to be harvested from unidentified persons under the coroner's jurisdiction, provided a four-hour search is conducted for the next of kin. Late in the evening of July 23, 1999, Texas District Judge Bob McGrath granted LifeGift's request, and the following morning a team of surgeons removed John Doe's heart, liver, pancreas, intestines, kidneys, and remaining lung. Four days after the organ removal, a technician at a neighboring police department, acting upon a request from the Tarrant County Medical Examiner's office, conducted a second fingerprint check and discovered that John Doe was actually Arthur Forge Jr. of Fort Worth. Subsequent investigation revealed that Forge's nephew had filed a missing persons report with the Fort Worth Police Department on Monday, July 20, two days before Forge's body was found and a full four days before the organ harvesting. At the time, Fort Worth Police officials could not explain why their fingerprint analysis was unsuccessful, nor could they offer any reason for their failure to check the missing persons list. While officials maintained that their search was reasonable and the organ harvesting proper, one commentator, reflecting on the incident, noted that Texas' presumed consent organ donation law might "scare people [into believing] that the state could be body snatchers. I don't think anybody had that in mind."

5. Fear of abuse or early harvesting will drive higher rates of opting out.


A decedent's death must be established before organs or tissues may be removed "in accordance with the law." It is the responsibility of each Member State to legally define the specific procedure for declaring death. In most countries, the law defines death as "brain death while the essential functions are artificially maintained." Article 16 provides a safeguard for the deceased person by insuring that the medical team who certifies death is not the same one that is involved in the transplant. "Failure to keep the two functions separate would jeopardize the public's trust in the transplantation system and might have an adverse affect on donation." Recognizing that individuals may opt out of organ donation if they sense that surgeons have conflicted interests in keeping patients alive, trust and respect are essential to a successful system of organ procurement.

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Negative Position Two: Public Backlash Destroys Presumed Consent [cont'd]
6. Backlash to changing policies could just as easily decrease organ supply by pushing people to opt out.


It is not easy to predict the effect on the supply of organs under Saunders' opt-out proposal partly because the proposal itself is not fully described. As already said, the proposal would not change the existing system from opt in to opt out because the existing system does not require people to opt in before their organs are taken. Saunders does not say whether he favours 'hard opt out', in which the family cannot veto retrieval, or 'soft opt out', in which they can. If families were really to be sidelined in practice, the resulting bad publicity may well cause the supply of organs to fall, whatever other objections there may be. If Saunders would allow families to veto retrieval, the major differences between his proposal and the existing system seem to be that his allows for a formal opt out, which the current system does not, and would involve spending resources on publicising organ donation. These relatively minor differences might, for all we know, cause the supply of organs to go up, down, or stay the same.

7. Mandated choice would be effective at yielding more organs because it avoids public backlash.


Within the consent framework, there are two options: mandated choice and presumed consent. Mandated choice is a system that requires adults to decide whether they wish to donate their organs when they die. The decision would most logically be required when obtaining a driver's license. Part of the problem with deciphering an individual's intent to donate his or her organs is that most people do not discuss organ donation with family members because mortality is a difficult and unpleasant topic of conversation. Under a system of mandated choice, each person is forced to consider the issue and make a decision. The individual's decision is then honored at the time of death. In a Gallup Poll conducted in 1993, only 30% of those surveyed had signed organ donor cards. When polled to see if those surveyed would enlist to donate if mandated choice became the law, 63% said they would enlist. The survey implicitly found that the more one thinks about organ donation, the more likely he or she is to donate. Of the 25% who said they had previously given organ donation serious consideration, 76% said that they would donate their organs. Based on the results of this survey, mandated choice would increase the number of available organs.

8. Disregarding the autonomy of the brain dead or the deceased justifies going further than presumed consent into mandatory harvesting and the seizure of life for the benefit of the state.


Interestingly, thirty-three states currently prevent the removal of life-sustaining medical care from an incompetent pregnant woman even when doing so denies the woman's express wishes stated in her living will. "The laws literally "take" the bodies of incompetent pregnant women, treating them like chattel that may be drafted into service as fetal incubators for the state." Pennsylvania acknowledges its "taking" of the incompetent pregnant woman's body by providing "just compensation" by paying the expenses associated with continued medical care. Two cases address the constitutional questions posed by state laws preventing the removal of life-sustaining medical care from an incompetent pregnant woman. In University Health Services v. Piazz, a Georgia court refused to allow a brain dead pregnant woman off life support until the birth of her fetus. The court held that Donna Piazz lacked power to terminate her pregnancy under state law, regardless of whether she had a will that provided those instructions. The court said that any constitutional right to refuse treatment and to terminate her pregnancy were privacy rights that were extinguished when she became brain dead. In DiNino v. State ex rel. Gorton, JoAnn DiNino sued the state seeking a declaratory judgment to uphold her living will even if she were pregnant. She argued that the state law suspending a living will during the course of pregnancy was unconstitutional. The Washington Supreme Court held that the case did not present a justiciable controversy because DiNino was neither terminally ill nor pregnant. Under the privacy/property dichotomy, the brain dead pregnant woman has "crossed the legal boundary separating life from death, and thus receives precisely the same treatment under law as a corpse." If she continues to have control over her body, the ownership must derive from property rather than privacy. It follows from this line of cases, that a system could be devised where organ donation could be compulsory. Under such a system, upon death, organs would belong to the state and could be harvested, regardless of the wishes of the decedent or the decedent's family. If thirty-three states maintain this law when a fetus is the competing interest, then surely a human life struggling for survival is more compelling.
1. It is likely that people will choose to opt out because they don’t believe they would be viable donors.


In 1995, the Iowa Statewide Organ Procurement Organization and the Iowa Social Science Institute conducted the Iowa Organ Procurement Study (“Iowa Study”). In the Iowa Study, 97 percent of those interviewed expressed support for organ donation. But while most Iowans seemed to support organ donation, only 43 percent had taken the affirmative step of joining the donor registry. Such discrepancies may be partly attributable to donation misconceptions that are related to healthcare of organ donors, religion, finances, fear, or a general inability to comprehend death. The theory that most Americans are misinformed about organ donation and thus do not take the proper steps to become organ donors is reinforced by the fact that the more educated a person is, the more likely he or she is to register as an organ donor. One of the major health-related reasons why people do not donate organs is because many believe that they will not be suitable donors due to their age or current health status. Another health-related reason is that many fear that their bodies will be mutilated by the donation process, which would prevent them from having an open casket at their wake or funeral services. Contrary to these prevalent misconceptions, organ donations have been made by people as old as seventy-nine. In addition, the fact that one donates his or her organs in no way affects his or her ability to have an open-casket wake or funeral. Another organ donation misconception held by Americans is that organ donation is forbidden by certain religions. Although "certain cultural expectations and religious doctrines emphasize human dignity, the sacredness of the body, and the preservation of life, even when medically the body may be considered dead," approximately thirty of the world's religions support organ donation. For example, Muslims, once forbidden from organ donation, may now make cadaveric gifts provided that donors give consent in advance. Furthermore, most Jewish sects allow organ donation, with some forbidding the donation of non-life saving organs, such as corneas.

2. The public is fearful of what organ donation entails. This would lead to high rates of opting out because people simply aren’t educated.


Fear is another factor that contributes to America's reluctance to affirmatively embrace organ donation. One "fear" that compels patients to choose against donation is premised on the misconception that doctors, nurses, and hospitals do not work as ardently to save the lives of potential organ donors because such organs can be used for a "better" purpose. The Organ Procurement and Transplantation Network, United Network for Organ Sharing, and the Coalition on Donation all refute this common misconception. The organ transplant community has gone to great lengths to assure the public that the care provided to potential donors is in no way compromised because a patient carries a donor card. Moreover, contrary to the misconception, treating emergency room physicians are in no way involved in the transplant process and are not permitted to harvest organs from accident victims. A second "fear" contributing to the reluctance to register is that an ordinary, healthy American generally avoids contemplating his or her own death. Although death is inevitable, the concept of death carries connotations of pain, fear, abruptness, loneliness, insecurity, and, of course, finality. Therefore, asking healthy citizens to sign organ donation cards, "compels the recognition of both the inevitability of one's mortality and its temporal uncertainty. To actually make the donation is to unequivocally affirm that recognition. Most of us would, for better or worse, prefer to remain oblivious to the angel of death resting on our shoulders." This inability to contemplate death is supported by the results of the Iowa Study, where a large percentage of subjects did not sign organ donation cards because "they simply had not thought long enough about the possibility of being [a donor]." In addition, the fact "that eighty percent of Americans die without [executing] a will ... suggests that even when there are compensating personal benefits, we are reluctant to come to grips with our own mortality." Financial misconceptions also shy Americans away from becoming organ donors. Some potential donors believe that they or their families will have "to pay the costs associated with the removal of [donated] organs." However, Neither organ donors nor their families pay any costs associated with the removal of donated organs. Rather, once a potential donor has been declared dead and consents ... , the subsequent cost of maintaining ... the donor's organs are effectively borne by the recipient [of the donated organ]. Even in the case of living donors, the cost[] of all evaluations, removal, [and] hospital stays ... are borne by the recipient.
3. The backlash to presumed consent is likely to be large— the vast majority of public disapproves of it.


Despite the possibility that its adoption would provide more organs for transplantation, the presumed consent idea did not receive wide endorsement. David Ogden, then President of the National Kidney Foundation, objected that it was "relatively coercive, compared to the more classical freedom of choice that characterizes our way of life." Others repeated Paul Ramsey's concern that presumed consent "would deprive individuals of the exercise of the virtue of generosity." The most telling objection, however, was that presumed consent was not acceptable to the public. A widely cited opinion poll, for example, reported that only 7 percent of the public supported the concept. Indeed, when a federal task force on organ transplantation rejected presumed consent in 1986, it gave lack of popular support as its only reason.

4. Presumed consent is assured to fail. It either will not go far enough and not overcome the key barrier of familial consent or it goes too far and incites massive backlash.


Proponents of "presumed consent" to organ donation have always faced an uphill battle. In supporting a presumption that people want to donate their organs after death - and a policy of organ removal in the absence of an objection by decedents or their family - advocates push a policy that goes against the grain of American individualism and is more at home in countries with a stronger communitarian ethic. Presumed consent also raises the specter of one of society's deepest fears - that unscrupulous doctors will take a person's heart, liver, kidneys, or other organs against the person's wishes, or even hasten a person's death to obtain the organs. Consider in this regard the resonance of Robin Cook's Coma, the best-selling thriller in which doctors put patients into a coma so their organs could be removed for transplantation, or a popular episode of the television series, Law & Order, in which a man was kidnapped and left in a park after his kidney was taken. While the United States has tried presumed consent on a very limited basis for roughly four decades, recent developments in the law suggest that even this highly limited use is being abandoned. Presumed consent appears to have failed because it went either too far or not far enough. It did not go far enough to the extent that family members were allowed to overcome the presumption that the dead person favored donation. By permitting families to reject donation, presumed consent did not address the major reason why people do not become organ donors after death - the refusal of family members to give consent. On the other hand, presumed consent went too far to the extent that public officials bypassed family members and avoided the possibility that they would refuse consent. Such action only validated fears that the desire for more organs for transplantation would result in organs being taken from dead persons who would not have wanted their organs removed. Presumed consent, in short, faced a Catch-22. If implemented in a way that was acceptable to the public, it could not solve the organ shortage. If implemented in a way that might alleviate the organ shortage, it became unacceptable to the public.

5. The backlash to presumed consent would be great because opponents are highly opinionated.


In particular, it may be the case that people who object to organ donation feel more strongly about their objection, even if not religiously based, than people who desire organ donation feel about their wishes. Under the current system, potential organ donors know that their desire to be an organ donor after death may be unfulfilled. In a presumed consent system, non-donors would know that their objections to organ donation might not be respected. It is very possible that the anxiety from the possibility of unwanted organ donation would be more serious than the anxiety from losing the chance to be an organ donor. People tend to worry more about losing something they have already, and wish to keep, than about not getting something they want. Indeed, there is good reason to think that the distress to the living from the possibility that their organs might be taken after death is more substantial than the distress from the possibility that organs might not be taken. While there are a number of lawsuits brought by family members when a dead person's organs or tissues have been removed without consent, there are not comparable lawsuits brought by family members when organs have not been removed despite the decedent's or family's wishes for donation. In sum, one can adduce good arguments from considerations of autonomy to both justify and reject a strong version of presumed consent that excludes family involvement. But even if one concludes that family involvement in the donation decision tends to result in family members overriding individual preferences in favor of donation, the option of excluding families from the donation decision has not proved feasible in the United States. Indeed, as discussed above, when coroners tried to exclude families from cornea donation decisions, they only provoked a backlash that led to the abandonment of presumed consent by the drafters of the 2006 UAGA. Why this happened is the topic for the next section of this Article.
1. **Presumed consent triggers legal challenges from the family, tying up the decision to donate into a giant court battle, destroying the organs and making the regime useless.**


The opinion did not prescribe the procedural steps that the state was obliged to follow. For the most part, the court seems to focus on the coroner's failure to conduct even a minimal inquiry into whether or not the family objected to removal. The opinion refers to what it termed the coroner's "intentional ignorance," which was "induced" by the Ohio corneal removal statute. According to the court's opinion, this statute "allows the [coroner's] office to take corneas from the bodies of deceased without considering the interest of any other parties, as long as they have no knowledge of any objection to such a removal." In this regard, it is noteworthy that the Ohio statute was amended in 1983 to delete a requirement that the coroner "make a reasonable effort to notify the family of the deceased." Thus, the court might simply be saying that there must be some procedure for notifying the coroner when the hospital is aware of an objection, and that failure to do so is a violation of due process. If this was what the court had in mind, however, it could easily have said so. Instead, it remanded the case to the district court for further proceedings. Furthermore, in discussing the requirement of due process, the court pointed out that "[t]he Supreme Court has often reiterated that a property interest may not be destroyed without a hearing.” This suggests that the court would insist on a predeprivation hearing of some sort before corneas could be removed. If the Sixth Circuit is insisting that a formal hearing be held before organs could be donated, this could invalidate current donation procedures, including the donor card system provided for in the UAGA. Arguably, these procedures might not satisfy a formal hearing requirement, particularly if due process fights inherent in the family and given that the UAGA permits the donor's disposition to override the family's wishes. If removal of organs for transplantation under state law triggers due process requirements, and if this means that there must be an actual administrative or judicial hearing before organs can be removed, then a presumed consent approach would be largely useless. Hearings would be expensive and cumbersome and would cause delay that might reduce or eliminate the usefulness of the organs for transplantation purposes. More importantly, since the next-of-kin would be interested parties entitled to participate in the hearing, requiring a hearing would be tantamount to prohibiting removal of organs without express familial permission for donation.

2. **Violating family consent opens the floodgates to legal battles and exposes people to civil liability.**


Apart from confronting constitutional issues, persons who removed organs without express permission from the decedent or the family might be concerned that they could be subject to criminal and civil liability. State law generally makes it a crime to mutilate or to mistreat a corpse. The term “mistreatment” is usually defined as an act that offends or outrages ordinary sensibilities. While removing organs for transplantation need not leave the corpse in a condition at the time of burial or cremation in which it appears to have been mutilated, or may be deemed to have been mistreated if removal without express permission is regarded as offensive or outrageous. Removing organs under a presumed consent approach might also give rise to civil liability for tortious interference with the fight of burial. The Restatement (Second) of Torts, which attempts to codify the common law, states that "[o]ne who intentionally, recklessly or negligently removes, withholds, mutilates or operates upon the body of a dead person or prevents its proper internment or cremation is subject to liability to a member of the family of the deceased who is entitled to the disposition of the body." The family might seek damages on the theory that removing organs without express permission was an intentional operation upon the deceased. In a recent Florida decision, Kirker v. Orange County, a state appellate court held that the mother of a deceased child stated a cause of action for intentional infliction of emotional distress when she alleged that the county medical examiner had removed the child's eyes over the mother's objection. The mother claimed that she discovered that the eyes had been removed after she noticed at the funeral that the eyes appeared depressed. Furthermore, she asserted that the child's attending physician had asked for permission to remove the child's corneas and kidneys, that the mother had refused, and that the refusal had been noted on the child's hospital chart. Finally, the mother claimed that the medical examiner had been aware of her objection and had attempted to cover up the unauthorized removal by falsifying the autopsy report.
3. Bypassing family consent would destroy the legitimacy of the system, leading to fears and backlash.


More importantly, families frequently block organ donation even when a person filled out an organ donor card while alive - and the override rate can be quite high. In Indiana in 2000, family members overrode a decedent's choice to donate in 74 out of 184 cases involving eligible donors who had indicated their wishes on their drivers' licenses. That 40% override rate led the legislature to modify the state's uniform anatomical gift act to make it clear that the decedent's wishes take priority over those of family members. While presumed consent in the United States did not deal with the possibility of families substituting their own preferences for those of the decedent, one could prevent inappropriate family decisions by implementing the stronger form of presumed consent that allows objections only from the decedent while alive. This policy option raises two questions: Do people generally want their organs taken after their deaths? If so, would it work to implement a presumed consent system that denies family members any opportunity to object to donation (that is, a stronger version of presumed consent)? As discussed below, one can mount a good, though not decisive, argument that people generally want to be organ donors after death and that presumed consent would vindicate patient autonomy. As to bypassing families, however, the experience in the United States with presumed consent indicates that it has not worked to take organs without family consultation. Excluding families from participation has too greatly reinforced concerns that the organ transplant system would abuse its presumed consent authority.

4. Pushing out the family’s role in consenting to donation opens up the medical system to corruption and misconduct as people are exploited for their organs.


Under a system of presumed consent that excludes a role for families, the risk that doctors or other professionals will cut corners to obtain organs for transplantation may be much greater than it is under a system of actual consent. With actual consent, there is greater oversight of the organ transplant system - family members have to be much more involved in the process of organ retrieval with actual consent since they are the primary givers of consent to posthumous organ donation. If transplant professionals were able to proceed with organ retrieval without speaking to family members, there would be less of an opportunity for family members to recognize unethical behavior. Excluding family participation in the organ donation decision may or may not promote unscrupulous practices by transplant professionals. Such a policy would result in more organs becoming available for transplantation, relieving a good deal of the organ shortage. With an increase in available organs, coroners, physicians, and others should feel less pressure to secure organs and therefore be more willing to meet their ethical and legal obligations. The historical evidence provides support for both possibilities. Grave robbing for medical study and research in the eighteenth and nineteenth centuries largely disappeared when legal reform generated a sufficient supply of cadavers for dissection. On the other hand, there are prominent recent examples of coroners abusing their presumed consent authority when their practices were not adequately monitored. As mentioned above and discussed further below, the recent examples of misconduct under presumed consent played a critical role in leading the drafters of the 2006 UAGA to abandon presumed consent.

5. Presumed consent undermines the integrity of the organ donation system.


If such a diminution occurred, it would be very important. Unfortunately, the serious shortage of organs has engendered a significant risk of misconduct. Contemporary examples of abuse are not difficult to find. Indeed, in the past few years alone, news media have highlighted a number of problems, including: . claims that a physician-led, criminal ring in India forcibly took hundreds of kidneys from poor laborers for transplantation, the removal of bone from British broadcaster Alistair Cooke's body and the taking of body parts from other persons without consent for sale to tissue processing companies, and . criminal charges against a transplant surgeon in California accused of hastening the death of a dying patient so his organs could be removed for transplantation. While there is reason to think that a strong version of presumed consent could have a salutary effect on physician conduct, the U.S. experience with presumed consent has in fact reinforced concerns that it would encourage additional misconduct. As discussed in the next section, the possibility that presumed consent would make organ removal practices prone to an even greater risk of abuse than exists currently under actual consent seems to have been realized.
Negative Position Three: Alternatives Are Superior

1. Presumed consent should be rejected. It is a paternalistic abuse of state power.


The state cannot justify the paternalistic intervention of presumed consent laws by claiming to act as Gerald Dworkin's insurance policy, protecting against decisions made under extreme pressure. Because organ donation typically requires a generally healthy body and a dead brain, potential donors are often the victims of sudden and extreme trauma. Therefore, the family's decision to make an anatomical gift will inevitably be made within a maelstrom of emotion, as a beloved family member unexpectedly lies dying. The nature and circumstances of the decision, which make the psychological pressure unavoidable, thus are not sufficient reason to confer donation power upon the state. Otherwise, the state could donate organs in every sudden death situation, simply because the family is upset. Finally, although Gerald Dworkin believes that paternalistic laws are permissible in some situations, he nevertheless feels that the state bears a heavy justification burden and must first utilize any available alternative means, regardless of cost or inconvenience. Using Dworkin's own analysis, the paternalism of presumed consent should be the last available option, and not just a mere expedient one. Conclusion Until the government either improves our current opt-in organ procurement system or fully adopts an opt-out model, with its concomitant expenditure of resources, it is not justified in using presumed consent to harvest organs from unidentified persons. The viable alternatives to presumed consent organ harvesting have not yet been exhausted. As it remains, presumed consent organ donation laws intrude upon constitutionally protected individual and family-based rights, allowing an increasingly dominant state to commandeer personal decisions and invade private bodies. By paternalistically "snatching bodies" according to its whims, the government has usurped people's autonomy in a wholesale disregard for their constitutional rights. Because organ donation decisions belong to the individual and the family, and not the state, presumed consent laws are both unethical and unconstitutional.

2. Mandatory choice upholds the social and justice benefits of increasing organ donation while still maintaining autonomy over life.


Furthermore, in refusing the notion of unconditional societal appropriation of cadaver organs, this proposal not only acknowledges the individual’s right to control his or her physical disposition rather than the State, but also maintains the non-patrimoniality status of the human body; as the body and its parts have no proprietary status they can be used to save the lives of others on condition that individual wishes are not infringed upon. The non availability and non-patrimoniality of the human body after death would be maintained together with the possibility of using suitable organs for the benefit of individuals in a situation of vital emergency if explicit refusal was not expressed during the deceased’s lifetime. Legislation concerning the disposition of the physical body and its components already exist since the conditions under which a live donor can donate organs are precisely stipulated; i.e. whether they can be donated or sold, to whom and concerning which organs. To remain coherent, this should equally apply to posthumous donation without it necessarily lapsing into the nationalisation or socialisation of the human body. This would unquestionably reassert, in certain well-defined cases, the Legislator’s intervention in the relationship between an individual and his body. In these cases, a restricted form of liberalism or ‘moral paternalism’ would prevail since the State interferes in the lives of its citizens above and beyond the reciprocal guarantee of protection from harm (Ogien 2007). In order to clearly establish an individual’s opposition to posthumous organ removal and to ensure the explicitness of this opposition, which is not currently the case, one cannot rely on a National Register of Organ Donation Refusal as only a very limited number of persons are aware of its existence. This lack of awareness and knowledge prohibits the supposition that an individual not registered on this database is not fundamentally opposed to posthumous organ donation. On the other hand, numerous countries have a National Health Insurance scheme and residents are issued with a special card or document indicating their affiliation. In France, since 1996 all National Health Insurance beneficiaries aged 16 and over and all French residents benefit from an electronic health insurance card, the ‘carte Vitale’ on which are registered all health insurance data.
3. Presumed consent raises massive issues with implementation. It demands ceaseless education campaigns, bureaucracy, and huge legal reform.


In a presumed consent system, doctors assume that every person wishes to become an organ donor upon death. Specifically, unless a person has rebutted the presumption of consent by affirmatively “opting out” of the system, the greater community may claim the right to remove much-needed organs. Presumed consent laws are based upon the belief that while most people wish to donate their organs, they are simply reluctant to address the seemingly remote issues of death and organ transplantation while still healthy. Thus, presumed consent allows the state to act upon a silent consensus and remove organs without explicit permission. Moreover, because everyone is considered a potential donor, subject to opt-out, supporters believe that presumed consent laws will result in an increased supply of organs for transplant and an end to donee waiting lists. A properly functioning presumed consent system must, of course, be based upon popular support. However, this protection alone is not sufficient. For example, because individuals must affirmatively express their refusal to donate organs while still legally competent, presumed consent systems require a well-educated and motivated public. Otherwise, the underlying support for the system is eroded, resulting in society's recovery of organs based upon people's "lethargy" and "ignorance," rather than their unexpressed true desires. A presumed consent system must also contain an effective mechanism for recording and reviewing opt-outs, such as a centralized data bank or registry. Finally, hospitals must be willing to face the legal ramifications and negative publicity that may accompany presumed consent organ harvesting. If doctors and administrators routinely fail to act upon presumed consent, any benefits of the system will likely be lost.

4. Tacit consent helps to ensure that the costs to opting out are low and removes any ambiguity concerning the meaning of silence.

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The consenting person should also have easy access to all relevant information about his options and the consequences of taking any of them. (As I suggested, it is up to him to decide whether or not to digest that information.) Another condition worth mentioning is that the person should be given a reasonable period of time, with a clear terminus, for making and expressing his decision, silence counting as the appropriate expression of one possible choice. Finally, the costs of registering dissent should be low, or even insignificant.[ix] In the case of explicit consent this is normally the case, although even then only contingently. (It may be very difficult to do nothing.) My claim is that an opt-out system like the variant I described satisfies all those requirements for interpreting abstaining from registering objections as genuine, albeit tacit consent.

5. Tacit consent is a subtle form of mandatory choice, but minimizes the danger of people resenting the system. 12

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Because proper tacit consent is a form of genuine consent, the tacit consent system actually is a mandatory choice system. It has the advantages but not the disadvantages of the no-default system usually referred to by that name. It has been claimed that ‘the essential ethical advantage of required response is its undiluted loyalty to the value of individual autonomy’ but this is equally true of tacit consent. It registers a relevant decision of every adult citizen or resident. With one exception, to be discussed presently, it guarantees that the relatives have some information about the preferences of the deceased, which the present opt-in systems do not give them in the majority of cases. That is the item of information they consider themselves the most relevant one for their decision. In addition, they do not have to make a decision at all if they do not feel up to the task, but unlike the standard mandatory choice system the tacit choice system does not rely on sanctions that are likely to be interpreted as forms of dé tournement de pouvoir and hence invite people to refuse donation out of resentment. People have an authority-right to control the entrance into their personal domain, including their bodies, but if they are properly informed about someone's wish to enter it and only need to say 'no' to prevent the execution of that wish, they have all the control they need. Therefore, a tacit consent system fully respects their authority-right.
6. There are numerous methods that can be used to increase organ supply that do not rely on changing the model of consent. 13


Does contracting out increase the supply of organs? The difference in the rates of organ donation between countries can be explained by several factors, such as the supply of potential donors (which may vary according to the rate of road-traffic accidents or gun laws, for example), religious and cultural responses to death and to the body after death, and practical issues—eg, the number of intensive-care beds available. Adverse publicity can seriously reduce the supply by reducing the number of potential donors or the consent of relatives. Supply can be increased by energetic educational campaigns, by having more transplant coordinators, by the provision of specialist teams to take over the care of potential donors, and by provision of financial incentives to encourage doctors and institutions to refer patients. All these factors are independent of the nature of the prevailing law.

7. Presumed consent is a fiction. No active consent is ever solicited, allowing organs to be stripped away without families knowing it.

P. Chouhan and H. Draper, Centre for Biomedical Ethics, Department of Primary Care and General Practice, The Medical School, University of Birmingham, JOURNAL OF MEDICAL ETHICS, “Modified mandated choice for organ procurement,” vol. 29, no. 3, pp. 157-162, June 2003, accessed 8.15.2014: academic search premiere.

Whilst there is still much to debate about the efficacy of a presumed consent system, such a system was rejected by the American Medical Association's (AMA) Council on Ethical and Judicial Affairs. The AMA argued that unless a view has been registered, society has no way of knowing what the deceased's preferences were, and presumed consent is therefore not likely to reflect the views of those who did not want to donate and did not register this preference. A survey of opinion in the USA, cited by the AMA, suggested this could amount to around 31% of the population, a figure similar to that found in surveys of opinion in the UK. Erin and Harris have argued that the concept of presumed consent is something of a fiction because although the term “consent” is used, in reality there is no consent at all. Whatever the philosophical objections to presumed consent, events in the UK may have overtaken attempts to introduce this system of organ procurement. Since the BMA's report was published, the public's perception in the UK about the acceptability of removing organs without explicit consent has inevitably been affected by the public outrage at reports that thousands of dead children over a period of several decades were systematically and routinely stripped of their organs without the knowledge or consent of their parents. Moreover, the subsequent inquiry into organ retention strongly recommended that the law be tightened to ensure fully informed and explicit consent to removal of organs. The government quickly accepted all of the report's recommendations, thereby effectively preventing any move towards a system of presumed consent for organ donation.

8. The shortage is due to ineffective requesting procedures, not a lack of altruism among the population.


Required request was devised to deal with what were believed to be the underlying reasons for the failure of encouraged voluntarism. Opinion polls showed that few people voluntarily donated their own organs or those of members of their own families. Yet the polls also showed that an overwhelming majority approved of organ donation in principle, and hospitals found that, when asked, most families consented to removing the organs of dead relatives. Asking families rather than the donors themselves therefore seemed the best approach to increasing the supply of organs. The problem was that, under encouraged voluntarism, the families were not being asked. Physicians and nurses were reluctant to ask families to consent to donation while their loved ones were still alive, and, once death had occurred, caregivers did not like to interrupt families during their time of grief. Physicians were also reported to be held back from discussing donation by the notion that the death of the patient was a medical failure. The typical separation of treatment and transplant teams within the hospital community also reduced structural incentives for establishing effective request procedures. The solution represented by required request was to overcome this professional and institutional resistance by using the force of the law. Accordingly, state and federal laws were amended to require hospitals to request donation from the families of suitable donors.
Underview: Presumed Consent Destroys Autonomy

1. Presumed consent undermines patient autonomy, the cornerstone of an ethical medical system.


The whole idea of presumed consent has been described as a fiction: unless a person consents, he has provided no consent. There are arguably three reasons why the doctrine of presumed consent does not sit well in the field of medicine. 1) it undermines patient autonomy; 2) it assumes knowledge on the part of the patient; and 3) it causes distress to relatives. Is it worth the ethical quagmire to implement such a policy? Patient autonomy is a fundamental principle in medical care. The patient doctor relationship is based on trust, and a presumed consent program of any nature takes the power away from the patient to expressly consent to a medical procedure. It has been suggested that by presuming consent, we are being disrespectful of individual autonomy and articulating a particular view of what is morally acceptable to do with a dead body when that person has not consented prior to death to such treatment after death. Parliament may be able to get away with presuming consent for smaller, less personal matters, such as unwanted physical contact on public transport, but the donation of our organs upon death is acknowledged by many to be a sacred gift, and to assume that all individuals are this altruistic will be seen by many as a step too far. Not all of us give to charity, and not all of us exercise the same moral values, so why should we all be assumed to consent to donating parts of our body? Any new Bill will need to be drafted very tightly to ensure that the medical profession could not take advantage of the presumed consent doctrine, or ignore a deceased’s wishes, which would be devastating to public support and trust if such neglectful practice was to be revealed.

2. Consent is an active, discrete activity. It cannot be presumed.

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There are several possible ways of meeting it. The most obvious way is to recognise the requirement of consent, but to hold that it can be overridden by pressing moral considerations, as all legal systems acknowledge when they allow autopsies to take place without the consent of the deceased. An alternative defence of opt-out systems suggests that even if in a particular case we have no compelling evidence of the consent of the deceased, we may have reason to 'presume' it. Actually, in the English-speaking world opt-out systems are generally known by the proper name of presumed consent systems. The appeal to presumed consent, however, turns out to be based on a mistaken conception of consent. If to consent to donation meant desiring it or preferring it to non-donation, it would make sense to act on the mere probability of such a desire, but if the requirement of consent is implied by our authority to make our own decisions, we have to exercise it by actually making such decisions.

Consent, in this view, is not a mental state but a public action with normative consequences. On a mental state view there might be no safe side to err on, but on the public action view there is: it is wrong to act without consent, but not to abstain from action in spite of consent. One does not get a claim of having one's organs removed merely by consenting to it.

3. Opt-in systems of organ donation are critical to protect the autonomy and consent of the deceased.


Defenders of opt-out can respond by insisting that they favour opt-out not just because it saves more lives, but chiefly because opt-out better tracks individuals' approval of organ donation. It is well-known that both opt-in and opt-out are vulnerable to measurement error: in the case of opt-in, we cannot be sure that those who fail to opt-in really refuse to donate, while in the case of opt-out we cannot be sure that all who tacitly consent really intend to donate. However, survey evidence typically shows broad support in favour of organ donation, suggesting the number of mistakes under opt-out will be significantly smaller than under opt-in. Of course, this argument crucially relies on actual consent reliably tracking public opinion in this regard. More importantly, the argument relies critically on giving equal significance to false positives (under opt-out) and false negatives (under opt-in). Against this we could argue that, while a person has a strong negative right to veto the postmortem use of her body, she has no comparable positive right to determine what happens to her body after death. Those who endorse this asymmetric perspective will insist that opt-in is more reliable for it protects us against the error that really matters – the posthumous use of one's organs without prior approval. Which consent procedure we ought to favour thus depends importantly on what we believe consent is meant to protect.
1. **Mandatory choice and better record keeping allows a clear understanding of the deceased’s wishes.**


This health insurance card or document cannot include a statement concerning organ donation as this innovation would be in contravention of the law if it registered an individual’s consent or refusal to organ donation without permitting its subsequent revocation, the law stipulating that an individual’s wishes are ‘revocable at all times’. It is not certain that this condition (a prerequisite to respecting individual wishes and their changeability) can be satisfied by an indication on an electronic card that cannot be modified by the individual concerned. On the other hand, it could act as a support mentioning, not whether an individual is for or against the use of his or her organs after death (a decision that must remain revocable), but whether the individual is fully aware of the legislation in force. This mention would be valid throughout the person’s lifetime, unless the legislation was subject to significant reforms. This would make the registration of individual preferences more reliable as it would thus be compared with the registered right to explicitly express opposition to organ removal. This registration would be coupled with a public obligation to inform. An explicit opposition to organ donation would be registered in a unique computerised national registry, made known to all citizens and modifiable at all times. This refusal would be registered by an individual fully informed of the legislation in force. The absence of an individual’s explicit refusal in the National Register, coupled with the mention of an individual’s full awareness of the legislation in force, would thus guarantee with certainty that, on the day of death, the said individual had no objections to society deciding on the fate of his/her organs. This would eliminate the need for difficult interviews with the next of kin. The only factor taken into account would be the deceased’s personal wishes. This measure thus respects the principle of individual autonomy and free-will without appealing to citizens’ altruism. It would safeguard the deceased’s next of kin from having to bear the weight of making a harrowing decision that by right belongs to the individual directly concerned. In addition, it would contribute to ensure a durable or enhanced supply of available organs for patients on the waiting list for transplants. More particularly, this conditional conscription, or consented social availability of the human body after death would simplify organ procurement procedures. Finally, it represents a more equitable organ procurement process in that each citizen would contribute to this national system in equal proportions, and the cost of donating equitably divided amongst the population as a whole. Over the last fifty years, human organs have become a resource that increasingly benefits the health of individuals. The current impossibility of artificially creating this resource makes it necessary to procure organs from the human body. Despite the absence of a legally defined proprietor, organ procurement has been entirely founded on the reiterated appeal to altruism, the incoherence and illegitimacy of which we have demonstrated. The situation in many countries is paradoxical in that the Legislator, from the founding laws in this field, had decided otherwise. Major difficulties in applying a law tend to nullify it and obliterate its validity. Our aim here was to outline conditions under which present legislation in the countries concerned could be applied whilst respecting two of the fundamental conditions orienting current methods and practices in the field of bioethics: the principle of individual autonomy and respect for the wishes of the individual directly concerned by the acts effectuated.

2. **Mandatory choice has the benefits of being supported by the medical community as well as the public, making the possibility of backlash very low.**


A system of mandated choice is the best alternative to increase organ donation in the United States. "Under a system of mandated choice, people would be required to opt out of or opt into the [transplant registry]." All citizens would be obligated to "make an affirmative choice either for or against cadaveric organ donation." The mandated choice system would require a citizen's organ donation preference to be recorded at a certain point during his or her life - for example, when a citizen "files a tax return or obtains or renews a driver's license." The American Medical Association's Council on Ethical and Judicial Affairs is one of the leading supporters of the adoption of a mandated choice system in the United States. Other advocates of a mandated choice system argue that the advantages of such a system include "the enhancement of individual autonomy since each person's actual wishes would be known and followed" and that such a system would ensure that fewer suitable organs would be lost to the human propensity to avoid planning for death. Furthermore, polls suggest that the implementation of a mandated choice system would appeal to the American public. For example, in a 1993 poll of 100 adults, only 14 percent indicated that they wanted their family to make the decision about their status as an organ donor; the majority wished to make the decision themselves.
Underview: Mandatory Choice is Effective [cont’d]

1. **Mandatory choice regimes can utilize informed consent in a way that ensures that any choice being made is being made for the “right reasons,” not out of ignorance.**

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   This leaves the question of how a system of mandated choice could accommodate the modification we have suggested—that is, the recognition of good and bad reasons for choosing with the onus being on those who refuse to justify this—and still allow people to choose freely. For the solution to this problem, we have borrowed an idea from the so called Spanish model. In Spain, transplant coordinators are not just charged with gaining the consent of relatives for organ donation, they are explicitly required to attempt to persuade relatives to donate. This is done by stressing the generosity of the gift, the benefits to recipients of donation, and the importance of social solidarity. What we propose is a system of mandated choice where the accompanying public education and information is similarly prodonation. For instance, all the available literature on cadaveric donation would be far more directive than it currently is, with the legitimate intention of inclining in favour of donation all but those with the strongest objections. To protect those who still do not wish to donate, however, the modified system would continue to guarantee confidentiality and no privileges would accrue whatever decision was made. The sense in which individuals will have to justify their decision not to donate would not require public investigation. Rather, the process of actively deciding against donation in the face of literature etc attempting to persuade one to do the opposite, is an active expression of autonomy and therefore worthy of respect without need for further investigations into the reasons, which we will presume to be at least strongly held. Thus, the system we propose accepts the force of the utilitarian argument in favour of obligatory and, therefore, compulsory donation: this is achieved by the strong presumption in favour of donation. It also accepts the Kantian value that is placed on autonomy, but seeks to ensure that an autonomous decision is actually made by both requiring people to reach a decision and by ensuring that a “bad” decision, in utilitarian terms, is at least one that is reached in the face of arguments to the contrary. In this sense it has the value of being an active decision, the reasoning behind which is likely to bring it closer to that which one might expect when upholding the ideal of the autonomous agent.

2. **Mandatory choice is the only way to avoid the pitfalls of undermining consent.**


   Our proposal, on the contrary, aims at identifying a method of directly obtaining the wishes of the individual concerned by posthumous organ removal; the individual’s explicit wish concerning the fate of his/her organs would thereby be taken into account and respected rather than that of close relations. This method will meet the previously analysed moral requirements regarding the respect of individual autonomy and the legal requirements in the application of existing legislation. It involves defending explicit refusal legislation, in the absence of which Civil Society would authorise the removal of organs from the deceased person. Legislation recognising the right of the individual to refuse posthumous organ donation would thereby respect the principle of individual autonomy. This system, going further than the presumed consent model, takes into consideration the societal need to ensure the supply flow of organs for the benefit of patients suffering from vital organ dysfunctions. In acknowledging an individual’s explicit refusal to donate, this proposal recognises the right to individual autonomy regarding the use of the human body after death, whilst taking into account the societal and therapeutic need for the effective availability of cadaveric organs. In what way does this proposal distinguish itself from current presumed consent legislation? Literally, it is essentially centered on the respect of an individual’s wishes regarding organ removal whereas present legislation, based on presumed consent, is just “presuming” the unknown wishes of the individual. Above all, this proposal reinstates the individual harvested as the principal actor in deciding the fate of his/her organs to the detriment of close relations to whom the decision is currently conferred. It replaces an unethical system based on presumption by one respecting an individual’s wishes as seems to be the current European trend (see “Action plan on Organ Donation and Transplantation (2009–2015)”, European Parliament resolution of 19th May 2010). It is an explicit “opt-out” system which overrides the “silent majority” trap observed in “opt-in” legislation and avoids the necessity of presuming an individual’s wishes. This proposal is based on the supposition that the means of collecting and registering individual preferences concerning posthumous organ donation will equally evolve. This would be necessary to override current practice that, in contravention of legal stipulations, gives primacy to the wishes expressed by close relations.
Underview: Mandatory Choice is Effective [cont’d]

3. Mandatory choice and public education campaigns are comparatively more just than presumed consent, avoid having to erect massive bureaucracies, and respect the core value of autonomy.


A more reasonable option is promoting public awareness of organ shortage and encouraging genuine organ donation. Although it was the failure of such efforts that prompted presumed consent laws, the fact that individuals do not designate themselves as donors even after learning about organ shortage has certain implications. If the public at large supports organ transplantation so overwhelmingly, it should then follow that individuals voluntarily announce themselves donors. Speculation of those who support transplantation that the absence of volunteerism is related to mere laziness or the inability to confront death does not adequately support audacious state legislation presuming that all citizens authorize the physical invasion and extraction of their remains by the state. Another less restrictive alternative suggested by some commentators is “mandated choice.” Under mandated choice, all individuals obtaining state identification are asked whether they wish to be organ donors. Rather than imposing the state's choice upon its citizens, the state could impose the lesser restriction of requiring citizens to make their own choice. Individuals unable to confront their future demise could simply refuse to donate initially, and thereafter amend their decision if they subsequently change their minds. Mandating a choice is certainly less restrictive than mandating a decision. Some would suggest that genuine opt-out measures would effectively resolve the constitutional dilemmas posed by presumed consent statues. Belgium, for example, has a centralized database accessible only to transplant officials for individuals desiring to opt-out of Belgium's version of presumed consent. Nonetheless, the Belgian model presents certain problems in our federal system, as presumed consent is a creature of state law, and federal involvement in organ transplant issues is only pursuant to congressional Commerce Clause powers. Privacy concerns are also relevant when national databases contain information regarding private citizens, particularly when such lists are likely to yield substantial numbers of adherents of minority faiths. Furthermore, to be even slightly protective of the rights of non-donors, strict legal sanctions would have to be imposed on those who extract organs without diligently searching the database. Regardless of the existence or constitutionality of a centralized database, such a system still places an onerous burden on private citizens wishing to be buried with their organs intact. Immigrants, the homeless, and the undereducated are highly unlikely to be aware of presumed consent laws. Indeed, many Texas lawyers are surprised by the existence of these statutes. Demanding that citizens acquaint themselves with the details of the various Texas state codes in order to avoid forfeiture of their body parts elevates the notion of constructive consent to absurdity. In conclusion, Texas' presumed consent statutes do not pass muster under Article I, Section 6 of the Texas Constitution, which vigorously defends freedom of conscience. Presumed consent imposes a substantial and unacceptable burden on individuals and families whose religions forbid organ harvesting. The state interest in preserving sight and lives can be achieved through less restrictive means, such as education and mandated choice.
Underview: Tacit Consent is Better than Presumed Consent

1. A tacit consent regime is distinct from and superior to a presumed consent one because it ensures that silence is an informed choice.

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In this paper, I want to consider an alternative way of justifying at least some possible opt-out systems, leaving it open to what extent actually existing ones can be justified in this way. According to this argument, when certain conditions have been met, the very fact that a person has not registered a refusal to have his organs removed provides us with sufficient evidence of consent. Such tacit consent should not be taken as a species of presumed consent, but as a form of genuine valid consent, fully legitimate even on a public action conception of consent. In giving their consent tacitly people are exercising their authority to make binding decisions about the fate of their mortal remains. THE APPEAL TO TACIT CONSENT Consider the following variant of the opt-out system. On reaching the age of 18 years each citizen is sent a letter asking him to register a decision concerning donation in the national donor register. The options include consent, refusal and delegation, to one's relatives or to a specific person, or perhaps even a conditional consent, giving the relatives a right of veto. If one fails to respond, the invitation is repeated a year later. If one still fails to respond, one is informed of being registered as a donor, and of the way to revise one's registration (by filling out a short form on paper or on-line). At regular intervals (let's say once in 5 years) one is informed again of one's status and of the possibility of revision. A system like this is at present being discussed both in Germany and in The Netherlands. The German Ethics Council calls it a two-tiered procurement system, the first tier consisting of an open choice between registration options, the second one of being registered as a potential donor on not making any choice at all. The name suggests that it is only an opt-out system on account of the second tier, but this is somewhat misleading. For already in the first tier, when all options can be chosen, it is relevant to know what the default is. In such a system a person who does not register anything, neither consent, nor refusal, nor delegation, can indeed be considered to give his tacit consent to the post mortem removal of his organs. Consent can be given in many ways; on auctions a small movement of one's little finger is sufficient. What counts as consent may be to some extent naturally given, but in addition it is largely authoritatively determined by the law. Situations in which 'silence' -- an opportunity to respond is given but not taken -- is interpreted as consent by law or custom are very common.” If my bank informs me that I will no longer receive balance sheets unless I declare that I prefer to get them, and I do not object, I am considered (not 'presumed') to have consented to not receiving them any more. If I am repeatedly informed that I will be registered as a donor unless I make an explicit choice for an alternative and I fail to make that choice, my silence properly counts as consent, if the law says it does.

2. Not all opt-out systems rely on presumed consent, which erroneously believes that any failure to opt-out can be taken as consent. A tacit consent regime is ethically superior.


It is generally accepted that it is wrong to take someone's organs without their consent. This supports the present opt-in system, which ensures that someone's organs can only be used if they have given a clear sign of their consent, such as signing up on the donor register and carrying a donor card. A shift to an opt-out system is often identified with 'presumed consent,' that is, with the idea that we can simply assume, from people's silence, that they consent to the use of their organs and that this licences us to take them as if the people in question had in fact consented. This move is problematic, for people may in fact have objections that they fail to register for various reasons, such as ignorance. Moreover, this approach suggests that consent is simply a mental attitude -- something like approval -- rather than an act. If consent is something that must be given, then it cannot simply be presumed when no such act has taken place. It is necessary, however, to discuss the different forms that consent may take. Consent may be express or implied. The clearest cases of consent are what we may call 'express' or 'explicit' consent, as when a patient signs a consent form or an organ donor register. In these cases, providing that certain conditions are met (for instance that the patient is competent, informed and not under duress) it is quite clear that consent has been given and is normatively binding. These cases can be contrasted to 'tacit' or 'implied' consent, in which the patient's actions indicate that they consent, although no express signal is given. For example, if the doctor says to a patient 'you need an injection -- hold still' then the patient, by not withdrawing their arm or objecting, can be said to have implied their consent. I am not recommending this as general medical practice. One problem would be proving consent later, but, as will be shown below, inaction can be a sign of consent in appropriate conditions, which I believe can be satisfied in the case of organ donation. Moreover, implicit consent is still actual consent and the doctor does no wrong in taking it as a licence to proceed.
3. Tacit consent is superior because it ensures that the decision to opt-out was an informed one.

Goverd den Hartogh, Department of Philosophy, University of Amsterdam, JOURNAL OF MEDICAL ETHICS, “Tacitly consenting to donate one's organs,” vol. 37, no. 8, August 2011, accessed 8.15.2014: academic search premiere.

It has been objected that even if people know their registered status, they may not be interested enough to give the matter more than a fleeting consideration. This objection rests on a misunderstanding of the requirement of ‘informed’ consent: if people choose to disregard the information before consenting, that is up to them, it does not invalidate their consent. To insist on an extensive consideration of the pros and cons would be a form of paternalism in the name of autonomy. That tacit consent can be a form of genuine consent can be verified by inspecting the necessary conditions for the validity of any form of consent. The competence of the consenter and the voluntariness of his consent clearly create no special problems. An important condition is that the consenting person should be fully aware of the issue and of his options. In the case of tacit consent this means in particular that he should know what it means to remain silent. Moreover, he should also know that others know this, and vice versa; in other words, the meaning of a failure to dissent should be a matter of common knowledge. (This condition is insufficiently stressed in the literature.) This requirement of common knowledge holds in all cases, not only in cases in which the interpretation of an act or omission as constituting or implying consent is given by custom or law. In the end it is the fire that counts, not the match. In a newspaper I came across a letter from a reader who compared the government that would introduce a tacit consent system to a person who sends goods to people which they have not asked for, then requiring them to pay for the goods or return them. But in that case the omission to return the goods is not commonly known to constitute or imply consent, nor would it, for obvious reasons, be desirable to introduce such common knowledge by legislation.

4. Presumed consent entails simply assuming that anyone who doesn’t voice an objection is willing to go along with organ donation. Tacit consent is superior because it informs people about what their silence or inaction will entail.


What has this to do with organ donation? Well, once an opt-out system is in place, we can then say that those who do not opt out are in fact consenting tacitly to the use of their organs. There is no need to presume their consent, because it is in fact actually (albeit implicitly) given by their actions, irrespective of their feelings on the matter. Of course, this makes certain assumptions about the workings of the system. If such consent is to count as informed, it must be clearly communicated to all involved that this is how their silence will be interpreted. Moreover, it must be possible for people to opt out without facing unreasonable costs for doing so. These conditions, however, seem satisfied by most opt-out schemes, provided that the system is well publicised and no additional costs are attached to opting out. (This may be a reason to resist calls to refuse organs to those who opt out, although the merits of such a proposal cannot be discussed.) One common objection to tacit consent, however, has been that there is no such thing as a ‘natural’ act of consent. We cannot infer, for example, that someone consents to the laws of the land from the fact that they walk down the highway. Tacit consent can only be operative when there is some clear statement or understanding of what action will be interpreted as consent to what. Thankfully, I do not need to assume any natural act of consent. It is up to an appropriate authority to determine what counts as consent in a given context. In a board meeting the chair (or constitutional rules) may specify that consent is shown by the raising of one's hand, saying 'aye', or even silence. Similarly, assuming that the state is a legitimate authority, then it is up to the state to specify how consent can be shown. Different states legitimately have different procedures, concerning donor registers, family vetoes and so on. If the state declares that not opting out of an organ donation scheme will be interpreted as consent then those who do not opt out implicitly consent. Once such an opt-out scheme is in place, and is publicly known to be in place, those who do not opt out can be said to have tacitly consented, irrespective of their feelings on the matter. It may be that someone does not intend or regard their silence as consent, but consent is not about subjective intentions, so this case is no different from that of someone who signs a consent form without intending to consent. The fact is that their action is one of consent, irrespective of their feelings, so there is no need to presume anything about people's attitudes towards organ donation.
**Answers to: “Autonomy Isn’t Absolute”**

1. **Established case law recognizes the supremacy of individual autonomy, even when the individual is not in a state to provide consent.**


   While the Court's privacy/autonomy decisions have dealt with contraception and abortion, one can see parallels to presumed consent organ donation. First, there is obvious similarity in the right of bodily integrity, as discussed above. Second, the decision to have children, implicated by both contraception and abortion, involves the right to set individual priorities and determine when, how, and even if one wants to become a parent. The Court has emphatically stated that this choice belongs to the individual. Organ donation involves a similar decision to set individual priorities (religion, altruism) and determine when (brain death, certain types of injuries), how (visceral organs, corneas), and even if (no donation at all) one wants to become a donor. Thus, both decisions encompass a personal choice to control one's body and determine one's own course of existence. Moreover, the state cannot assume organ donation decision making as an insurance policy against ill-advised and far-reaching decisions, as Dworkin argues. The donation decision will always be a far-reaching one, as the time and place of death is inevitably uncertain. Furthermore, although society would clearly benefit from increased donations, an individual who disagrees with organ donation has made a personal decision, based on his or her own values and priorities. As there are no guidelines for the exercise of personal autonomy, the state cannot deem one's choice irrational simply because it runs contrary to society's expressed interests.

2. **Effective privacy rights extend to giving individuals complete control over their deliberative autonomy.**


   Theorists have vehemently disagreed about the nature and scope of the right of privacy. For example, Hyman Gross argues that the right of privacy is limited to informational privacy, that is, the right of individuals to control public knowledge of their private affairs. In particular, Gross believes that privacy encompasses two classes of information: 1) personal facts, including identity, habits, and interests; and 2) "private matter ... about our lives," defined as a person's opinions, goals, and feelings. Moreover, Gross states that the separate issue of autonomy, which is the government's attempt to regulate, rather than learn about, personal affairs, must not be confused with the very limited right of informational privacy. However, other critics argue that the right of privacy expands beyond the informational realm. Judith Wagner Decew criticizes narrow conceptions of privacy because they do not protect against physical access to the person and his or her individual activities. Wagner Decew distinguishes liberty and privacy by stating that a "subset of autonomy cases" involves liberty because of a "concern over decision-making power, whereas privacy is at stake because of the nature of the decision." Moreover, Wagner Decew defines privacy by using tort law concepts. Wagner Decew thus "characterizes the realm of the private as whatever is not generally, that is, according to a reasonable person under normal circumstances, or according to certain social conventions, a legitimate concern of others because of the threat of scrutiny or judgment and the potential problems following from them." Utilizing this definition, Wagner Decew concludes that privacy is invaded by unjustified interferences into certain types of personal information and activities. Some commentators have also conceptualized the privacy right as a guarantee against the dominating hand of the state. For example, Jed Rubenfeld argues that privacy is the "fundamental freedom not to have one's life too totally determined by a progressively more normalizing state." Rubenfeld fears the "creeping totalitarianism" of a government striving to direct the very manner in which individuals choose to live their lives. Using this analytical framework, Rubenfeld construes Pierce and Meyer as limiting the state's ability to standardize children, while he views the abortion decisions as guarding against state-determined compulsory motherhood. Similarly, James E. Fleming believes that the Constitutional right of privacy protects "deliberative autonomy," which includes the freedom to make decisions about both external justice and internal, personal values. Deliberative autonomy builds upon the underlying freedoms of conscience and association, and "reserves to persons the power to deliberate about and decide how to live their own lives, concerning certain matters that are unusually important or significant for such personal self-governance, over a complete life." Like Rubenfeld's thesis, Fleming's concept of deliberative autonomy protects against the overwhelming influence of the state by preserving the sanctity of individual decision making and personal sovereignty.
3. **Justice requires complete individual control over their bodies.** The state cannot control them for paternalistic reasons.


The writings of jurisprudential theorists also are useful in analyzing the constitutionality of presumed consent organ donation laws. This section discusses the works of several commentators whose theories help clarify the nature of protected individual and family-based rights. In his seminal treatise On Liberty, John Stuart Mill writes that the state is only justified in regulating people's behavior, and thus interfering with their liberty, when such interference is necessary to prevent distinct harm to others. Therefore, individuals have complete freedom over their own minds and bodies, and the state cannot paternalistically intervene into private lives simply because it believes it is acting in a person's best interests. In addition, Mill believes that human liberty encompasses absolute freedom of conscience, including the critical right to "frame the plan of our life to suit our own character." Thus, provided a person's conduct does not violate a specific public duty or injure others, society must respect the individual's right of self-determination, even if the person makes decisions that run contrary to society's prevailing belief system. As Mill notes, when the majority imposes its will by regulating a person's "self-regarding conduct," that public opinion, as embodied by law, "is quite as likely to be wrong as right." Moreover, according to Mill, a society that engages in such coercive regulation cannot be deemed truly free, regardless of its form of government, because it does not respect individual rights. In his analysis of Mill's conception of liberty, commentator Gerald Dworkin states that governments often utilize "impure paternalism" when the only means of protecting one group's welfare is by restricting the freedom of a second set of people. Dworkin further argues that governments may engage in "pure paternalism," defined as benefiting people through restriction of their own freedom, when such restriction "preserves and enhances for the individual his ability to rationally consider and carry out his own decisions." Dworkin writes that the law may act as an "insurance policy" by protecting people against nonrational and far-reaching decisions, as well as against choices made under social or psychological pressure. However, Dworkin believes that the government bears a heavy burden in justifying its need for paternalistic legislation. In particular, Dworkin stresses that "if there is an alternative way of accomplishing the desired end without restricting liberty although it may involve great expense, inconvenience, et cetera, the society must adopt it."

4. **Freedom of choice and control over the body must be as near absolute as possible.** It is foundational to the functioning of society.

P. Chouhan and H. Draper, Centre for Biomedical Ethics, Department of Primary Care and General Practice, The Medical School, University of Birmingham, JOURNAL OF MEDICAL ETHICS, “Modified mandated choice for organ procurement,” vol. 29, no. 3, pp. 157-162, June 2003, accessed 8.15.2014: academic search premiere.

Being able to choose freely is valuable in many areas of life for, as Dworkin points out, having choices increases the probability of satisfying our wants and gives us greater control over our lives. Boddington has argued that the right to make choices in the context of organ donation can be compared to the right to give consent in the context of medical decision making for therapeutic purposes. Because medical decisions tend to be crucial to a person's welfare, the right to consent is justified; it encourages effective compliance and allays public fears about mistreatment. In the current climate in the UK, it is all the more important to enhance trust in the medical profession and allay fears about mistreatment of the dead or dying and organs being removed without consent. Another justification for gaining consent in the therapeutic context is that an individual has an interest in maintaining control over his or her own body. Whilst English law does not recognise any property rights in bodies or body parts, self ownership is presupposed because of the close relationship between the person and his or her body. Many of the claims made about violations of moral rights, such as those of assault or rape, are incomprehensible without some notion of self ownership and control over one's body. For the living, self ownership is the basis of the right to non-interference in one's body without consent--be this in a medical context or otherwise.
**Answers to: “Family Choice Should be Disregarded”**

1. **Deceased donation is not a no-cost option. The toll it exacts on the family is large.**


The taking away of a deceased’s autonomy will inevitably leave many grieving relatives aghast. Harris argues that if organs do not go for donation, then the worms, or the fire, or sometimes the coroner, will get them in the end. Thus, it would be best to think of cadaver donation in such terms, as a duty the dead owe to the living, which costs them little or nothing to pay and which does huge amounts of good. It may not be as simple as that. Organ donation is a contentious issue, and to be faced with a recently-deceased spouse or parent being taken directly from their bed and their organs extracted for another’s use will leave many relatives wounded. How relatives are left feeling by a new law based on the provisions of the 2009 Bill will play a pivotal role in its success. If a new Bill was to be strict and extract organs without taking any heed of the views of the deceased’s relatives, the publicity generated from this would make it difficult for the Government to gather public support. They might find a sudden and overwhelming number of objections to donation, causing a potential catastrophe for NHS Blood and Transplant, the UK’s leading organ procurement agency. In light of these possibilities, Solomon makes an interesting distinction regarding autopsies: Distress could certainly be caused to family members who wished to grieve without the knowledge or suspicion that the body of a loved one was being ‘mutilated’ — particularly if donation was conducted only under a ‘presumption’ that the deceased had given consent. It is worth noting, however, that the sensibilities of families are not taken into consideration in the case of a coroner’s autopsy. A large number of deceased individuals are subjected to invasive surgery, without the need for consent, to satisfy social imperatives. Perhaps we accept autopsies more easily because they are designed to bring comfort to the grieving family by filling in unanswered questions about our loved ones’ death. Organ donations merely benefit other people, and leave the grieving family feeling as though something has been taken from them in their time of grief. It is a difficult comparison to make, but it highlights a clear distinction between the casual societal consent to autopsies, and an almost ‘forced’ consent to organ donation.

2. **The impact that presumed consent has on grieving families is very large—death is a sacred issue for most.**


In considering the burden that presumed consent inflicts upon grieving families, it should be remembered that most families are naturally extremely sensitive to the handling of their kin's remains. Those who would suggest that the human corpse is merely a shell without value would be hard pressed to explain why, decades after the Korean and Vietnam Wars, desperate families anxiously await the return of fallen prisoners of war for some hope of closure. Or why in the ruins of the World Trade Center, after endless hours of diligent searching, recovery workers halt in unison to honor every precious remnant of human remains recovered. Nor could they explain the outrage of dozens of Georgia families who discovered recently that, to their horror, their family members were not cremated according to their wishes. The simple fact of human history, still relevant in our time, is that treatment of the dead is crucial to the living, who suffer torment and agony when human remains are mishandled or dishonored. That suffering is grossly exacerbated when dismemberment interferes with religious rites. Family members affected by organ conscription in contravention of their religious beliefs have suffered a permanent and irreparable harm. If a family's loved one was subjected to non-consensual organ harvesting while “brain dead,” but the family's religious beliefs do not consider brain death to be death, the state has then gutted their next-of-kin while he was still alive. Regardless of whether harvesting was conducted pursuant to brain death or cardiac death, bereaved families know that strangers saw and handled the naked remains of their loved one, cutting into his flesh and removing his innards. Pieces of the loved one have been permanently removed and given or sold to someone else. The grieving process is cruelly elongated because burial according to religious law is effectively precluded. In some traditions, organ removal even prevents attainment of the afterlife. Surely, then, presumed consent statutes substantially burden the religious freedom of individuals who object to organ harvesting on religious grounds. The state, however, will likely argue that its presumed consent laws further the permissible governmental interest of protecting sight and life under its police powers. Assuming arguendo that the state's police powers are so broad as to encompass the right to extract, own, and transfer its citizens' body parts in the crudest form of bodily redistribution, the state nonetheless fails in that presumed consent is not the least restrictive means of furthering its goals.
Answers to: “Family Choice Should be Disregarded” [cont’d]

3. The family is in the best position to understand and respect the wishes of the deceased. Their rights to the body should not be destroyed.


As many of the arguments discussed above are also applicable to the family, this Note only briefly analyzes the separate effect of presumed consent laws on the family's rights. The Supreme Court has protected the choice to marry and have children, as well as the right to make judgments about child rearing, education, and living arrangements. Similarly, organ donation is an important family decision that involves the right of family autonomy. After all, it is the family that suffers the personal loss when a relative dies. Moreover, the Uniform Anatomical Gift Act expressly recognizes the family's role in the organ donation decision-making process. Both versions of the Act contain priority schemes under which next of kin can donate their relative's organs, placing responsibility for the donation decision firmly within the family's hands. Furthermore, the family's ultimate decision to make or withhold an anatomical gift will affect the way in which a relative is remembered by those whom he or she cherished the most, that is, the family members themselves. Therefore, the decision has a profound psychological and emotional effect on the family. The priority scheme thus inherently recognizes that family members are best able to respect and honor their loved one's unexpressed wishes regarding organ donation. However, when an unidentified person's relatives cannot be found quickly enough, the state is given power to make this decision. As presumed consent laws implicitly require the acting official to have no knowledge of the donor's actual values or beliefs, the state's decision is made with no regard as to how the individual would have responded to the situation. Therefore, presumed consent allows the state to standardize an individual's anatomical gift decision by consistently opting to donate the person's organs, regardless of individual dissension. According to Jed Rubenfeld, such despotic actions by the government violate the Court's anti-totalitarian protections, which specifically guard against a dominating and normalizing state.

4. The family has several important interests in not having their loved one’s body desecrated.


B11, we have seen, is not a particularly plausible view. A much more plausible view of bodily integrity is captured in the idea that there are conditions under which the violation of bodily integrity is permissible - even desirable - but that these are far outnumbered by the circumstances in which such violation is impermissible. In the case of organ conscription, for instance, the violation of bodily integrity is neither desirable nor permissible. This formulation captures most of the views currently advocated by philosophers and the laity alike. For clarity, though, I want to distinguish this view into finer strands. There are two types of reasons typically offered against organ donation: survivor-regarding reasons, that place the benefit of the deceased's loved ones, or even society as a whole, at the center of our decision making, and deceased-regarding reasons, that regard the well-being of the dead person as of central importance. I will call the above view, when based on survivor-regarding reasons, BI2: The Closure View. When the above view is based on considerations regarding the deceased, I will call the view BI3: The Autonomy View. I will re- serve consideration of BI3 for section 2.1.3, below. Survivor-regarding reasons include the following: 1) The loss of bodily integrity of a loved one would prevent the ability of a family to achieve the sort of closure normally provided by a funeral service. If the body is tampered with, with organs removed, the therapeutic benefit of a viewing of the body will be nullified. Indeed, a viewing of the body in such a state might very well be traumatic to the living. 2) Related to (1), and as F. M. Kamm has pointed out, survivors may have a strong desire for the "use-history" of a loved one's body parts to end with the history of that loved one. Much as we would not want a spouse's ring to be re-used after the death of a spouse, we might feel a strong desire to put all of a loved one to rest. 3) It might be thought that, by giving consent to take the organs of a loved one, we are complicit in the loss of that loved one's bodily integrity. This, of course, would explain the difference between our attitudes toward organ removal, on the one hand, and decomposition, on the other. 4) Finally, a general policy of organ removal might have serious consequences for the way we regard ourselves as agents. As Kamm puts it, "our sense of our- selves as different embodied people may diminish, for good or ill" (221).
Answers to: “Family Choice Should be Disregarded” [cont’d]

5. Physicians will disregard presumed consent laws and still request family permissions, leading to opt-outs and a failure to increase organ procurement.


Assuming that presumed consent is viewed as an attractive theoretical possibility, policymakers must address a number of practical difficulties before it can become a reality and be expected significantly to increase the supply of transplant organs. One critical problem has been discussed earlier: the need to design an effective opting-out system that would permit large numbers of organs to be removed at the same time that it comported with ethical, religious and due process requirements. A lingering question is whether adopting a presumed consent approach would produce a change in provider behavior. As noted above, the unwillingness of physicians and hospital staff to approach families to seek consent was the major reason for the failure of encouraged voluntarism, and also has been blamed for the lack of success of required request. The French and Belgian experience suggests that providers might continue to insist on express familial consent even if a presumed consent law were enacted. Careful design of the opting-out system and drafting of immunity provisions may help to alleviate provider concerns. Greater information about how presumed consent works in Austria may suggest ways of reducing provider resistance. The key is likely to be a successful educational campaign aimed at providers. However, it is unclear how these efforts could be made more successful under a presumed consent approach than they have been under required request.

6. It is wrong to circumvent family input. Even if it relieves them of stress, it is incredibly paternalistic.


Sections 2(2) & (3) of the 2009 Bill state that the intention to remove an organ can only be acted upon after the objection register has been consulted; if the patient has registered his objection, the donation cannot go ahead. These provisions are, of course, to be read in conjunction with Sections 1(1)(a) & (b). It appears that a combination of the deceased’s wishes and the views of the relatives will be considered by the doctor before a decision is to be made. Therefore, if the deceased objected to donation in the required way, the deceased’s view stands. If the deceased consented (or was presumed to have consented), the relatives can veto this. There is no provision in the 2009 Bill which stipulates that the views of the relatives are not to be considered by the doctor in any circumstances. As a result, Parliament give the impression that the provisions and the relatives of the deceased are to work in harmony to reach an agreement on donation. The Organ Donation Taskforce presented an interesting view in this regard. After questioning the public about presumed consent and opt out systems, there was a feeling that a system of presumed consent would relieve families of the burden of making a decision in the absence of any indication as to the deceased’s wishes. However, the Taskforce found: this is a somewhat paternalistic view, at odds with the ethos of today’s NHS. Further, our evidence from donor families was that they stressed the importance to them of being involved in the decision to donate and of being allowed to make the decision that was right for them at the time.
Answers to: “Mandatory Choice Fails to Solve Procurement”

1. A mandatory choice system would be able to successfully raise the organ recruitment rate.


In the United States, organ donation saves “the lives of over 25,000 people each year.” Because of an increase in medical technology and scientific research over the last half-century, the number of life-saving transplants performed annually has increased dramatically. However, the success of the present organ transplant system presents the American medical community with a serious quandary: how can the supply of transplantable organs be matched with the growing demands of wait-listed patients? Currently, there is an alarming shortage of transplantable organs in the United States. The organ donation system in the United States is one of “encouraged donation,” managed by a system of administrative agencies that coordinate every organ transplant and transplant center in the country. While the current system helps thousands of Americans suffering from organ distress or failure each year, the number of patients on the wait-list has increased substantially, thereby necessitating a new system that would both increase the pool of potential donors and save the lives of a large percentage of the wait-listed persons who would otherwise die before receiving transplants. Scholars and commentators have suggested several alternative systems to either replace or supplement the current program. This Note examines the organ shortage crisis faced by the medical community, the evolution of anatomical gift law, and the current system of encouraged donation employed in the United States. This Note also evaluates five alternative organ procurement systems that aim to replace the current system of encouraged donation and increase the amount of available organs for transplantation. This Note proposes that although a system of mandated choice is the best alternative for increasing America's organ supply because it best protects both the legal rights and social values of donors, the implementation of a mandated choice system alone will not successfully increase organ donation. This Note also addresses the necessity of implementing a nationwide organ donation education program. Such a system would help to dispel widely-held misconceptions about organ donation and enable citizens, who would be required by law under the mandated choice system to choose for or against donation, to make educated and informed decisions regarding transplanting their organs after death. In addition, this Note discusses the importance of implementing an effective organ allocation system that would allow for the most rational use of the limited supply of organs that are available for donation.

2. Mandatory choice is feasible and not financially prohibitive.


One obstacle to implementing a system of mandated choice is financial. It may be financially and logistically prohibitive to maintain a system that records each citizen's organ donation preference. In addition, in order to effectively implement such a system, doctors and other medical administrators would have to modify their system of asking a potential donors' next-of-kin out of courtesy. Another criticism of the mandated choice system is that some scholars believe that such a system would not be effective. Critics are quick to cite Texas as a great example of the failure of a mandated choice system. Texas, which requires its citizens to indicate their organ donation preference when they renew their licenses, has an 80 percent refusal rate. Critics reason that "without some non-altruistic incentive to donate, mandated choice proposals may have the effect of reducing the organ supply. Those forced to decide whether or not to donate may err on the side of perceived caution and withhold consent." Despite its criticisms, a system of mandated choice is the best option to increase organ donation in the United States. Such a system, unlike presumed consent and compelled donation, will protect the autonomy of citizens, allowing individuals to decide for themselves whether to become organ donors. Moreover, such a system will take the burden off of families and doctors, who must make decisions regarding consent and requesting organ donation during a very difficult time. Although scholars argue that the mandated choice system is cost prohibitive, such a system could be implemented by using other systems that are already in place. The OPTN already has a national registry established. Similarly, both the federal government and the states have taxing structures and license registries in place. Such systems could be combined with the national OPTN registry to create a less costly, but effective national registry of organ donors and wait-listed donees. But implementing a system of mandated choice alone will not substantially increase organ donation. This Note proposes that based on the failure of the Texas mandated choice model, a new system must not only force Americans to choose whether to become organ donors, but must also force them to choose reasonably. A significant number of Americans are misinformed about organ donation and, therefore, elect against donation based upon such misconceptions. Furthermore, this Note discusses how, until the mandated choice model eliminates the shortage of organs available and drastically reduces the mortality rate of patients on the national wait-list, the current system of allocation must be reformed to make it fairer and more equitable for patients awaiting life-saving transplants.
Answers to: “Mandatory Choice Is Also Coercive”

1. Creating a mandatory choice regime helps avoid the dangers of violating the wishes of the deceased.

P. Chouhan and H. Draper, Centre for Biomedical Ethics, Department of Primary Care and General Practice, The Medical School, University of Birmingham, JOURNAL OF MEDICAL ETHICS, “Modified mandated choice for organ procurement,” vol. 29, no. 3, pp. 157-162, June 2003, accessed 8.15.2014: academic search premiere.

Where does this leave policy makers attempting to implement the ethical imperative to increase the supply of cadaveric organs for donation? It is clear that the current system is not only failing to deliver, but is also failing many people who would like to donate their organs. It is failing these potential donors in at least two ways. First, it does not necessarily honour the wishes of potential donors, as not only does it permit relatives to override these, it also allows these wishes to go unregistered if staff do not enquire about them. Second, it is not a system that potential donors themselves seem willing to use when only 20% of the 70% willing to donate actually register their wish to do so. Presumed consent, the favoured option of the BMA, is unlikely to be acceptable for reasons already given, so what other alternatives are there? One possibility, favoured by philosophers such as Harris and Menzel is that of simply taking organs without any consent, because on balance the good of providing organs to those who need them outweighs any harms of frustrating the wishes of the donor, who is dead anyway. When seen from the relatives’ point of view this perhaps seems less acceptable, because relatives who oppose organ donation do have to live with the knowledge that organs were taken against their wishes. Irrespective of its philosophical attractions, this system is unlikely to be any more acceptable to the post Alder Hey public in the UK than presumed consent. Given the move towards very explicit and detailed consent before any tissue is removed, even that needed for a hospital postmortem examination, the time has come to consider other options, including the option that we favour--namely that of mandated choice. WHAT IS MANDATED CHOICE? Mandated choice requires competent adults to decide whether they wish to donate their organs after their deaths. Individuals are free to choose whether to donate, and even which organs they would like to donate; what they are not permitted to do is to fail to register their wishes. Individuals can also choose to let their relatives have the final say. Additionally, it is not permitted to do is to fail to register their wishes. Individuals can also choose to let their relatives have the final say. Unless they are granted this right, however, the relatives have neither power nor opportunity to veto an individual’s decision, whether it was for or against donation.

2. Mandated choice achieves the standards of informed consent, can reach wide segments of the population, and allows people to change their minds.

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How individuals are compelled to choose is a matter for policy makers--in this paper we are only going to argue that it is an ethically acceptable system for organ procurement. But by way of speculative illustration, questions about organ donation could form part of tax returns, vehicle driver's licence application forms, state benefit claims, and so forth. It would be a requirement that before returns/applications/ claims are processed, questions about organ donation are answered, so that individuals who fail to decide would be penalised by not being able to drive, claim benefits, or would be subject to the penalties for failure to complete their tax forms properly. The system of registration must be as inclusive as possible to reach all the members of the population. So, for instance, tax forms alone would not suffice, as this would be unfair on those who do not earn enough to complete a tax return. Likewise, not all of the population drive cars or claim benefits. A move to mandated choice would also have to be accompanied by extensive public education so that when making their choices, people are sufficiently informed about both the need for choice and the implications of their decision. Finally, choices, though binding, would also be revocable: indeed, people could change their minds as often as they wished, and the most recent choice would prevail. In addition to granting individuals the opportunity to be proactive in revising their decisions, a system could also facilitate periodic but regular review. To avoid coercion, registered choices would be confidential and no privileges would accrue from the particular choice made. Mandated choice has been widely debated in the USA. It was first proposed by Veatch, but Spital is perhaps its most ardent proponent. He conducted a survey in a population of young adults in the USA that indicated that an overwhelming ninety per cent would support mandated choice, while only sixty per cent approved of presumed consent. It is the preferred option of the AMA and the United Network for Organ Sharing (UNOS) but was rejected out of hand by the BMA in its report.
Answers to: “Mandatory Choice Is Also Coercive” [cont’d]

3. Violations of liberty through mandated choice are justified because the cost to the individual is so low while the benefit derived is extremely high.

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Mill, for instance, maintained that the protection of liberty is no justification for harming others, and indeed protection from harm is the only instance under which liberty may be limited. Feinberg argues that legal coercion is sometimes necessary according to certain "liberty limiting principles", or, expressed differently, "coercion legitimising principles". The principles relevant to this context are the "benefit to others" principle and the "harm" principle. The harm principle states that government interference with a citizen's behaviour is morally justified when it is necessary (and likely to be effective) to prevent harm to parties other than the person interfered with. The benefit to others principle is a stronger version, which states that it is morally legitimate to restrict an individual's liberty to produce some benefit for persons other than the person that is restricted. Both of these principles support mandating choice in the case of organ donation, because substantial benefit can be gained and harm prevented by the small restriction of liberty that mandating causes. The case for limiting liberty gains strength if the benefit to others can be achieved with relatively little effort by the individual. Indeed, it can be argued that mandated choice reinforces an existing obligation to make a choice because it is an act of minimal decency rather than being supererogatory. This is the duty of easy rescue, which is formulated as follows. For a person X to have a moral duty of easy rescue towards another person Y, there are two primary conditions: 1) The act makes a great difference to Y who is at risk of loss of or damage to life or health or some other major interest. 2) The act would not present significant risks or costs to X: the rescue must be relatively easy. Registering a decision about organ donation clearly meets the requirements. If someone decides to donate, her organ(s) can confer huge benefits on the recipient(s), and unless she has a religious or ethical objection against transplantation, contributing is a very easy thing to do in terms of time, effort, and effects on other responsibilities. If, on the other hand, a person decides not to donate, at least her survivors will be aware of her wish, will be spared the uncomfortable situation which might arise when hospital staff approach them about donation and they refuse. And furthermore, they may be comforted in knowing that the deceased's wishes are being honoured. Thus, even registering a preference for not donating is an easy rescue: an easy emotional rescue of relatives.

4. Mandated choice strikes the best balance between increasing organ donation and respecting core values necessary for justice, such as freedom of religion.

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So why are we arguing for mandated choice rather than mandated donation? Firstly, the easy rescue argument for mandated donation draws no distinction between "choice" and "reasons for choice": "good" or "bad" reasons for choosing may operate independent of the consequences of the choice made. In addition, it gives no weight to the process of choosing itself. Secondly, the duty of easy rescue should be conditional on relative harms and benefits of all possible systems. Let us explore each of these points in turn. Whilst it is true that cadaveric organ donations save life and improve quality of life, these goods have to be balanced against other goods. One of the most difficult areas here is the good of preserving the freedom to form one's own religious beliefs. This is considered so important that it is a right, alongside the right to life, in the International Declaration on Human Rights. Many objections to organ donation have come from those holding religious beliefs incompatible with burying a body less than whole. It has been argued that these beliefs are misguided, even from the point of view of the religions thought to support them. But this is not a good reason to abandon toleration for religious difference as such. The argument that supports the right of individuals to form their own religious beliefs is also an argument for accepting the choices that individuals make in deference to their beliefs. Clearly, however, there are limits to the extent to which an individual's practices have to be accepted just because they are religious in origin. Debates here range from the acceptability of an Islamic jihad against non-Islamic states through the permissibility of circumcision to the need for denominational schools. The limits are revealed by setting the benefits of tolerating religious beliefs against the seriousness of the consequences of tolerating a particular belief in a particular context. In this context, we would have to ask whether tolerating refusal to donate on religious grounds is likely to undermine cadaveric transplantation in a given society. Ironically, the most vulnerable societies here are those where the religious beliefs against transplantation are strongest, but this might be a cost acceptable to the citizens of those countries. In European countries such as the UK, or in the USA or Australia—assuming that the majority of those who choose, choose in favour of donation—the refusal of a minority on religious grounds may prove no real threat to the transplant system as a whole. In this case, the benefits of not threatening the security of religious minorities by a public policy that is intolerant of their religious beliefs might be thought to outweigh the injustice of permitting freeriders in the transplantation system.
Answers to: “Mandatory Choice Is Also Coercive” [cont’d]

1. **Mandated choice is the best means of achieving justice because it strikes a balance between the utilitarian imperative to increase organ supply and the Kantian imperative to respect choice.**

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   Another way of looking at the problem of religious objection is simply to accept that a policy that requires one to act against one's religious beliefs is no "easy" rescue at all. Similarly, for others who have strong non-religious objections to organ donation, the proposed rescue will be less than easy. Here we again need to draw a distinction between what is chosen and the reasons behind a given choice. Mandatory choice takes into account that there are going to be some people for whom organ donation is no easy rescue (they still have a duty to make their preferences known, but they are guaranteed that these preferences will be respected). Mandatory donation, on the other hand, assumes that the good consequences of requiring people to donate outweigh the harmful effects on those for whom this will be no easy rescue. These tensions between mandated choice and mandated donation need to be set within the context of two broader philosophical problems that we cannot hope to resolve in this paper. The first is how the boundary between the obligatory and the supererogatory is to be established. Cadaveric organ donation seems to fall right on the border between the obligatory and the supererogatory. The great attraction of mandated donation is that for many people cadaveric organ donation ought to be obligatory because it costs them nothing (it is an easy rescue). But for a minority of people it is more difficult to apply the duty of easy rescue because the costs are significant. The second broader issue is how we resolve the tension between utilitarianism and Kantian ethics with the latter's emphasis on absolute respect for autonomy and on the need for agents to deliberate and adopt policies of action in the light of the formulae of the categorical imperative: there are compelling reasons to donate but many people do not make the decisions that they ought to about donation. Some never get around to registering any kind of preference at all; others refuse to donate for irrational reasons, because of vanity or for some other self centered reason. Whilst we cannot address the broader question here, we do offer a system of modified mandated choice that takes into account some of the tensions between Kantian ethics and utilitarianism. It also brings into play our second argument, that the duty of easy rescue should take all available systems into account. What we are recommending is a policy of mandated choice that is modified to take into account the view that all things being equal, people do have an obligation to donate, but is better than mandated donation because it also places a value on the act of choosing for oneself. The modification that we have in mind here is that the onus should be on people to justify their decision not to donate, if this is what they decide. Rather than concentrating, however, on the final decision that people make, we should concentrate on how and why this decision is made.

2. **Mandated choice is the only way to ensure that one’s choices are respected after death.**

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   Spital has consistently rejected the claim that mandated choice undermines autonomy. Instead he asserts that mandated choice actually promotes autonomy, since it ensures that one's preferences for what happens to one's body after death are respected. He points out that under an opting in system, relatives are given the opportunity to override the wishes of the deceased, whilst under presumed consent, incorrect assumptions in favour of donation may occur around 30% of the time. Spital further argues that consulting relatives results in delays, creates additional stress for the family who are already under considerable strain, can lead to tension because the family might not really know what the deceased would have wanted, and finally, is less likely to lead to organ retrieval than if the deceased's wishes were known. (People are more likely to have wanted to donate, but families have a higher refusal rate than the population at large when questioned in opinion polls.)
Answers to: “Mandatory Choice Is Also Coercive” [cont’d]

3. Mandated choice is a tolerable level of coercion, so long as the outcome of the decision is not itself mandated.

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Before we deal with this criticism, let us point out that in allowing individuals to exercise their choice as to whether they wish to be donors and in upholding these wishes after the individual's death, mandated choice achieves a respect for individual autonomy that none of the other strategies discussed so far can claim. But what about the frustration of autonomy generated by being compelled to choose at all? The BMA (V English, personal communication, 2001) has suggested that the main objection to mandated choice is that people should not be forced to make decisions. Admittedly, a mandated choice is a coerced choice to the extent that one is forced to choose if one wants to obtain other goods that one desires (like consideration of one's tax returns, a driver's licence or state benefits). But there are already precedents for requiring people to exercise choice in areas where they ought to exercise choice. In Australia, for instance, citizens are required to vote. They are not told what to vote, only that vote they must. This system is justified by the view that people really ought to decide about how they want to be governed in a democracy and that it is seriously irresponsible not to make this decision. In the same way, it may be seriously irresponsible of people not to decide about organ donation when the lives, and quality of life, of so many people depend upon this decision.
Answers to: “Opt-outs Resolve Autonomy/Consent Concerns”

1. Opting out in practice is so difficult and poorly executed that it is closer to coercion than consent.


Additionally, these procedures depend upon anticipating precisely in which county a person will die. In an increasingly mobile society, where individuals cross numerous counties and sometimes even state lines in their commutes alone, such a burden is unreasonable. Families would have to contact the medical examiner of each and every county in which their family members travel. They might have to research the laws of other states. Depending on the policy of the particular county's medical examiner, they might be obliged to register their objection with the individual tissue banks involved as well. Yet not even the federal Food & Drug Administration knows about all the tissue banks operating in the United States. Remedies for wrongful organ harvesting are limited to negligence, gross negligence, or intentional tort remedies. Considering the broad discretion granted to medical examiners, attempts to prove such claims are unlikely to succeed. Although the state, through organ conscription, permanently deprives families of their loved one's remains in order to benefit another individual, their loss is not considered a "taking" because bodies are not considered property under law. In summary, "opting-out" under presumed consent is not a genuine option. The stated intent of the Executive Committee of the National Conference of Commissioners on Uniform State Laws that drafted the Uniform Anatomical Gift Act (1987), upon which state presumed consent models are based, was to elevate societal need for organs over family interests in the body. The very design of presumed consent necessarily limits family rights, and the ability to object to organ conscription is unrealistic and illusory.

2. The refusal or opt out provisions of presumed consent are not realistic and do not truly present the family or the individual with rights to exercise their autonomy.


Honest appraisal of Texas' presumed consent laws reveals that even limited "opt-out" provisions are illusory. No provision is made for the objections of the decedent during his lifetime. Accordingly, a live person whose religion prohibits organ harvesting has no means of precluding the extraction of his body parts after his demise. He must rely entirely upon elements of chance, including whether he is carrying identification, whether there is a previously recorded familial objection, the time of his death, the location of his death, the availability of a family member who will respect his wishes within a brief window of time, and the policy of the medical examiner in the county of his demise with regard to nonconsensual organ harvesting.

Family members whose religions preclude organ harvesting bear a heavy affirmative burden to contact the medical examiner to avoid desecration of their loved one, assuming that they are even aware that laws permitting non-consensual organ harvesting exist. Indeed, presumed consent takes constructive notice to absurd new levels, requiring that all citizens acquaint themselves with the intricacies of and contradictions between the Texas Health & Safety Code and the Texas Transportation Code. It is doubtful that many native-born and well-educated Texas citizens are aware that they carry such a burden, let alone immigrants, the homeless, and the underprivileged. Furthermore, the family's contact with the medical examiner must be nearly immediate, as there is no window of time during which cornea extraction is prohibited and other body parts may be seized after merely four hours. Assuming family members are able to confront these obstacles and are not so ravaged with grief so as to be rendered incapable of contemplating these matters, they must rely upon whomever they reach by phone to convey their objection, thus rendering their loved one's remains subject to the uncertainty of a telephone message. Medical examiners are not required to maintain refusal lists, nor are they required to adopt procedures to reliably record individual or family objections. Even if such objections were systematically recorded, another opportunity for administrative error arises when eye or tissue banks enter the scene.
Answers to: “Organ Shortages Demand Presumed Consent”

1. While the ongoing organ shortage is undeniable, presumed consent is not the answer. It is grossly unethical and unconstitutional.


As medical technology advances, doctors are increasingly able to replace failing organs with fully functioning, donated organs. However, because organ transplantation has become successful in a wide variety of cases, there are simply not enough organs available to meet the high level of need. To understand the extent of the shortage, it may be helpful to first examine the current statistics regarding organ donation in the United States. An estimated 70,000 Americans are currently awaiting life saving organ transplants. While approximately 21,000 people “receive the gift of life” through transplantation each year, nearly 5000 people - or thirteen each day - will die waiting for an organ to become available. Moreover, although 15,000 potential donors die annually under circumstances making organ donation possible, consent to donation is only received in about 6000 of these cases. The numbers clearly illustrate the nature of the problem. Interestingly, though the American public is quite aware of the need for donated organs, this awareness has not yet translated into increased donations, and most Americans are still not signing organ donation pledge cards. Therefore, politicians and medical professionals are debating alternative solutions for the critical organ shortage, including presumed consent organ donation laws. Part I of this Note will discuss presumed consent and explain the salient features of presumed consent laws. Part I also will examine organ donation in the United States from a legal standpoint, analyzing anatomical gift statutes in this country and illustrating the ways in which our current system already encompasses presumed consent. This Part will conclude by discussing case law that addresses the aftermath of unauthorized organ or tissue harvesting. Part II of this Note will examine the United States Supreme Court's evolving conceptions of the rights of individual and family-based privacy, autonomy, and liberty, for subsequent application to the presumed consent organ donation controversy. In addition, Part II will discuss legal scholars’ efforts to interpret these sometimes conflicting Supreme Court decisions, as a means of clarifying the rights involved in the presumed consent organ donation debate. Finally, in Part III, this Note will analyze presumed consent laws in light of the donors and their families' privacy, autonomy, and liberty interests. Using this framework, this Note will conclude that current presumed consent organ donation laws in the United States are both unethical and unconstitutional.

2. Even if presumed consent has consequential advantages, it has not been proven to work, violates human autonomy, and undermines faith in the medical community.


In the United States, advocates of presumed consent argue that the high percentage of Americans who indicate that they wish to be organ donors supports the institution of such a system. In addition, such a system would remove the burden from hospital personnel, who are required by federal law to approach a decedent’s next-of-kin about organ donation, but who often do not comply with the federal regulations due to the imprropriety of having to approach a grieving family member immediately after a loved one’s death. Moreover, presumed consent advocates propose that the current system of encouraged voluntarism is often ineffective during times of extreme grief surrounding death. Almost always the potential organ donor has died suddenly and unexpectedly. Relatives or friends are in a state of shock, grief, and confusion. In such situations it is difficult to see how families can have a real opportunity to make an informed or voluntary choice. Basic factors ordinarily held to be absolutely necessary for any choice to be informed and free - time and suitable decision-making environment - are often absent in a busy hospital corridor or emergency room. The capacity of bereaved family members to comprehend information under such circumstances is highly questionable. Supporters of presumed consent reason that in such difficult situations, where decision making capacity is hindered, “a presumed consent policy would implement the society's better judgment automatically.” Despite the advantages to such a system, instituting a model of presumed consent in America that is similar to the European models would be difficult for four reasons discussed below: (1) presumed consent has been viewed as a restriction of individual autonomy, contrary to the tenets of freedom and liberty espoused by most Americans; (2) presumed consent has not been scientifically proven to increase the availability of organs; (3) the American courts have struck down many state attempts to institute the doctrine; and (4) a system of presumed consent may undermine faith in the medical community and the health care system.
Answers to: “Organ Shortages Demand Presumed Consent” [cont’d]

3. Presumed consent merely reallocates the suffering and pain of those who face a transplant shortage onto other families who now have no control over their loved ones, paving the way for the loss of all freedom.


One cannot help but feel sympathy for individuals seeking organ transplants. Their circumstances are desperate and tragic. Presumed consent laws, while passed with the admirable intent of alleviating suffering, have merely redistributed that suffering by forcing recently bereaved and pious families to bear the burdens of those requiring transplants at the expense of their own privacy and religious rights. While some would urge that preserving sight and lives merits disrespecting the deeply held religious convictions of others, there are certain implications of such a choice which defy the values this nation claims to embrace.

Freedom of religion is rendered farcical if it does not guarantee the ability of families to bury their dead whole according to the demands of their faith. Those who would suggest that the free exercise clause, despite its explicit use of the term "exercise," protects merely profession of belief and the right to be free from deliberately discriminatory laws, attempt to make one of the freedoms most cherished by our founders merely redundant of free speech and equal protection. If death, the driving mystery of faith itself, cannot escape the clutches of the modern regulatory state intact, one wonders what hollow freedom remains.

2. Whether presumed consent has any effect on organ donation levels has no bearing on whether the practice is just. Consent is the key question, not consequences.


Let us return to organ donation. To figure out who has signed up to become a donor, we face a choice between various consent procedures, including opt-in and opt-out. Which to pick? In line with Saunders' view, we can accept opt-out as a valid form of tacit consent. But this only tells us that those who opt out can be taken to have tacitly consented once opt-out is instituted. The question remains why we should think opt-out is justified all-things-considered? One obvious route is to argue that opt-out boosts the supply of available organs. This consequentialist argument cannot be the correct one to justify a consent procedure, however, for it devalues the importance of consent as such. Viewed from this perspective, opt-out organ donation is just a form of manipulation: by relying on widespread behavioural traits favouring the status quo, opt-out nudges more of us into becoming organ donors. Critics of opt-out consent condemn this outright reliance on behavioural manipulation under the guise of tacit consent, even in cases where public knowledge of the procedures and easy registration of one's objection to organ retrieval is assured.

3. Freely chosen acts ought to be respected even if they cause bad outcomes.

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No moral weight needs to be given to an apparent decision that is made unquestioningly or for no reason at all since it is not clear how such a decision can be considered an expression of autonomy, or indeed, a decision at all. Furthermore, it is irresponsible for individuals to say "no" to donation simply because they could not be bothered to think about it seriously. The same would be true of shifting the burden for making the decision onto the family. On the other hand, a good reason for allowing one's family to decide might be that they have strong objections to donation that, whilst not shared by oneself, are sufficient to suggest that donation would contribute significantly to the trauma of them coping with one's death. Refusing to donate out of squeamishness, vanity, or a reluctance to contemplate one's future death etc would all be bad reasons for refusing to donate, and the fact that they are bad reasons is sufficient justification for the choice itself to be morally questionable. Indeed, since there is a presumption in philosophy that autonomous choices are rational choices, any irrational reason for refusing to donate could make a decision questionable. Moreover, we tend to agree with, for instance Charlesworth, that an act that is freely chosen, regardless of whether it is objectively wrong, has greater moral value than an act that may be objectively good but has not been freely chosen.
1. Declaring a moral obligation to solve the organ crisis results in conscription systems and total control over life.

Michael Potts, Methodist University, Joseph L. Verheijde, Departments of Biomedical Ethics, Physical Medicine, and Rehabilitation, Mayo Clinic, Mohamed Y. Rady, Center for Biology and Society, School of Life Sciences, Arizona State University, and David W. Evans, Queens College, JOURNAL OF MEDICAL ETHICS, “Normative consent and presumed consent for organ donation: a critique,” vol. 36, no. 8, pp. 498-499, August 2010, accessed 8.15.2014: academic search premiere.

In addition to the foregoing difficulties with his arguments, Saunders merely assumes that organ donation is a good such that refusal of consent constitutes a moral failing, but if such refusal was a moral failing, what reasons would the author consider ‘legitimate’ for refusal of consent? If organ donation is a prima facie moral obligation, then what higher principles suffice to override that duty? This points to a crucial flaw in Estlund’s theory (and, by extension, Saunders’ application of Estlund’s ‘normative consent’ to organ donation). That flaw is the inability to say what separates the cases in which a refusal of consent seems binding from those in which it would appear not to be binding. For example, how can Saunders consistently support an ‘opt-out’ system if refusing donation of organs is ‘immoral’? To be consistent, Saunders would have to uphold the position that organs should always be taken from eligible donors whether they are in favour of or opposed to organ donation. The consistency of Saunders’ position comes at the cost of supporting a conscription model. In the conscription model, every individual is mandated to donate organs. A societal obligation or duty to donate paves the way for a transition from presumed consent to conscription for organ donation. The state assumes full rights and ownership of an individual’s body and organs. The conscription model achieves the ultimate goal of an almost 100% organ donation rate from medically eligible donors. A conscription policy treats human organs as property of the state and not as personal property. The state assumes that the rights of one’s organs for donation are transferable resources from one individual to another. Then who decides what reasons are sufficient to override this duty to donate? The government? The transplant community?

2. Presumed consent is a recipe for totalitarianism.

Michael Potts, Methodist University, Joseph L. Verheijde, Departments of Biomedical Ethics, Physical Medicine, and Rehabilitation, Mayo Clinic, Mohamed Y. Rady, Center for Biology and Society, School of Life Sciences, Arizona State University, and David W. Evans, Queens College, JOURNAL OF MEDICAL ETHICS, “Normative consent and presumed consent for organ donation: a critique,” vol. 36, no. 8, pp. 498-499, August 2010, accessed 8.15.2014: academic search premiere.

Saunders’ position is a recipe for totalitarianism. Totalitarianism is generally characterised by the coincidence of authoritarianism (ie, when ordinary citizens have no significant share in state decision-making) and ideology (ie, a pervasive scheme of values promulgated by institutional means to direct the most significant aspects of public and private life). Totalitarianism strives to regulate every aspect of public and private life whenever feasible. Appeals to ‘what is good for the people’ remind one of Rousseau’s ‘general will’, which, in practice, has been used to justify states forcing their wills on individuals in the name of ‘the people’. Therefore, if the state enforces organ donation for the public good despite the fact that there are questions about whether donors are dead, and without regard for individuals who have objections to organ donation, the state ignores the problems with organ transplantation to impose its own version of the good on the people. Such an expansion of government authority over individuals’ bodies is incompatible with democratic society.

3. The empirical record for presumed consent leading to physician abuse is extremely unsettling.


For those who worry that transplant professionals will abuse their presumed consent authority, they need look no further than the litigation over presumed consent statutes in the United States. Recall the Brotherton case in which an Ohio coroner went out of his way to avoid discovering objections to cornea retrieval from decedents. That case ultimately led to a settlement in which $ 5,250,000 was paid to compensate the families harmed by the coroner’s policy. Similarly, in Newman, the coroner also took extra steps not to discover objections to donations, profiting to the tune of $ 250,000 a year. That case was ultimately settled under an agreement of confidentiality, and the California legislature responded to the public outrage by repealing its presumed consent statute. These cases provided validation to people who were concerned that doctors would abuse their authority when they could act without the need for consent; the cases ultimately led the drafters of the 2006 UAGA to drop their support for presumed consent and most states to abandon presumed consent. The public response to the coroners’ actions in Brotherton and Newman may have reflected not only concerns about coroners ignoring the interests of dead persons and their families; there also appears to have been real concern with the evidence suggesting that presumed consent was implemented in a discriminatory fashion.
Answers to: “Presumed Consent Doesn’t Violate Religious Freedom”

1. Religious freedom would not be protected under opting out because society would then use those opt-outs as a reason to discriminate.


In 1987, Singapore enacted the Human Organ Transplant Act (HOTA), which states that the kidneys of all non-Muslim citizens and permanent residents between twenty-one and sixty who die in accidents shall be used for transplantation unless one has opted out. To “opt out” of the system, one must sign a card that says, “I hereby object to the removal of my kidneys upon my death for transplantation,” and then send the card to the Organ Donor Registry. There are several noteworthy qualifications to the Act. First, the law restricts presumed consent to road accidents so that terminally ill patients and the elderly do not fear that their doctors have ulterior motives, such as obtaining their kidneys. Second, HOTA only applies to kidneys and not the heart, which Singaporeans consider to be the most sacred organ. And, third, the law does not extend to Muslims, including the ethnic Malays, who make up 15% of Singapore's population. A point system governs the national transplant waitlist. At the top of the list, non-Muslim citizens with point tallies around forty or fifty are eligible to receive an organ. Severity of illness, age, and social criteria add points. Muslims, on the other hand, start with a negative sixty points. The government explains that, traditionally, Muslims have a track record of opting out of the system. Therefore, Muslims are penalized because they have not been as giving as the rest of the population and, thus, should not receive the benefits. No one else, however, in Singapore who opts out is treated this way. Furthermore, no other country has ever penalized people who are not organ donors. In Singapore, the organ registry is arguably a method of institutionalizing discrimination.

2. Presumed consent violates core tenets of a liberal society, especially the freedom of religion.


Claims involving the removal of body parts without consent or claims regarding organ harvesting in excess of permission granted are frequently litigated as claims involving takings, equal protection, negligence, federal civil rights statutes, criminal statutes pertaining to interference with a corpse, and intentional infliction of emotional distress. As of yet, there has not been a distinct claim that presumed consent laws are unconstitutional on their face, or as applied, on religious liberties grounds. This is, perhaps, related to the scant success of families challenging presumed consent on other grounds and general despair over free exercise following the Supreme Court's decision in Employment Division v. Smith. Smith did not overrule the Sherbert-Yoder strict scrutiny test for burdens on religious liberties, but it did hold that neutral and generally applicable laws do not require elevated scrutiny, even if they incidentally burden the free exercise of religion. Nonetheless, grounds for relief are available in Texas under the Texas Constitution and the Texas Religious Freedom Restoration Act. Furthermore, Smith does not preclude federal relief under the United States Constitution, because presumed consent laws are not generally applicable and other constitutional rights are implicated, creating a hybrid scenario. Moreover, international norms and the moral devotion surrounding the increasingly rapacious demand for human organs provide powerful legal and policy arguments against presumed consent laws. A. Presumed consent is unconstitutional under the vigorous religious liberties guaranteed by the Texas Constitution. The State and people of Texas asserted their firm and binding resolve to protect religious liberty in the Freedom of Worship Clause of the Texas Constitution, Article I, Section 6, which states: All men have a natural and indefeasible right to worship Almighty God according to the dictates of their own consciences. No man shall be compelled to attend, erect or support any place of worship, or to maintain any ministry against his consent. No human authority ought, in any case whatever, to control or interfere with the rights of conscience in matters of religion, and no preference shall ever be given by law to any religious society or mode of worship. But it shall be the duty of the Legislature to pass such laws as may be necessary to protect equally every religious denomination in the peaceable enjoyment of its own mode of public worship.
Answers to: “Presumed Consent Empirically Effective”

1. The empirical record with presumed consent in the United States was abysmal. It either failed to overcome family objections or drove up fears that the medical community sought to steal organs, resulting in rejection of the system.


As the gap between the need for organ transplants and the supply of organs has increasingly widened, many scholars have urged the adoption of “presumed consent” to organ donation. Under a presumed consent regime, the state would assume that a person agreed to organ donation after death unless the person (or a family member) had lodged an objection to posthumous organ donation. Such an assumption would reverse existing law - currently, it is generally the case that organ donation requires actual consent from the donor or a family member of the donor. For some forty years in a little-known experiment, the United States tried presumed consent on a limited basis. In many states, when dead persons came under the custody of coroners or medical examiners, those officials could authorize cornea donation - or even organ donation - in the absence of a known objection to the donation by the decedent or a family member. However, in 2006, the Revised Uniform Anatomical Gift Act recommended against presumed consent, and most states have followed its lead. This Article reviews the history of presumed consent in the United States and concludes that presumed consent failed because it could not overcome the major reason why people do not become organ donors after death - the refusal of family members to give consent to donation. To the extent that presumed consent allowed family members to overcome the presumption and withhold consent, it did not address the reasons why family members say no. To the extent that professionals tried to preserve the presumption by bypassing families, they validated fears that doctors will be too quick to take organs from dead persons who would not have wanted their organs removed. The United States's history with presumed consent indicates that other proposed reforms will be needed to address the shortage of organs for transplantation.

2. Presumed consent has already been tried and declared a failure.


Many of these persons would have wanted to donate their organs, but consent was not obtained. People often do not consider the question of posthumous donation while still alive, physicians may fail to ask family members for surrogate consent, or family members withhold consent to donation even when the dead person would have preferred to be a donor. To capture the organs that could be transplanted but are lost for lack of consent, many scholars have urged broad adoption of presumed consent to donation. Under a presumed consent regime, the state would assume that a dead person has consented to the posthumous donation of organs unless an objection has been lodged either by the person while alive or by a family member after the person's death. Such a presumption would reverse the law's existing presumption. For the most part, laws in the fifty states assume a person has not consented to organ donation in the absence of actual consent by the person or by a family member. In other words, presumed consent would replace an "opt-out" system for organ donation with an "opt-in" system. Instead of placing the burden on health care professionals to obtain consent, the burden would be on individuals and their families to document their objections. While the law has generally eschewed presumed consent, many states employed presumed consent on a limited basis for a number of years. Starting in the late 1960s, states began to authorize retrieval of corneas and other eye tissues, pituitary glands, and sometimes any tissues or organs (including hearts, lungs, livers, and kidneys) from dead persons who came under the custody of coroners or medical examiners. Since these people would be undergoing an autopsy to determine the cause of death, their bodies already would be subjected to a major intrusion. Retrieving some tissues or organs at the same time to provide great benefit to living persons had an obvious attraction to lawmakers. Under these presumed consent statutes, coroners or medical examiners could authorize the donation of the tissues or organs as long as they were not aware of an objection by the person or a family member. The 1987 Uniform Anatomical Gift Act (1987 UAGA) reinforced this trend in presumed consent statutes when it recommended presumed consent for the donation of any organ or tissue from cadavers under the custody of coroners or medical examiners. At one time or another, more than two-thirds of the states adopted presumed consent statutes. However, the 2006 Revised Uniform Anatomical Gift Act (2006 UAGA) has eliminated the presumed consent provisions of the 1987 UAGA and now recommends retrieval of corneas, other tissues, and organs only when there is actual consent by the dead person or by a family member of the decedent. States have quickly taken up the 2006 UAGA, with thirty-three states and the District of Columbia passing the 2006 UAGA in either 2007 or 2008. To be sure, some of those states have retained presumed consent at least for corneas if not for organs, but we are now seeing a major retrenchment in the use of presumed consent in the United States.
3. Presumed Consent does not result in higher rates of organ recruitment because it often fails to pass scrutiny by the family.


One can adduce powerful deontological arguments as well for presumed consent. There is much appeal to the position that people do not "own" their bodies in the way that they own their homes, cars, or clothing. In this view, bodies are not property to be sold or even given away at the discretion of the individual. Rather, people hold their organs in stewardship for God or for society, and when they have gotten their full benefit from the organs, it is time to pass the organs onto other persons who can continue to benefit. That said, presumed consent has not been successful in the United States, and for several reasons: A. Presumed Consent Did Not Address the Main Reason Why People Do Not Become Organ Donors After Death Importantly, presumed consent in the United States was premised on faulty assumptions about organ donation decisions. The presumed consent statutes were designed to create a default rule in the law that more accurately reflected people's preferences and that overcame obstacles to the vindication of those preferences. Accordingly, for presumed consent laws to have increased the organ supply, the following conditions needed to be true: (a) people generally want to donate their organs, but (b) people's wishes to donate are frustrated because they do not get around to documenting their preferences while alive, and family members often are unreachable to give consent in the short time period in which organs must be removed for transplantation. The Florida Supreme Court's opinion in State v. Powell illustrates this thinking: An affidavit in the record reveals that, before legislation authorized medical examiners in California to remove corneas without the consent of the next of kin, the majority of the families asked by the Los Angeles medical examiner's office responded positively; however, approximately eighty percent of the families could not be located in sufficient time for medical examiners to remove usable corneal tissue from the decedents. By replacing a requirement for explicit consent with a policy of presumed consent, it was thought that transplant programs would be more likely to obtain organs or tissues that they should be obtaining. It turns out, however, that organ donation is not frustrated by the inability of transplant personnel to contact family members. Rather, a key reason why organs are not obtained after a person's death is the unwillingness of family members to give consent. Studies have shown that physicians generally are able to talk to family members about donation, but family members often refuse to permit donation. For example, in one careful, national study, researchers found that a family member was unavailable to give consent in less than 3% of cases, but that when family members were asked, they did not give consent 46% of the time. Other researchers also have found a refusal rate of about 50% from families. Because presumed consent as implemented in the United States allowed families to object to donation, it did not address the problem of refusal by family members.
Answers to: “Presumed Consent Is Constitutional”

1. Courts have ruled that presumed consent and the failure to ask the family constitutes a breach of privacy and property rights.


The legal tide against presumed consent began to turn in 1991, when the U.S. Court of Appeals for the Sixth Circuit expressed concerns about taking corneas from cadavers without family members having some opportunity to be heard on the matter. In Brotherton v. Cleveland, Deborah Brotherton sued when she found out from an autopsy report that her husband's corneas had been removed. Steven Brotherton died by suicide and therefore came under the custody of the Hamilton County, Ohio coroner, Dr. Frank Cleveland. Ohio's presumed consent statute was typical - coroners were allowed to retrieve corneas for transplantation as long as they were unaware "of any objection by the decedent, the decedent's spouse, or, if there is no spouse, the next of kin, the guardian, or the person authorized to dispose of the body." As it happened, Deborah Brotherton had refused consent to the taking of her husband's corneas, and her objection was documented in his medical record. However, the Hamilton County coroner's office had adopted a policy "not to obtain a next of kin's consent or to inspect the medical records or hospital documents before removing corneas." Indeed, when personnel at the local eye bank started asking about the existence of objections to removals, Dr. Cleveland instructed his staff to withhold information about next of kin. In contrast to the state courts that rejected constitutional claims, the Sixth Circuit recognized a Fourteenth Amendment procedural due process right for family members. The court hinted that actual consent might be required before corneas could be taken, noting that family members have (limited) property rights in a dead person's body under state law and that prior United States Supreme Court case law required a formal hearing before property rights could be infringed under an official government policy like the one in Brotherton. In the end, the court did not decide exactly what level of process was due to Ms. Brotherton, holding only that some process was due to her before the corneas could be taken. One could read Brotherton in one of several ways: as requiring only that coroners (and medical examiners) peruse the medical record to make sure they find any documented objections, as requiring coroners to follow the 1987 UAGA and make reasonable efforts to speak to next of kin, or as requiring that coroners actually obtain the next of kin's consent (since a formal hearing would give next of kin the opportunity to either consent or object). The Ninth Circuit followed the lead of the Sixth Circuit when it faced a similar case to Brotherton, Newman v. Sathyavaglswaran. Newman arose out of rather seamy practices at the Los Angeles County coroner's office. According to an expose in the Los Angeles Times, the L.A. coroner studiously avoided any efforts to speak with family members about taking corneas from cadavers, so no objections could be identified, and there was a strong profit motive for the practice. The coroner's office sold the corneas to a-for-profit tissue bank, receiving about $ 250,000 a year.

2. The clear legal trend has been to find presumed consent faulty under the law.


The Newman court's opinion reads much like that of the Brotherton court. After reviewing the history of property rights in cadavers, the court cited the Brotherton court's analysis and stated its agreement that family members may claim property rights in the body of a deceased person. The Newman court then concluded with essentially the same the Fourteenth Amendment procedural due process analysis as did the Brotherton court. It cited the U.S. Supreme Court's opinions in which the Court required a formal hearing before property rights could be infringed by the state when the state acted under official government policy, but declined to decide exactly what process is due before corneas can be retrieved by coroners or other public officials. Although the Brotherton and Newman courts did not decide what process is due before corneas can be taken from a cadaver for transplantation, their suggestions of a hearing before retrieval raised serious questions about the validity of the presumed consent statutes. In 2006, the drafters of the 2006 UAGA eliminated the provision for presumed consent, citing the Brotherton case and observing that the change was made in light of "lawsuits in which [the coroner's] [medical examiner's] actions were held to violate the property rights of surviving family members." In 2007 and 2008, thirty-three states and the District of Columbia enacted the 2006 UAGA, with most of them eliminating presumed consent entirely and only a few retaining it, primarily just for corneas. In sum, within fifteen years of the Brotherton decision, a consensus began to develop that presumed consent should be abandoned. Indeed, in the same year as the issuance of the 2006 UAGA, an influential panel of the Institute of Medicine reviewed the arguments for and against presumed consent and concluded that states should keep explicit consent requirements for organ donation. This chronology of events raises an important question - why is presumed consent apparently being abandoned in the United States?
Answers to: “Presumed Consent Is Informed Consent”

1. Lax consent requirements mean that medical providers will not go out of their way to provide informed consent but rather will rely on public ignorance in order to meet supply.


Medical examiners who aggressively promote organ harvesting have established policies of "intentional ignorance," whereby they deliberately do not seek consent from family members, even if they are available. In Ohio, whose presumed consent law pertaining to corneas is similar to that of Texas, one medical examiner actively encouraged his subordinates not to seek information on objections to corneal removal and refused to give the Cincinnati Eye Bank the contact information for decedents' next-of-kin when asked. The "smoking gun" memorandum by the Ohio medical examiner provided unusual evidence upon which to base a claim for intentional deprivation of civil rights. In Brotherton v. Cleveland, family members who had not consented to the cornea removal of their next-of-kin appealed to the United States Court of Appeals for the Sixth Circuit. The court held that state law granting families a quasi-property interest in their deceased family members constituted a "legitimate claim of entitlement" which would require pre-deprivation due process of law. The resulting class action suit involved over 500 class members. Such widespread objection to nonconsensual cornea harvesting in one county alone suggests that presumed consent is, in fact, presumptuous. It is rare for medical examiners or others involved in tissue harvesting to express their intent as blatantly as Dr. Cleveland. The settlement in this suit was unusual, and other families affected by presumed consent face an uphill battle proving intentional injury. Nonetheless, the case is illustrative of the possibility for the abuse inherent in presumed consent laws, which rely upon known objections rather than requiring express authorization.

2. Consent is not a mindset. It requires action in order to effectively demonstrate it.


This should be clearer if we consider hypothetical consent. Sometimes, a patient cannot give their actual consent, even tacitly -- for instance, because they are unconscious. In these cases, doctors usually consider what they would (counter-factually) have consented to, if they were in a position to do so. It is ordinarily assumed that rational patients would consent for doctors to act in their best interests, particularly when that involves administering urgent life-saving treatment. (When treatment can wait and the incapacitation is only temporary, it is generally accepted that doctors should wait so they can gain the patient's actual consent.) If consent was simply an attitude of approval or willingness, then many cases that we are inclined to regard as ones of hypothetical consent would in fact be actual (although non-expressed) consent. In this case, hypothetical consent would only have application when a patient could not form the necessary mental attitude. In other words, there would be no need to invoke a patient's 'hypothetical consent' for something she endorses or accepts, if this mental attitude was itself the consent. Rather, we should say that she did consent; she merely had not expressed it. This is, as I have been arguing, a faulty understanding of consent. Consent is sometimes identified with a mental attitude, but consent is not a mental attitude, but an action. It can be given tacitly, but it must actually be given (when possible). This explains why the notion of 'presumed consent' is problematic. It is often alleged that those who favour an opt-out system of organ donation are presuming that those who do not explicitly object (opt out) are consenting.
Answers to: “Presumed Consent Is Informed Consent” [cont’d]

3. Presumed consent cannot be taken for informed consent. It is very difficult for information to reach wide swathes of the public.


The doctrine of presumed consent assumes not only that every individual in the land is consenting to a particular procedure, but that every such individual is aware of what he is consenting to. This is a dangerous assumption. There are many groups of people, from many cultures and backgrounds, who may not understand such a law. The influx of migrant workers in the UK from other European countries means that many of our inhabitants may have difficulty comprehending the new legislation. Others may not wish to be a part of the new law but do not understand how to register an objection, some may not have ever heard of the new law, and others may be too lethargic to investigate the law. Many individuals are simply ignorant of the law, and it would require a massive publicity crusade on the part of the Government to educate every relevant member of society about what will happen to their body and their organs in the event of their death. During this national publicity, it is also vital that the rationale behind any new Bill is not portrayed as the ‘common altruistic standard of society’. Many people will not agree, or feel a part, of the broad moral assumption that everybody wishes to donate their organs upon death. Individuals may feel pressured into consenting to donation simply because the act of opting-out could be viewed as anti-social.

4. It is impossible to reasonably determine presumed consent because not everyone has equal access to knowledge or opting out opportunities.


To turn to tacit consent, Saunders claims that when in certain conditions people do not opt out of donating, they have tacitly consented to the retrieval of their organs, and tacit consent is genuine consent. To take a common example, when the chair says ‘speak now if you do not accept the minutes of the meeting’, those present who keep quiet have consented to accept the minutes. I accept that tacit consent can be genuine consent. If we ask what it is about inaction that could constitute tacit consent (as opposed to simply inaction), one requirement may be that expressing dissent should be easy and costless. An opt-out system could meet this requirement by imposing no penalty for opting out and by using frequent approaches, reply-paid envelopes, and web-based opting out. What of those people who know about the opt-out system but fail to get round to opting out or those who do not know of the system at all? Could they be said to have consented? Saunders would claim they can. Consent, for Saunders, does not require the intention to be bound or any pro-attitude to the (in)action in question. All that consent requires is the opportunity to opt in or out in favourable choosing circumstances. When people eat in a restaurant, he says, they have consented to pay whatever their mental attitude towards doing so. I think he has made a mistake about consent. People may be bound to pay in the restaurant whatever their mental attitudes because the restaurateur has relied on payment; but it is more accurate to see the case as one in which it is reasonable to treat patrons as if they have consented rather than have actually consented. Could it then be that those who fail to opt out had had a reasonable opportunity to do so and so may be treated as if they had consented? What counts as a reasonable opportunity will depend on such matters as whether people can reasonably be expected to pay attention to the unlikely event of their becoming suitable deceased donors, whether the burdens of opting out would fall on the disadvantaged, the rights of potential donors, and the needs of potential recipients. Assessing these factors is a large task and, perhaps for reasons of space, Saunders does not show that his proposal would provide a reasonable opportunity to avoid organ retrieval.
Answers to: “Presumed Consent Is Sufficient for Autonomy”

1. Presumed consent oversteps the government’s limited role in accessing a person’s body.


Because viable organ removal requires a living, breathing donor with a beating heart, presumed consent organ donation implicates the donor's constitutional rights, despite the Powell court's contrary conclusion. This Note analyzes individual rights by utilizing Judith Wagner Decew's broad definition of privacy as an unjustified interference into a person's activities, rather than as a limited protection of information. Wagner Decew's definition is most consistent with the Court's privacy decisions, which have included such non-informational subjects as abortion and contraception. Moreover, Wagner Decew's definition provides a helpful construct for applying privacy decisions made in other contexts to the presumed consent organ donation debate. In identifying privacy violations, Wagner Decew uses a reasonable person standard and examines the potential problems arising from external scrutiny into the private realm. In the case of presumed consent organ harvesting, a reasonable person would likely find organ and tissue removal to be a deeply personal matter, simply based on the government's limited right of access to a person's body. For example, the Casey opinion expressly states that the protections of liberty encompass bodily integrity, expanding upon prior Court decisions that guarded against particularly violent governmental intrusions into the body. The unauthorized harvesting of organs and tissues is highly invasive, as it requires the state to enter the person's body and physically remove the machinery of human life. Even corneal removal, hailed as minimally invasive by the Powell court, still involves an external intrusion upon the body and the forcible removal of tissue. Harvesting is thus different from the mandatory smallpox vaccinations that were upheld in the Jacobsen decision, because vaccinations only require a quick prick of the skin rather than the physical extraction of human body parts.

2. Opt-out provisions are not sufficient to prove consent because it only looks at actions, not intentions.


Saunders' argument hinges on a strong interpretation of consent as a performatif act in which the act is sufficient and the mental attitude is unnecessary. Once social conventions have established which (in)action constitutes consent, Saunders argues, a person who has performed the relevant act -- whether expressly or tacitly -- incurs the obligations pursuant to giving her consent. The fact that she may not have performed this act without intending to consent is immaterial. This last point seems to take us a step too far. Instead of insisting that an act constitutes consent regardless of a person's intention to approve, it seems more reasonable to adopt the view that, under normal circumstances, acts of consent ought to be minimally approval-tracking. We might think a consent procedure to be 'minimally approval-tracking' when the probability of the consenting act coinciding with what the 'consenter' really wants (independently of the procedure) satisfies some threshold value -- for example, more than 50%.

3. Presumed consent violates core liberalist values such as privacy and control over one's person.


In sum, presumed consent organ donation, in which the state assumes control over an otherwise privately made decision, infringes upon the Constitution's guarantee of personal privacy. In addition, the so-called safeguards of presumed consent laws, including organ request, reasonable search, and lack of knowledge of objection, are inadequate measures of due process. As the Arthur Forge Jr. incident demonstrates, there is some question as to the degree of diligence used in searching for the records of unidentified, presumably homeless people. Certainly, in Forge's case, his fingerprints and missing persons report were on file for all to see, yet neither was found until after the organ harvesting. Even with the best of intentions, the overriding goal of expedience seems to cut against a diligent, and thus time-consuming, search. It is also important to remember that the United States currently employs an opt-in organ procurement system, under which people generally record, or otherwise make known, their decision to donate organs. Thus, unlike the European presumed consent or opt-out systems, a person is under no obligation to register an organ donation objection. Moreover, the European models show that true opt-out systems require widespread public education and motivation to ensure a general understanding of the consequences of inaction; no such protections are in place in the United States. Finally, the fact that most Americans claim to support organ donation is irrelevant when analyzing presumed consent, for, as John Stuart Mill notes, laws based on public opinion are quite likely to be wrong when applied to the individual.
4. Presumed consent cannot achieve justice because it is an exercise of pure paternalism, destroying rights of the autonomous individual.


Furthermore, the Jacobsen opinion could at least be justified by a real health emergency, namely, the need to protect others from the deadly contagion of smallpox. Using John Stuart Mill's thesis of self-regarding actions, the smallpox vaccinations were permissible state interferences into liberty, because they were necessary to prevent a distinct harm to others. Specifically, during a smallpox epidemic, an unvaccinated person likely will spread a highly contagious virus, causing illness and death to others, unless the state acts to protect its citizens. Presumed consent organ donation, on the other hand, is not a preventative measure designed to ensure that the affected individual refrains from injuring others. Rather, presumed consent harvesting, like Gerald Dworkin's concept of impure paternalism, involves the state's affirmative removal of one person's body part to benefit some unknown other person. Although such altruism, when voluntary, is to be commended, it is certainly not required in a democratic society. Of course, Mill writes that a society that engages in such compulsion is not truly free. Returning to Wagner Decew's definition of privacy, she next argues that state intrusions into the personal realm are unjustified when there is a threat of external scrutiny and its corresponding problems. With presumed consent harvesting, the danger lies in its violation of personal autonomy. In Casey, the Supreme Court clarified its prior privacy decisions as creating a sphere of individual autonomy within which a person can make fundamental life decisions, including the right to define his or her own existence. The Court's conception of the autonomy right is thus consistent with Mill's belief that liberty includes the right to idiosyncratically plan one's life, as well as James E. Fleming's notion of deliberative autonomy as the right of self-governance.

5. Presumed consent violates constitutional protections concerning family autonomy, privacy, and control.


In addition, although the donation decision impacts others, it still primarily involves the family. In particular, the decision to make an anatomical gift will obviously benefit waiting-list patients who need new organs to survive. The recipient's family and friends also will gain from having their loved one restored to health. However, these external benefits do not detract from the family-oriented nature of the donation decision. To analogize, the Court has protected a parent's autonomy in directing the upbringing of a child, even though that child's character, personality, and intelligence will eventually affect society in myriad ways. Thus, external effects do not transform a family decision about the structure and course of family life into a societal one. In choosing to make an anatomical gift, family members assume decision-making power for their incompetent loved one. Similarly, the Court has protected parental choices made on behalf of young children who, because of age and sophistication, cannot make their own informed decisions about education and religion. Both scenarios respect the family members' right to make these determinations, based on their familiarity with and love for the affected individual. As noted above, presumed consent organ donation instead gives this responsibility to the state, which has no personal attachment to or affection for the incompetent person. In sum, organ donation is an autonomous family decision, much like other family choices already protected by the Supreme Court. Presumed consent laws, which usurp the family's authority, violate the Constitution's protections of privacy, autonomy, and liberty.
Answers to: “Presumed Consent Resolves Deliberation Errors”

1. Setting the default position to organ donation does not respect individual deliberation. It manipulates the process of decision-making.

Govert den Hartogh, Department of Philosophy, University of Amsterdam, JOURNAL OF MEDICAL ETHICS, “Tacitly consenting to donate one's organs,” vol. 37, no. 8, August 2011, accessed 8.15.2014: academic search premiere.

A final objection is the following. If opt-out systems generally tend to have better results than opt-in systems, even when the burdens attached to registering consent and refusal are hardly distinguishable, this has to be explained by the general relevance the choice of the default has in people's decision-making. In deliberation people need clear and decisive reasons for deviating from the default, and in cases in which it is difficult to weigh the reasons pro and contra they will usually stick to the default. This explains the fact that the number of consenters in opt-out systems with the largest number of dissenters exceeds the number of consenters in opt-in systems with the largest number of dissenters. It also explains why the rate of family refusal in cases in which no explicit decision by the deceased has been registered is much lower in opt-out than in opt-in systems. This fact, however, means that even if abstaining from dissent can be said to amount to valid consent in a particular system, such tacit consent will tend to be less fully rational than valid consent in an opt-in system. If that is true, it might be said that by choosing the removal of organs as the default, a government to some extent manipulates its citizens in the interests of harvesting organs.

2. Obtaining actual consent is necessary. It also prevents from aggressively over-recruiting from marginalized populations by presuming they would be fine with donation.


There also is evidence supporting the view that there are fewer erroneous non-donations under a policy of actual consent than there would be erroneous donations under a policy of presumed consent. The argument for presumed consent rests in large part on the survey data showing a strong majority of people who say they would want their organs taken after death. But while a large majority of the public reports a preference for organ retrieval, barely more than half of the public actually document a desire to be an organ donor after death. How then do we interpret this discrepancy? Is it that the great majority of persons do want to donate, but many simply fail to take the necessary steps to document their preferences? Or is it that almost half of persons really do not want to be organ donors, but many of them give the socially preferred response in public opinion surveys? If barely half of the public actually wants to be an organ donor, then a policy of presumed consent could easily lead to more erroneous donations than the number of erroneous non-donations that occur under our policy of actual consent. The possibility that people really do not want to be organ donors is particularly important with minorities. Public opinion surveys find less support among the poor and minorities than among the well-to-do or whites. While 60.5% of whites have granted permission for organ donation on their drivers' licenses, only 39.3% of Latinos, and 31.2% of blacks have done so. Vulnerable populations are not only less likely to support organ donation; they also would be less likely to realize that presumed consent statutes exist and that they would need to lodge their objections to organ donation. Without a reliable method of opting out of presumed consent, presumed consent could easily operate to the particular disadvantage of vulnerable populations. Indeed, Marie-Andree Jacob has argued that the possibility of unfairness to vulnerable populations should push us toward actual consent. Analogizing to contract law, which places on the more powerful party the burden of contracting out of default rules, she suggests that default rules for posthumous organ donation place the burden on doctors to overcome the rules. In other words, the burden should remain on physicians to obtain consent to organ donation rather than placing the burden on individuals to express their objection to donation.
Answers to: “Presumed Consent Resolves Illicit Trafficking”

1. Presumed consent only encourages the objectification of life and greater trafficking on the black market by weakening international norms.


Organ harvesting and transplantation issues are a worldwide concern. Corroborated tales of children kidnapped and sold for their organs, murderous organ gangs, adoption rings in which children are blinded for their corneas, and live donation by the poor for money, are gradually emerging from all corners of the globe. International human rights laws currently address these bioethical and privacy concerns, and, as a nation that adheres to the rule of law and promotes individual rights, the United States should abide by these standards. Nonconsensual organ harvesting is questionable under the United Nations Universal Declaration of Human Rights, which protects liberty and security of person. "Arbitrary interference with... privacy, family, [or] home" is prohibited. Furthermore, the family is accorded special protection from society and the state as "the natural and fundamental group unit of society." Freedom of religion under the Declaration includes the right to actually observe one's religion rather than simply profess a belief. Presumed consent offends these international human rights protections by violating bodily integrity, family privacy, and freedom of religion.

2. The empirical evidence for presumed consent’s success is misleading.


Unfortunately, the information from Europe can be deceiving. While France technically adopted a presumed consent approach in 1976, French physicians routinely ask families for permission before removing organs. Therefore, the experience in France reflects the operation of an encouraged voluntary or routine request system, rather than a true presumed consent approach. A similar practice prevails in Belgium; although physicians in Belgium are permitted legally to remove organs without permission, as a practical matter they inform families of the option to refuse and ask if the families have any objections.

3. Presumed consent goes too far with its consequentialist premise, creating an overwhelming obligation to donate organs in every instance, leading to compulsion.

Michael Potts, Methodist University, Joseph L. Verheijde, Departments of Biomedical Ethics, Physical Medicine, and Rehabilitation, Mayo Clinic, Mohamed Y. Rady, Center for Biology and Society, School of Life Sciences, Arizona State University, and David W. Evans, Queens College, JOURNAL OF MEDICAL ETHICS, "Normative consent and presumed consent for organ donation: a critique," vol. 36, no. 8, pp. 498-499, August 2010, accessed 8.15.2014: academic search premiere.

Much of Saunders' argument that 'it is wrong for (most) people to withhold their consent to postmortem organ donation' hinges on Peter Singer's 'greater moral evil principle'. Saunders' version of the principle in the context of organ procurement is 'when we can prevent something bad, such as a death, without sacrificing anything of comparable moral importance, we ought to do so'. If Singer is correct, the application of Estlund's position to the issue of consent for organ donation seems to follow. Saunders recognises that it is critical to validate adequately his crucial premise that withholding consent to postmortem organ donation constitutes an immoral act. However, Saunders' version of Singer's position produces a duty to donate in almost all circumstances. If death caused by the absence of organ transplant is the operational premise, then, there is nothing of comparable moral precedence under which a person is not obligated to donate. Saunders' position is also based on a flawed interpretation of cause and effect between organ availability and death. For example, patients with end-stage kidney disease can survive for many years with either haemodialysis or peritoneal dialysis. The consequences of Saunders' position are that: ( 1) by definition, the objective of preventing death, that is, saving the lives of those with end-stage organ disease, outweighs the moral costs of the practice of organ procurement; and ( 2) a utilitarian approach in achieving the primary objective by maximising opportunities for organ transplantation is justified. These two premises effectively turn organ procurement practice into an ideology justifying certain practices and laws that may otherwise be unacceptable to members of society. The ideology leaves the assumptions for a particular practice largely untested and unchallenged and presents them as neutral. The concepts of the ideology become dominant and in control of the most private aspects of life in society.
4. Presumed consent would unfairly target minority populations, exploiting them.


On closer consideration, concerns about fairness are very serious. While the state statutes cover any person who comes under the custody of a coroner or medical examiner, the population of such persons may be disproportionately poor and minority, at least in major urban centers. Moreover, disparities may exist when coroners or medical examiners decide whether to retrieve organs or tissues from a dead person under their custody. When the Los Angeles Times exposed the cornea retrieval practices of the county coroner, the newspaper found that that over 80% of the corneas came from blacks or Latinos even though only 44% of autopsies involved blacks or Latinos. Given the overrepresentation of minorities and poor persons, one has to wonder whether the presumed consent statutes would ever have been passed if they applied equally to wealthy white families as to poor black families. In sum, the experience in the United States with presumed consent can easily be seen by the public as validation for their fears that physicians will abuse their authority when families are excluded from the organ donation decision.

Apparently, physicians will take organs in disregard of people's wishes, and they will do so in a discriminatory fashion. To be sure, it is important to remember that all of this discussion about abuse is not dispositive, but only suggestive. One could argue that the coroners in Brotherton and Newman would not have abused their authority if the law had called for presumed consent and excluded families from participation in the donation decision. After all, it was the exclusion of families that constituted the primary abuse by the two coroners. But whether or not a different approach to presumed consent would have played out differently, the drafters of the 2006 UAGA and state legislatures have decided to abandon presumed consent, and it is difficult to envision a revival of presumed consent in a stronger version in the near future. Indeed, even in other countries which have had a better experience with presumed consent than in the United States, there is a tremendous reluctance to proceed without family involvement.
Answers to: “Tacit Consent is Presumed Consent”

1. While the dissemination of information will never be perfect, a tacit consent system is sufficient to know that consent rests on more than presumption.

Goverd den Hartogh, Department of Philosophy, University of Amsterdam, JOURNAL OF MEDICAL ETHICS, “Tacitly consenting to donate one's organs,” vol. 37, no. 8, August 2011, accessed 8.15.2014: academic search premiere.

It could be objected that no system can guarantee that really everyone will know his status: some people do not open their letters, in particular when they have been sent by government agencies, others are unable to read, or can read only in languages that will not be used in the invitation to register. It should be noted that most of these people in such matters rely on the assistance of others, otherwise they could not function in a modern society at all, but for some of these people it is true that the conditions for ascribing tacit consent to them will not be satisfied. We could reply that such problems occur in opt-in systems as well: illiterate people are unable to register as a donor, even if they would prefer that option if they knew they had it. The force of this reply depends on the mental state conception of consent I rejected. The right to make decisions concerning one’s body is a negative authority-right, and this means that in regard to consent there is a safe side to err on: abstaining from taking out the organs is the proper default. If you do not know that you have the option to register as a donor, your right is not violated, as it is sometimes suggested. You only lack an opportunity to exercise it. However, impure opt-in systems as we know them, as well as mandatory choice systems, really are necessarily confronted with the same problem, and to the same extent: the very same persons who lack the capacities and the external assistance to get to know that silence means willingness to donate will not come to understand either that it means delegating your decision to your relatives, even if every possible measure has been taken to inform them about that. It should simply be conceded that the objection points to a real problem for any system of tacit consent. Short of introducing a new register with data about the relevant capacities of reading and understanding of all inhabitants (suggested by Neades, probably in the spirit of a reductio ad absurdum), there may be other means of identifying most of these people. If the default of the system is interpreted as: I consent to donating unless my relatives object, the relatives will usually know that the deceased did not understand this, but the problem cannot fully be solved. This problem, however, is not special to this domain. The fact is that the modern state has no alternative but to arrange its relations to its citizens on the presupposition (the presumption) of minimal literacy. It cannot excuse illiterate people for not paying taxes, violating the law unwittingly and so on. Educational policies should aim at promoting literacy, and assistance should be freely available for the remaining illiterate individuals; that is all the state can do.

2. Tacit consent is the only way to match up actions with decisions to donate. Presumed consent goes too far.


I do not, however, think it is necessary for an opt-out system to presume anything about consent. If consent was simply an attitude of acceptance, then perhaps it would be reasonable to presume that non-objectors consented. If consent is an action that has to be performed or given, then it cannot be presumed. It is absurd to ‘presume’ that people have given consent, when they clearly have not in fact done so. An opt-out system need not, however, be identified with presumed consent, which would merely be one possible (and, I believe, inadequate) justification for it. Rather than presuming the presence of consent, we can simply appeal to the familiar idea of tacit consent. As was noted above, an opt-in system ensures the express consent of all donors. We do not ordinarily believe that consent, to be valid, must always be explicitly given. In many cases, consent is implied by people’s actions. For instance, the chairperson of a meeting may declare a motion carried if no one voices an objection, in which cases it is clear that silence implies acquiescence. Similarly, one who walks into a restaurant, orders and eats a meal, does not usually explicitly promise to pay for it, but we say that her actions signify her consent to do so. Given our social conventions, it is clear how her actions would be understood, and it would be no more reasonable for her to protest that she had not meant to give her consent than to say that she had not meant to consent in signing a consent form (language meaning, after all, is also a matter of social convention). This highlights the other side of my claim that consenting is an action, rather than a mental attitude. It is not simply that the action is necessary and the mental attitude insufficient. It is also that the action is sufficient and mental attitude unnecessary. Someone who has performed the relevant consent action -- whether that be signing an explicit declaration or some action understood as tacit consent -- cannot escape their obligation simply by saying that they did not mean to give their consent. Their intentions are irrelevant to what they in fact did. Perhaps, if it is not too late, they may be allowed to withdraw their consent, but they cannot change the past.