
#### Hi everyone! We hope you enjoy the first installment of Premier Debate Briefs for the September/October 2014 topic “Resolved: A just society ought to presume consent for organ procurement from the deceased.” This file contains more evidence than any of our competitors’ briefs, and it’s free! Our goal is to provide high-quality evidence in a usable form, so you’ll note that all of our cards are tagged, organized thematically, and lined-down. These blocks are ready-to-read.

#### That said, best practice for brief use is to re-cut the original articles to ensure that you have a good grasp of the material. Second, you should highlight any cards you plan on using. This gives you a better handle on the evidence and ensures you only read the parts you need in round. You should also re-tag the evidence based on how you’re using it.

#### Recommended viewing for those who have not used a debate template: Make sure you are in draft view and have the navigation pane showing in Word. This will allow you to see the organization and avoid having big white spaces!

#### If there is a particular position or argument that you find especially compelling, make sure to vote for it in the upcoming poll and we’ll develop an in-depth brief on that argument.

#### Finally, if there’s anything you’d like to see from us in next topic’s installment, feel free to contact us at premierdebate@gmail.com.

#### Thanks,

#### Bob Overing and Tom Placido

#### - Policy Debaters for the Trojan Debate Squad at USC

#### - Coaches for Loyola High School of Los Angeles

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# Aff

## Advantage – Organ Shortage

### Inherency

#### Organ shortage is due to misperceptions about the donation system – squo can’t solve

Bard 12

Jennifer S. Bard (2012) pf @ Texas Tech, Lack of Political Will and Public Trust Dooms Presumed Consent, The American Journal of Bioethics, 12:2, 44-46 [PDI]

As I wrote in a review ofMichelle Goodwin’s book Black Markets: Exploring The Racial Implications of Offering Compensation to the Families of Potential Organ Donors (Bard 2007), **the underlying reason so many organs are buried rather than donated is because potential donors and their families believe that the organ distribution system is unfair and, worse, that potential donors receive less aggressive medical care. In the face of these fears, we cannot hope to reach the levels of donation enjoyed by European countries such as Spain**—**let alone get presumed consent laws that have helped those countries** achieve these results. Laws are introduced and passed by politicians who hope to be reelected. The consistent failure and bleak legislative history of presumed consent laws in the United States give us no reason to think they can play an effective role in increasing organ supplies. Presumed consent laws, such as those advocated by the authors, are doomed to failure until the true reasons for reluctance are identified and more importantly addressed (Smith 2011a; 2011b).

#### **Mandatory choice coming in the status quo *[could be a neg squo solves card but the authors don’t advocate that it works]***

Kessler and Roth 14

By Judd B. Kessler, dept of econ @ UPenn, and Alvin E. Roth\*, dept of econ @ Stanford, “Getting More Organs for Transplantation” American Economic Review: Papers & Proceedings 2014, 104(5): 425–430 [PDI]

Instead of moving to presumed consent, therefore, **the predominant policy change in the United States has been to switch the organ donation registration question from an opt-in frame to a “mandated choice” frame** (also called a “forced choice” or an “active choice” frame). Under an opt-in frame, the individual who is being asked to register, usually at a state department of motor vehicles, checks a box to register and leaves it blank not to register. Under a mandated choice frame, **the organ donation request is framed as a “yes” or “no” question** whereby answering yes adds the individual to the registry and answering no does not. **This policy change has been recently implemented by a number of US states (e.g., Illinois, California, New York) as well as by the United Kingdom.** While this switch to **mandated choice has been pushed by organ donor advocates,** the **support** for the policy **comes from hypothetical choice data in which individuals were more likely to report being willing to join a registry when asked under a mandated choice with no prior default** than when asked under an opt-in frame when individuals were presumed to not be donors (Johnson and Goldstein 2003, 2004). Additional results have come from the use of mandated choice in Illinois (Thaler 2009), which was implemented among other changes including simplifying the registration process and making organ donor registration legally binding.

### Kidneys

#### 5,000 die from kidney disease every year – 100,000 are on the wait list. The impacts are systemic and ongoing

Badhwar 14

Neera K. Badhwar, “Kidneys, Commerce, and Communities” (Forthcoming in Commerce and Community, ed. Rob Garnett, Lenore Ealy, Paul Lewis Routledge, July 2014) [PDI]

**The absence of legal markets in kidneys has also created a situation in which tens of thousands of people all over the world needlessly suffer and die. The number of kidney patients on the waiting list in the U.S. now is around 98,787**. 3 Only 16,812 got a transplant **in 2012** and **4,903 died for want of a kidney**4 – not including those who were never put on the waiting list **because the doctors judged that, in their condition, they would never get a kidney in time**. It is not, of course, only kidneys that are in short supply; so are other transplantable organs, such as livers and hearts. But the shortage of kidneys is special for two reasons: one is that nature has been unusually generous by endowing **each of us [has]** with **a spare kidney, and** the other is that kidney removal and **transplantation [is]** are **now extremely safe for both parties**, at least in the West. Yet most of us spend our lives carting around an extra healthy kidney, and take both of them with us when we die, even as those with kidney disease usually lose both kidneys and die for lack of a kidney. These facts make the issue of the kidney shortage especially urgent and poignant.

### Stats on Stats

#### A meta-study of 26 independent studies confirms presumed consent increases organ donation.

Rithalia et al. 9, (Amber Rithalia, research fellow, Catriona McDaid, research fellow, corresponding author, Sara Suekarran, research fellow, Lindsey Myers, information specialist, and Amanda Sowden, deputy director Centre for Reviews and Dissemination, University of York, Impact of presumed consent for organ donation on donation rates: a systematic review, British Medical Journal, 2009; 338: a3162, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2628300/#\_\_notesid949841title) [PDI]

Studies reviewed Five studies comparing donation rates before and after the introduction of legislation for presumed consent (before and after studies); eight studies comparing donation rates in countries with and without presumed consent systems (between country comparisons); 13 surveys of public and professional attitudes to presumed consent.¶ Results The five before and after studies represented three countries: all reported an increase in donation rates after the introduction of presumed consent, but there was little investigation of any other changes taking place concurrently with the change in legislation. In the four best quality between country comparisons, presumed consent law or practice was associated with increased organ donation—increases of 25-30%, 21-26%, 2.7 more donors per million population, and 6.14 more donors per million population in the four studies. Other factors found to be important in at least one study were mortality from road traffic accidents and cerebrovascular causes, transplant capacity, gross domestic product per capita, health expenditure per capita, religion (Catholicism), education, public access to information, and a common law legal system. Eight surveys of attitudes to presumed consent were of the UK public. These surveys varied in the level of support for presumed consent, with surveys conducted before 2000 reporting the lowest levels of support (28-57%). The most recent survey, in 2007, reported that 64% of respondents supported a change to presumed consent.

#### **The largest study in terms of scope and length affirms – presumed consent increases donation rates**

Bilgel 12

Fırat Bilgel, Department of Economics, University of Bologna, “The impact of presumed consent laws and institutions on deceased organ donation” Eur J Health Econ (2012) 13:29–38 [PDI]

Data source and descriptive statistics The data cover [28 countries] **Australia, Austria, Belgium, Canada, Croatia, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Ireland, Israel, Italy, Luxembourg, Netherlands, Norway, New Zealand, Poland, Portugal, Slovak Republic, Slovenia, Spain, Switzerland, Sweden, United Kingdom, and the United States.** Data on total population is obtained from World Bank, Health, Nutrition and Population statistics database [29]. Data on the number of total deceased donations are compiled from the Transplant Procurement Management, International Registry of Donation and Transplantation [28]. Registered number of deaths caused by cerebro vascular diseases, motor vehicle accidents, and homicides are compiled from the World Health Organization (WHO) Mortality database [31]. The number of deceased donations and registered deaths are divided by the population and multiplied by million to obtain the total deceased donation rates and registered death rates per million population (pmp). Data on the purchasing power parity adjusted per capita total health expenditure is obtained from the WHO statistical information system database [30]. Information on consent legislation is compiled from Abadie and Gay [1] and Healy [15]. Consent legislation variable takes the value of 1 for countries which enacted presumed consent and 0 for countries which enacted informed consent legislation. The data on civil rights and liberties is compiled from Freedom House [10]. The civil liberties index comprises of freedom of expression and belief, associational and organizational rights, rule of law, personal autonomy, and individual rights. In the sample, the total number of points awarded to civil rights and liberties corresponds to a point between 4 and 1, 1 being the highest and 4 being the lowest level of freedom. Data on legal systems have been collected from the CIA, World Factbook [6]. The legal system variable takes the value of 1 for common law countries and 0 for civil law countries. Information on donor registry and family consent is obtained from the Global Observatory on Donation and Transplantation [13], Abadie and Gay [1] and via personal communication with the national transplant authorities. The family consent variable takes the value of 1 if next-of-kin consent is always sought in deceased donations and 0 otherwise.4 The combined registry variable takes the value of 1 if the country maintains a combined registry in any year and 0 if the country maintains at most a single registry in any year.5

Table 1 displays **[based on] country-by-country deceased donation rates, legislative defaults and consensual practices** in the year 2006. With the exception of Greece, Portugal and Slovak Republic (Sweden and Poland), all presumed consent countries in the sample which (do not) routinely seek family consent also (do not) allow family to veto their nextof- kin’s wishes. On the other hand, all informed consent countries with the exception of Canada allow family veto irrespective of whether family consent is routinely sought. Only about 29 percent of the sample countries managed a combined registry system in 2006. The descriptive statistics are given in Table 2. The mean deceased donation rate is slightly higher in presumed consent countries with a 14-year average of 15.25 compared to an average of 14.15 deceased donation rate for informed consent countries.

Results Four of the 28 countries were discarded from the regression analysis. Switzerland is discarded because the consent legislation varies by canton, although it is an informed consent country by federal law. Israel is discarded in order to reduce heterogeneity in social norms.6 Greece is discarded on the grounds that the cause of low transplant rates is a low number of medical staff and intensive care units and not a low deceased donation rate [18]. Luxembourg is discarded due to data inconsistencies on deceased donation rates. After removing Switzerland, Israel, Greece and Luxembourg, the **regressions were performed for the remaining 24 countries over the period of 1993–2006.**

In empirical studies, most often the interest is on the impact of time-invariant or almost time-invariant variables on the dependent variable. The researcher may want to estimate the impact of institutions or laws which do not change in the short-run. In such cases, a fixed effect (FE) error component model does not allow the estimation of the parameters of these time-invariant variables. In the case of slowly changing variables with little within variance, an FE model further results in inefficiency that leads to highly unreliable point estimates and misleading inference. Under these circumstances, the existing solution to estimating the impact of time-invariant or almost time-invariant explanatory variables is to employ a pooled ordinary least squares (OLS) or a random effects (RE) estimation. However, both RE model and pooled OLS will be biased if the unobserved effects are correlated with the regressors and the latter estimation will be less efficient than a RE estimation even if the unobserved country effects are uncorrelated with the explanatory variables. In this article, the impact of presumed consent laws on deceased donations is estimated via the fixed effects vector decomposition (FEVD) proposed by Plu¨mper and Troeger [24]. It is a superior three-stage estimator that allows estimating the impact of time- invariant variables and that is more efficient than the FE model in estimating parameters of almost time-invariant variables.7 The estimation results are reported in Table 3.

Column (1) displays the entire sample estimation results with only consent legislation variable as the explanatory factor. **Without taking into account of the potential remaining factors, presumed consent countries exhibit 3.5 percent higher deceased donation rates on average, compared to informed consent countries**.8

The likelihood of medically becoming a donor is greater for individuals who have been exposed to situations in which irreversible brain injury resulting in brain death is more likely. Consequently, given medical compatibility, victims of motor vehicle accidents, assault and cerebro vascular diseases are suitable candidates for transplantation. In column (2), we incorporated the potential donor pool as a factor that might affect deceased donation rates. The estimation results detect a sizeable but lower impact of potential donor pool on deceased donation rates than previously predicted.9

Column (3) shows that **presumed consent countries exhibit 5.3 percent higher deceased donation rates on average compared to informed consent countries after accounting for total per capita health expenditure, death rates caused by cerebro vascular diseases, motor vehicle accidents and homicides, civil rights and liberties and legal systems, whose coefficients are statistically significantly different from zero at conventional levels**.10

The impact of presumed consent laws on deceased donation can be challenged by the fact that significant variations in deceased donation rates are accounted by the way consent laws are practiced and not only by the legal framework. It is argued that the practice of presumed consent regime highly depends on family referral and donor administration through registries. First, with notable exceptions most of the countries have either a national registry of volunteers or refusals. In presumed consent countries where the default rule is to donate, a registry of refusal (non-donor) allows individuals to explicitly oppose donation. In contrast, in informed consent countries where the default rule is not donate, a registry of volunteers (donor) allows individuals to explicitly consent to donation. It might be argued that if family consent is sought, donor administration should have no impact on deceased donation. However, donor registry can serve as a signaling device both to the next-of-kin and the hospital [3]. It is known that the preference of the potential donor is the major predictor of family preference [26]. However, this signaling depends on the legislative default. Under presumed consent, a combined registry allows some individuals to be registered as donors besides those who explicitly object donation. In turn, the family who previously would have likely denied consent because of the unknown preferences of the potential donor under a single registry will consent to donation knowing their deceased next-of kin is a registered donor. However, the consent rates for those who are not registered will decline because if the individual did not go through the trouble of registering, families may infer that the person was against donation.11 On the other hand, under informed consent, a combined registry allows some individuals whose preferences toward donation were previously unknown to be registered as non-donors in addition to those who explicitly consent to donate. In turn, the family will deny consent knowing their deceased next-ofkin is a registered non-donor. However, the consent rates for those who are not registered may rise because if the individual did not register as a non-donor, the next-of-kin may infer that the individual would have wanted to donate. Therefore, it remains ambiguous whether establishing a combined registry will increase deceased donation rates.

**In order to correctly identify the impact of presumed consent on deceased donations, we included family consent and donor registry variables** in columns (4) and (5) as well as all the relevant interactions of presumed consent, family consent and donor registry variables in column (6).12 Based on the estimation results displayed in the last column of Table 3, the impact of presumed consent law and other procurement attributes on deceased donation rates are reported in Table 4 in which the sample countries are divided into eight groups based on the information on consent legislation, family consent, and national registry. Each cell gives the impact of the row group on the corresponding column group. The particular interest is the impact of presumed consent legislation on deceased donation rates, given its interaction with the family consent and the national registry variables.

**Countries in which presumed consent is enacted exhibit 19 percent higher deceased donation rates on average compared to informed consent countries, given both types of countries do not routinely seek family consent, irrespective of the donor administration system** (cells corresponding to third row seventh column and fourth row eighth column). On the other hand, if family consent is routinely sought but at most a single registry is maintained, presumed consent countries exhibit only 8 percent higher deceased donation rates on average (cell corresponding to first row fifth column). **In contrast, if both types of countries maintain combined registries and always seek family consent, the impact of presumed consent on deceased donation rates is substantially higher around 75 percent on average** (cell corresponding to second row sixth column).

Within presumed consent countries, **routinely seeking family consent exhibit 15 percent lower donations on average under a single registry system** (cell corresponding to first row third column) but 36 percent higher donation rates on average if a combined registry is maintained (cell corresponding to second row fourth column). On the other hand, **routinely seeking family consent has a negative impact on deceased donation rates, around 7 percent, within informed consent countries irrespective of the type of donor registry** (cells corresponding to fifth row seventh column and sixth row eighth column).

Maintaining a combined registry exhibit a negative impact on deceased donation rates, around 26 percent, within informed consent countries (cells corresponding to eighth row seventh column and sixth row fifth column), whereas maintaining a combined registry exhibit 19 percent higher deceased donation rates on average within presumed consent countries which routinely seek family consent (cell corresponding to second row first column). However, maintaining a combined registry exhibits a negative impact on deceased donation rates, around 26 percent on average, within presumed consent countries which do not routinely seek family consent (cell corresponding to fourth row third column). This result might indicate that **maintaining a combined registry in presumed consent countries functions as a positive signaling device when families are always asked for consent**. A possible explanation is that **in an opt-out system** in which only those who explicitly oppose donation can register, **most of the individuals who do not oppose donation cannot signal or express their preferences to their families, especially when discussing issues of donating one’s organs upon his or her death is a difficult task and considered a taboo.** Upon the introduction of a donor registry in such opt-out systems, **by registering as ‘‘donor’’, some individuals will no longer have unknown preferences. This will induce families to allow donation of the organs of their deceased next-of-kin.** On the other hand, if families are not asked for consent, they will be offended by being excluded from the procurement process and oppose donation, even if the decedent was a registered donor, on the grounds that they assert a right on the body of their next-of-kin; however, such a right is not allowed to be exercised. However, exceptions do exist. In Austria and Czech republic, where the former country long considered the body of the deceased a property of the state, the deceased donation rates are substantially higher not only because the procurement process is well organized and efficient but also the public tends to reconcile with the strict enforcement of consent legislation and internalize the practice of exclusion of the family from the decision-making process.

#### Empirics prove—presumed consent policies would increase organ donation by 25-30%.

Abadie and Gay 6, (Alberto Abadie, Harvard University and NBER, Sebastien Gay, University of Chicago, The Impact of Presumed Consent Legislation on Cadaveric Organ Donation: A Cross Country Study, Journal of Health Economics 25.4 (2006): 599-620, http://www.sciencedirect.com/science/article/pii/S016762960600004X) [PDI]

In this article, we argue that legislative defaults on organ donation may affect the consent decisions of the families, even if they are not enforced. First, we use a simple model to illustrate how presumed consent laws may affect organ donation rates. In addition, using a panel of countries, we show that, once other determinants of organ donation are accounted for, cadaveric donation rates are 25% to 30% higher on average in presumed consent countries. The magnitude of this estimate does not vary much across the different specifications of our empirical model. Furthermore, using the panel structure of our data we are able to reject the presence of additive fixed effects.¶ Health professionals and organ donation activists in the U.S., Great Britain, and several other countries have proposed changing legislative defaults on organ donation to presumed consent. The results of this article suggest that presumed consent laws may alleviate organ shortages.

#### Spain, Belgium, and Austria prove—presumed consent increases organ donation.

Gundle 4, (Kenneth Gundle, BA Stanford University, Presumed Consent for Organ Donation: Perspectives of Health Policy Specialists, Stanford Undergraduate Research Journal, (2004) Spring, pp. 28-32, http://web.stanford.edu/group/journal/cgi-bin/wordpress/wp-content/uploads/2012/09/Gundle\_SocSci\_2004.pdf) [PDI]

Organ donation rates in Spain, Belgium, and Austria suggest that presumed consent might have a posi- tive effect on rates of organ donation. In 1999 Spain had an organ donation rate of 33.6 donors per million people (a 142% increase in ten years) while in the same year, the United States had 21.8 donors per million (Matesanz et al., 1996; Matesanz and Miranda, 2000). Spain’s success was not necessarily the result of presumed consent, as its infra- structure and education systems greatly improved during that same time period, but the effect of Spain’s policy change to presumed consent may have been an important factor. After Belgium passed presumed consent legislation in 1986, its donation rates also rose dramatically (Michielsen, 1996). A frequently cited example is that of two similar transplant centers in Belgium – one in Leuven and one in Antwerp. Leuven switched to presumed consent with the passage of the law and in three years, its donation rate climbed from 15 to 40 donors per million, while Antwerp did not change its policy and only maintained previous levels (Kennedy et al., 1998). In Austria, presumed consent became law in 1982, and by 1990, the rates of donation had quadrupled, to the point where the num- ber of patients awaiting kidneys nearly equaled the number of kidney trans- plants performed (Gnant et al., 1991). Implementation of presumed consent was followed by increased organ dona- tion rates in these three countries.

#### 34 countries over 5 years prove—presumed consent increases organ donation by 21-26%.

Neto et al. 7, (Giacomo Balbinotto Neto, Economics Department, the Federal University of Rio Grande do Sul, Ana Katarina Campelo, Professor of Economics, Everton Nunes da Silva, Ph.D student at UFRGS, The Impact of Presumed Consent Law on Organ Donation, Berkeley Program in Law and Economics, Latin American and Caribbean Law and Economics Association (ALACDE) Annual Papers 05-29-2007, escholarship.org/uc/item/46670901) [PDI]

The aim of this paper was to discuss some issues related to the presumed consent law, and to bring up empirical evidence of the supposed impact of this legislation on cadaveric organ donation. In order to do this, a review of related works was carried out. For the empirical part, a sample of 34 countries over 5 years was analyzed. The method applied was quantile regression for panel data, which we believe is an appropriate way to investigate such a heterogeneous sample as there has been criticism of results obtained by conditional mean approaches due to some outliers (especially the Spanish case, which has the biggest cadaveric organ donation rate by far). This paper is the first to apply this method of investigation to this subject.¶ As it has been stressed, in this paper and others, the two kinds of legislation on cadaveric organ donation are imperfect, because there are always people whose true wills are not executed. In this way, policy makers must weigh the pros and cons of each piece of legislation. The results reported in this paper could be used to clarify the benefits of adopting presumed consent, which has a positive effect of 21-26% on cadaveric organ donation related to informed consent countries. Also, the methodology applied in this paper was able to provide evidence against a common belief in related literature that presumed consent has a positive effect only because of the outstanding Spanish donation rate. The left tail of distribution (countries with lower organ donation rate) has shown a positive impact on the response variable, which contradicts this common belief.

#### **Several studies show presumed consent increases donation rates by 25-30%**

English 07
Veronica English deputy head of medical ethics, British Medical Association, “Is presumed consent the answer to organ shortages?” BMJ | 26 may 2007 | Volume 334 [PDI]

Of course, the key question is does it work? It is notoriously difficult to prove a causal relation between particular determinants and donation rates and to extrapolate from the experiences of one country to another. Nevertheless, **careful analyses seem to indicate that presumed consent improves donation rates. Analysis of 28 countries found that those countries that consistently implemented a policy of presumed consent had higher donation rates than those that did not**.6 Abadie and Gay did **a detailed regression analysis comparing 22 countries over 10 years taking account of determinants that might affect donation rates**: gross domestic product per capita, health expenditure, reli‑ gious beliefs, legislative system, and number of deaths from traffic crashes and cerebrovas‑ cular diseases.7 They **concluded that “When other determinants of donation rates are accounted for, presumed consent countries have roughly 25-30% higher donation rates than informed consent countries**.” One explanation is that, even if the family has the final say, countries with presumed consent legislation have fewer refusals. **Spain has the highest recorded donor rate in the world, at 35.1 donors per million** pop‑ ulation (compared with 12.8 in the UK).8 So what can we learn from there? Spain has a presumed consent system (although in prac‑ tice relatives are consulted) and has invested heavily in transplantation9 : over a decade the number of transplant coordinator teams increased from 25 to 139.10 This combination of a system of **presumed consent**, which portrays a positive attitude towards donation, major financial investment, and good organi‑ sation, **seems to be the way forward**.

#### Several studies show presumed consent increases organ supply

Pierscionek 08

Barbara K Pierscionek, pf in the Department of Biomedical Sciences, University of Ulster, “What is presumed when we presume consent?” biomedcentral.com/1472-6939/9/8 [PDI]

**According to one mathematical model, organ availability is likely to be higher when presumed consent measures are introduced**, even when other confounding factors are taken into account, but ambiguities in the model are acknowledged [19]. **Results of a study on twenty-two countries show that** whilst **the highest rates of donation are found in countries** like Spain, Austria, Latvia, Portugal and Belgium **where presumed consent operates**, there is a greater rate of donation (per million population) from Ireland (where informed consent is required) than from France, Slovenia, Czech Republic, Hungary and Italy where presumed consent applies [19]. The factors that influence donation have not been fully identified. **It is notable that, with some exceptions, the Catholic countries of Europe, where the legal system is based on Roman law, presume consent** [19,22,23] **and stress the importance of 'for the greater good'** [23]. In Protestant countries, individual rights are considered foremost and informed consent is more likely to be required [23].

### Spain + Europe Pro-dict

#### The Spain and European statistics are legit – lots of controls and comparisons – don’t buy their alt cause arguments

Gundle 05

KENNETH GUNDLE, “Presumed Consent: An International Comparison and Possibilities for Change in the United States” Cambridge Quarterly of Healthcare Ethics (2005), 14, 113–118. [PDI]

This effort to reorganize **the Spanish model bore great dividends**. In 1989 there were 14 donors per million people, and **by 1999 the number had continually grown up to 33.6 donors per million—the highest in the world.** This success has benefits beyond shortened waiting lists and increased quality of life. Spain estimates that its 10,000 renal transplant recipients save approximately $207,000,000 every year. “In Spain, transplanting a single kidney represents a savings of more than 200,000 euros in relation to the alternative of maintaining the patient on dialysis.” 5 Spain’s system has shown itself to be a success, and presumed consent is not the sole cause. As noted above, education and media promotion, along with the ONT’s strong infrastructure, had much to do with the success of the system. What Spain did was match solid infrastructure and education to a foundation of available organs in the population as a whole. Presumed consent is the backbone of the system, but it alone does not contain the entire solution. **Is the success of Spain’s organ donation policy an anomaly? Could it be that something in their culture is the real source of success? Certainly culture does play a role** in defining how a society will respond to the issue of organ donation. Research in the United States about acceptance and political feasibility of presumed consent is necessary. **If Spain were the exception, then one would predict that other countries with presumed consent would not share their success; however, this is not the case.** Until 1986 Belgium did not have a presumed consent law, and although Perspectives 114 organ transplantation began early in that country, organ shortage was a serious problem. “Major efforts had been made to increase the number of donors by sensitizing the media and informing the public and the medical profession. However, the number of donors increased only slowly.” 6 The issue of changing the **[when the] Belgium law** was hotly contested, but after the bill **passed** never more than 2% of the population has registered an objection to organ donation. In 1985 Belgium had 20 kidneys donated per million, but by only 1988 **the number had risen [from 20] to 37.4 per million**—**a very dramatic rise in a few years under presumed consent.** **Was the increase in donation in Belgium due to the change in legislative framework or simply the increased publicity** regarding organ donation that accompanied the legislative debate? **Two similar transplant centers in Belgium, in Antwerp and Leuven, make for a good comparison. Antwerp did not switch to presumed consent following the passage of the law whereas Leuven did. Over a three-year period Leuven saw its donor rate climb from 15 to 40 donors per year, whereas Antwerp only maintained its previous levels.** Another comparison could be made between Belgium and the nearby Netherlands. Whereas in 1986 Belgium chose presumed consent, **The Netherlands continued with expressed consent. Both countries started doing transplants early, have a high population density, and operate a large number of hospitals with functioning ICUs. But between 1993 and 1995 Belgium had 39.9 kidney donors per million people, whereas The Netherlands has only 27.9 per million,** a trend that is similar in other organs as well. Other countries continue this pattern of differences between opt-out and opt-in systems. In Austria presumed consent was first introduced in 1982 and the rates of donation quadrupled by 1990. The case there has been so dramatic that in 1990 the number of patients on the kidney waiting list nearly equaled the number of kidney transplants performed. And **Denmark, which switched from presumed consent to expressed consent in 1986, saw its previously high donation rates fall by half.** A recent study sought to determine predictors of cadaveric organ donation in Europe. Even though the study excluded Spain due to its “extreme outlier status” its conclusions “clearly suggest that the practice of presumed consent (opting-out) legislation has had a significant effect on the number of cadaveric donors per million population.” 7 **This statistical analysis succinctly shows that policy can make a significant impact, and that presumed consent results in greater numbers of organs procured. Occasionally a critique will cite that higher than average traffic accidents** in countries like Spain, Austria, and Belgium **are the real contributing factor** to higher donation rates simply because more people die on the road and their organs are used for transplantation. **The evidence, however, does not support this. During the periods in which both Spain and Belgium’s donation rates grew most rapidly, both countries saw steady declines in their rates of roadway accidents. In Austria only 30% of all organ donors come from road victims, so that this alone cannot explain the higher donation rates**.

### AT Increases Refusals

#### **Stats say otherwise – Spain has created a positive view of donation through presumed consent**

Hamm and Tizzard 08

Danielle Hamm and Juliet Tizzard, Presumed Consent for Organ Donation, BMJ: British Medical Journal, Vol. 336, No. 7638 (Feb. 2, 2008), p. 230 [PDI]

A key question is whether **such a system would increase organ donation rates; [based on] a growing body of evidence** indicates that it would. The relation between presumed consent and donation rates is notoriously hard to understand because of other determinants that affect donation rates. **A study in 2006 compared 22 countries over 10 years; it took account of determi nants that might affect donation rates**, such as health expenditure and number of deaths from road crashes.4 It concluded that "When other determinants of dona tion rates are accounted for, **presumed consent coun tries have roughly 25-30% higher donation rates than informed consent countries." A study in 2003 found similar results**.5 Spain consistently has the highest donor rate in Europe. One major difference between **Spain** and the UK is that it **has an exceptionally highly organ ised and well funded system.** The recent report of the UK Organ Donation Taskforce has drawn on the experience of **Spain** and has centered its recommen dations on increasing organ donation rates through **improved infrastructure, coordination, and funding**. The other major difference with Spain is that it has a system of presumed consent. Although relatives are still consulted, **the system of** presumed consent, **which** presents a very positive view of donation**, has resulted in a decrease in the number of relatives' refusals**.4 The UK can learn two lessons from Spain, one regarding improvements to infrastructure-which the BMA wel comes government commitment to-and the other regarding presumed consent.

### AT Vulnerable Populations

#### Presumed consent would include exemptions

Neades 09

Barbara L Neades, pf Napier University, “Presumed Consent to Organ Donation in Three European Countries” Nursing Ethics 2009 16 (3) 2009 [PDI]

The application of PCL is often facilitated by the use of registers of objection. Although these may provide a method for competent individuals to record their consent or objection to donation, questions remain about the protection of incapacitated and vulnerable persons from automatically being identified as donors resulting from their inability to record an objection. **If PCL were to be applied in the UK, a systematic infrastructure for recording individual objection to organ donation would require to be established. Vulnerable or incapacitated people would have to be protected. This would potentially require a review of all individuals over the age of consent who would be considered exempt, such as persons with severe mental health problems, those with severe learning difficulties or who do not speak English well enough to comprehend the legislation. Such people would have to be identified and considered as automatically exempt from the legislation.** Even if these data could be collected, a regular system of updating would be needed to maintain a ‘live’ register. The organizational and financial implications of establishing such a system would be huge and would need to be explored before a change in legislation could be considered. Practical aspects on how transplant co-ordinators, often but not exclusively nurses in the UK, would appropriately access and use this information also requires to be examined.

## Advantage – Econ

#### Increased organ donation helps the economy—saves millions in healthcare costs.

Gundle 4, (Kenneth Gundle, BA Stanford University, Presumed Consent for Organ Donation: Perspectives of Health Policy Specialists, Stanford Undergraduate Research Journal, (2004) Spring, pp. 28-32, http://web.stanford.edu/group/journal/cgi-bin/wordpress/wp-content/uploads/2012/09/Gundle\_SocSci\_2004.pdf) [PDI]

Higher rates of organ donation not only result in saved lives, but frequently in saved financial resources. Spain esti- mates that its 10,000 renal transplants save approximately $207 million every year (López-Navidad et al., 2002). Compared to dialysis, transplanting a kidney is beneficial both in quality of life for the patient and in money spent. In the United States, there are currently over 50,000 people on the waiting list for kidney transplants, which potentially represents a large savings in healthcare expenditures.

## Advantage – Black Markets

#### Presumed consent solves black markets—demand for organs is reduced legally.

Glaser 5, (Sheri R. Glaser, J.D. candidate at the Washington College of Law, "Formula to stop the illegal organ trade: presumed consent laws and mandatory reporting requirements for doctors." Human Rights Br. 12 (2005): 20-46, digitalcommons.wcl.american.edu/cgi/viewcontent.cgi?article=1311&context=hrbrief) [PDI]

Presumed consent, when the state strictly follows it, is the best- practice method of legally obtaining organs. In countries with presumed consent laws, there is a higher procurement rate for organs than in countries without these laws. Many argue that if the demand for organs were met legally, then people would have less incentive to illegally obtain organs and the black market would eventually diminish. On a more basic level, if there were more organs available for transplant, then more people’s lives would be saved. In addition, presumed consent leads to improvements in tis- sue matching between donor organs and recipients, and it allows surgeons to be more particular about which organs are selected. Furthermore, these laws allow for more careful application of brain-death criteria because the increased supply of donor organs diminishes incentive to obtain organs through “inappropriate” means. For example, there have been cases in Russia and Argentina where organs were removed from comatose patients who were pre- maturely declared brain-dead. Presumed consent also ensures that organs are “fresher” because it eliminates the doctor’s need to con- tact the deceased’s next of kin, thus shortening the time between death and determination of consent. Lastly, the decision as to whether or not to donate organs is not made during the grieving period immediately following someone’s death.

## Mechanism - Family Involvement

### Solves Autonomy

#### Presumed consent requires abiding by the family’s wishes – that solves the autonomy problem

Neades 09

Barbara L Neades, pf Napier University, “Presumed Consent to Organ Donation in Three European Countries” Nursing Ethics 2009 16 (3) 2009 [PDI]

**A striking feature of the legislation of the three countries was the requirement for the family to be involved in the organ donation decision-making process. In Norway, the next of kin must be approached to confirm that the potential donor had not expressed any objection** to organ donation. **In Belgium, the legislation specifies that,** if there is an expressed wish to donate recorded by the deceased person, the family cannot object. The participants stated that **families were always approached to confirm** deceased persons’ lack of objection. **Those in Portugal also reported confirming with families** their deceased relatives’ lack of objection and exploring objections to proceeding to donation. However, despite legislative terms giving families no right to veto a deceased relative’s decision, the HCPs reported that, **if relatives became distressed or objected to organ donation, they would find it very difficult to override their wishes and proceed to organ donation.** They confirmed that, **in practice, they would always defer to the wishes of the family.** However, the absence of a deceased person’s name on the objection register would facilitate open discussion about organ donation with family members.

#### Good for family bereavement

Neades 09

Barbara L Neades, pf Napier University, “Presumed Consent to Organ Donation in Three European Countries” Nursing Ethics 2009 16 (3) 2009 [PDI]

The participants also suggested that **family involvement aided** family **acceptance of the deceased person’s death.** In their view, relatives’ **agreement to donation afforded them comfort in the knowledge that ‘something positive’ had been possible, despite their personal tragedy.** However, bereaved families’ ability to participate in the decision making was often dependent on their prior knowledge and understanding of the law and organ donation. It is interesting to note that the participants also expressed the view that exclusion of families from the decision making holds the potential to develop negative publicity among the general population. In their opinion, if this occurred, suspicion and fears would be raised in the minds of the public concerning unacceptable practices in organ donation.

## Various Morals Affs

### Rights of the Deceased

#### Dead people aren’t moral agents

Hughes 09

Paul M. Hughes, Ph.D., Professor of Philosophy, Department of Literature, Philosophy, and the Arts, University of Michigan-Dearborn, “Presumed Consent: State Organ Confiscation or Mandated Charity?” HEC Forum (2009) 21(1): 1–26 [PDI]

In a general definition, Cherry explains that **persons are those beings who possess cognitive abilities to “understand themselves in a self-conscious, self-reflexive way”** (2005, p. 22). Rationality and the consciousness inseparable from thinking are central to our ability to choose, make agreements, and engage in collective activities. **Invoking Kant’s moralized notion of personhood as an agent capable of making autonomous choices and bearing responsibility,** **Cherry claims that “once beings permanently lose** **the cognitive capacities that sustain personhood, they become** beings, if not **things, which have the character of being former persons**” (p. 22).24 From this, Cherry infers that **former persons cannot, in principle, “possess concern for ownership of or trade in human organs,” since they are not moral agents.**

#### The body is a vessel for a person but after death there’s no need for the vessel

Pierscionek 08

Barbara K Pierscionek, pf in the Department of Biomedical Sciences, University of Ulster, “What is presumed when we presume consent?” biomedcentral.com/1472-6939/9/8 [PDI]

**If functionality of body organs becomes of prevailing importance, it could be argued that the body is predominantly a vessel equipped with all the necessary instrumentation for maintaining life and that is occupied and used by the person to whom the body belongs. Consequently, if presumed consent is advocated, it could be reasoned that since after death the 'occupant' no longer needs the 'vessel', if any of the instrumentation is still functional it should be used to better or save the life of another.** The acceptance of this premise and hence of the liberty of the state to assume the rights to decide about further usage (pending no objections) raises further issues about the right of ownership and hence who should benefit from body organs, and how presumed consent will extend to competent minors and mentally incompetent adults.

### Polls

#### UK affirms

BBC 07

“Most back opt-out organ donation” 18 October 2007 [PDI]

**A large majority** of the population **support** the idea of **presumed consent** for organ donation, survey findings have suggested. **Two-thirds of more than 2,000 people surveyed by the British Medical Association said the UK should move to an opt-out system.** At present organs can only be taken from people who have actively chosen to be donors, and carry donor cards. Every year hundreds of people die because of a shortage of donor organs.

#### U.S. public opinion polls favor presumed consent—multiple warrants.

Orentlicher 9, (David Orentlicher, Professor of Law, Indiana University School of Law- Indianapolis; Adjunct Professor, Indiana University School of Medicine; J.D., Harvard Law School, 1986; M.D., Harvard Medical School, 1981, PRESUMED CONSENT TO ORGAN DONATION: ITS RISE AND FALL IN THE UNITED STATES, RUTGERS LAW REVIEW, VOL. 61, 2009, http://ssrn.com/abstract=1207862) [PDI]

Public views can help us decide whether presumed or actual consent better serves the interests of patient autonomy. How, then, do people feel about presumed consent versus actual consent to organ donation? Polling data sends a mixed message. In a 2005 national survey, 85.9% of the public thought that presumed consent would increase the organ supply, but only 43.2% supported a system of presumed consent.93 On the other hand, only 31.3% said they would opt out of a presumed consent system.94¶ There may be better ways to measure people’s actual preferences. As James Muyskens has argued, we should consider the question of consent to posthumous organ donation as a question of “health insurance” and ask what a rational person would be willing to “pay” in order to have the health care needed in the event of organ failure.95 From that perspective, he observes, people generally would be willing to relinquish their right to be buried intact in order to have a decent chance of receiving an organ transplant at a time of need.96 Very likely, people would choose the greater opportunity to live longer over the greater opportunity to retain organs after death.97¶ One could come to the same conclusion by asking which policy will have the smaller risk of error. Under current policies of actual consent, how many people do not become organ donors despite their desire to donate (erroneous non-donations)? On the other hand, if policies of presumed consent were adopted, how many people would become organ donors despite their opposition to donating (erroneous donations)? We could choose the policy that maximizes the number of people whose wishes are fulfilled.¶ Under this approach, it appears that presumed consent is the better policy.98 Public opinion surveys consistently find that a majority of people say they want to have their organs used for transplantation after death.99 More than 70% of the public states that they are somewhat or very likely to donate,100 and about 53.2% of people have documented their willingness to donate.101 It makes sense to base the law’s “default” rule according to the majority’s preference. That is, if 70% of people want to donate organs and only 30% do not want to donate, the law should assume that people want to donate, thereby satisfying 70% rather than 30% of the population.

### Saunders’ Normative Consent

#### If it’s wrong to withhold consent, then there’s no obligation to respect the lack of consent

Potts et al 10 summarizes Saunders [they conclude in disagreement]
[Michael Potts1 Joseph L Verheijde,2,3 Mohamed Y Rady,4,5 David W Evans6 Methodist University, Fayetteville, North Carolina, USA 2 Departments of Biomedical Ethics, Physical Medicine, and Rehabilitation, Mayo Clinic, Phoenix, Arizona, USA 3 Center for Biology and Society, School of Life Sciences, Arizona State University, Tempe, Arizona, USA 4 Department of Critical Care Medicine, Mayo Clinic, Phoenix, Arizona, USA 5 Center for Biology and Society, School of Life Sciences, Arizona State University, Tempe, Arizona, USA 6 Queens College, Cambridge, UK] “Normative consent and presumed consent for organ donation: a critique” J Med Ethics 2010;36:498e499 [PDI]

Saunders bases his argument on the notion of ‘normative consent’, an idea he borrows from David Estlund. Estlund claims **there are situations in which people withhold consent ‘wrongly’ so that such non-consent is ‘defective’.** 7 He means ‘wrongly’ in the moral sense; **sometimes the goods gained by consenting to X are such that withholding consent from X is morally wrong.** **Saunders claims that it is morally wrong to withhold consent for donating one’s ‘cadaveric organs’. Therefore, even if the wishes of a potential organ donor are not known at the time he or she is a candidate to donate his or her organs, it is morally legitimate to take those organs.** The idea is that **if the patient had been previously opposed to organ donation and would not have given consent, such lack of consent would have been morally wrong, and there is no moral obligation to go along with an immoral lack of consent**. ‘Implicit or explicit’ consent to donate one’s organs ‘is not needed’. 6 Saunders claims that **[t]his view ‘supports an opt-out system** which provides protection for those who have genuine reasons to refuse donation and spares the worries as to what the deceased would actually have wanted.

### Intention/Social Norms

#### **Presumed consent laws intend to increase donation rates – the law expresses a social norm in favor of increasing organ supply**

Bilgel 12

Fırat Bilgel, Department of Economics, U of Bologna, “The impact of presumed consent laws and institutions on deceased organ donation” Eur J Health Econ ‘12 13:29–38 [PDI]

On the other hand, **presumed consent laws express a social norm about the default course of action.** On the contrary of informed consent where donation is a special option (opt-in), it is assumed to be the default option (opt out) under presumed consent [15]. Therefore, **a higher number of deceased organs is expected to be procured because individuals who do not legally express their wishes to not donate are considered as having no opposition to have their organs removed.** **Based on this view, enforcing presumed consent may have a positive effect on donation rates** but it may not be of great magnitude because in practice families can override the wish of the deceased individual to donate.

## AT Autonomy

### Consent is Not Absolute

#### **There are exceptions to consent when the stakes are high**

Collins 09

Mike Collins, Ph.D. (Candidate), CUNY Graduate Center, Department of Philosophy, “Consent for Organ Retrieval Cannot be Presumed,” HEC Forum (2009) 21(1): 71–106 [PDI]

**Sometimes obtaining explicit informed consent is not possible and the consequences of waiting for the opportunity to do so before going ahead with some medical intervention are dire. In these cases,** because the consequences are dire and because **it is not possible to obtain consent, medical professionals are morally justified in proceeding without explicit consent, on the presumption that, were this person capable of so doing, she would consent to such an intervention.** Life-saving interventions are the paradigm example of this circumstance. When a team of paramedics arrive at a scene on a report of a severe case of asthma and find a young person in respiratory arrest or what appears to be impending respiratory arrest, they are not required to engage in a discussion of the risks and benefits associated with emergent intubation. **The patient is in no condition to have this conversation, so consent is not possible, and the consequences of not intervening on her behalf include the likelihood of death. In this case, consent can be presumed** – but on what grounds?

### Public Disagrees

#### If there is an autonomy violation, it’s not the kind that people care about

Neades 09

Barbara L Neades, pf Napier University, “Presumed Consent to Organ Donation in Three European Countries” Nursing Ethics 2009 16 (3) 2009 [PDI]

**Opponents** of PCL **suggested** that such legislation would lead to **a loss of individual autonomy and a perception of state**/government **control** of individuals.19 The HCPs, **however**, indicated that **the public expressed no sense of state ownership of individuals or organs**. The [idea of] government owning a person who lives in a country – when you are dying you are their property – is not a good way to think. **Instead**, **the respondents from all three countries believed that**, under PCL, **individuals retained the power to donate their organs as an altruistic or community-spirited act. They could also decide not to donate their organs by recording their objection on the register, thus preserving their autonomy.** On the contrary, if you are saying, well if you are dying, if you can give your organs to somebody, it is more important ... to say you can make a gift after your death and organize this. We respect the patients’ wishes if these are confirmed; if they don’t want to donate they can register their objection and that is no problem. Alternatively, where no register existed **individuals could express their views to their family, who could represent this view.** In the case of those without the capacity Presumed consent to organ donation to consent, such as a child, the respondents were confident that **a parent or individual with parental responsibility would be asked to consent** to organ donation. However, in the case of an incapacitated adult, HCPs could not confirm that these individuals would not automatically become organ donors as a result of their names not appearing on the objection register. HCPs did report that the **normal practice for incapacitated individuals was either to exclude them from organ donation or to seek the agreement of their advocate or legal guardian.** The participants were not aware of any method of identifying the names of vulnerable individuals or those with incapacity to secure their exemption.

### Family Veto Good

#### Families can be used as a proxy – that might avoid autonomy problems

Neades 09

Barbara L Neades, pf Napier University, “Presumed Consent to Organ Donation in Three European Countries” Nursing Ethics 2009 16 (3) 2009 [PDI]

Thus, despite any intention recorded by the deceased person**, it could be said that families are used as a method of proxy authorization or refusal for organ donation. Allowing families to object to organ donation in this manner if the deceased person has indicated a wish to donate poses questions concerning individuals’ right to determine what happens to their body after death.** The need to respect the wishes of dead persons while also respecting the wishes of their families presented a dilemma for the HCP participants. **The view expressed by some participants was that families were able to represent deceased relatives’ wishes in relation to organ donation.** Without concrete evidence of deceased persons’ views, however, this assertion is difficult to support. The role of families in representing their deceased relatives’ wishes and the validity of any consent given by families to proceed to organ donation therefore requires to be clarified.

#### The rights of the family aren’t violated by presumed consent

Neades 09

Barbara L Neades, pf Napier University, “Presumed Consent to Organ Donation in Three European Countries” Nursing Ethics 2009 16 (3) 2009 [PDI]

The **routine involvement of families in decision making in organ donation [occurs]** despite the legislation in place **in Portugal, Norway and Belgium** had not previously been identified or publicized. This supports the findings of a study in France that found HCPs did not use the full powers of the legislation but allowed families’ views to influence their decision to progress to organ donation.42 **In Portugal and Norway, objections raised by families veto any agreement to donation recorded previously by the donor.** Only in Belgium was a positive decision to donate recorded by the deceased person in life upheld regardless of family opposition.

### Family Veto Bad

#### In the status quo, families can veto consent which violates the deceased’s autonomy. Presumed consent solves

Gundle 05

KENNETH GUNDLE, “Presumed Consent: An International Comparison and Possibilities for Change in the United States” Cambridge Quarterly of Healthcare Ethics (2005), 14, 113–118. [PDI]

There certainly is opposition to presumed consent, with some believing that presumed consent is unethical. **One objection is that presumed consent takes away individual autonomy** and that people will be disenfranchised from their own bodies. **However**, I argue that **presumed consent provides more thorough individual choice than under the current system.** **The present “encouraged volunteerism” relies more on the consent of the family than the individual. “We do not ask relatives to make decisions for adults and so there may seem something odd about asking them about donation of adult material, particularly if the prior views of the deceased are known.”**10 **Relatives are certainly unable to change the legal will** of the deceased, **so it is uncertain why they are able to alter the advance directive of a donor card.** Although this may be a type of familial autonomy, **the individual’s choice is subject to filial clearance**. **Under presumed consent, if a person opposes organ donation and fills out a card, he or she will certainly have that wish fulfilled.** This would require a national registry system, which is feasible. If the purpose of the organ donation community is to raise donation rates, but only through ethical means, then **it follows that the wishes of those opposed to donation must be protected.** More so than in the current United States system, **presumed consent protects the right to refuse to donate. Is this not individual autonomy?**

### Information + Family Solves

#### Good information means donors and families retain control

Hamm and Tizzard 08

Danielle Hamm and Juliet Tizzard, Presumed Consent for Organ Donation, BMJ: British Medical Journal, Vol. 336, No. 7638 (Feb. 2, 2008), p. 230 [PDI]

**One of the major concerns** people have with a presumed consent system **is that individuals will lose control over what will happen to their body after death, and the state will take over. This is not the case.** Like the current system, **under presumed consent people would retain** the **choice** over whether or not to donate after death. Imperative to **any change in legislation would [include]** be a **widespread public information campaign**, **which would target sections of society that are hard to reach**. Mechanisms must be in place to ensure **all members of the public are informed of their choices and can register an objection quickly and easily**-for example, **through their general practitioner, post office, or electoral registration forms.** As an added safeguard, **the system would retain a role for relatives. After death, relatives would be informed** that the deceased person had not opted out of donation and, **unless they object** either because they know of an unregistered objection by the person or because it would cause major distress to the close relatives-**the donation would proceed**.

### Education + Democracy Solves

#### Consent can be presumed if everyone knows the policy and it was passed by democratic means

Hughes 09

Paul M. Hughes, Ph.D., Professor of Philosophy, Department of Literature, Philosophy, and the Arts, University of Michigan-Dearborn, “Presumed Consent: State Organ Confiscation or Mandated Charity?” HEC Forum (2009) 21(1): 1–26 [PDI]

**One way to construe omissive behavior as tacit consent or agreement is to ensure that everyone affected by the decisions of the state authority understands that such behavior is tantamount to consent.** A common example is collective decision-making in which a duly recognized authority (e.g., department chair, company president) issues a proposal accompanied by a request for objections and revisions. If nobody objects or suggests changes it seems reasonable to construe that lack of response as a kind of voluntary agreement. What makes this plausible is the context in which participation in decision-making is common practice, and **the formal and informal rules that govern the interaction are (or should be) understood by all participants.** This example suggests that we might regard a policy of presumed consent similarly, at least **insofar as we could plausibly regard the public as being aware of the policy and its implications as well as the option of expressly dissenting from participation in the program. Perhaps something like the participatory nature of the collective decision-making context in the aforementioned example can be accomplished via a rigorous campaign of public education accompanied by a state by state or even national election on a presumed consent proposal**.

### No Coercion

#### Opting-out is easy enough that it can’t really be called coercion, and it gives the same option to not donate as the status quo

Den Hartogh 11

GOVERT DEN HARTOGH, “Can Consent be Presumed?” Journal of Applied Philosophy,Vol. 28, No. 3, 2011 [PDI]

A final remark. If opt-out systems fail to satisfy the requirement of consent, **should we conclude that in such systems people are coerced to allow the removal of their organs for transplantation?** Many opponents of ‘presumed consent’ see hardly any difference from conscription.48 **This seems altogether wrong. You can hardly claim that you have been coerced** into entering military service **when all you had to do in order to escape from it is to register an** (unexplained) **objection**. But suppose you didn’t know that you had this escape option? Then the question is whose fault this is. It will not do to refer to the usual fiction of the law that ‘every citizen is supposed to know the law’; **the government should at least take reasonable efforts to provide people with the relevant information. If that has been done**, however, **it may be true of opt-out systems** as we know them **that they** allow taking organs without consent, but they **cannot be considered to be coercive** for that reason.**They recognize your right to refuse the removal of your organs, even if they do not recognize to the same extent the right not to have them removed without your consent**.

#### Presumed consent doesn’t de facto exclude people from opting out—it’s just a question of accessibility and publicity.

Welbourn 14, (Hannah Welbourn, School of Medicine, University of Hull, UK, A principlist approach to presumed consent for organ donation, Clinical Ethics, 2014, Vol. 9(1) 10–16, http://cet.sagepub.com/content/9/1/10) [PDI]

The shortage of donors means that not all patients who require an organ transplantation have an equal opportunity to receive a donor organ; inevitably, decisions have to be made about the allocation of limited resources, which means that some patients miss out. Any measure that is likely to increase the supply of organs is therefore congruent with the principle of just- ice, which requires equal opportunities for all. However, it must be ensured that all of those who object to organ donation have the opportunity to register their wishes under a system of presumed consent. Those who do not understand or are not aware of a change to a system of presumed consent, such as individuals who aren’t fluent in the English language, and hard-to-reach groups such as the homeless, may potentially be disadvantaged by this system.4 This is not an insurmountable problem, and recognising these challenges serves to emphasise the importance of having a clear, easily accessible and widely publicised route for opting out of organ donation.

### Two Violations -> Minimize Total Violations

#### Violations of autonomy are inevitable under any paradigm of organ donation, so we should default to the system that produces the fewest violations of autonomy—that requires presumed consent.

Gill 4, (Michael B. Gill, Department of Philosophy, University of Arizona, Presumed Consent, Autonomy, and Organ Donation, Journal of Medicine and Philosophy 2004, Vol. 29, No. 1, pp. 37–59, www.u.arizona.edu/~gillm/media/articles/presumedconsent.pdf) [PDI]

I believe both sides have to admit that mistakes will occur under either system. No matter how well the current system is instituted, there will still be cases in which people who would have preferred to donate their organs will be buried with all their organs intact; call these mistaken non-removals. And no matter how well presumed consent is instituted, there will still be some cases in which people who would have preferred to be buried with all their organs intact will have some of their organs removed; call these mistaken removals. (There will probably also be some mistaken non-removals under presumed consent and some mistaken removals under the current system, but these kinds of mistakes are likely to be considerably rarer.)¶ Proponents of presumed consent can plausibly claim that under their proposal there will be fewer mistakes than under the current system. They can claim this not only because a majority of Americans prefer to donate their organs, but also because it is plausible to believe that a person who does not want to donate is more likely to opt out under a system of presumed consent than a person who does want to donate is to opt in under the current system. This belief is based on the idea that most of those opposed to organ transplantation have conspicuous religious or moral objections of which they themselves are very aware, and that as a result these people are unlikely to neglect to opt out of a system of presumed consent, unlikely in the same way a Quaker is unlikely to forget to register as a conscientious objector to the draft, or as a Jehovah’s Witness is to forget to inform her physician of his opposition to blood transfusion. The wish to donate one’s organs, in contrast, is usually tied to religious and moral values that are relatively unremarkable, and so people who wish to donate are less likely to register their preference.¶ Proponents of presumed consent maintain, then, that their policy will lead us to follow the wishes of more decedents than the current system does, that the current system produces more mistakes than a policy of presumed consent will. Those who argue for presumed consent in this way believe that from the standpoint of trying to respect the wishes of decedents, mistaken removals and mistaken non-removals are morally equivalent or symmetrical. Both kinds of mistakes violate the wishes of decedents, and so they are both morally unfortunate in the same way. We should, therefore, implement the policy that produces the fewest mistakes, without regard to the ratio of mistaken removals to mistaken non-removals. That means that even if presumed consent will lead to more mistaken removals than the current system, it will still be the right policy to implement if, as a result of greatly decreasing the number of mistaken non-removals, it leads to fewer mistakes overall. Call this the ‘‘fewer mistakes claim’’ for presumed consent.6

#### Qualitatively, mistaken removals and mistaken non-removals are equal violations of autonomy, which means you should evaluate autonomy debates based on minimizing the quantity of violations.

Gill 4, (Michael B. Gill, Department of Philosophy, University of Arizona, Presumed Consent, Autonomy, and Organ Donation, Journal of Medicine and Philosophy 2004, Vol. 29, No. 1, pp. 37–59, www.u.arizona.edu/~gillm/media/articles/presumedconsent.pdf) [PDI]

The key to seeing the moral equivalence between mistaken removals and mistaken non-removals is to distinguish between two models of respect for autonomy. These two models are closely related and usually overlap when the treatment of competent persons is concerned, but they will almost always come apart when the treatment of the bodies of brain-dead individuals is concerned. The first is what we can call the non-interference model of autonomy: it tells us that it is wrong to interfere with a person’s body unless that person has given us explicit permission to do so. The second is what we can call the respect-for-wishes model of autonomy: it tells us that we ought to treat a person’s body in the way that he wishes it to be treated.¶ It is reasonable to hold that the non-interference model of autonomy ought to govern our treatment of competent individuals. If someone is awake and aware, then we ought to assume that he would tell us if he wanted us to do anything to his body. So we ought not to do anything to the body of someone who is awake and aware unless he gives us explicit permission to do so.¶ But it is not reasonable to hold that the non-interference model ought to govern our treatment of brain-dead individuals. For the non-interference model implies that we would have to refrain from doing anything at all to the bodies of brain-dead individuals who had left no explicit instructions about how they wanted their bodies to be treated. But we have to do something to the bodies of such people. We have to treat them in one way or another. Literal non-interference – letting their bodies lay untouched where they fall – is not an option. So how do we go about trying to respect the autonomy of the brain- dead? We do so by acting under the respect-for-wishes model of autonomy, which tells us to do our best to treat persons’ bodies in the ways they wanted them to be treated. On this model, each type of mistake is on a moral par, for each type of mistake involves treating a person’s body in a way the person did not want.¶ If, then, our goal is to respect the autonomy of brain-dead individuals, we have no choice but to operate under the respect-for-wishes model of autonomy. And according to the respect-for-wishes model, we ought to implement the organ procurement policy that results in the fewest mistakes. If, therefore, presumed consent will result in fewer mistakes than the current system, presumed consent will be more respectful of autonomy than the current system.7

### AT Children/Adults Who Lack Capacity

#### Presumed consent legislation wouldn’t apply to those who can’t legally consent—solves autonomy violations.

Welbourn 14, (Hannah Welbourn, School of Medicine, University of Hull, UK, A principlist approach to presumed consent for organ donation, Clinical Ethics, 2014, Vol. 9(1) 10–16, http://cet.sagepub.com/content/9/1/10) [PDI]

Those members of society who are unable to make autonomous decisions, including children, and adults who lack the capacity required to consent, must be adequately protected by any consent system. The British Medical Association advises that children under 16 years of age, and adults who lack capacity, should be excluded from an opt-out system, with responsibility for giving consent to donation after death remaining with the individual’s parents or rela- tives.20 Some children younger than 16 years will be able to understand and weigh up the information sur- rounding this issue, and therefore should still be given the opportunity to opt in to organ donation themselves. Adults who lack capacity are not able to make an independent decision to opt-out, and it is therefore right to exclude these individuals from a change in legislation, in order to protect them from potential exploitation. There has been a concern that this approach may run the risk of propagating the unintended impression that the organs of such individuals are inferior in value21; however, it would be simple for any legislation to clearly explain that incorporating this approach into a system of presumed consent just ensures that vulnerable adults are adequately safeguarded.

### AT Property Rights

#### **Death without opting-out can be seen as a property rights transfer**

Hughes 09

Paul M. Hughes, Ph.D., Professor of Philosophy, Department of Literature, Philosophy, and the Arts, University of Michigan-Dearborn, “Presumed Consent: State Organ Confiscation or Mandated Charity?” HEC Forum (2009) 21(1): 1–26 [PDI]

**Assuming that people do have property rights in their bodies and body parts that permit them, as with other property, to voluntarily alienate them under certain circumstances, then** **if they fail to opt out of a program of presumed consent to organ harvesting of which they are aware it follows either that they have waived their property rights to their body/body parts and, thus, that state appropriation of those organs may not be theft** (though this would depend on what “waiving” such rights entails about who or what subsequently controls that body), **or that they transfer those rights, perhaps by forfeit, to the state.** But since the idea of waiving one’s property rights leaves in limbo the status of the property thus alienated and a policy of presumed consent is intended to exclude anyone other than the state from asserting a property right in the decedent’s body parts, then **presumed consent may be** more accurately **viewed as a program of property rights transfer, not merely the abandoning or forfeit of those rights or an agreement not to press them**.

### AT Greenawalt

#### Even consent is not enough to protect autonomy in all cases because of coercive relationships

Hughes 09

Paul M. Hughes, Ph.D., Professor of Philosophy, Department of Literature, Philosophy, and the Arts, University of Michigan-Dearborn, “Presumed Consent: State Organ Confiscation or Mandated Charity?” HEC Forum (2009) 21(1): 1–26 [PDI]

However, **Greenawalt’s examples** actually **suggest how easy it is for tacit promises or implied consent to fail**, especially if the context does not provide for relatively easy dissent and exit. Indeed, **even express consent may fail if a person verbally agrees to go along with a policy under pressure or duress**. Note that **his example involves a university dean explaining to a prospective new hire a policy relevant to the conditions of a position** for which she has applied. Although **such exchanges** are often innocuous and voluntariness is preserved, it is equally clear that they **may be coercive**. **In circumstances in which people are not on an equal footing with the authority** making a proposal and soliciting feedback, **it is often reasonable to refrain from voicing dissent since doing so may result in unacceptable consequences**, such as undermining a job offer. This applies as well to instances of implicit agreement or tacit promises. The general point is that **a person may have good reasons both for explicitly agreeing to a proposal and for refraining from dissenting from it; reasons which do not signify their commitment to abide by the proposal**, at least in a strong sense of voluntarily consenting to it.10

## AT Driver’s License CP

#### Presumed consent solves better – it doesn’t alienate families or force people to think about their mortality

Bard 12

Jennifer S. Bard (2012) pf @ Texas Tech, Lack of Political Will and Public Trust Dooms Presumed Consent, The American Journal of Bioethics, 12:2, 44-46 [PDI]

The low rate of organ donation in the United States has created a severe shortage that results in the premature death of thousands of men, women, and children every year. **Two frequently made proposals are to require potential donors to express a choice in writing and to pass laws which presume** everyone **consent**s to be a donor unless they specify otherwise (AMA 2005). **Whyte [et al]**, Selinger, Caplan and Sadowski (2012) write **oppos[es] a proposal to require a choice fromapplicants for driver’s license because** they believe that **rather than “nudging” people toward donation, and thus further “nudging” their loved ones to release the organs if the applicant becomes an eligible donor, it will do the opposite.** They believe that **requiring people to think about their own death when applying to engage in a dangerous activity will result in fewer drivers choosing to become donors.** Instead, they advocate for **presumed consent laws,** which, they believe, **will serve the same purpose of “nudging” families to release organs for donation**.

## AT Increase Donor Cards CP

#### Fears about lawsuits and upsetting the family prevent donor cards from being effective

Gundle 05

KENNETH GUNDLE, “Presumed Consent: An International Comparison and Possibilities for Change in the United States” Cambridge Quarterly of Healthcare Ethics (2005), 14, 113–118. [PDI]

It is commonly thought that **increasing the number of people with donor cards will alleviate the organ shortage in the United States.** “**Unfortunately**, organ **donor cards have not had a substantial effect on increasing the sup-ply of organs and tissues available for transplantation.”** 8 The Federal Patient Self-Determination Act of 1991 (PSDA) amended the Federal Medicare and Medicaid statutes, and as part of that act “advance directives” were emphasized as legal documents, which must be upheld by the doctor and hospital. **A donor card meets all legal requirements** of an advance directive, **yet health providers are reticent to rely on just a donor card, and “many requestors have set a de facto precedent of seeking consent from families before donation takes place.”** 9 Some of this may trace back to before the PSDA, when family consent was required as part of the Omnibus Reconciliation Act of 1986. Questionnaire results often indicate that **unease about litigation is also one common reason for ignoring any valid donor document. Despite precedence for the use of organ donor cards it is the potential donor’s family that can prevent transplantation from ever happening**.

## AT Legalize Sales CP

#### Legalizing organ sales cheats the poor – the market offers little money for botched surgeries which don’t help them at all because of lost work time and health

Badhwar 14

Neera K. Badhwar, “Kidneys, Commerce, and Communities” (Forthcoming in Commerce and Community, ed. Rob Garnett, Lenore Ealy, Paul Lewis Routledge, July 2014) [PDI]

**Kidney markets**, both black and legal, **face special problems** in India, **thanks to a generalized distrust and lack of mutual goodwill between the various classes: the well-off often prey on the not-so-well-off, the not-so-well-off on the poor, and the poor on the very poor**. Sometimes, as Katherine Boo documents in her book on an Indian slum, the very poor also prey on each other (2012). 17 The vast socio-economic differences between the various strata of society, and the struggle for existence on the margins by the poor, serve as a barrier both to the development of a sense of community, and to a strong rule of law. And **the absence or weakness of a sense of community and the rule of law serves as a barrier to a genuinely free, non-exploitative market in kidneys. The result, all too often, are involuntary or exploitative exchanges. Poor people are promised huge sums of money that dwindle to a fraction of the original sum after the surgery, or fail to materialize at all** (Goyal et al. 2002; Jha 2004; Taylor 2006). 18 **Even when they are not cheated, they are offered paltry sums (between $1,000 and $2,000) for their kidneys, and often undergo badly-performed nephrectomies, with little or no post-operative medical care forthcoming. This, in turn, often leads to an inability to work, leaving them worse off financially as well. In short, the poor are treated as a collection of “spare parts”** (Scheper-Hughes 2002), 19 **mere means to the ends of others**. Some studies – although not all - have reported that **the vast majority of vendors in India, Pakistan, Egypt, and the Philippines regret their decision to sell their kidneys on account of worsening health and, consequently, worsening financial condition** (Goyal et al. 2002). 20 For their part, **desperate to earn some money, vendors sometimes deliberately hide their problems from doctors** (or doctors from patients) **and pass on their infections** to kidney recipients.21 **Thus, kidney markets in India are often involuntary, and even when they are not involuntary, they are often exploitative of kidney vendors in taking unfair advantage of their desperation** (Feinberg 1988: 178 ff.). In short, exchanges in kidney black markets in India, like exchanges in drug black markets, are often predatory.22 Kidney black markets in India also often have adverse third party effects, such as **husbands coerc**ing **wives to sell their kidneys**, or **money-lenders pressur**ing **their debtors to sell** their own or their wives’ kidneys to pay off their debt, or **insisting on their kidneys as collateral before making a loan** (Satz 2010). 23 Extreme poverty, lack of community bonds, and the demand for kidneys together suffice for these third party effects. Yet selling a kidney is sometimes the better alternative: if it weren’t for their kidneys, it might be their children that poor people had to sell.24

#### These sales are coercive

Badhwar 14

Neera K. Badhwar, “Kidneys, Commerce, and Communities” (Forthcoming in Commerce and Community, ed. Rob Garnett, Lenore Ealy, Paul Lewis Routledge, July 2014) [PDI]

However, **the claim that all exchanges free of force and fraud are equally voluntary and equally just rests on very narrow conceptions of voluntariness and justice**, conceptions that reflect neither everyday thinking about, nor philosophical analysis of, either notion. **Consider**, for example, **a desperately poor but healthy woman whose family is on the brink of starvation because of a drought. Her circumstances have reduced her options to only bad ones. Hence, when she agrees to sell her kidney in exchange for $100 or a large sack of rice from a well-off man** (a payment actually deemed sufficient by a nephrologist in Manila), **her choice is made under duress**.27 **It is not coerced, but it has a feature in common with coerced choices: it is made unwillingly, in response to unusually constrained external circumstances and an unreasonable offer far below the usual market price. Her action is neither involuntary nor fully voluntary, but mixed, done only to avoid something even worse** (Aristotle 1999). 28 Likewise, **when her well-off buyer drives, as we say, “a hard bargain”, he doesn’t coerce her, but his action has a feature in common with coercion: it exploits her vulnerability to gain a hugely disproportionate advantage for himself**. **Like coercion (and fraud), an exploitative exchange shows scant regard for the vulnerable person.** This last might invite the reply that since the exchange in question both respects the kidney vendor’s rights and saves her life, it can hardly be described as showing scant regard for her. Nothing I’ve said so far shows that a non-coercive, mutually advantageous exchange can be exploitative. The kidney-for-a-sack-of-rice deal will enable the kidney seller and her family to survive for a month instead of, say, only five days. The claim that an exchange must be harmful to one party to count as exploitative has been disputed. For example, Feinberg argues that **exploitation can occur “without harming the exploitee's interests** and … despite the exploitee's fully voluntary consent to the exploitative behavior….” (op. cit. 176–79). But whether or not harm is necessary for exploitation, **in the case at hand the harsh terms of the exchange do make it harmful to the kidney vendor in the long run. For a nephrectomy on a woman about to go on a starvation diet is all but guaranteed to kill her. The kidney recipient saves the desperate woman’s life at time t1 at the cost of depriving her of her health and perhaps even life at time t2.** Compared to the baseline of no-exchange (and certain death from starvation in five days), she is better off. This is reason enough not to ban kidney sales. As Alan Wertheimer argues, however, the no-exchange baseline is not the only relevant baseline in evaluating an exchange (Wertheimer 1996; Wertheimer, Zwolinski, 2013). 29 Evaluating the justice of an exchange requires comparing it to the baseline of a just exchange, an exchange that does not take advantage of either party’s vulnerability to harm her. And by this baseline, the woman is worse off. The woman’s situation is akin to that of a man dying of thirst in a desert, and the buyer’s to that of a well-stocked, well-off tourist who agrees to give the dying man water in return for all his property after they reach home. **Every philosophical theory of ethics joins commonsense morality in condemning such a deal as unconscionable,** and the common law agrees by refusing to uphold it if the thirsty man reneges on it. **For an almost costless rescue such as this ought to be done without demanding anything in return** (even though, as most of us believe, it ought not to be legally compulsory). Any well-off tourist with water to spare ought to give the thirsty man some water just because the thirsty man is a human being like himself who has been rendered helpless by circumstance. Likewise, **any well-off buyer of a kidney ought to give the desperate woman the price she would have commanded had she not been desperate, and ought to do so just because the kidney seller is a human being like himself rendered helpless by circumstance**. The tourist and the kidney buyer would see this for themselves if they asked themselves that most familiar of questions: “**How would you like it if someone did this to you?”** In both the desert and the kidney exchanges, the well-off parties save the desperate individuals from imminent death in exchange for long-term advantage to themselves and long-term grievous harm, perhaps even death, for the desperate individuals. In so doing, **they treat the desperate individuals as mere means to their ends, resources to be sucked dry and left to their fate**. Their actions and attitudes say, in effect, that the life and well-being of these individuals are of no moment after they have served the interests of the better-off parties. Thus, **they both degrade the vulnerable individuals and harm them. The snapshot view of exchanges typical of economics obscures these facts because it omits the details that make them visible.** Like force and fraud, benefiting ourselves by imposing a grave cost on others just because we can violates Kant’s “humanity principle”, the principle that says that people are ends in themselves, not mere means to our ends. And violating this principle is unjust, because it fails to give people their due.30

## AT Mandatory Consent CP

### No Solvo

#### Mandatory consent doesn’t solve the problem – some people will still neglect to explicitly decide

Den Hartogh 11

GOVERT DEN HARTOGH, EMERITUS PROFESSOR, DEPARTMENT OF PHILOSOPHY, UNIVERSITY OF AMSTERDAM, “Can Consent be Presumed?” Journal of Applied Philosophy,Vol. 28, No. 3, 2011 [PDI]

Legal systems regulating the procurement of post-mortal organs for transplantation are usually classified into opt-in and opt-out systems. Systems of both types purport to respect the decision of the deceased person, whether his decision is to donate or to refuse donation, or to hand over the decision to his relatives (or to some other person). The basic difference between these systems of organ procurement concerns what they take to be the default: what will happen when the deceased has not made any decision at all. In pure opt-in systems the default is that no removal of organs will take place, in opt-out systems that it will take place. In the systems commonly known as opt-in systems, however, the actual default is that the decision will be made by the family of the deceased; hence a threefold classification would be more accurate than the present one **Theoretically we could have a no-default system, in which the law requires every citizen to make an explicit decision. But people will need some time to make a decision, and during that time they may tragically die and leave organs suitable for transplantation. And there will always be some people who fail to decide, whatever the sanctions attached to such failure. Hence even so-called mandatory choice systems will as a matter of fact have to identify a default.**

#### **In the Netherlands, mandated choice only got 41% response – most people don’t care or can’t decide**

Den Hartogh 11

GOVERT DEN HARTOGH, EMERITUS PROFESSOR, DEPARTMENT OF PHILOSOPHY, UNIVERSITY OF AMSTERDAM, “Can Consent be Presumed?” Journal of Applied Philosophy, Vol. 28, No. 3, 2011 [PDI]

However, it is unclear whether such polls really show what they are supposed to show. **Take for example** the case of the **Netherlands**, where the polling results are at the same high level.16 At the introduction of a Donor Register in 1998 **all Dutch citizens were asked to declare whether they want to be a donor, object to being one, or leave the decision to their relatives** or to a named person. Since 1998 everyone is asked to make this choice on reaching the age of 18. But **only 41% of the population have actually registered a choice,** and only 56% of those (23% of the population) have registered as donors.17 Even more revealing may be the fact that in opinion surveys up to 45% of the people interviewed say they have registered as donors. We don’t know to what extent this misrepresentation is intentional or not. It may be paying homage to the socially desirable, but it may also largely be wishful thinking. Why do 59% fail to register? **Many people are not sufficiently interested in the issue** to spend time on making up their minds; in particular, **they don’t want to be confronted with** their own **mortality**. **A** much larger **number of people are unable to make up their minds.** Yes, they are in favour of transplantation medicine because of the extent to which it improves patients’ chances of survival and their welfare. But this rather abstract general attitude is counterbalanced by a number of doubts concerning their own individual cases: **the burden for the relatives, some mistrust of doctors, the wish to leave the dead body intact for some time, and more or less vague religious objections.** Interestingly these doubts tend to be expressed, not as beliefs to which one clearly subscribes, but only as ‘feelings’.1

### Solvency Turn

#### **Mandatory choice decreases organ donations – families decide to veto, empirical studies prove**

Kessler and Roth 14

By Judd B. Kessler, dept of econ @ UPenn, and Alvin E. Roth\*, dept of econ @ Stanford, “Getting More Organs for Transplantation” American Economic Review: Papers & Proceedings 2014, 104(5): 425–430 [PDI]

In ongoing work, we are investigating whether the effect of framing the organ donor registration question as a mandated choice increases registration rates over an opt-in frame where individuals check a box to register and leave it blank not to register. **Results from an experimental study of actual organ donor decisions** on the Massachusetts Organ and Tissue Donor Registry **suggest that the mandated choice frame may not deliver an increase in registrations as promised** (Kessler and Roth 2013). In addition, we find that **mandated choice may have a negative effect on organ donation,** even if it leaves organ donor registration unchanged. As discussed above, registrations are not the only way organs can become available for transplant; **the organs of an unregistered deceased can be donated by surviving next of kin. In a hypothetical choice experiment we ask subjects to report whether they think next of kin should donate a deceased’s organs. We show subjects the decision screen the deceased saw (either a mandated choice frame or an opt in frame) and indicate the choice made by the deceased (either to join the registry or not to join the registry). Subjects are less likely to report that next of kin should donate the organs of an unregistered deceased if the deceased explicitly said no to registration in a mandated choice framed question than if the deceased simply chose not to opt in.** This suggests that asking individuals to register under **a mandated choice frame may make it harder to get permission** for organ donation from the next of kin of those who remain unregistered. **This is particularly important because the historical data in Massachusetts suggests that over half of the unregistered donors have their organs recovered after next of kin gives permission**.

### Harms Autonomy

#### Mandated choice would violate informed consent because patients are forced to take a stance on organ donation regardless of their knowledge of how it works.

Gill 4, (Michael B. Gill, Department of Philosophy, University of Arizona, Presumed Consent, Autonomy, and Organ Donation, Journal of Medicine and Philosophy 2004, Vol. 29, No. 1, pp. 37–59, www.u.arizona.edu/~gillm/media/articles/presumedconsent.pdf) [PDI]

Furthermore, I think there are moral (and not merely practical) reasons to worry about implementing mandated choice in the United States today. Our concept of informed consent embodies the idea that there is a significant moral difference between informed consent and mere consent. A patient’s right to self-determination has been protected if, before undergoing a procedure, she gives informed consent. But a patient’s right to self-determination has not necessarily been protected if, before undergoing a procedure, she merely agrees to it, or signs a form. What distinguishes informed consent, of course, is that the patient is informed. A patient who has given informed consent is one who knows the facts relevant to the decision at hand. If, in contrast, a patient does not know the relevant facts, then her consent to a procedure is morally tainted.¶ The problem with mandated choice in our current circumstances is that some of the people who would be forced to answer the donation question on their tax forms or driver’s license applications would lack the information necessary to make a truly informed decision. Someone with a false belief about the circumstances of donation and transplantation might check one box (‘‘Yes’’ or ‘‘No’’), but would have checked the other box if she had known the whole truth. Her choice, as a result, will be as morally tainted as that of a patient who decides to undergo (or not undergo) an operation only because she is influenced by a false belief. Thus, so long as a significant proportion of the U.S. population remains misinformed about the circumstances of organ donation and transplantation, organ procurement based on mandated choice will not completely accord with the principles underlying informed consent.

#### Mandatory consent forces people to give up rights

Bird 10

Sheila Bird senior statistician, MRC Biostatistics Unit, What about mandated choice? Authors’ reply, BMJ: British Medical Journal, Vol. 340, No. 7760 (19 June 2010), p. 1320 [PDI]

The Organ Donation Taskforce argued that a 50% increase in heart-beating brain-stem dead donors by 2013 was possible through structural changes to NHS. We challenge this. There is simply no precedent for such a major shift in relatives' refusal rate. And evidence from the UK shows that even major sustained publicity about transplantation was capable of inducing only a quarter reduction in relatives' refusal rate. The UK's 40% relatives' refusal rate, higher than in France,4 is a massive problem. **Mandated choice obliges citizens to register or forfeit, for example, their right to drive.3 Well informed citizens who mistrust Big Brother databases but favour organ donation are in a bind.**

# Neg

## AT Organ Supply Adv

### On Solvency

#### Presumed consent legislation is insufficient to increase organ donation—cultural factors and education are much larger determinants—means the aff doesn’t solve and increases uninformed decisions about organ donation.

Mone 11, (Thomas Mone, Board Member Donate Life California & CEO OneLegacy, Donate Life California Presumed Consent White Paper, September 2011, www.onelegacy.org/docs/DLC\_WhitePaper\_PresumedConsent\_0911.pdf) [PDI]

Today 75% of Americans who can become organ donors actually donate and save lives under our Opt-In VC system iv (by comparison, only 7% of potential blood donors actually donate v). This results is a US donation rate of 25.4 donors per million population vi which is the second highest donation rate in the world, second only to Spain vii (which contrary to common belief also relies on a Opt-In, VC system viii). In fact, when you adjust for the varying donor potential (estimated with death rates normalized to the US death rate) the major European PC countries’ donation rates range from 11.4 to 20.6 nDPM (normalized Donors per Million), well below the US’s 25.4. Further, and especially important to Californians, our death rate and donor potential are only 3/4ths the US rate and only 62% of Spain’s donor potential, so when donation data is normalized for donor potential estimated from comparative death rates, Californians donate at a higher rate than any country in the world, including Spain. ix¶ Even Inter-country European data do not support PC with the 5 major PC countries averaging 17.3 nDPM and the 5 major VC countries average 17.8 nDPM; a result that the British Medical Journal survey noted was not statistically definitive x. This insignificant difference in DPM suggests that social, cultural, and operational factors rather than legal structures are at play. For example, the 5 countries with more than 50% Roman Catholic populations average 23.0 nDPM while the five countries with populations that are less than 50% Roman Catholic averaging only 13.5 nDPM; with a mix of PC and VC in each group of countries. Thus, it is very likely that religion plays a far more dominant and successful role in increasing organ donation in Europe than Presumed Consent.¶ These data show quite clearly that Presumed Consent is not the panacea that some would hope for, but why is that? A look at our own significant variance between the 37% xi of Americans who register to be donors while applying for driver licenses and the 75% who actually donate at the time of death suggests an answer: when people are applying for a driver license they are not focused on their end of life planning and a significant majority either feel under-informed, are misinformed, oppose donation, or simply do not choose to register at that time. Yet, when confronting the unavoidable end of life and the need to make final decisions, individuals and families seek and are receptive to information that prompts them to choose to donate. Unfortunately, under a Presumed Consent system, the “Opt-Out” provision would capture people’s premature, under-informed, and unplanned decisions to NOT donate, while focusing on the bureaucratic maze of getting a driver license. And, once recorded as a “No” there is little opportunity to address misinformation and inspire individuals and families to donate; the work we in the four California OPOs help to do today that moves us from the 37% who register as donors to the 75% who actually donate.¶ The significance of misinformation is not merely anecdotal; as reported in the 2010 Donate Life America/Astellas independent xii poll that found that a shocking 52 percent of people incorrectly believe that doctors may not try as hard to save their lives if they know they wish to be organ or tissue donors, that 48 percent believe a black market exists in the U.S. for organs and tissue, and a remarkably high 61 percent mistakenly believe it may be possible for a brain dead person to recover from his or her injuries. With these serious misconceptions out there, it is very realistic to conclude that an Opt-Out, Presumed Consent decision, made early in life, without access to accurate information would lead to millions of ill- informed decisions and no chance to address these misconceptions when the opportunity to donate occurred.

#### Aff doesn’t solve—Family members of the deceased will block organ donations after the fact.

Orentlicher 9, (David Orentlicher, Professor of Law, Indiana University School of Law- Indianapolis; Adjunct Professor, Indiana University School of Medicine; J.D., Harvard Law School, 1986; M.D., Harvard Medical School, 1981, PRESUMED CONSENT TO ORGAN DONATION: ITS RISE AND FALL IN THE UNITED STATES, RUTGERS LAW REVIEW, VOL. 61, 2009, http://ssrn.com/abstract=1207862) [PDI]

There is good reason to deny family members the option to withhold consent to organ retrieval. Although the law gives decision- making authority to the family to carry out the decedent’s wishes, family members often do not accurately reflect a dead person’s preferences.82 A person may have wanted to donate organs after death, but family members might refuse consent nevertheless. Indeed, many family members substitute their own preferences for those of the decedent.83 For example, while family members generally indicate that they base their refusals on the wishes of the decedent,84 they also often give reasons for their refusals that seem to reflect their own interests. Many family members report that they “had been through enough and therefore could not tolerate the organ donation process,” or that they “were concerned that donation would disfigure the body and/or preclude an open-casket funeral.”85¶ 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.86 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.87 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.88

#### Implementing presumed consent is costly, complicated, and causes backlash against donation due to information security concerns.

Bramhall 11, (Simon Bramhall, Consultant Liver Transplant Surgeon, Annals of The Royal College of Surgeons of England, 2011, V. 93: 268–272, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3363073/) [PDI]

Presumed consent is alternatively known as an ‘opt-out’ sys- tem and means that unless the deceased has expressed a wish in life not to be an organ donor then consent will be assumed. This can be divided into what is known as a ‘hard opt-out’ where the family are not consulted or a ‘soft opt- out’ when the family’s wishes are considered in the same manner as with the current ‘opt-in’ system.¶ A number of countries have a system of presumed con- sent, including Spain, but very few use the system in prac- tice. In Spain presumed consent had been part of statute for 10 years prior to the organisational changes without any effect on rates of donation.3 The US does not have pre- sumed consent legislation. Both have impressive rates of¶ organ donation and both have seen a rapid increase in a relatively short period of time. Sweden switched to a pre- sumed consent system in 1996 but continues to have very poor rates of organ donation (10 PMP) and attempts to intro- duce presumed consent legislation in Brazil and France led to a backlash against organ donation.¶ The question of whether the UK should change to a sys- tem of presumed consent is a finely balanced one, generat- ing impassioned debate and a wide range of opinion. There is no doubt that there is an urgent need to address the poor and reducing rates of organ donation in the UK and super- ficially several factors support a change in the legislation. The consent rates in the UK are poor when compared with other European countries (approximately 60% compared with over 80% in Spain); however, UK consent rates are ac- tually very similar to those in the US but donation rates in the UK are half that of the US. This implies that there are factors other than consent rates that need addressing in the UK prior to blaming our low rates of organ donation on fam- ily consent.2¶ There are no fundamental ethical or legal barriers to introducing soft presumed consent legislation in the UK; however, legal advice has suggested that a hard presumed consent law would open to challenge under the European Convention on Human Rights.¶ There is a belief among some members of the medical profession that the introduction of presumed consent might damage the relationship of trust between clinicians caring for patients at the end of life and their families (survey of In- tensive Care Society members, 2008). There is a possibility that some clinicians could opt out of donation programmes at a time when their support is required to improve rates of organ donation. In addition, evidence from recipients of or- gans suggests that many need to know that organs had been donated without coercion by the organ donor and his or her family. The families of organ donors usually find great com- fort in being an active part of the decision to donate.¶ The introduction of a system of presumed consent would be highly complex and costly if it were to command the trust of the involved professions and the general public. Every member of the UK public at the time of introduction and moving forward would need to be contacted and offered the choice of opting out. This would require a significant and sustained communication programme and any ‘opt- out’ register would need a robust IT system to support the process. There are real concerns among the general public about centrally controlled IT registers containing personal information and the introduction of such a personal data- base at this time is probably ill conceived.4¶ Despite support among the UK population for organ do- nation an attempt to introduce a system of presumed con- sent might provoke anti-donation feelings and even active anti-donation campaigning among some vocal groups. This view has been supported by some faith leaders who under the current system support organ donation.5

### Alt causes

#### **Comparisons with France and Austria prove there are alternative institutional factors that explain high donation rates**

Wright 07

Linda Wright bioethicist, University Health Network and Joint Centre for Bioethics, University of Toronto, “Is presumed consent the answer to organ shortages?” BMJ | 26 may 2007 | Volume 334 [PDI]

**The effect of presumed consent is hard to evaluate as it is implemented in different ways in different contexts, with different results. More organs may be avail‑ able for transplantation because of the number of intensive care beds, transplant surgeons, coordinators, and specialised units or because of which organs are needed and the predomi‑ nant cause of deaths**.5 **The rate of donation in France** in 2005 **was 22.2** donors per mil‑ lion population **while in Spain it was 35.1** per million.6 Both countries operate presumed consent and routinely ask families for their consent to donation, yet their organ donation rates vary greatly. **In Austria, where** such **permission is not routinely sought, the rate of donation was 24.8** in 2005.6 Spain expands its donor pool by using dec‑ larations of death based on not only neuro‑ logical but also cardiocirculatory criteria—that is, declaring death when the cardiorespiratory system is believed to have stopped functioning. This system has been credited with increasing donation rates in some parts of the US, which has an opting-in system.7 8 Singapore’s law on presumed consent makes exemptions for Muslims on religious grounds.9 The need for public acceptance of organ donation means that **a strategy may work in one society, but not another.** Other factors that might explain Spain’s enviable rates of organ donation include an environment that treats organ donation as a priority. Transplantation has a strong support system, a dedicated budget, and accountabil‑ ity for performance.10 Staff are trained how to approach grieving families about organ dona‑ tion. **Donation will not increase without the necessary equipment, trained staff, and inten‑ sive care beds to enable a potential donor to donate viable organs. These institutional fac‑ tors contribute to the donation rate and seem to account for some of the variation in rates of organ availability**.

#### The distinction between presumed consent and other policies is blurred – it’s hard to make a definitive conclusion given all the different factors

Pierscionek 08

Barbara K Pierscionek, pf in the Department of Biomedical Sciences, University of Ulster, “What is presumed when we presume consent?” biomedcentral.com/1472-6939/9/8 [PDI]

Introduction of presumed consent into law can take a number of forms, and variations in the application of presumed consent [19] have been broadly classed as 'strong' ('hard') or 'soft' [7,19] depending essentially on whether or not permission of relatives is required. However, **the distinction between the options is blurred. Even in countries in which presumption of consent does not officially require the permission of relatives, this is sought and taken into account** [11,19]. There is no conclusive evidence **showing which option is the more successful in obtaining donor organs** [2]. **In France and Spain**, where consent of relatives is routinely sought, the **donor rates**, in 2005, **were 22.2 and 35.1 per million** population, respectively; **in Austria where consent of relatives is not routinely sought, the figure was 24.8 per million** population [2]. It is worth noting that **in Spain, organs are taken from heart-beating and non heart-beating donors and this has been credited with increasing donation rates** [2]. With limitations, in the UK, on organ availability from donors who have suffered brain stem death (heart-beating donors), measures to increase the number of organs retrieved from non heart-beating donors are being advocated [20,21].

#### Presumed consent is never fully enforced and there are alt causes from a cultural commitment to donation in addition to the new laws

Bilgel 12

Fırat Bilgel, Department of Economics, U of Bologna, “The impact of presumed consent laws and institutions on deceased organ donation” Eur J Health Econ (2012) 13:29–38 [PDI]

Most of the European countries have adopted presumed consent legislation, and it is suggested that presumed consent can play an important role in increasing donation rates [1, 12, 17, 21]. However, **disunity continues within the medical community and experts have expressed their skepticism whether any change in legislation per se could increase donations** [19]. **Healy** [15] **asserts that countries that enacted presumed consent regime also implemented a number of other practices to increase deceased donation rates. Thus, presumed consent is an indicator of a country’s commitment to donation rather than a direct cause of high donation rates**.2 Under presumed consent, the wishes of the decedent’s family are not taken into account and the next-of-kin is not allowed to override the donor’s wish to donate. However **in practice, countries that adopted presumed consent consider families’ wishes and next-of-kin is allowed to veto donation even if the decedent has previously revealed her preference to donate organs**.3 **The reason for considering families’ decision in the process has been to avoid public backlash, liability suits, and to show respect for the grieving family** [15, 20]. **Thus, presumed consent is not fully enforced and families are still allowed to make the final decision regarding organ donation. From this perspective, it is not clear whether enforcing presumed consent legislation has a positive effect on organ donation rates**.

### Vulnerable Populations

#### Presumed consent doesn’t solve for those who are systematically excluded by the healthcare system – African Americans are most likely to die while on the transplant list

Strosberg and Gimbel 10

Martin A, pf of healthcare policy and management @ Union Graduate College, Ronald W, pf F Edward Herbert School of Medicine, “Kidney Donation: When All Else Fails, Try a Regulated Market” J Natl Med Assoc 102:44-45 [PDI]

Is it plausible to think the organ procurement program as currently constructed and currently constrained by market prohibitions could ever close the gap? **Proposed initiatives to improve program performance include presumed consent,** required response, moral incentives, standardized hospital policies and best practices, refocused public education, and expanded organ acceptance criteria.5-7 **While there is some empirical evidence to suggest that these initiatives do work, individually they are not a panacea** for closing the organ gap.8,9 Even if all of these proposed initiatives were fully implemented, most observers believe that their cumulative impact could not fully close the gap. **This is especially true for African Americans, Asians, and Pacific Islanders, who are 3 times more likely than whites to suffer from end-stage renal disease and where human leukocyte antigens** (HLAs) **typing plays a role in these patients’ compatible matching to available organs.**10,11 **Tellingly, African Americans are most likely to die while waiting on the transplant list**.

### Empirics – Brazil

#### **Brazil switched to presumed consent which caused huge backlash and decreased donations**

Bilgel 12

Fırat Bilgel, Department of Economics, U of Bologna, “The impact of presumed consent laws and institutions on deceased organ donation” Eur J Health Econ (2012) 13:29–38 [PDI]

These results may have serious implications in the course of switching from an informed to presumed consent legislation. **As the Brazilian experience with the presumed consent regime showed, potentially perverse effects that might arise due to failure to build social support and to establish better and timely organization** of the procurement processes should not be ruled out. **Brazil switched to presumed consent** regime in 1998 that allowed organ removal from the deceased without seeking family consent **and later attempted to reinforce the system** by the threat of prosecuting doctors who refused to extract the organs of the deceased. **Not only the presumed consent legislation has received a public backlash causing many to register as non-donors but also suffered from severe lack of medical infrastructure, timely organization of the procurement process and efficient allocation of organs** [16]. **The legislation is inevitably abolished few years later.** Therefore, it seems early to conclude for advocates, for example, in the United Kingdom that switching to presumed consent laws by observing the successes of Spain on one side and Austria on the other side would increase deceased donations even though both countries enacted presumed consent law, yet practices seem to differ to a large extent.

### Empirics – Chile

#### **Presumed consent in Chile decreased donations by 29% and increased family refusal by 14%**

Dominguez and Rojas 13

J. Domínguez and J.L. Rojas “Presumed Consent Legislation Failed to Improve Organ Donation in Chile,” Transplantation Proceedings, 45, 1316–1317 (2013) [PDI]

Background. Presumed consent legislation has been advocated by some as an effective measure to improve organ donation. In Chile, a new presumed consent legislation was passed, replacing an informed consent legislation. As of January 2010, Chilean citizens older than 18 years were considered to be organ donors unless they had previously declined donation. The aim of this study was to evaluate the impact of this legislation on donation rates at 2 years after its implementation. Methods. Retrospective review of donor registries from Corporació del Trasplante and Coordinación Nacional de Trasplante between January 2000 and December 2011 revealed donation rates (donors per million population [pmp]), family refusal, and number/ percentage of nondonors. Organ donation rates decreased after passage of the new law from 6.5 (n = 111) in 2009 to 5.4 in 2010 (n = 92) and 6.5 donors pmp in 2011 (n = 113). **Mean donation rate from 2000 to 2009 (before presumed consent) was 8.31 and from 2010 to 2011 (after presumed consent) 5.95 donors pmp; which represents a 29% decrease. Family refusal** **fluctuated between 32% and 41% between 2000 and 2009, but** **increased to an all-time high of 50.4% in 2011.** Finally as of December 2011, 2,520, citizens appeared to be nondonors in the Registry, which roughly represents 37% of those renewing their identification card (IC) or driving license (DI). Conclusion. **In Chile, presumed consent legislation not only did not increase but seems to have had a deleterious effect on organ donation, reflecting an increase in family refusals and a high percentage of nondonors in the registry**.

## AT Various Morals Affs

### AT State Altruism

#### It makes more sense to think of the individual as being altruistic, but even then, if the donation is to solve a pressing need, it’s less a gift and more an entitlement

Hughes 09

Paul M. Hughes, Ph.D., Professor of Philosophy, Department of Literature, Philosophy, and the Arts, University of Michigan-Dearborn, “Presumed Consent: State Organ Confiscation or Mandated Charity?” HEC Forum (2009) 21(1): 1–26 [PDI]

**Perhaps the state is the altruistic agent** inasmuch as the policy is intended to enhance human well-being and the state authorizes the retrieval and distribution of organs to those in need of organ transplants. **Again, however, in those cases in which the harvested viable organs were taken from people who were ignorant of the policy, or would have opted out if exit costs did not constrain them from doing so, it seems implausible** (though not conceptually impossible) **to describe the taking and reallocating of those organs as an act of state altruism, for those people cannot have agreed to any such use of their organs by a third party**.19 Moreover, even in cases in which the donor did know about the policy and deliberately refrained from opting out because she regarded it as a good policy and wished to take advantage of it for the sake of helping others, **it would be appropriate to regard the donor as the altruistic agent, not the state.** **At best, it seems we could view the state as enabling the altruistic exchange via the policy of presumed consent.** But **such an agent would have no need of the policy of presumed consent were there other ways** (as there are) **to make her intention effective. Thus it seems that presumed consent cannot be regarded as itself an altruistic public policy.** Perhaps presumed consent could be regarded as altruistic if the public as a whole endorsed the policy because of a desire to help others prolong their lives. Similar to mandatory social service in some countries where graduates of college or medical or other professional schools are required to spend two years as teachers, counselors, farmhands, and so forth, assisting their fellow citizens in need of specific services, one might analogously suppose that allowing one’s organs to be harvested upon one’s death is a gift not to the specific recipient of the organ, but to the state, which then awards the organ to the neediest person. This type of social service, however, is not usually regarded as optional or voluntary, but as conscripted and, thus, mandatory.20 Moreover, **if recipients of transplant organs deserve them because theirs is the most pressing need, then it is not clear that the state awarding an organ on this basis could count, conceptually, as a gift.** After all, **the person in greatest need is in some sense entitled to the organ, and on the usual sense of that concept is not the recipient of a gift**.

### AT No Rights of the Deceased

#### Turn – most organ donors are declared brain dead, but that’s not really death

Collins 09

Mike Collins, Ph.D. (Candidate), CUNY Graduate Center, Department of Philosophy, “Consent for Organ Retrieval Cannot be Presumed,” HEC Forum (2009) 21(1): 71–106 [PDI]

**The majority of organ donors are individuals declared dead on the basis of neurological criteria, or, are brain dead.** Tissue and bone can be recovered from donors declared dead by cardio-respiratory criteria, but due to the sensitivity of human organs to ischemic damage, viable solid organs can only be removed from a donor with a perfusing cardiac rhythm.14

There is a tripartite distinction between the conceptual definition of death, the physiological criteria which must be satisfied in order for death to have occurred, and the diagnostic tests which are indicators of the satisfaction of those physiological criteria (Bernat, et al., 1981). The standard defense of current medical practice proceeds in the following way. Death is the cessation of integrative unity, or the cessation of the functioning of the organism as a whole. Since the brain is necessary as the integrator which directs the metabolic and dynamic processes of the various organ systems into a unified system which jointly resists entropy and maintains homeostasis, then without a functioning brain, the organism as a whole no longer exists. It is a mere collection of parts, and hence, is dead. The physiological criteria for death to have occurred are the irreversible cessation of functioning of the circulatory and respiratory systems, or the irreversible cessation of functioning of the entire brain, including the brain stem (Beecher, 1968; Bernat et al., 1981; President’s Commission Report, 1981). The diagnostic tests used to determine that the physiological criteria have been satisfied include unresponsiveness, absence of cranial nerve reflexes as determined by bedside tests, and prolonged apnea in the presence of elevated arterial carbon dioxide pressure. Confirmatory tests such as EEGs and angiograms are not necessary to make the diagnosis except in special circumstances (American Academy of Neurology, Practice Standards Subcommittee, 1995).

**The most pressing arguments against the equivalence of brain death with death can be separated into two categories. First, the diagnostic tests** used to determine the satisfaction of the physiological criteria **are unreliable: significantly many cases of false positives have been demonstrated. Second** and more importantly, **the physiological criteria are unjustified**: even given perfectly reliable diagnostic tests, **an individual with a completely nonfunctioning brain who is maintained on a ventilator and sustains spontaneous circulation is no more dead than an individual with loss of all kidney function who is maintained on dialysis**.

**Some patients who have been declared dead by neurological criteria have been shown,** through EEG studies, **to retain cortical electrical activity** (Grigg et al., 1987; Rodin et al., 1985; Deliyannakis et al., 1975). **Others have been shown to maintain electrical** (but not behavioral) **connections to their environment** through the demonstration of normal or near-normal evoked potentials, for auditory (Barelli et al., 1990), visual (Ferbert et al., 1986), and somatosensory (Anziska and Cracco, 1980) modalities. Some reply that these studies demonstrate mere activity, but not function (Bernat, 1998; 2006). However, **the brain is far too complex of an organ for us to claim to know precisely which activity should count as “functional” and which should not.**15 Further, the evoked potential studies do indeed demonstrate the preservation of function, since it is clearly a function of the nervous system to receive and encode information about the organism’s environment. A normal sensory evoked potential demonstrates that the transducer mechanisms take ambient energy, convert it into an electro-chemical signal, and then pass a wave of depolarization, through ionic movement and chemical signaling processes, through sub-cortical and then cortical areas. Surely, this complicated process of energy transduction and information transfer is a function of the brain and nervous system more generally.

In addition to the electrical studies, it is apparent from clinical practice (through the absence of polyuria) that **many if not most brain dead patients** either **do not develop central diabetes insipidus** or develop nephrogenic (and not central) diabetes insipidus (Grenvik, 1978; Fiser et al., 1987; Hohenegger et al., 1990; Schrader et al., 1980; Outwater and Rockoff, 1984; Fackler et al., 1988). **Hence, the hypothalamus is receiving information about the status of free water in the bloodstream and regulates the secretion of the anti-diuretic hormone through the pituitary. The regulation of free water homeostasis is also a function of the brain. Many brain dead patients have also been shown spontaneously to maintain hemodynamic stability, suggesting residual function of the medulla** (Shewmon, 1998a; 1998b; 2001).

**A defender of the brain-oriented concept of death may reply that some functions are insignificant** (Bernat 1992). **This is both ad hoc and a non sequitur.** It is ad hoc because **there is no reason,** prior to this debate, **for anyone to claim that sensory transduction and information encoding, the maintenance of free water homeostasis, or the regulation of hemodynamic stability are insignificant functions, while pupillary and corneal reflexes** (which are tested in order to assess cranial nerve function) **are significant functions** (Truog and Robinson, 2003, make a similar point). It is a non sequitur because **which functions are significant and which are not is irrelevant** to this debate. **According to the standard justification** and the Uniform Determination of Death Act, **an individual is dead if all functions of the brain have ceased, not just the ones that are deemed “significant”.** **Demarcating the significant from the insignificant functions of the brain leads only to the essentialism of the higher-brain concept of death**, which is not at issue here.

It is important to recognize that thus far I have only argued that the tests for brain death are not reliable, and hence this might be rectified by devising more reliable tests. I have reviewed some of the objections that have been made in the literature over the years partially in order to put all of them in one place, so we can see the force of them more clearly. But more importantly, it is important to clarify the debate: **discussions of function versus activity are misguided and irrelevant since preservation of function remains and discussions of significant versus insignificant functions is both ad hoc and also irrelevant**. What if we had perfect tests?

**Even given perfectly reliable tests for all brain function, the loss of such function is unjustified as a physiological criterion for death. Since we are supposing** (as the standard formulation does) that **the organism is dead when she ceases to function as an integrated unity** which maintains internal homeostasis and resists entropy, **then the individual is alive so long as some of these functions remain.** **An extensive list has been compiled of functions that can be and, in cases of brain death, are carried out in the absence of any unification** or modulation **by the brain** (Shewmon, 2001). **This constitutes a legitimate counterexample to the empirical hypothesis that without the brain the body ceases to function as a unified whole. This list includes elimination, detoxification, and recycling of waste, cellular respiration, nutrition, development of the febrile response, and wound healing.** Each of these are functions that serve to maintain homeostasis and resist entropy, and as such, **an organism that carries out these functions is not dead**.

Finally, it should be noted that **integration does not imply the need for an integrator**. **Plants and embryos are biologically complex systems that lack a central integrator yet act as a unified whole in order to maintain homeostasis** (Shewman, 2001). Thus, **the above list of counterexamples demonstrates that the empirical hypothesis that the brain is the body’s integrator** without which it would cease to function in an integrated fashion **is false**. But the revelation that biologically living systems exist which lack central integrators at all demonstrates that the empirical hypothesis was a conceptually confused one to begin with. **Brain death, hence, is not equivalent to death**.16

#### **The brain-dead standard for donation is false and misleads families and caretakers, violating their right to informed consent**

Collins 09

Mike Collins, Ph.D. (Candidate), CUNY Graduate Center, Department of Philosophy, “Consent for Organ Retrieval Cannot be Presumed,” HEC Forum (2009) 21(1): 71–106 [PDI]

[CLARIFICATION…Let “death-1” refer to the biological concept of death, which is not species or culture specific and pertains to the biological functioning of the organism as a whole. When the organism as a whole ceases to resist entropy and maintain homeostasis, the organism is dead-1. Let “death-2” signify the socio-legal concept of death. On this usage, when an individual is dead-2, she is no longer a full member of the moral community in the same way that she was before her injury or disease…] The second point we must consider is how these different meanings of “death” affect a conversation with surrogate decision makers when they and the physician discuss whether to go ahead with organ donation or not. **The physician must, in effect, say that “the patient is dead”, in order to request or suggest organ donation,** since in our society we overwhelmingly accept the dead donor rule, which says that vital organs cannot be removed from a living individual, and the act of removing vital organs must not be the proximate cause of death.19 Because of the wide acceptance of the dead donor rule, in order to even suggest the option of organ donation, the physician must declare the patient dead, and inform the family of the patient’s death. Therein lies a very big problem. When the physician declares a patient dead by neurological criteria and informs the family, what do her words actually mean? On the one hand, **the physician may say, “your family member is dead”,** where “dead” is semantically equivalent to what we have identified as “dead-1”. **In this case, her statement is false: if the patient is maintained on a ventilator and has a spontaneous heartbeat, at the very least there is cellular respiration occurring** (made possible by the ventilator, but this is not any more relevant than that excretion of waste is made possible by a dialysis machine) **otherwise the heart would not beat. Hence, the individual organism continues to resist entropy and maintain internal homeostasis, even though, of course, his prognosis is quite bleak.** But prognosis is not diagnosis, so if “dead” means “dead-1”, then the physician has made a false statement.2 However, what if “death” has undergone semantic evolution, as words have a tendency to do, and now, in this context at least, “death” really means 88 HEC Forum (2009) 21(1): 71–106 something semantically equivalent to “death-2”? In this case, the statement made by the physician is true, but entirely misleading. **To say that “your family member is dead”, where “dead” now means [brain-dead]** “dead-2”, **is to use technical jargon, which is inappropriate in any conversation for informed consent.** It is particularly bad in this instance, however, since that jargon is homonymous with the colloquial word “dead”, which, emphatically, does not mean “lacking membership in a community of moral agents”. Rather, the colloquial word “dead” is far more similar to dead-1 than it is to dead-2, since death itself is not species-specific. Being dead (colloquial use here) is a state that the family dog, the family matriarch, and the insect in the backyard can all instantiate. Being dead-2, on the other hand, is something that only a human can instantiate. **It is thus completely reasonable to conclude that the colloquial word “dead” has far more in common with the biological word** “dead-1” **than the socio-legal word [brain-dead]** “dead-2”. Because of this circumstance, **it is entirely misleading to claim to a family, “your family member is dead”, when what was really meant was, “your family member has been deemed to no longer be a member of the community of moral agents by virtue of her severe and irreversible brain damage”. Therefore, whenever a conversation is had in order to obtain informed consent for organ retrieval, the physician must, in order to respect the dead donor rule, claim that the patient is dead. But this claim is either false or entirely misleading.**

#### It’s not about respecting the interests of the dead but of living people – e.g. it is moral to care about people’s wills after they die

Den Hartogh 11

GOVERT DEN HARTOGH, EMERITUS PROFESSOR, DEPARTMENT OF PHILOSOPHY, UNIVERSITY OF AMSTERDAM, “Can Consent be Presumed?” Journal of Applied Philosophy,Vol. 28, No. 3, 2011 [PDI]

**It is sometimes objected** to this view **that it makes no sense to prohibit entering the private domain of the dead** without their consent.**The dead have no interests which can be protected in this way.**5 **However, the dead body does not belong to the private domain of the dead but of the living. Living people can have interests concerning what happens to their life’s work, their reputation, their body and their possessions after their death, which is why the law recognizes corresponding post-mortal rights.** Hence **there is nothing paradoxical in the idea of making binding decisions during one’s life concerning states of affairs which will only occur after one’s death.**6

### AT Polls – AT Gallup

#### The 70%-30% figure is inaccurate—multiple warrants.

Gill 4, (Michael B. Gill, Department of Philosophy, University of Arizona, Presumed Consent, Autonomy, and Organ Donation, Journal of Medicine and Philosophy 2004, Vol. 29, No. 1, pp. 37–59, www.u.arizona.edu/~gillm/media/articles/presumedconsent.pdf) [PDI]

It’s striking that the argument for presumed consent and the argument against it both start from the same datum: that about 70% of Americans want to donate their organs after death; or, if you like, that about 30% of Americans do not want to donate their organs after death. Where does this 70%–30% figure come from? It comes from a 1993 Gallup Poll, to which most recent commentators on both sides of the issue have referred (Gallup Survey, 1993). Now there are a number of problems with using these poll numbers. First of all, the poll was taken a decade ago, and attitudes toward donation may have changed since then. Secondly, it seems that a significant number of those polled who said they would be unlikely to donate their organs after death answered in this way not because they necessarily preferred not to donate but because they believed that their age would make their organs unsuitable for donation. Thirdly, some of those polled may have been misinformed about organ donation procedures, which throws into question the moral significance of their answer (I will discuss this point in more detail in section VI). And fourthly, polls in general are an imperfect measurement of the intention to donate or not to donate, since a person’s saying in response to a poll that he would act a certain way is far from a guarantee that he will actually act that way. But the fact is that the 1993 Gallup Poll still constitutes the best estimate we have of Americans’ attitudes towards organ donation. It is important to keep in mind, however, that the arguments that follow do depend on this imperfect estimate of Americans’ desires to donate their organs after death. As such, the conclusions I draw should be taken to be conditional, based as they are on an empirical assumption that may have to be revised in light of future evidence.5

### AT Saunders/Singer

#### The application Singer’s “greater moral evil principle” is over-demanding and leads to unintuitive results to maximize utils everywhere

Potts et al 10
[Michael Potts1 Joseph L Verheijde,2,3 Mohamed Y Rady,4,5 David W Evans6 Methodist University, Fayetteville, North Carolina, USA 2 Departments of Biomedical Ethics, Physical Medicine, and Rehabilitation, Mayo Clinic, Phoenix, Arizona, USA 3 Center for Biology and Society, School of Life Sciences, Arizona State University, Tempe, Arizona, USA 4 Department of Critical Care Medicine, Mayo Clinic, Phoenix, Arizona, USA 5 Center for Biology and Society, School of Life Sciences, Arizona State University, Tempe, Arizona, USA 6 Queens College, Cambridge, UK] “Normative consent and presumed consent for organ donation: a critique” J Med Ethics 2010;36:498e499 [PDI]

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’.6 8 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.9

#### Saunders’ theory is contradictory since it doesn’t imply opt-out – it implies no one should be allowed to opt-out since organ donations are always obligatory

Potts et al 10
[Michael Potts1 Joseph L Verheijde,2,3 Mohamed Y Rady,4,5 David W Evans6 Methodist University, Fayetteville, North Carolina, USA 2 Departments of Biomedical Ethics, Physical Medicine, and Rehabilitation, Mayo Clinic, Phoenix, Arizona, USA 3 Center for Biology and Society, School of Life Sciences, Arizona State University, Tempe, Arizona, USA 4 Department of Critical Care Medicine, Mayo Clinic, Phoenix, Arizona, USA 5 Center for Biology and Society, School of Life Sciences, Arizona State University, Tempe, Arizona, USA 6 Queens College, Cambridge, UK] “Normative consent and presumed consent for organ donation: a critique” J Med Ethics 2010;36:498e499

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 were 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.16 **A societal obligation or duty to donate paves the way for a transition from presumed consent to conscription for organ donation.**9 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?

#### Counter-example: the obligation to donate justifies totalitarianism

Potts et al 10
[Michael Potts1 Joseph L Verheijde,2,3 Mohamed Y Rady,4,5 David W Evans6 Methodist University, Fayetteville, North Carolina, USA 2 Departments of Biomedical Ethics, Physical Medicine, and Rehabilitation, Mayo Clinic, Phoenix, Arizona, USA 3 Center for Biology and Society, School of Life Sciences, Arizona State University, Tempe, Arizona, USA 4 Department of Critical Care Medicine, Mayo Clinic, Phoenix, Arizona, USA 5 Center for Biology and Society, School of Life Sciences, Arizona State University, Tempe, Arizona, USA 6 Queens College, Cambridge, UK] “Normative consent and presumed consent for organ donation: a critique” J Med Ethics 2010;36:498e499 [PDI]

**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).17 **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’,18 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**.

## Autonomy

### Negative Outweighs Positive

#### There’s no positive obligation to use one’s organs, so it’s better to err on the side of caution and not risk using someone’s organs against his/her will

Den Hartogh 11

GOVERT DEN HARTOGH, EMERITUS PROFESSOR, DEPARTMENT OF PHILOSOPHY, UNIVERSITY OF AMSTERDAM, “Can Consent be Presumed?” Journal of Applied Philosophy,Vol. 28, No. 3, 2011 [PDI]

As I indicated, the term ‘presumed consent’ suggests that systems of this kind are compatible with people’s right to make decisions concerning their own bodies. This right should not be seen as simply an aspect of a more general right to self-determination. Such **a general ‘right’ is** nothing but **a presumption of freedom: the freedom to do what one wants to do should only be curtailed for good reasons. My right to dispose of my own body, however, is much more specific and has much more moral force** than this rather vague presumption. **It follows from the special relation that exists between me and my body, a relation which** (fundamentally) **changes but does not end with my death.** In a sense **I am my** (living) **body**, I am constituted by it, actually or even essentially.3 **The relevant right is basically a negative, not a positive right: it prohibits other people from doing things with my body without my consent, but it doesn’t give me the power to claim positive efforts from them**.4 **The number of possible destinations for corpses which exclude risks of harm to other people is actually very limited,** **and this risk is the only reason why we are not only not allowed to choose other options but also may expect others to act on our choices.** But **if you choose to put your body at the disposal of science, science isn’t obligated to accept the offer**. In some countries medical teams are legally obligated to consult a Donation Register and to remove organs for transplantation if they find a registration as donor (or do not find a registered objection); this obligation, however, **[that your organs should be procured] does not follow from people’s (actual or ‘presumed’) decision to be a donor**, but rather from the claims of patients in need of an organ. **A negative right like this one can be seen as protecting a certain private domain by erecting a barrier around it**. **Legitimate access to the domain can only be obtained if the barrier is lifted, which is done by (valid) consent.** (It is an extremely difficult question under which conditions consent is invalidated, either by deception, coercion or intoxication; but fortunately, this question can be set aside for the purposes of this paper.) **It is plausible to consider one’s body, even one’s dead body, to be pre-eminently part of this private domain**.

#### Mistaken removal of organs is a higher order violation of autonomy than mistaken non-removals—outweighs aff turns.

Orentlicher 9, (David Orentlicher, Professor of Law, Indiana University School of Law- Indianapolis; Adjunct Professor, Indiana University School of Medicine; J.D., Harvard Law School, 1986; M.D., Harvard Medical School, 1981, PRESUMED CONSENT TO ORGAN DONATION: ITS RISE AND FALL IN THE UNITED STATES, RUTGERS LAW REVIEW, VOL. 61, 2009, http://ssrn.com/abstract=1207862) [PDI]

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.121 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.122 Indeed, organ donation is permitted by many mainstream religious denominations.123 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.124 At the same time, religious doctrine may even impose a duty to donate one’s organs.125 In short, it does not appear that religious considerations should doom presumed consent, but other considerations might.¶ 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.126 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.127¶ 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,128 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.

### Autonomy Promotion

#### Informed consent better promotes rational agents making decisions for themselves

Collins 09

Mike Collins, Ph.D. (Candidate), CUNY Graduate Center, Department of Philosophy, “Consent for Organ Retrieval Cannot be Presumed,” HEC Forum (2009) 21(1): 71–106 [PDI]

Baruch Brody (2001) argues in favor of the former position, which “sees **obtaining informed consent [is] a means to realizing an important intrinsic moral value … [which is] the value of individuals acting autonomously”** (Brody, 2001, p. 1). He argues that informed consent cannot be justified on the grounds of respecting an individual’s right of autonomy, as he interprets this as “the right of noninterference by others in carrying out one’s autonomous choices” (p. 1), which entails only the obligation to refrain from interfering, but not that of the active promotion of the making of autonomous decisions. Since **the concept of informed consent in medicine and research seems to call for the promotion of the making of autonomous decisions,** he concludes that **[hence] he moral justification for informed consent lies in the claim that (i) rational agents acting autonomously is, from an evaluative/normative perspective, a good thing, hence (ii) the promotion of this by means of obtaining informed consent is instrumentally valuable.**

### Slippery Slope

#### Violating consent in this context might spill over to other legal contexts, diminishing autonomy across the board

Neades 09

Barbara L Neades, pf Napier University, “Presumed Consent to Organ Donation in Three European Countries” Nursing Ethics 2009 16 (3) 2009

Controversy exists surrounding the nature of consent that allows organ donation to proceed. Price16 acknowledged the fundamental ideal that **autonomy in health care should be expressed in consent, normally demonstrated by written instructions.** Prottas and Batten supported this view, stating that **the principles of informed consent and encouraged voluntarism that underpin the act of organ donation are vital and cannot be overlooked**.17 Beauchamp and Childress,18 however, highlighted that another form of consent exists, namely tacit or implicit or implied consent, expressed silently or passively by omission. Price16 also noted that **using presumed consent as a form of consent is unusual,** highlighting that **silence is not recognized as consent in most other legal contexts.** Nursing and **medical practice normally require formal written consent from patients for any invasive procedures to be undertaken. This raises the question of whether the lack of an objection to donation can be viewed as consent** to or authorization of this procedure by individuals. Other authors have challenged the validity of using tacit or implied consent in organ donation, arguing that implied consent in this situation is consent by default.19–21 They further question if this can actually be regarded as con sent, suggesting that **it represents an erosion of individuals’ right to determine the outcome of their organs after death**. They caution that **using tacit consent may in due course impact on other rights to autonomous informed decision making and create a ‘slippery slope’, with people feeling that they are state owned commodities with little autonomy**. Some go further, suggesting that **consent provided by default when no evidence of a deceased person’s agreement** or objection to organ donation **exists** **is ethically unsustainable.**22,23

### Consent Must be Informed

#### No guarantee that the deceased knew the presumed consent law means it violates their rights – public education is key

Neades 09

Barbara L Neades, pf Napier University, “Presumed Consent to Organ Donation in Three European Countries” Nursing Ethics 2009 16 (3) 2009 [PDI]

Beauchamp and Childress18 do, however, clarify that this form of **consent can be acceptable if it can be demonstrated that the individuals concerned were fully informed of the need to consent or object** to an action and also fully aware of the consequences. **This suggests** that, in order for presumed consent to be valid, **evidence of deceased persons’ prior knowledge of the law** concerning organ donation **and the necessary actions in relation to this legislation are required. If there is no evidence** that tacit or implied consent exists or that deceased persons were aware of the law and the need to record their consent or objection, **then the practice of removing organs under presumed consent perhaps expropriates those organs without any regard to consent. This underlines the need for public education for presumed consent to be valid**.

### Shifts Burden of Proof

#### PC laws shift the burden of proof on the individual which is an undue burden, compromising individual autonomy

Hughes 09

Paul M. Hughes, Ph.D., Professor of Philosophy, Department of Literature, Philosophy, and the Arts, University of Michigan-Dearborn, “Presumed Consent: State Organ Confiscation or Mandated Charity?” HEC Forum (2009) 21(1): 1–26 [PDI]

As noted, **presumptions often create a burden of proof or shift an existing one.** For example, the presumption of innocence in the United States criminal justice system places a burden of proof on the state to demonstrate, beyond a reasonable doubt, that a person accused of a crime actually committed the offense. **The presumption in presumed consent** similarly **places a burden on those who wish not to have the viable organs of their dead bodies harvested for transplantation to demonstrate that choice by formally opting out of the policy.** There is an important difference between the presumption of innocence until proven guilty, and the presumption that one consents to having his viable organs harvested unless he expressly opts out of a policy of presumed consent. The difference is that the former establishes a burden of proof whereas the latter **[This] shifts a current burden of proof from the state to those individuals who do not wish to participate in an organ harvesting or donation program**. The current practice that the state must secure express consent before it can harvest the viable organs of the dead for transplantation is not a formal presumption as is the presumption of innocence in criminal law, which is linked to due process and general notions of justice. However, **the longstanding status quo in which express consent must be secured by the state prior to harvesting transplant organs is tantamount to placing a burden of proof on the state.** In this sense, **adopting a policy of presumed consent in the United States would shift the burden of proof from the state to the individual, which raises the question whether this is a reasonable or an undue burden on the public at large. One way it may be an undue burden is if it compromises individual autonomy.**11 The current state of affairs in which the burden of proof is on the state to secure explicit consent to harvest viable cadaveric organs for transplant arguably reflects respect for personal autonomy in the sense that the **disposition of one’s remains has traditionally been regarded as a deeply personal decision rightly left up to individuals**. The idea that the disposition of one’s corpse has long been viewed as a matter of personal choice does not imply that people have private property rights in their bodies while they are living or that they have posthumous rights or interests in their post-mortem cadavers. Instead, and more weakly (though significant nevertheless) **the longstanding assumption that people should have control over their (alive and dead) bodies has generated a legitimate expectation that such control is an important part of the liberal moral and political tradition of allowing people to live their lives as they see fit**, subject to the usual caveats about participating in the common good and not harming others. In other words, **the legitimate expectation that people have control over the disposition of their cadavers is part of the constellation of knowledge, assumptions, values, beliefs, attitudes, and emotions that constitute persons’ self-understanding as autonomous agents**.12 **A policy of presumed consent would nullify that expectation.** The shift from having one’s consent actively sought by the state to having to actively provide the state with one’s dissent may not signal a sea change in our subjective experience of ourselves as autonomous, or a change that would warrant deeming a policy of presumed consent unjustifiable, but **it is** nevertheless **a change of considerable magnitude**. Although personal autonomy may not be a universal value, it is clearly the preeminent one in Anglo-American discussions of bioethics in general and transplant organ procurement in particular, and so if the shift in burden of proof involved in a policy of presumed consent compromises autonomy in any way it is surely relevant to our assessment of the moral status of that policy.

### Laundry List of Autonomy Violations

#### PC violates autonomy, six ways

Hughes 09

Paul M. Hughes, Ph.D., Professor of Philosophy, Department of Literature, Philosophy, and the Arts, University of Michigan-Dearborn, “Presumed Consent: State Organ Confiscation or Mandated Charity?” HEC Forum (2009) 21(1): 1–26 [PDI]

**First**, many, if not **most, people are notoriously reluctant to face end of life issues** and decide how they want those issues to be resolved. It seems reasonable to suppose that this reluctance is in part a consequence of **[because of] squeamishness about personal mortality and how best to manage matters related to the end of one’s life** (Zeller, 2008, pp. 1-19). **Second**, **some religious believers regard their bodies as a gift of God and not, therefore, as** their or anyone else’s **property**. **The prospect of their bodies and body parts being treated as medical salvage may cause great anxiety** in those whose religious or moral convictions conflict with the presuppositions about the nature of persons and body parts that undergird policies of presumed consent. A **third** concern is that **there are likely to be people whose legal status or social circumstances make the cost of publicly opting out of the policy too high. Illegal aliens and others whose actions are being monitored by the state or those whom the state is seeking (e.g., crime suspects) may view officially registering their desire not to have their dead bodies used as requiring that they incur costs (e.g., being jailed, fined, deported or otherwise harassed) that for them make opting out of a policy of presumed consent very difficult, if not impossible.** **Fourth**, **some people view any involvement with technology and the government as inconsistent with their religious beliefs (e.g., the Amish), and others view the increasing collection and use of personal information by government and business as an erosion of personal privacy to which they wish to avoid contributing.** These **people may view officially opting out** of a policy of presumed consent **as fueling the collection of personal information by government and commercial organizations for the purposes of widespread citizen/consumer monitoring and manipulation of their and others’ behavior.** Over twenty years ago Gary Marx called the development and use of **information technologies to gather and disseminate personal information, create “virtually” eternal records on individuals and groups, and to monitor the population at large, [and]** “the new surveillance” (2006, pp. 3-13).15 The **recent largely unchecked and constitutionally questionable use of such information-gathering technologies in extra-legal and pro-active law enforcement initiatives in Post 9-11 America have exacerbated the worries** raised by Marx to the point where there now exists in the United States a culture of deep suspicion and fear of government collection and (mis)use of personal information (see, e.g., Umansky, 2008; Goold, 2006). Reasonable citizens are justifiably wary of contributing to the expansion of this regime of information abuse and compromised civil liberties. **Fifth**, there is good reason to think that **some groups** of people **who have been historically marginalized are deeply suspicious of government sponsored health care initiatives** in particular, **which have discriminated against them and even used them for nefarious purposes.** For these groups officially **opting out may be regarded as just another way of cooperating with an untrustworthy authority**.16 **Sixth**, it is probably the case that **some of those who fail to opt out of a policy of presumed consent will simply not have made up their minds about whether to donate their organs, or simply have not yet gotten around to registering their desire not to participate, or are in a state of ambivalence** strong enough to raise the question whether in not opting out they are freely choosing to opt in. **Arguably, such people will not have given their free consent to have their dead bodies used for harvestable transplant organs, despite their not having opted out of the policy**. And so in some cases the epistemic burden will not be met, and the presumption in presumed consent not justified.

### AT Opting-Out Solves

#### Opting-out isn’t accessible for marginalized people for whom it might be costly

Hughes 09

Paul M. Hughes, Ph.D., Professor of Philosophy, Department of Literature, Philosophy, and the Arts, University of Michigan-Dearborn, “Presumed Consent: State Organ Confiscation or Mandated Charity?” HEC Forum (2009) 21(1): 1–26 [PDI]

In response to these concerns, **it might be argued that people who harbor such worries or hold such views may opt out** of the presumed consent program, thereby maintaining the integrity of their convictions or their indecisiveness or unwillingness to face end of life issues**. This reply, however, will not work for that group of marginalized individuals for whom opting out carries a significant price. Those who fail to opt out because they just have not gotten around to it, or have not yet made up their minds on the issue of organ donation, or, more importantly, are in such a state of ambivalence over the matter that they cannot choose to opt out, may not have given their consent to have their dead bodies used for harvestable transplant organs**.17 It is probably impossible to know how many people will fall into the above categories of persons who have not decided whether to donate organs upon their death, are irreconcilably divided over doing so, or would have opted out if the costs of doing so were not so significant. The point, however, is that there will be such people, and a policy of **presumed consent will, by default, wrongly regard them as consenting to the removal of their viable organs.**

### U.S. Case Law and Common Law

#### **Case law recognizes a right to autonomy – the shift in burden of proof brought by presumed consent violates that trump card**

Hughes 09

Paul M. Hughes, Ph.D., Professor of Philosophy, Department of Literature, Philosophy, and the Arts, University of Michigan-Dearborn, “Presumed Consent: State Organ Confiscation or Mandated Charity?” HEC Forum (2009) 21(1): 1–26 [PDI]

According to Cherry, **the interest persons have in their bodies**, the things connected to their bodies, and their bodily integrity **have traditionally been recognized and protected by common law and private property rights, as recent case law in the United States attests. The rights to reproductive freedom, especially regarding abortion, are cited as examples of how the law supports a robust conception of personal authority over one’s body.** And **recent law on the use or removal of artificial life support** to sustain or terminate human life **underscores the importance of personal control** over our bodies. These and other cases (e.g., Schmerber v. California, 1966, in which it was held that the value of **personal bodily integrity trumped the state’s right to secure evidence of a crime** that the state sought to obtain via a surgical procedure) are marshaled as support both for the contention that **persons are distinct from their body parts over which they have authority, and that they own those body parts**.25 I have commented elsewhere on Cherry’s use of case law on abortion as support for “the principle … that **personal decisions that profoundly affect bodily integrity should be largely beyond the reach of government,**” noting that recent legal decisions on abortion have actually weakened that principle (Hughes, forthcoming). I note here that Cherry’s use of such cases and others to illustrate the core moral concern that **as the significance of personal integrity increases so too does the burden of proof on those who would interfere with personal choice about the use of his body** mirrors the observation in an earlier section of this essay that **a policy of presumed consent, in shifting the burden of proof from the state** securing consent to harvest viable cadaveric organs **to the individual** expressly opting out of the policy, **would weaken the significance of personal authority over one’s body**.

### Religious/Cultural Objections

#### Organ donation at brain-death is forbidden by Islamic law

Bresnahan and Mahler 10

Mary Jiang Bresnahan, pf MSU phd Michigan, and Kevin Mahler, MA MSU, “Ethical Debate Over Organ Donation in the Context of Brain Death,” Bioethics, 24.2 p. 60, 2010. [PDI]

**An even greater metaphysical stumbling block** described by Abdulaziz et al. (2007) **is the Islamic concept of death. ‘Death in Islam is an active process, a transition for the soul from the material world to a spiritual world. Brain death, technically, is not considered death as far as Islamic metaphysics is concerned. That is not to say that Islamic scholars have not recognized the clinical role of brain death. However, as concerns end-of-life rituals, a person is not considered to be dead until the body has become cold and rigor mortis sets in. In this sense, the family should be allowed to stay with the patient and continue with end-of-life rituals until cardiopulmonary arrest is complete and the signs of death have become apparent to the laity.’** Given this set of beliefs linked to Islamic theology, **the reluctance of family members to allow physicians to cut into the breathing body of their loved one being sustained by life support is understandable and this set of beliefs is not easily reversed.**

 Other more conservative Islamic websites are less supportive of any kind of organ donation. [The 2007 Report of the Council of Muslim Theologians states] ‘The bequest (Wasiyyat) of a person that after his death, his organs be donated is forbidden in Shariah.’ Another conservative Islamic website offers this advice: ‘**Organ donation would be considered the forbidden desecration of the body of a Muslim. Reception of such an organ obtained under those circumstances would be opposed.’** The opinions represented on these websites show that brain death organ donation is a source of controversy for followers of Islam.

#### Religious debates on organ donation are at best ambiguous

Bresnahan and Mahler 10

Mary Jiang Bresnahan, pf MSU phd Michigan, and Kevin Mahler, MA MSU, “Ethical Debate Over Organ Donation in the Context of Brain Death,” Bioethics, 24.2 p. 60, 2010. [PDI]

Health-information-seeking theory suggests 46 that **when people receive a medical diagnosis that they do not fully comprehend, such as the declaration that someone that they care about is brain-dead and will never recover, they are likely to seek information online where copious, easily available information is readily accessible.** While there are more sophisticated health-information search engines, Google is the default search engine for most users of the Internet, handling a staggering 26% of all Internet traffic.47 **If family members of a brain-dead person sustained by life support go online to see what their religion has to say about the ethics of brain-dead organ donation, they are likely to learn that brain-dead organ donation is controversial in the five religions included in this study.** The first page of the Google search **results listed for each of these religions reveals a substantial amount of ethical debate on the issue of brain-dead organ donation**. The claim of organ procurement agencies, promoted on their websites, that all major world religions approve of organ donation, doesn’t tell the whole story of the ethical debate in many religions on the meaning of brain death and organ donation and the difficulty that such decisions pose for many families confronted with the request to donate organs of a loved one. **This analysis of five major world religious organizations about brain death and organ donation shows that the situation has greater ambiguity and complexity than the simple religious endorsement suggested by organ procurement websites.** The websites included in this study are sites that people would be likely to see first if they seek information online. The controversy about the meaning of brain death extends beyond lay people to politicians and planners, health reporters in the mass media, theologians and ministers of religion, and to members of the medical com- munity and bio-ethicists who continue to debate the definition of brain death.48 The ethics of organ donation in the context of brain death is not as clear as organ procurement agencies’ claim about approval would suggest. This is an important issue for procurement agencies because the discrepancy between the need for organs and their availability has continued to increase.49

#### **Presumed consent violates some cultural and religious reasons for non-donation**

Raza and Hedayat 04

M. Raza and K.M. Hedayat, “Some Sociocultural Aspects of Cadaver Organ Donation: Recent Rulings from Iran,” Transplantation Proceedings, 36, p. 2889. Elsevier. 2004. [PDI]

 Iran has one of the highest traffic fatality rates in the world with 60% of the population under 25 years of age. **Legal mechanisms for cadaveric donation have been in place since 2000, and religious support for it has existed for as long as 35 years.** An efficient and socially supported cadaveric donation program would be the ideal way to alleviate the suffering of those requiring organ transplantation for palliation or cure of their illnesses. **However, cultural and social factors, especially family relations and filial obligations, continue to negatively influence cadaver organ removal.**

 **Despite the legal and religious acknowledgment of patient autonomy, multigenerational decision-making continues to occur, taking an undeniable and important role in medical decision making. It has been a major barrier in removal of organs from a cadaver.** Waiver of family permission in the case of an advanced directive should positively influence cadaveric donation. In addition, the exemption of diyyah should encourage physicians to remove organs from cadavers without fear of legal repercussions.

### Rights Violation by Definition

#### **Voiding consent is irreversible – by definition it’s not a presumption of willingness but rather a presumption of the state’s right to the body of the deceased**

Pierscionek 08

Barbara K Pierscionek, pf in the Department of Biomedical Sciences, University of Ulster, “What is presumed when we presume consent?” biomedcentral.com/1472-6939/9/8 [PDI]

Unlike the presumptions in law or the hypotheses of science, **presumption of consent for the use of body organs cannot afford any possibility of abandoning the presumption, reversing the decision or of retracting any action based on the decision** (clearly, the deceased donor cannot raise objections). **The presumption of consent for organ donation cannot therefore be taken as a presumption of donor willingness**, with the specific understanding that there will be a provision for changing the course of action should further evidence emerge, **but rather as a presumption of state rights to post-mortem body organs, unless an objection by the 'occupant' of the body is raised whilst the 'occupant' is still in 'residence'. Opponents of presumed consent argue that the absence of donor willingness is morally unacceptable because it can be seen as a violation of their wishes** [4]. (It has even been suggested that the term presumed consent be replaced by 'specified refusal' to put the emphasis on the action taken rather than on assumption [5]).

### Right to Donate

#### **Presumed consent takes away the power to donate altruistically**

Pierscionek 08

Barbara K Pierscionek, pf in the Department of Biomedical Sciences, University of Ulster, “What is presumed when we presume consent?” biomedcentral.com/1472-6939/9/8 [PDI]

It is clear that **presumed consent is advocated as a means of meeting organ donor shortages and not because the state wishes to assume ownership of body parts** per se. **Nevertheless, it places the greater emphasis on functionality of body organs and how they can be best utilised** to sustain life **rather than on the importance of requiring permission** of the individual to donate his or her organs. **It** also **takes away the power to 'gift' that donorship confers** [6].

### Right to Inheritance

#### **PC violates the right to inheritance – a living person has the right to gift their organs after death just like part of their estate**

Pierscionek 08

Barbara K Pierscionek, pf in the Department of Biomedical Sciences, University of Ulster, “What is presumed when we presume consent?” biomedcentral.com/1472-6939/9/8 [PDI]

The debate about presumed consent and importance of optimising the functionality of body organs can extend to ownership and the right to sell these organs [7-9]. It has even been argued, in accordance with a rights-based theory of justice, that **body organs are akin to goods to which a person can claim rights** [10]; **the prospect of treating body organs, in future, as 'property' has been raised in a common law case** [11]. Whilst alive, **the 'occupant' has an acknowledged right of ownership as evidenced in medical and other research practice: autonomy of mentally competent adults is respected and consent to medical treatment and/or study on any part of the body must always be sought.** It could be argued that consent is required for research and medical treatment because there may be risks involved and that these risks no longer apply post-mortem, but this does not take into account all the underlying reasons for consent. One of these is the fundamental respect for the right of the individual to make decisions about his or her own body and in certain situations to accept payment for its usage as is evidenced when remuneration is offered for participation in research. It is not a quantum leap to suggest that if functionality of body organs is so valued and remuneration for research on the living body permitted, **the worth of body organs** (just like land and other acquired assets), **should be allowed, after death, to pass to relatives or any other beneficiaries nominated by the deceased in a will.** Indeed, this may be considered a natural extension of current practice: that next of kin take care of the deceased body [12]. **If the state wishes to presume consent** to organ donation (in the absence of any objections) **and to treat these as transferable resources, the question of why individuals should not be permitted to organise for the sale of their body organs post-mortem, for the financial benefit of family and loved ones, could very well be raised.** The sale of body organs is highly contentious but paradoxically, such a debate may raise awareness of the need for organs and the suggestion of a financial incentive could even encourage organ donation [7, 8]. James Stacey Taylor [9] points out that any suggestion of establishing a market in body organs needs to be seen as a means of increasing supply for the benefit of those who are in need and therefore has sound moral grounding [9]. It should be considered alongside other measures and be properly controlled and implemented to avoid exploitation [9]. These arguments in support of the sale of body parts, are made with the assumption that what is considered to be 'morally permissible' does not take into account any objections based on religious beliefs [8]. **Religious and cultural views need to be given just consideration because certain beliefs and traditions oppose** the sale of body organs and indeed **the notion of presumed consent** [13]. Conversely, for others such measures are acceptable; surgeons from India have protested against the objections to body organ trade [14].

### Children and Mentally Incompetent Adults

Consent is problematic in cases of children and mentally incompetent adults – presuming in those cases violates their rights

Pierscionek 08

Barbara K Pierscionek, pf in the Department of Biomedical Sciences, University of Ulster, “What is presumed when we presume consent?” biomedcentral.com/1472-6939/9/8 [PDI]

Presumed consent in the case of children The age at which autonomy is granted varies in the UK depending on whether it is with regard to consent to medical treatment or consent to participation in research. In the former case, children are given the status of autonomous adults at the age of sixteen; in the latter the age of consent is eighteen. This distinction has not been properly qualified in the UK and can lead to bizarre situations [15]. Before presumed consent can be permitted, there would need to be a decision made about the age at which autonomy of an individual to object to organ donation is respected. Once such an age is decided, it will inevitably lead, in the UK, to the question of Gillick competency. This term arose from English case law and is applied in relation to consent to medical treatment where there is a question about the rights of a minor to make autonomous decisions about such matters [16]. A Gillick competent child is one who, although chronologically below the determined age of consenting to medical treatment, is deemed to be intelligent and mature enough to understand the consequences of such a treatment and therefore is considered as able to be treated as an autonomous adult [16]. Whilst the notion of Gillick competency arose from the law, **the decision about whether or not to treat a child as** Gillick **competent** (and hence as an autonomous adult) **is left to the medical practitioner. The decision about whether or not to allow a minor the autonomous status of an adult with regard to medical treatment is fraught with difficulty and uncertainties. It would become even more complicated if it were applied to presuming consent to organ donation, for the differences between appreciating the consequences of medical treatment, and hence being able to consent to it, and being sufficiently competent to understand what refusal of organ donation may mean, are vast.** The former requires the young person to have an understanding of what the treatment will mean to him or her. **The latter requires a much more evolved perspective on fundamental issues of life and death and the ability to make a balanced judgment and decision without being pressured by feelings of guilt that refusal will deprive another human being of life.** It may be considered safer to reject the notion of Gillick competency for presumed consent altogether and leave the right of refusal for minors in all cases up to parents, guardians and carers. This does not simplify matters. Reliance solely on the decision of parents or guardians, could mean ignoring the wishes of a fourteen year old mother, who is estranged from her own parents and who on her death bed insists that she does not want any of her organs donated. (It is recognised that this situation can only occur where organ recovery is to be made without brain stem death). If Gillick competency to presumed consent cannot be invoked, it **[presumed consent]** **would permit taking organs from a minor in cases where no autonomous adult authorised to object to such a measure were available**.

Presumed consent in the case of mentally incompetent adults **Decisions on behalf of the mentally incompetent need to be made** in cases of medical treatment and in such situations, common law in the UK sets the principle that such decisions should always be made in the best interests of the patient [17]. There have been instances in which it has been difficult to ascertain exactly what these best interests are. In one of the more controversial legal cases [18], the decision was made that it would be in best interests of Y, a physically and mentally handicapped woman, to transplant her bone marrow in order to save the life of her (mentally competent) sister even though the procedure was not without risk and provided no benefit to Y. The justification given for why this was in Y's best interests was that the sister had a young child who, without its mother, would be left in the care of its grandmother (Y's mother) who would then not be available to see Y as often as she did. Notwithstanding whether or not this explanation justified the best interests argument, it emphasizes the vulnerability of the mentally incompetent to the decisions that can be made whilst they are alive. The situation is even more uncertain after death. **The 'best interests' argument that is used in the case of a living donor cannot be applied post-mortem. A mentally incompetent adult will be unable to raise objections to organ donation because**, like a child, **the mentally incompetent adult is deemed to be unable to understand the concept. However**, unlike the child with parents who are able to make a decision about refusing donation, **the mentally incompetent adult may have no living relatives able or permitted to make such a refusal on his/her behalf. The vulnerability of these individuals highlights one of the most potentially dangerous aspects of presumed consent**. If presumption of consent is permitted, provision would need to be made to protect such individuals in order to avoid **inadvertently exploiting the mentally incompetent as reservoirs of body organs**.

### No Informed Consent Means No Presumed Consent

**Presumed consent is impossible because it assumes that individuals have the ability to make informed decisions about organ removal in the first place. If no such informed consent is possible, then any presumed consent policy is coercive. The brain-death criteria allows physicians to mislead patients and proxies into allowing them to kill living persons**

Collins 09

Mike Collins, Ph.D. (Candidate), CUNY Graduate Center, Department of Philosophy, “Consent for Organ Retrieval Cannot be Presumed,” HEC Forum (2009) 21(1): 71–106 [PDI]

In order for a consent to count as an informed consent, it must be made in the presence of substantial understanding of an adequate amount of relevant information**, where what constitutes relevance can be determined in one of two ways, as discussed above. Discussions of informed consent are generally discussions of the obligations of physicians and researchers for disclosure,** and rightfully so, since it is the physician/researcher who must have a conversation with the patient/subject, laying out the relevant information including risks, benefits, procedures, etc. **But what has not been noticed thus far is that, if the medical community in general, and thus most physicians in particular, are themselves unclear about their subject matter, then they are in no position to impart adequate and relevant information to their patients or their patients’ surrogate decision makers.** Failure to obtain informed consent can occur not simply because the physician has failed to impart the relevant information, but also if the physician imparts misinformation. Our first reason to question the adequacy of decision-makers’ understanding of the relevant information involving organ donation starts here. As noted above, there is a substantial amount of confusion, in the primary literature on brain death, about the equivalence (or rather lack of equivalence) of brain death with death. The discussions of function versus activity are misguided and irrelevant: the complexity of the human central nervous system is far beyond the reach of simple “functional” versus “nonfunctional” attributions to its inner workings. Further, the use of the EEG to make these sorts of claims is entirely unreliable. The number of active neurons that contribute to any single EEG spike is on the order of hundreds of thousands, if not more. Researchers are still trying to tease apart whether the minute voltage differences found at the scalp result from action potentials, pre-synaptic potentials, post-synaptic potentials, a combination of them, or even something else. This does not make for simple attributions of function versus non-function. But this is irrelevant, since obvious preservation of function exists anyway. Another source of confusion is the discussion of significant versus insignificant functions, where it is argued that if the function has something to do with the endocrine system it is somehow “insignificant”.21 Again, the physiological criteria for death operative in this debate are stated in terms of the irreversible cessation of all functions of the brain, not just some, and not just the ones deemed significant (although I repeat my claim that surely the preserved functions discussed—maintenance of free water homeostasis, energy transduction and information transfer, and perhaps also preservation of hemodynamic stability—are significant). If we want to change the subject and have a debate about essentialism and the higher-brain conception of death (as this is the inevitable destination of this line of reasoning), we can certainly do that, but that constitutes a change of subject. Another source of confusion appears to be the difference between prognosis and diagnosis. It has been argued that it is morally acceptable to remove organs from brain dead patients because their prognosis is exceedingly poor.22 This may be a valid line of moral reasoning, but it would apply equally to the alert and oriented terminal cancer patient as to the brain dead patient. Further, it does not constitute an argument whose conclusion is that the patient who is brain dead is in fact already dead. Brain death is a prognostic indicator of imminent death, but it is not a diagnostic indicator of the occurrence of death. Yet another source of the rampant confusion is the claim that the brain is the central integrator without which integrative unity is lost. Not only has it been shown that this empirical hypothesis is false, but the very fact that complex, biologically living systems exist which admit of integration yet lack any central integrator, demonstrates that the hypothesis was a confused one to start with. Consciousness is another factor that makes for confusion. Shewmon has argued that both brain death and spinal shock (of the cervico-medullary junction) admit of extraordinary similarities, both in our theoretical understanding of them as well as practical guidelines for care (1998). In both cases, the body is entirely cut off from communication with the brain,23 however we do not hesitate to claim that the spinal shock patient is alive. As he is at pains to point out, this is not because in the spinal shock case the patient is conscious. Rather, the justification for identifying loss of all functions of the brain as the physiological criterion that must be satisfied in order for the definition of death to be satisfied is the integrative unity argument. Consciousness is a red herring here. Further, if consciousness were a factor, we would then not hesitate to call anencephalic infants and patients in permanent vegetative states dead (since they are not conscious), but we do not. So it is not consciousness or the lack of it that marks the difference between life and death. Recall also our discussion of the biological and sociological conceptions of death, where the latter has to do with what sorts of rights are conferred or not conferred upon an individual in different physiological states. The differentiation of these conceptions of death only serves to obfuscate the real nature of the brain death debate, which is not a non-normative, technical scientific debate about the nature of death. It is and always has been a normative debate about when organ retrieval is morally permissible. But so long as the nature of that debate remains obscured in the confused muddle of the brain death literature, forthright discussions of the normative issue here, that is, of what is actually at issue,24 will fail to take place. **With this much confusion in the primary brain death literature, and with the large and growing number of philosophers, physicians, and other bioethicists arguing against the equivalence of brain death with death, we should think that this would be far from a settled matter among physicians in general. But it is.** As Shewmon writes (2001, p. 457), “‘**brain death’ … is generally regarded as one of the few relatively settled issues of contemporary bioethics** [citing Bernat, 1994, p. 115]. **Such consensus [is] at the level of statutory law and clinical praxis**…”. Miller and Truog (2008, p. 3) write, **“[m]ost physicians have been taught to regard the equivalence of ‘brain death’ with ‘death’ as a medical ‘fact’** on a par with the Kreb’s cycle”. The equivalence of brain death with death is widely accepted by the majority of physicians to this day. Because it is so **widely accepted, and because that acceptance is based on a** confused **(and confusing) primary literature which is riddled with non sequiturs,** it follows that the average physician is in no position to provide adequate, relevant information to her patients or patients’ proxy decision makers about organ donation**.** Regardless of whether we use the hypothetical reasonable physician, one of whose primary patient care goals is to further (or at least respect) her patient’s autonomy as our standard, or the hypothetical reasonable and prudent patient, we get the same conclusion. Both the reasonable physician and the reasonable patient would want to know the answer to the most basic question of all before consenting to donate: **Is the patient dead? If the physician herself is unclear about the difference between brain death and death, and since brain death is widely accepted as death, then she is in no position** (clearly and truthfully) **to answer that question for the patient or the patient’s surrogate decision makers**. I am not alone in claiming that the medical community, and the transplant community in particular, are unclear about brain death and its relation to death. Amir Halevy writes (2001, p. 496), “many health care professionals, including those actively involved in organ transplantation, are confused about the current definition, criteria, and tests for determining brain death” [my emphasis].25 He goes on (p. 497) to quote Youngner et al., (1992) as suggesting that **the confusion among health care professionals “may be one of the factors impeding effective communication with families about their option to donate organs”.** Shewmon (2001, pp. 457-458) writes that “the conceptual basis for equating a dead brain with a dead human individual remains as confused and controversial today as ever.” **This is our first reason to doubt that explicit consents obtained for organ donation are informed consents.** Second, recall our discussion of the meaning of “death”. “Death” has either evolved to take on a new meaning, where “death” now (at least in the context of discussions of brain death and organ donation) means something like death-2, or it has not. **However, when a physician declares a patient dead by neurological criteria, this is by no means a reliable indicator either that all functions of the brain have irreversibly ceased, or that the organism as a whole has ceased to function as an integrated whole in its maintenance of internal homeostasis and the resistance of entropy. Thus, if “death” has not evolved to have this new meaning, then when a physician declares a patient dead by neurological criteria, her sentence, “the patient is dead”, is false. If “death” has taken on this new meaning, then her sentence “the patient is dead”, is misleading, since here “dead” is technical jargon that is homonymous with but semantically distinct from the colloquial word “dead”.** Because of this, the physician is going to have an extraordinarily difficult time communicating with the family. Because of our acceptance of the dead donor rule (as well as the laws prohibiting intentional killing), the physician must say that the patient is dead. But since this claim is either false or misleading, the decision makers thus lack a crucial piece of information that is relevant to deciding whether to consent to donation or not. Again, this piece of information would fall under the “relevant” rubric whether we use the reasonable physician or the reasonable patient standard. So the first reason is that, since brain death is so widely accepted as death it is likely that there is substantial confusion among the medical community thus precluding effective communication on the part of the speaker (the physician). The second reason is that, because of the differentiation of different conceptions of death to be used for different purposes, which obfuscates the real nature of this debate and creates misleading technical jargon, effective communication is again precluded on the part of the hearer (the family or patient) due to the use of jargon that sounds like a word to which non-specialists attach a much different meaning (i.e., “death”). Either way, effective communication is blocked and decision makers are not afforded information about the most basic and highly relevant factor in deciding whether or not to donate, which is whether or not the patient is dead.26 **Consent for organ donation is not only obtained from surrogate decision makers once a patient has suffered massive neurological trauma, through the sort of conversation envisioned above. Many people sign up to be donors through advance directives, such as donor cards or through their state department of motor vehicles as they obtain or renew a driver’s license. Should we assume that these consents obtained through advance directives are valid informed consents?** Here we have some recent empirical research to appeal to, and the results of the study I describe below clearly suggest that explicit consents obtained for organ procurement are not informed. Since organ procurement organizations (OPOs) increasingly make use of the internet for organ donation consent, **Woien et al. (2006) analyzed the United States OPO websites available to the public for enrollment and consent for organ donation. There were 60 websites serving the 50 states** plus Guam and Puerto Rico. In their analysis, they scored the websites according to four content scores: donor knowledge, donor consent reinforcement, donation promotion, and informed consent. The scores were calculated according to the minimal information recommended by the United States Department of Health and Human Services recommendations for informed consent,27 as percentages of the recommended data elements. For example, recommended data elements for informed consent include the following: criteria for brain death, criteria for cardiac death, organ donor end-of-life care, organ procurement timing in cardiac or imminent death donation, medical tests necessary for organ procurement, and disclosure of confidential medical records to OPOs. Data elements for donor knowledge include the above, in addition to types of ante-mortem tests or invasive procedures necessary for cardiac/imminent death donations (e.g., cannulation), aspects of end-of-life care incompatible with donation, death at home and organ donation, body disfigurement, and others. Data elements that were considered part of donation promotion content include that the OPO is nonprofit, several kinds of outreach programs, media promotion, and recruitment and training of volunteers for organ donation promotion. Finally, data elements for consent reinforcement content include altruistic reasons to donate, religious views condoning donation, tips for persuasion of donor’s family for consent, claims that donor’s family’s grief is alleviated by organ donation, and that the family is not responsible for organ procurement expenses (see Woien et al., 2006, for a complete list). The difference between brain death donation and donation after cardiac death becomes relevant here. For donation after cardiac death, changes to end-of-life care must take place. The patient cannot be allowed to die at home, cannulation of the femoral artery usually takes place ante-mortem to prepare for the cooling agent used to slow the damage from ischemia, the patient will typically be administered medications that are not intended to treat or alleviate pain in the patient, but only for the purpose of preserving the organs; further, once in the operating room, the elapsed time after a nonperfusing cardiac rhythm begins until death is declared (and organ retrieval begins) varies from state to state and even hospital to hospital. Whether we take the reasonable physician or the reasonable patient as our standard for relevant information disclosure, each of these factors must count as relevant information necessary for a rational agent to make an autonomous choice based on their own value system whether or not to donate organs. With respect to donation after brain death, the criteria for brain death, (and as argued at length above) an answer to the question of whether the patient is dead or not, are relevant factors. Further, organ donor end-of-life care, including CPR and further attempts at resuscitation, will be performed on a brain dead individual28 who has agreed to be a donor (in order to preserve the organs) as well as the release of confidential medical information to OPOs, are also relevant factors that any reasonable and prudent patient should want to know in order to exercise an informed choice on whether to donate. Each of these are also factors that any reasonable physician concerned to promote or respect autonomy should want to transparently discuss with her patient in order to give her patient the opportunity to make an informed, autonomous decision. **What did the authors of this study discover?** The overall content scores for donation promotion and donor consent reinforcement were 75% and 79% respectively. **The overall content score for donor knowledge was 33%, and the overall content score for informed consent was: 0%. Not a single website out of all 60 disclosed any information at all on criteria for brain death and cardiac death, on organ donor end-of-life care, or on organ procurement timing in cardiac or imminent death donation.** In 9 states (17%) the consent forms disclosed medical tests necessary for organ procurement, and 8 states (15%) disclosed the fact that confidential medical records would be given to OPOs. With respect to the donor knowledge score, not a single state disclosed information on aspects of end-of-life care incompatible with organ donation, options available for hospice care and organ donation, or changes to medical care at the end of life for organ donation. Only a single website provided information for each of the following: types of ante-mortem tests required for cardiac or imminent death donation, types of ante-mortem invasive procedures required for cardiac or imminent death donation, and timing of the organ donation process for both brain and cardiac death. On the other hand, the scores for donor consent reinforcement and donation promotion, as noted above, were very high. Woien et al. write, Our findings showed that the disclosure on OPO Web sites and in online consent forms lacked pertinent information required for informed enrollment for deceased organ donation… The Web sites predominantly provide positive reinforcement and promotional information rather than the transparent disclosure of [the] organ donation process (2006, p. 14). Thus, the OPO websites and the consent forms available on them do not in any way provide adequate and relevant information necessary for the informed exercise of a choice. Rather, they are simply advertisements designed to promote organ donation and increase the donor pool without providing the information necessary for prospective donors to choose autonomously, based on substantial understanding of the relevant information. The consents obtained through these means, therefore, are not informed consents. Despite the increase in donations after cardiac death, **the majority of donations still come from brain dead donors, and the consent for donation most likely comes from the family.** So we have two cases here. **In the one case, consent for donation after brain death comes from surrogate decision makers. In this instance, there must be a candid conversation between physician and family in order to obtain consent. For the numerous reasons discussed above, effective communication is blocked, and adequate and relevant information can be neither imparted nor understood. In that case, the explicit consents obtained are not informed. On the other hand, consent for organ donation comes through an advance directive. However**, as shown by Woien et al., **the consent forms obtainable online which constitute those advance directives, do not contain adequate and relevant information necessary to make an informed choice.** In that case as well, the explicit consents obtained are not informed. Thus, on either tenable interpretation of informed consent (reasonable physician or patient), the explicit consents obtained for organ donation are not informed.29 I have thus demonstrated the truth of the antecedent of my conditional, so we must conclude the following. Since we cannot presume, had an individual provided consent, that it would have been an informed consent, we cannot presume consent at all. **The concept of presumed consent does not justify organ retrieval in the absence of explicit consent.** 7. Objections and Conclusion There are two final considerations to discuss before concluding. First, we should consider the possibility that I have provided a counterexample to my own claim.30 Since I have argued for the truth of the antecedent of my conditional, I have argued that very few if any consents to organ retrieval are legitimate. This seems counterintuitive, especially when we consider that in order to respect the autonomy of a person who desperately wanted to be an organ donor we would not allow her to do so unless she is well-versed in the difference between biological death and brain death. There are two separate issues here. The first is the claim that few if any consents obtained for organ retrieval are legitimate. This may be counterintuitive, it certainly is unfortunate, but it is also true; hence my arguments do not imply something false or otherwise unacceptable. It thus does not count as a counterexample or a reductio ad absurdum. While, again, this is an unfortunate consequence (and should provide motivation for changing our current practice), I have argued that it is also true. The second issue is whether we should deny a person the opportunity to donate unless that person is well-versed in the distinction between biological death and brain death. If it did follow from my arguments, it may count as a counterexample. However, my arguments do not imply this conclusion. There is a difference between adequate understanding and complete understanding, and further, there are standards (namely, the reasonable physician and reasonable patient standards) to determine what constitutes the relevant amount of information to be adequately understood. While the dividing line between incomplete but adequate and inadequate understanding is amorphous, still it seems reasonable to assume adequacy of understanding if the patient or surrogate decision-maker can repeat the information back to 96 HEC Forum (2009) 21(1): 71–106 the doctor in her own words. The more important issue is to determine how much information is relevant. On both relevancy standards, the potential donor should be aware that (i) when donating after brain death she would not in fact be dead, however, (ii) she is very close to death. Further, (iii) she will be completely and permanently unconscious, with (iv) significant and irreversible brain trauma, and (v) zero chance of recovery with an extreme likelihood of cardiac arrest within a few days. If considering donation after cardiac death, she should be aware of the changes to end-of-life care that must take place, the timing of organ retrieval, as well as the several other factors mentioned above in the context of discussion of the Woien et al. article. It is also worth noting that the Department of Health and Human Services considers an understanding of the criteria for brain death and cardiac death to be necessary elements of the informed consent process, and hence, would consider these to fall under the “relevant” rubric. Thus, my arguments do not imply that a patient who wants to donate should be denied the opportunity to do so, so this is not a counterexample. However, perhaps I have simply overstated my case. My arguments for the antecedent of the conditional conclude that in the current medico-legal climate, consents are not informed. Because of the current lack of informed consent we should not presume consent. Perhaps there is a simple solution here. If persons were informed of the conditions enumerated in the paragraph immediately above and had adequate understanding of them, then they would be able to provide informed consent. Should the medical climate change such that the majority of donors provide informed consent, then I would have to withdraw my claim that we ought not presume consent. Further, since the Department of Health and Human Services considers an understanding of the criteria for brain and cardiac death necessary elements of the informed consent process, does not my claim reduce to the relatively insignificant claim that the current standards for informed consent ought to be adhered to, and when they are, we will then be justified in presuming consent? First, I have argued that being justified in presuming consent requires two components. We must be justified in assuming that, had consent been obtained, it would have been an informed consent. Further, the procedure must be mandated by some widely shared goal or conception of the good in the way that life-saving procedures are. I have only discussed the first component. So if my claim regarding the lack of informed consent were withdrawn this does not imply that the second component is satisfied. It would take further argumentation to demonstrate that consequence. Second, I have not argued the insignificant thesis that merely the current standards for informed consent ought to be adhered to. While it is the case HEC Forum (2009) 21(1): 71–106 97 that they are not, I have argued that the current standards are insufficient. Rather, I have advanced a far stronger claim: (i) brain death is not death, but potential donors are being erroneously informed that it is, and (ii) potential donors must be informed that, as a brain dead donor, they would not be dead when the organ recovery process begins, but they will be dead when it is over. To put it bluntly, potential donors must understand that they will be killed by the organ donation process. This is a far cry from the current official guidelines. We should not underestimate the significance of the change that would have to take place in order for these standards to be satisfied. That the intentional killing of an innocent person is morally prohibited, regardless of any good consequences and regardless of whether the person competently so requests it, is firmly entrenched in most of Western culture. That brain death is equal to death and that the dead donor rule is sacrosanct, is firmly entrenched in American medical culture.31 **In order for the medical community to meet the standards for informed consent for which I have argued, potential (brain dead) donors would need to be informed of the fact that they would not be dead when organ recovery begins, that they would be killed by the process, and they would have to consent to the procedure nonetheless.** In order for this to occur, **the dead donor rule will have to be abandoned, legal changes must take place recognizing that the Universal Determination of Death Act has gotten it wrong, and homicide laws must be revised to allow organ removal as a legally acceptable proximate cause of death**. Discussion of such outcomes, however, is beyond the scope of this paper.32

#### AT Excludes: There’s some amount of medical information that’s sufficient for consent

Collins 09

Mike Collins, Ph.D. (Candidate), CUNY Graduate Center, Department of Philosophy, “Consent for Organ Retrieval Cannot be Presumed,” HEC Forum (2009) 21(1): 71–106 [PDI]

The second issue is whether we should deny a person the opportunity to donate unless that person is well-versed in the distinction between biological death and brain death. If it did follow from my arguments, it may count as a counterexample. However, my arguments do not imply this conclusion. **There is a difference between adequate understanding and complete understanding, and further, there are standards** (namely, the reasonable physician and reasonable patient standards) **to determine what constitutes the relevant amount of information to be adequately understood.** **While the dividing line between incomplete but adequate and inadequate understanding is amorphous, still it seems reasonable to assume adequacy of understanding if the patient or surrogate decision-maker can repeat the information back to the doctor in her own words. The more important issue is to determine how much information is relevant**. On both relevancy standards, **the potential donor should be aware that (i) when donating after brain death she would not in fact be dead, however, (ii) she is very close to death. Further, (iii) she will be completely and permanently unconscious, with (iv) significant and irreversible brain trauma, and (v) zero chance of recovery with an extreme likelihood of cardiac arrest within a few days.** If considering donation after cardiac death, she should be aware of the changes to end-of-life care that must take place, the timing of organ retrieval, as well as the several other factors mentioned above in the context of discussion of the Woien et al. article. It is also worth noting that the Department of Health and Human Services considers an understanding of the criteria for brain death and cardiac death to be necessary elements of the informed consent process, and hence, would consider these to fall under the “relevant” rubric. **Thus, my arguments do not imply that a patient who wants to donate should be denied the opportunity to do so,** so this is not a counterexample.

### AT Hypothetical Consent

#### Hypothetical consent is a useless fiction

Den Hartogh 11

GOVERT DEN HARTOGH, EMERITUS PROFESSOR, DEPARTMENT OF PHILOSOPHY, UNIVERSITY OF AMSTERDAM, “Can Consent be Presumed?” Journal of Applied Philosophy,Vol. 28, No. 3, 2011 [PDI]

There is a second and more fundamental objection to be considered. **Even if all people who haven’t registered a decision would, if asked,** declare their willingness to **consent**, **that would not be enough. Their right to decide about their own dead bodies implies that nothing can be done to those bodies without their consent.** But the presumption of consent doesn’t mean **that it can be safely assumed that consent has been given. We know it hasn’t. It only means that it can be assumed that people would consent under hypothetical circumstances. But hypothetical consent is no consent, anymore than false money is money**, a potential donor (or person) is a donor (or person), or a shadow cabinet is a cabinet.21 **Therefore presumed consent is a fiction**.22

#### AT “It’s What She Would Want”

#### **Just because an action aligns with someone’s preferences doesn’t mean she’d consent to it**

Den Hartogh 11

GOVERT DEN HARTOGH, EMERITUS PROFESSOR, DEPARTMENT OF PHILOSOPHY, UNIVERSITY OF AMSTERDAM, “Can Consent be Presumed?” Journal of Applied Philosophy,Vol. 28, No. 3, 2011 [PDI]

**Some authors defend** a mental state conception of consent, in which **to consent to something means to be in favour of it.** On this conception, a right to decide which implies a requirement of consent is nothing but the correlate of other people’s duties to act in your best interest.24Take, however, any paradigmatic case in which someone’s consent is required for your action, for example when you are using his property. In such a case **it is not enough for you to show that your action fits well into the owner’s preference-orderings as you have reason to assume them to be. (‘If this baker only knew how hungry I am, he would gladly offer me his fancy cakes for free.’)** On the other hand, **it seems quite possible for a person to give valid consent to something which she does not really wish to be done at all, for example out of weakness of will. It seems equally possible for her to want something to be done and yet to withhold her consent, for example because she knows she will regret it in the future.** This can only be denied if one understands someone to ‘prefer’ whatever his actions tend to promote, but such ‘revealed preferences’ are not mental states

#### Rights can be violated even if it’s what the deceased would want

Den Hartogh 11

GOVERT DEN HARTOGH, EMERITUS PROFESSOR, DEPARTMENT OF PHILOSOPHY, UNIVERSITY OF AMSTERDAM, “Can Consent be Presumed?” Journal of Applied Philosophy,Vol. 28, No. 3, 2011 [PDI]

The nearest alternative to a mental state conception of consent is a mental act conception. Such a conception understands consenting to be a decision or choice, hence a kind of intention.30 But objections can be raised against this conception as well. **Suppose your neighbour requests to borrow your car for a day. You reply that you will consider the matter. Considering it, you decide that you have no objections. But just before you communicate your decision to him, you discover that he has already taken the car. In this case he has not acted against your preferences, he has not even acted against your decision, but nevertheless he has acted without your consent. He may not have harmed you,** at least not directly, **but he has wronged you by violating your rights, and as a result you also suffer an indirect harm, consisting in the lack of respect shown to your rights and hence to you**.

#### Only a performed action can be a reliable basis for consent

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GOVERT DEN HARTOGH, EMERITUS PROFESSOR, DEPARTMENT OF PHILOSOPHY, UNIVERSITY OF AMSTERDAM, “Can Consent be Presumed?” Journal of Applied Philosophy,Vol. 28, No. 3, 2011 [PDI]

An advocate of a mental act conception of consent could reply to this objection that in this case there is no real violation but only a presumed violation of your right, or at least of the basic core of it which is independent of and prior to your dignity interest. However, **in order to make it possible for your consent to change not only other people’s normative status, but their awareness of the fact, you have to perform a publicly observable action, so that when people cross the border into your private domain, they should not have to worry whether or not the barrier is really lifted; they should be allowed to rely on what you did.** Therefore **consenting in the relevant sense should be seen, not as a mental but as a public act, a ‘performative’, which by itself has the effect of changing other people’s normative status, their reasons to act or to refrain from acting.**32 Such acts are normally done voluntarily, and if they are not, there is at least an ‘infelicity’ and quite probably a ‘misfire’, to use Austin’s terms. Hence they are normally accompanied by a decision to lift the barrier, and can be said to express that decision. But **the barrier is only lifted by the act itself, not by the decision to lift it. Such public acts get their meaning by convention**.33

#### Accidentally being in line with a person’s intention doesn’t make it consensual

Den Hartogh 11

GOVERT DEN HARTOGH, EMERITUS PROFESSOR, DEPARTMENT OF PHILOSOPHY, UNIVERSITY OF AMSTERDAM, Emeritus Professor, Department of Philosophy, University of Amsterdam, “Can Consent be Presumed?” Journal of Applied Philosophy,Vol. 28, No. 3, 2011 [PDI]

The advocate of the mental act conception could reply to this objection: yes, we can only decide on the basis of public evidence of the mental act, and normally the act of expressing consent is what provides that evidence. But that need not always be the case.34 **In NewYork v. Bink,** for example, **the defendant was accused of assault against a fellow prison inmate, who turned out to have cooperated with the police in an effort to get Bink convicted.**35 **So the other prisoner actually intended Bink to attack him;** he had only failed to express his intention, at least to Bink, for the obvious reason that this would have been the surest way to frustrate it. **Did Bink violate a right of his fellow prisoner?** The court in this case, following a mental act conception of consent, decided that he did not. But **it is hard to understand how the fellow prisoner’s plans did authorize Bink to do what he did. If you leave your car in the woods for a night hoping that it will be stolen,** which will enable you to collect the insurance money, **that doesn’t justify anyone else in taking your car, not even if, accidentally, he is informed about your intentions**.36 What these examples show is that the meaning of a consenting act should be available in a transparent way, as a matter of common knowledge. 37

### AT No Property Rights

#### **No property rights negates since it means the state has no right to take organs**

Hughes 09

Paul M. Hughes, Ph.D., Professor of Philosophy, Department of Literature, Philosophy, and the Arts, University of Michigan-Dearborn, “Presumed Consent: State Organ Confiscation or Mandated Charity?” HEC Forum (2009) 21(1): 1–26 [PDI]

Cherry’s analysis of the importance of bodily integrity and personal authority over one’s body is part of his overall strategy for arguing that brain dead people have no property rights to their bodies or body parts, since only persons have such rights. This suggests **that [if] there are no post-mortem rights in body parts or organs** and, therefore, that **state appropriation of viable cadaveric transplant organs is neither theft nor the violation of a decedent’s property rights**. In response **[However] it might be argued that there are no such rights even for living persons, and so the use of brain death criteria as a basis for determining persons’ rights to bodies and body parts is not relevant.** Instead, some other criteria are needed to justify state confiscation of viable transplant organs either from the living or the dead.

### AT Cherry / No Rights of the Dead

#### **The argument that some body parts are merely contingently ours is to say they are like private property**

Hughes 09

Paul M. Hughes, Ph.D., Professor of Philosophy, Department of Literature, Philosophy, and the Arts, University of Michigan-Dearborn, “Presumed Consent: State Organ Confiscation or Mandated Charity?” HEC Forum (2009) 21(1): 1–26 [PDI]

The conceptual wedge Cherry seeks to make between persons and their parts in an effort to show how there may be a moral claim to property in the body may in the end be implausible. Citing James W. Harris as the source of the claim that the inference from the fact that I am not a slave to the claim that I own myself is invalid, Donna Dickinson argues that the idea of selfownership is a “nonsensical concept” (2007, p. 36). This conclusion, though, is too, hasty. Although it does not follow from the fact that one is not a slave that one owns oneself the further assertion that the notion of self-ownership is absurd does not follow. **Cherry’s view that** **we may regard the human body as a composite of body parts some of which we can live without, which he uses to ground the notion that, on analogy with typical private property,** **we can view some body parts as merely contingently ours and, thus, alienable,** only **supports the conclusion that we might own parts of ourselves,** not ourselves as a totality of parts. It remains to be determined whether we may in some sense own the collection of parts (i.e., the self understood as that collection). Dickenson’s assertion that the self-ownership model of personhood and ownership rights therein appears committed to a kind of mind (brain)-body dualism in which the subject is “some disembodied force possessing the body” misses the mark (2007, p. 37). More accurately, I think, **Cherry’s view appears to commit him to the notion that one part of the body (the higher brain) possesses or at least controls the other parts and has the authority to treat them as objects that can be objectified and alienated from it.** Though this view of personhood may not be universally accepted, it is not, as Dickenson seems to think, clearly untenable.

### AT “Public Treasure”/Public Good

#### This argument begs the question – they need to prove that there is some greater concern than personal autonomy, which is answered by the framework debate

Hughes 09

Paul M. Hughes, Ph.D., Professor of Philosophy, Department of Literature, Philosophy, and the Arts, University of Michigan-Dearborn, “Presumed Consent: State Organ Confiscation or Mandated Charity?” HEC Forum (2009) 21(1): 1–26 [PDI]

Second, **there is the sense in which an authority may take away something that rightfully belongs to someone** not as a means of penalty or punishment but **simply “for the public treasure.” The idea** here **seems to be that the public may have a greater need for that which is taken than could** (or does) **the person from whom it is taken. That such a taking is justified is unclear,** if on this sense of the term we mean to convey both the idea that the public need for that which is taken is greater than is the need of the individual, yet that which is confiscated nevertheless rightfully “belongs to” the individual. **This again raises the question of rightful possession, for whether the viable bodily organs of the dead are properly confiscable will ultimately depend on whether they are the private property of** (or at least in some sense legitimately “belong to”) **the deceased** (or, perhaps, to the deceased’s estate or next of kin), **or become part of the public domain**, or whether the state authority views the property as having been forfeited, and takes it as its or as public property or belonging. This latter possibility could make sense only on analogy with the above examples of forfeiting something as a result of failing to meet a requirement, since we can hardly be punishing the dead by taking organs from cadavers.23

## Constitution

#### Presumed consent is unconstitutional—violates privacy rights and due process.

Liddy 1, (Maryellen Liddy, J.D. Candidate, Fordham University School of Law, 2001, THE “NEW BODY SNATCHERS”: ANALYZING THE EFFECT OF PRESUMED CONSENT ORGAN DONATION LAWS ON PRIVACY, AUTONOMY, AND LIBERTY, FORDHAM URBAN LAW JOURNAL, VOL. 28, 2001, ir.lawnet.fordham.edu/cgi/viewcontent.cgi?article=1817&context=ulj) [PDI]

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 con- trary conclusion. 79 This Note analyzes individual rights by utiliz- ing 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.8 0 Wagner Decew's definition is most consistent with the Court's privacy decisions, which have in- cluded such non-informational subjects as abortion and contracep- tion. 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 reasona- ble person standard and examines the potential problems arising from external scrutiny into the private realm.28' In the case of pre- sumed consent organ harvesting, a reasonable person would likely find organ and tissue removal to be a deeply personal matter, sim- ply 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,282 expanding upon prior Court decisions that guarded against particularly vio- lent governmental intrusions into the body. The unauthorized har- vesting of organs and tissues is highly invasive, as it requires the state to enter the person's body and physically remove the machin- ery of human life. Even corneal removal, hailed as minimally inva- sive by the Powell court, 83 still involves an external intrusion upon the body and the forcible removal of tissue. Harvesting is thus dif- ferent 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.¶ 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,284 the smallpox vaccinations were permis- sible 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 conta- gious 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, pre- sumed consent harvesting, like Gerald Dworkin's concept of im- pure paternalism,285 involves the state's affirmative removal of one person's body part to benefit some unknown other person. Al- though 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. 286¶ Returning to Wagner Decew's definition of privacy, she next ar- gues that state intrusions into the personal realm are unjustified when there is a threat of external scrutiny and its corresponding problems.287 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 individ- ual autonomy within which a person can make fundamental life decisions, including the right to define his or her own existence.288 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.¶ While the Court's privacy/autonomy decisions have dealt with contraception and abortion, one can see parallels to presumed con- sent organ donation. First, there is obvious similarity in the right of bodily integrity, as discussed above.289 Second, the decision to have children, implicated by both contraception and abortion, in- volves 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 dona- tion 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.29° 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.¶ In sum, presumed consent organ donation, in which the state as- sumes 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,29' are inadequate measures of due process.

## Incentives CP

#### Financial and wait-list incentives increase organ supply while avoiding alienation of certain groups

Wright 07

Linda Wright bioethicist, University Health Network and Joint Centre for Bioethics, University of Toronto, “Is presumed consent the answer to organ shortages?” BMJ | 26 may 2007 | Volume 334 [PDI]

Currently organ donation is conceptualised as an altruistic act, and **legislation exists in most countries to outlaw any material benefit for donation**. **However, more people might donate if they were offered financial incentives. Another possible incentive would be to give increased priority for a donor organ to people who have recorded their willingness to donate.**12 **Tactics to identify those who want to donate and encouraging them** to inform their families about their wishes **would inform the procurement system about a donor’s wishes and facilitate decision making on organ donation.** Donor cards would surely help families decide whether to donate a relative’s organs.13 We must not forget that many countries today are multicultural societies, where diverse groups view organ donation differ‑ ently. **Trust in the healthcare system is not universal. Presumed consent could alienate even further those groups that lack this trust, and feed negative attitudes towards organ donation. Engagement of the leaders of communities and attention to religious and cultural beliefs and practices around organ donation may help the public to build the necessary trust to favour organ donation.**

## Information/Education CP

### Note

A lot of the cards in the aff answers to autonomy are probably relevant here, e.g. the Hamm and Tizzard on public information.

### Solves Organ Supply

#### Education measures can achieve voluntary organ donation rates approaching 90%.

Mone 11, (Thomas Mone, Board Member Donate Life California & CEO OneLegacy, Donate Life California Presumed Consent White Paper, September 2011, www.onelegacy.org/docs/DLC\_WhitePaper\_PresumedConsent\_0911.pdf) [PDI]

So, if Presumed Consent is not the solution, how can we increase organ donation to ensure that no one dies while waiting for an organ? According to Rafael Matesanz, head of Spain’s ONT, the answer lies in its highly structured and managed transplant coordination network with intensive care transplant coordinators based at the site of the donation. Versions of this system are also used in the US, with in- house Organ Procurement Coordinators and Intensivist consultants, and have been shown to be remarkably effective, and merit expansion across all major hospitals.¶ While the four California OPOs can and have made great strides to a statewide 72% Donation rate and a death rate normalized donation rate that exceeds even Spain, we can and need to do much better in order to end deaths on the waitlist. Specifically, we must choose as providers of care, societies, and a state to invest in vigorous and targeted education programs aimed at teenagers before they get their first license and public education programs designed to assist recent immigrants from countries without long-standing donation and transplantation programs or with end-of-life cultural traditions that might hinder donation. It is clear that donation rates are highest across the country where multiple generations of the population have been exposed to and educated in the value of donation and transplant, with a culturally homogenous state with a long history of state and community sponsored education like our colleague OPO in Madison Wisconsin being a prime example with a 90%+ Voluntary Consent donation rate.

#### Education and information are key to avoid mistrust and misunderstanding which decrease the likelihood of donation

Neades 09

Barbara L Neades, pf Napier University, “Presumed Consent to Organ Donation in Three European Countries” Nursing Ethics 2009 16 (3) 2009 [PDI]

Impact of organ donation on families Opinions are divided on the benefits and problems of families being involved in decision making about organ donation. Gore et al.28 stressed that the level of support provided by HCPs at the time was very important in facilitating both family members’ understanding of the procedure for diagnosing brain death and their decision to consider a relative as an organ donor. **If** this level of **support is not provided, family objections to organ donation may increase.** Haddow29 supported this view, suggesting that **negative beliefs in relation to donation and** **lack of understanding** of organ donation procedures **led to mistrust** of HCPs and underpinned families’ refusal to allow organ donation to proceed. **Others warn of potential harm to families if they are asked to make a decision about organ donation very soon after being informed of the sudden death of a relative.**30,31 In recognizing the potential detrimental impact on bereaved families involved in the decision-making process in organ donation, Sque and Payne32 demonstrated the need for these families to be approached and supported by appropriately trained HCPs when a request for donation is made. At the time of the donation, **bereaved families also have to be provided with appropriate information concerning their need to discuss and understand the concepts of brain death and organ donation, and allowed time to come to terms with these.** **The importance of education programmes to prepare HCPs to undertake this complex role has been highlighted by a number of observers.**33–35

### Solves Autonomy

#### Public education is key to make consent valid

Neades 09

Barbara L Neades, pf Napier University, “Presumed Consent to Organ Donation in Three European Countries” Nursing Ethics 2009 16 (3) 2009

Beauchamp and Childress18 do, however, clarify that this form of **consent can be acceptable if it can be demonstrated that the individuals concerned were fully informed of the need to consent or object** to an action and also fully aware of the consequences. **This suggests** that, in order for presumed consent to be valid, **evidence of deceased persons’ prior knowledge of the law** concerning organ donation **and the necessary actions in relation to this legislation are required. If there is no evidence** that tacit or implied consent exists or that deceased persons were aware of the law and the need to record their consent or objection, **then the practice of removing organs under presumed consent perhaps expropriates those organs without any regard to consent. This underlines the need for public education for presumed consent to be valid**.

### Solves Polls

#### Survey data shows people care about public knowledge on organ donation

Neades 09

Barbara L Neades, pf Napier University, “Presumed Consent to Organ Donation in Three European Countries” Nursing Ethics 2009 16 (3) 2009 [PDI]

The **participants indicated that public knowledge about legislation and organ donation processes was vital to facilitate families’ full participation in the decisionmaking process, and** therefore in **the success of opt out** organ donation programmes. Evidence was also obtained of major government-funded public awareness campaigns using a variety of media to increase knowledge of organ donation legislation. **The respondents suggested that educating schoolchildren to promote understanding and discussion of organ donation in society contributed to the greater good and acceptance of presumed consent by the public.** They also highlighted the vital requirement for sensitivity in relation to cultural beliefs around death, autopsy and care of the body after death. They reported the involvement of clergy or other relevant religious or spiritual advisors as part of the multidisciplinary team when approaching a family about donation.

## Legalize Sales CP

### Solves Vulnerable Populations

#### A regulated market for organ sales would increase supply and solve those systematically excluded by status quo organ distribution

Strosberg and Gimbel 10

Martin A, pf of healthcare policy and management @ Union Graduate College, Ronald W, pf F Edward Herbert School of Medicine, “Kidney Donation: When All Else Fails, Try a Regulated Market” J Natl Med Assoc 102:44-45 [PDI]

Is it plausible to think the organ procurement program as currently constructed and currently constrained by market prohibitions could ever close the gap? **Proposed initiatives to improve program performance include presumed consent,** required response, moral incentives, standardized hospital policies and best practices, refocused public education, and expanded organ acceptance criteria.5-7 While there is some empirical evidence to suggest that these initiatives do work, individually they are not a panacea for closing the organ gap.8,9 Even if all of these proposed initiatives were fully implemented, most observers believe that **their cumulative impact could not fully close the gap. This is especially true for African Americans, Asians, and Pacific Islanders, who are 3 times more likely than whites to suffer from end-stage renal disease and where human leukocyte antigens (HLAs) typing plays a role in these patients’ compatible matching to available organs.10,11 Tellingly, African Americans are most likely to die while waiting on the transplant list.** In the formulation phase of the policymaking process, policy makers consider and choose among various alternatives. Robert Veatch recounts testimony at the 1983 congressional hearings leading to the passage of the NOTA and the prohibition against the sale of organs. He notes that there was almost universal endorsement of this prohibition in part as a reaction to a description of egregious market abuses.5 As a result, there was little serious consideration of commercialization, a regulated market, or financial incentives as alternative approaches to encourage organ donation.5 Neither was there subsequent consideration by the Task Force on Organ Transplantation of 1986, created by the law to guide program implementation. Nevertheless, during the last 2 decades there have been serious analyses of the pros and cons of market forces in organ procurement that are relevant to Steinbuch’s proposal.12-16 **In** Steinbuch’s **regulated market, the government or its designee would become the monopoly purchaser of kidneys from live donors and would continue to distribute them according to current UNOS criteria. Clearly there are large advantages in cost effectiveness (survival, quality of life, restored economic contribution) of transplantation over dialysis, and live over cadaveric donation. Considering the potential savings that would accrue to the Medicare program, it would behoove policy makers to set the price high enough to assure an appropriate supply.** Although Steinbuch’s regulated market proposal would go a long way toward minimizing many of the aspects of markets that ethicists have traditionally found morally objectionable, it cannot eliminate their objections (eg, the commodification of body parts and the substitution of money for altruism as the motivating force in donation). However, Steinbuch brings to the equation an important argument that could tip the balance toward markets: **African Americans suffer disproportionately because of a flawed policy.** By aiming his **[the] regulated market proposal [is aimed] “toward improving the health and welfare of the historically underprivileged,”** he is building on momentum generated by America’s growing commitment to the elimination of racial disparities in health services utilization and health status.17 In doing so, he is hastening the day when the regulated market will receive a spot on the national health policy agenda.

### AT Altruism Crowd-out

#### Most donations aren’t purely altruistic anyway

Badhwar 14

Neera K. Badhwar, “Kidneys, Commerce, and Communities” (Forthcoming in Commerce and Community, ed. Rob Garnett, Lenore Ealy, Paul Lewis Routledge, July 2014) [PDI]

**The quest for** such **Kantian purity**, however, **is elusive**: human beings typically have multiple motives for their actions, a fact that led Kant himself to declare that we could never be sure that our actions came from a pure heart (Kant). The many excellent arguments against this (what can only be called) altruism-fetishism have largely fallen on deaf ears. These arguments point out that **many so-called altruistic donations are motivated by shame or guilt in the face of family pressure, rather than by, or in addition to, altruism**. Moreover, **most living donors are relatives or close friends of the recipients.** Hence **their motives are a mixture of self-interest and altruism.** In addition, **many live donations are actually paired or chain exchanges, in which the altruistic component of the donor’s motivation is directed at someone other than the recipient. In paired exchanges, if A wants to donate to B,** but cannot do so **because** her blood type is incompatible with B’s, **she makes an agreement** with C, who is in the same situation vis-à-vis D, to donate her kidney to D in exchange for C’s donating to B. When a paired exchange is not possible because either A or C or both are incompatible with both prospective recipients, a chain exchange involving more potential donors and recipients can save several people (Sack 2012). 9 **Purely altruistic live donations from one stranger to another are rare**. Cadaveric donations, which in 2012 were more than twice as many as live donations (11,043 vs. 5769, according to the NKF), are of course made largely for altruistic reasons, but are far from meeting the need for kidneys

### Increases Supply – Empirics

#### **Blood and plasma sales prove that money increases donations**

Badhwar 14

Neera K. Badhwar, “Kidneys, Commerce, and Communities” (Forthcoming in Commerce and Community, ed. Rob Garnett, Lenore Ealy, Paul Lewis Routledge, July 2014) [PDI]

A third reason for the ITC’s opposition to kidney markets is also based on the assumption that markets would “crowd out” the altruistic motive. **The worry here is the practical one that without this [altruistic] motive, we would get even fewer kidneys for transplantation**. Granting, again, that the assumption is true, is it plausible that the crowding-out of altruism would reduce the supply of kidneys? If common sense and evidence from analogous phenomena are any guide, **there is reason to believe the exact opposite. Blood donations went down after payment for blood** (though not all material incentives) (Domen 1995), 13 **was banned in the U.S., whereas plasma, which continues to be paid for, is so abundant that the U.S. now exports a large amount of the world’s plasma stock** (Hippen and Satel 2008: 100-101). **In the U.K., which never allowed payment either for plasma or for blood, there is a constant shortage of both.** In both the U.S. and U.K., as in many other countries, organizations constantly appeal for volunteers to donate blood to keep their transfusion stock at a safe level (3 days, in the U.S.). The only time there is more than enough volunteer blood in the U.S is during emergencies. By contrast, **Iran eliminated its waiting list for kidneys 11 years after it legalized kidney markets**. **If an altruism-only policy fails even for plasma, the donation of which requires less of a sacrifice in terms of time, pain, and risk than a kidney donation, and a largely-altruism policy just barely works for blood, what reason is there to think that it will ever work for kidneys?** Conversely, **if payment produces an abundance of plasma in the U.S. and eliminates a shortage of kidneys in Iran, what reason is there to believe that payment for kidneys will have the opposite effect here or anywhere else?** More strongly, if markets in other goods for which there is a strong demand make those goods more plentiful, why should a market in kidneys make kidneys less plentiful? The idea that this might happen is contrary to the most basic law of economics: the law of supply and demand, and to one of the most basic features of human psychology: the desire for, and expectation of, reciprocity. **Ignorance of markets has combined with wishful thinking and altruism-fetishism to perpetrate an ongoing tragedy**

### AT Harms the Poor

#### A free market for organs would avoid harming the poor by barring them from donations based on disease risk. The operation is safe and the government could give free medical care for follow-ups

Badhwar 14

Neera K. Badhwar, “Kidneys, Commerce, and Communities” (Forthcoming in Commerce and Community, ed. Rob Garnett, Lenore Ealy, Paul Lewis Routledge, July 2014) [PDI]

While this claim has some merit in developing countries, it has little in the U.S. or, I expect, other developed countries. I will start with inter vivos markets in the U.S., since a successful defense of these is also a successful argument for cadaveric markets. **The first point to note is that in the U.S., many poor would-be vendors would be excluded from the market precisely because low socioeconomic status is an independent risk factor for kidney disease** (Hossain et al. 2009). It is true, however, that of the healthy candidates, most would be relatively poor14 – as would most kidney recipients, who would continue to be paid for by Medicare. 15 But is it such a terrible thing that most kidney vendors would be relatively poor? After all, **only relatively poor people take janitorial jobs, house cleaning jobs, or exhausting farm jobs. For many people, selling a kidney would be far preferable to picking blackberries all day in the sun, or cleaning office buildings every day, for a fraction of the sum they would get for a kidney, and not much more of a risk, since laparoscopic nephrectomy, the procedure used in the U.S. for removing a kidney, is extremely safe.** 16 Since a patient on dialysis is far more expensive to maintain than a patient who gets a kidney transplant, **the American government and insurance companies would save money even if they paid a kidney vendor up to $90,000 and provided him free medical care for all subsequent problems related to the nephrectomy** (Major 2008). In addition to poverty, **being African-American is also an independent risk factor for kidney disease, yet African-Americans rarely donate kidneys. If poor but healthy African-American could sell their kidneys, they would improve their own lot, and also provide better-matched kidneys for other African-Americans.** This last point also applies to members of other minority groups. Far from exacerbating inequality, then, **a legal market in kidneys would reduce inequality and strengthen the bonds of community. It would also reduce exploitation in poor countries by reducing black market “transplant tourism”**.

#### The free market solves best – competition increases accountability, raises the price, encourages charities and reduces mistakes

Badhwar 14

Neera K. Badhwar, “Kidneys, Commerce, and Communities” (Forthcoming in Commerce and Community, ed. Rob Garnett, Lenore Ealy, Paul Lewis Routledge, July 2014) [PDI]

Ironically, it is the attempt to save people from exploitation or coercion by **banning kidney markets** that **has led to the unimaginably high levels of exploitation and coercion that we see in underground kidney deals. Although fewer people in India sell kidneys now than before the 1994 ban, those who do have no possibility of legal redress against those who cheat or coerce them. The ban has also created more rent-seeking opportunities for bureaucrats, who now have the power to harass potential “donors” who need their permission to “donate”, but who cannot get it without wading through several yards of red tape, multiple layers of bureaucracy, and absurd last-minute additional requirements** (“Kidneys Still for Sale” 1997), (Iyer and Masand 2012). Legalizing kidney markets in India would not, of course, solve all the problems of coercion, fraud, exploitation, corrupt politicians, or adverse third party effects, because most of these problems are due to extreme poverty and ignorance combined with a lack of community spirit and the rule of law. But **legalizing kidney markets would allow investigative journalism and social media to expose poor quality transplant centers and cheating or exploitative brokers and doctors more easily, and give some legal recourse to those who are cheated. It would also lead to a healthy competition among transplant centers, brokers, and doctors for vendors and kidney recipients, and create more nephrologists and transplant surgeons like Thiagarajan, Reddy, et al, whose careful selection methods, including extensive counseling of prospective vendors, successful surgeries, and three years’ free follow-up medical care, made them the most “popular” team in South India** (Thiagarajan et al. 1990). 31 Unfortunately, some of the wide-spread anti-market bias among professionals infects even Thiagarajan, Reddy, et al, who state proudly that when kidney sales were legal, they did not advertise or allow the market to play a role in deciding payment for the vendor. But **advertising would incentivize transplant clinics to improve, and spread news of trustworthy clinics to prospective vendors. The market price would be higher** than what seemed then, and seems to be still, the going price in India: between $1,000 and $2,000.32 **The higher price would enable the prudent vendor to escape his poverty and also have the salutary effect of preventing government hospitals too poor to pay for patients’ anti-rejection drugs from performing transplants on people too poor to buy anti-rejection drugs.** But far greater improvements would result from a global free trade in kidneys. 33 **Global markets would lead Western insurance companies and transplant centers to establish branches in poor countries that brought higher standards of screening with more sophisticated laboratory facilities, better drugs, better postoperative care, and perhaps life-long free care for any problems connected with the nephrectomy.** Under a consistently free trade regime, people would be free to go anywhere to get transplants or sell kidneys. Consequently, **prices would rise in poor countries and fall in wealthy countries, as they do in other products that are allowed to be freely traded. This would also reduce incentives for black markets** that, apparently, still exist in Iran, where kidney vendors are not allowed to sell to foreigners (Ghods and Savaj 2006). 34 Moreover, immigrants to the U.S. and other Western countries who have a smaller potential supply of kidneys from their own ethnic group in their chosen countries, could go to their countries of origin in order to get [better]-matched kidneys. Finally, if kidney markets were legalized, **charitable organizations would spring up to help people in poor countries who couldn’t afford a kidney transplant or the necessary drugs after the transplant**.

## Mandatory Choice CP

#### Mandatory choice best respects autonomy and increases organ donation.

Springer 12, (Daniel Springer, BA Oakland University 2012, “Organ Donation: Autonomy, Presumed Consent, and Mandated Choice,” www.oakland.edu/upload/docs/Philosophy/Springer\_Essay.pdf) [PDI]

What both proponents and opponents of presumed consent often overlook is the individual’s choice prior to death. Mandated choice is a prime example of how to transform the ineffective system we currently have while simultaneously avoiding much of the controversy between presumed refusal and presumed consent. By eliminating the “presumed” nearly every individual could explicitly state their wishes prior to death. “Under mandated choice, individuals would be required to state their preferences regarding organ donation when they renew their driver’s licenses, file income tax forms, or perform some other task mandated by the state.” (p. 809) By enacting mandated choice, it removes the barrier of presumption, and requires that citizens consider their own death and how they feel about organ donation. Often in the cases of presumed refusal and in proposed models of presumed consent, it is the family of the individual that must decide whether or not to donate their organs. Amid the chaos and anxiety that engulfs the family during the death of a loved one, it seems unfair to ask them whether they wish to donate their loved one’s organs. By mandating that each person decide for themselves, it spares the family the agonizing decision while simultaneously bolstering the individual’s autonomy.¶ Both presumed refusal and presumed consent seek to respect the autonomy of individuals, but both fail to do so. Regardless of which system is enacted, there will be people whose desires are not met. There will be some who wish to donate, but under a presumed refusal system, their organs will not be donated. Likewise, there will be some who do not wish to donate, but under a presumed consent system, their organs will be donated. Either way, there will be wishes of people violated. By enacting the alternative, mandatory choice, this would not be the case. Each person would be required to explicitly state, legally, their wishes. Not only would this prove to be the most autonomous avenue, if the surveys and polls prove accurate, the number of people willing and able to donate would rise tremendously, thus lessening the gap between the supply and demand for organs. Therefore, mandated choice is the best possible alternative to the organ procurement dilemma because it respects individuals’ autonomy, removes family members from making difficult decisions, and raises supply of available organs for transplantation.

## States CP

### Solvency Advocate

#### **State-level presumed consent would enhance research and understanding of the issue – it’s a prerequisite to meaningful federal policy**

Gundle 05

KENNETH GUNDLE, “Presumed Consent: An International Comparison and Possibilities for Change in the United States” Cambridge Quarterly of Healthcare Ethics (2005), 14, 113–118. [PDI]

The possibility of **passing legislation changing the U.S. policy is a more complicated issue. If legislation is to move forward, more research should be done** to assess the current knowledge and opinions regarding organ donation policy and specified refusal in the transplant community and on Capitol Hill. More in-depth, qualitative interviews may be more useful than surveys, especially to examine attitudes toward presumed consent as a term. **Such knowledge** **would allow better informed policy to be developed with a maximum probability of success.** **There is also the option of trying to pass specified refusal legislation in several states as a preemptive measure to an eventual nationwide policy. This could prove the efficacy of specified refusal and provide an organizational framework for the national system.**

### Solves

#### States solve best—presumed consent has to be tested in different forms by the states to best tailor policies to particular circumstances.

ACOT 4, (Advisory Committee on Organ Transplantation, U.S. Department of Health and Human Services, Recommendations 36-41, November 2004, http://organdonor.gov/legislation/acotrecs3641.html) [PDI]

Recommendation 37: The ACOT recommends that the Secretary of HHS encourage States to undertake demonstration projects to test the feasibility of adopting a model of presumed consent to organ donation.¶ The current system for the donation of human organs from deceased donors is based on a default assumption that individuals prefer not to donate their organs after their death. A policy of presumed consent would include as a default assumption that individuals do prefer to donate their organs for transplantation at death. Because of the life-saving potential of transplantation, a presumed consent model would be a moral improvement over the current system, provided individual autonomy is appropriately protected through a system of declining to donate.¶ The ACOT, therefore, recommends that the Secretary authorize, encourage, and support State demonstration projects to design and implement "presumed consent" models for making anatomical gifts. The precise design of such models should be left to the states, provided that any State demonstration project authorized by the Secretary shall include provisions to ensure adequate notification and education of the citizens of the State and a method designed to permit any person not wishing to authorize an anatomical gift at death to register a decision to refuse to authorize an anatomical gift.¶ ACOT believes that until presumed consent models are tested, HHS cannot make an informed decision on whether presumed consent is a viable alternative for increasing donation rates. Such project(s) will be reviewed by HHS to determine if these program(s) increase the supply of organs as a result of presumed consent.

## Minorities DA

#### Presumed consent legislation would adversely affect vulnerable populations who lack the knowledge or ability to opt out.

Orentlicher 9, (David Orentlicher, Professor of Law, Indiana University School of Law- Indianapolis; Adjunct Professor, Indiana University School of Medicine; J.D., Harvard Law School, 1986; M.D., Harvard Medical School, 1981, PRESUMED CONSENT TO ORGAN DONATION: ITS RISE AND FALL IN THE UNITED STATES, RUTGERS LAW REVIEW, VOL. 61, 2009, http://ssrn.com/abstract=1207862) [PDI]

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.110 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.111 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-Andrée Jacob has argued that the possibility of unfairness to vulnerable populations should push us toward actual consent.112 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.113 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.114

#### Presumed consent laws would be used as a justification to harvest organs from the poor and minority groups—history proves.

Orentlicher 9, (David Orentlicher, Professor of Law, Indiana University School of Law- Indianapolis; Adjunct Professor, Indiana University School of Medicine; J.D., Harvard Law School, 1986; M.D., Harvard Medical School, 1981, PRESUMED CONSENT TO ORGAN DONATION: ITS RISE AND FALL IN THE UNITED STATES, RUTGERS LAW REVIEW, VOL. 61, 2009, http://ssrn.com/abstract=1207862) [PDI]

Nearly twenty years ago, in a provocative article about mandatory organ donation, Guido Calabresi observed that legal obligations for people to be organ donors might not be unconstitutional, as long as the laws were applied evenhandedly.161 As he implied, it might not be any worse for the state to take hearts, livers, or kidneys after a person’s death for transplantation than to tax a person’s income to fund social services.162 But even if legal mandates to donate organs might be constitutionally acceptable, they would have to apply to all persons, regardless of their race, sex, religion, etc. If we are going to impose duties to come to the aid of others, Calabresi argued, we must be careful not to impose those duties only on minorities who cannot protect themselves from the majority.163 If the duties are imposed in a discriminatory way, then they should be struck down by the courts.164¶ How do considerations of fairness apply to presumed consent in the United States? Recall that the presumed consent statutes authorized presumed consent only for persons under the custody of coroners or medical examiners. At first glance, this seems like a reasonable restriction. For those cadavers, coroners and medical examiners already will be performing autopsies. Inasmuch as an autopsy entails a major invasion of the cadaver, taking organs for transplantation seems less offensive than it might otherwise be. In this regard, it is important that states have been more likely to permit retrieval of corneas with presumed consent than to permit retrieval of hearts, livers, and other organs. Corneas are a thin, transparent layer of tissue whose presence or absence cannot be detected by the naked eye. The intrusion from taking a cornea does not compare to the intrusion of an autopsy.165¶ Moreover, while people under the custody of coroners or medical examiners are not representative of the general population, they may be representative of the population of potential organ donors. Data indicate that over half and perhaps two-thirds of potential organ donors are under the custody of coroners or medical examiners,166 so restricting organ retrieval to such persons may not disfavor minorities.¶ 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.167 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.168 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.

## Politics DA

### Link

#### **Presumed consent will require lots of fighting interest groups, religious groups, secular voters, Republicans and will cause backlash at Obama – 20 years of empirics on this question. Even if it passes, it’ll be fought in court and rolled back.**

Bard 12

Jennifer S. Bard (2012) pf @ Texas Tech, Lack of Political Will and Public Trust Dooms Presumed Consent, The American Journal of Bioethics, 12:2, 44-46 [PDI]

For example, in January 2011, **a presumed consent bill**, A. 9865, 233rd Sess. (N.Y. 2010), which would have made New York the first state to require individuals to opt out of being donors, **was dropped by its sponsor in the face of strong opposition led by Assemblyman** Dov **Hikind**. Assemblyman Hikind represented **a number of organized religious groups including** the **Rabbinical Alliance** of America, **the Catholic League**, the National **Council of Young Israel**, and **leaders from Chesed Shel Emes**. **Hinkindwas quoted** as saying, “There was no doubt in my mind that if this bill had become law, **we would have ended up fighting protracted legal battles to prevent illegal organ harvesting** . . . I felt this legislation was tantamount to entrapment” (“Proposed Presumed Consent Bill Dropped” 2010). **The concerns are not limited to religious groups but rather strike a chord of mistrust among secular voters as well.** Commenting on a **similar** proposed **bill in Colorado**, S.B. 11-042, 68th Reg. Sess. (Colo. 2011), which **was also dropped by its sponsor after considerable vocal opposition**, a **Republican State Senator**, Shawn Mitchell, **was quoted** as saying, “If enough people aren’t volunteering, that doesn’t mean the government can suddenly lay claim to their body and to their organs after they die. People, I would hope, would be willing to make this choice, but if they’re not, **the government doesn’t own their bodies**. They do and after they’re dead, their families do” (Sayani 2011). Although Senator Mitchell is technically incorrect about body ownership, he is correct that **the public mistrusts the government when it comes to health care. The concern that President Obama’s health care reform efforts included “death panels” that would decide who would and would not get needed treatment is a facet of that same fear that the government and the health care system will abuse their power** (“Death Panels Revisited” 2010). **These withdrawals of the bills following strong opposition from those who fear that presumed consent** will lead to involuntary donation **are consistent with efforts to pass the same kinds of laws 10 and even 20 years ago.** One challenge in studying presumed consent laws is that **they are so unpopular in the United States and often withdrawn before they are voted on** that it is difficult to trace their history. **When histories are available, they show clear evidence of rejection. A failed 2003 Texas** presumed consent **bill**, Texas House Bill 2111 78th Leg. (Tex. 2003), however, provides insight into the depths of the idea’s unpopularity because it **was presented with four other bills promoting organ donation House Bill 89 (paid leave for state employees who serve as organ donors), Senate Bill 160 (resources for education about organ donation provided to health care providers and attorney regarding anatomical gifts), Senate Bill 1225 (removal of organ or tissue from deceased under circumstances requiring inquest), and Senate Bill 1226 (related to formation of kidney-sharing pool)** **andwas the only one that failed to be voted into law**.

#### Presumed consent is hugely unpopular—the term has such negative connotations that the aff would get repealed. Only dedicated education campaigns can overcome the negative perception.

Gundle 4, (Kenneth Gundle, BA Stanford University, Presumed Consent for Organ Donation: Perspectives of Health Policy Specialists, Stanford Undergraduate Research Journal, (2004) Spring, pp. 28-32, http://web.stanford.edu/group/journal/cgi-bin/wordpress/wp-content/uploads/2012/09/Gundle\_SocSci\_2004.pdf) [PDI]

The results indicated that health policy specialists in Washington, D.C. had significant problems with ‘presumed consent’ as a term. Informants indicated the term had negative connotations, sounded coercive, and would be difficult for the public to understand. ‘Specified refusal’ received mixed responses as an alternative to ‘presumed consent’. Some considered this terminology such a problem that continuing to name this ‘opt-out’ policy presumed consent might prevent its adoption as policy.¶ Without exception, participants believed that ‘words matter’ in the context of policymaking. Addition- ally, positive media coverage and the right public education were labeled as factors influencing whether or not pre- sumed consent would be accepted and passed into law. These findings suggest a significant change in how addressing the organ shortage from a policy standpoint¶ should be approached.¶ Having a policy that can potentially¶ increase rates of organ donation is not enough in and of itself. These infor- mants, who are involved in the creation of health policy, suggest that semantics and marketing are just as important as efficacy in influencing political feasibil- ity.

## Biopower K

#### Presumed consent laws are another means of biopolitical surveillance that curtails civil liberties in the U.S.

Hughes 09

Paul M. Hughes, Ph.D., Professor of Philosophy, Department of Literature, Philosophy, and the Arts, University of Michigan-Dearborn, “Presumed Consent: State Organ Confiscation or Mandated Charity?” HEC Forum (2009) 21(1): 1–26 [PDI]

Fourth, some people view any involvement with technology and the government as inconsistent with their religious beliefs (e.g., the Amish), and others **[some] view** **the increasing collection and use of personal information by government and business as an erosion of personal privacy to which they wish to avoid contributing.** These people may view **officially opting out of a policy of presumed consent** as **fuel[s]**ing **the collection of personal information by government and commercial organizations for the purposes of widespread citizen/consumer monitoring and manipulation of their and others’ behavior.** Over twenty years ago Gary Marx called the development and use of information technologies to gather and disseminate personal information, create “virtually” eternal records on individuals and groups, and to monitor the population at large, “the new surveillance” (2006, pp. 3-13).15 **The recent largely unchecked and constitutionally questionable use of such information-gathering technologies in extra-legal and pro-active law enforcement initiatives in Post 9-11 America have exacerbated** the **worries** raised by Marx **to the point where there now exists in the United States a culture of deep suspicion and fear of government collection and (mis)use of personal information** (see, e.g., Umansky, 2008; Goold, 2006). **Reasonable citizens are justifiably wary of contributing to the expansion of this regime of information abuse and compromised civil liberties.**

## Medicalization K

### Link

#### Discussions of organ transplantation and consent laws cedes too much control to physicians

Collins 09

Mike Collins, Ph.D. (Candidate), CUNY Graduate Center, Department of Philosophy, “Consent for Organ Retrieval Cannot be Presumed,” HEC Forum (2009) 21(1): 71–106 [PDI]

**According to the community practice standard, adequate and relevant information has been imparted when the physician has discussed with the patient however much** (or little) **is** the **common practice** among her peer physicians. **This standard has been criticized for allowing too much room for physician paternalism** (Brody, 1989, p. 6), **as well as on the grounds that it leaves the decision about how much information is relevant in the hands of the physicians themselves, which is inappropriate.**7 Both of these are legitimate objections, but a more pressing one is that this is an obvious case of the naturalistic fallacy: “is” does not imply “ought”, and hence, even if all physicians are in the habit of non-disclosure or minimal disclosure to their patients, this does not imply that that is what they ought to be doing. Further, **especially when we consider the historical role of paternalism in medicine and the relatively recent emergence of respect for autonomy and selfdetermination as being accepted as a binding moral standard on physicians, we see that there are historical reasons why the community of physicians might not be in the habit of adequate disclosure. The community practice standard, interpreted in terms of statistical regularities in physician behavior, is** an **untenable** standard for adequate disclosure of information

### Impact – Turns Case

#### Fear over physician and scientific control of the organ-donation process decreases donations

Neades 09

Barbara L Neades, pf Napier University, “Presumed Consent to Organ Donation in Three European Countries” Nursing Ethics 2009 16 (3) 2009 [PDI]

**Public confidence in scientific professionals** in the UK **is at a low level**.15 **Any public mistrust in the organ donation system engendered by the introduction of PCL may not only fail to improve the supply of organs for transplant but may also reduce the numbers currently available.** This could in turn produce professional and legal consequences for nurses and other HCPs. **Few data exist concerning families’ knowledge or public understanding of organ donation concepts** prior to them being involved in this experience.24 Both Robertson25 and Koppelman26 suggested that **confusion about definitions of death also results in misunderstandings** between HCPs in relation to organ donation practices. **The reported public fear that organ harvesting could start prior to people being pronounced dead**27 **raises questions** about exactly what members of the public understand concerning organ donation. Impact of organ donation on families Opinions are divided on the benefits and problems of families being involved in deci sion making about organ donation. Gore et al.28 stressed that the level of support provided by HCPs at the time was very important in facilitating both family members’ understanding of the procedure for diagnosing brain death and their decision to consider a relative as an organ donor. If this level of support is not provided, **family objections to organ donation may increase.** Haddow29 supported this view, suggesting that **negative beliefs in relation to donation and lack of understanding of organ donation procedures led to mistrust of HCPs and underpinned families’ refusal to allow organ donation to proceed.** Others warn of potential harm to families if they are asked to make a decision about organ donation very soon after being informed of the sudden death of a relative.30,31 In recognizing the potential detrimental impact on bereaved families involved in the decision-making process in organ donation, Sque and Payne32 demonstrated the need for these families to be approached and supported by appropriately trained HCPs when a request for donation is made. At the time of the donation, bereaved families also have to be provided with appropriate information concerning their need to discuss and understand the concepts of brain death and organ donation, and allowed time to come to terms with these. The importance of education programmes to prepare HCPs to undertake this complex role has been highlighted by a number of observers.33–35

### Root Cause

#### Can’t solve organ shortage until we deal with underlying fears – this is terminal defense on the aff so only a risk of alt solvency is sufficient to vote neg

Bard 12

Jennifer S. Bard (2012) pf @ Texas Tech, Lack of Political Will and Public Trust Dooms Presumed Consent, The American Journal of Bioethics, 12:2, 44-46 [PDI]

As I wrote in a review ofMichelle Goodwin’s book Black Markets: Exploring The Racial Implications of Offering Compensation to the Families of Potential Organ Donors (Bard 2007), **the underlying reason so many organs are buried rather than donated is because potential donors and their families believe that the organ distribution system is unfair and, worse, that potential donors receive less aggressive medical care. In the face of these fears, we cannot hope to reach the levels of donation enjoyed by European countries such as Spain**—**let alone get presumed consent laws that have helped those countries** achieve these results. Laws are introduced and passed by politicians who hope to be reelected. **The consistent failure and bleak legislative history of presumed consent laws** in the United States **give us no reason to think they can play an effective role in increasing organ supplies. Presumed consent laws**, such as those advocated by the authors, **are doomed to failure until the true reasons for reluctance are identified and** more importantly **addressed** (Smith 2011a; 2011b).

## Discourse Arguments

### “Presumed Consent” Bad

#### **Presumed consent indicates a lack of choice – specified refusal refers to an intentional action**

Gundle 05

KENNETH GUNDLE, “Presumed Consent: An International Comparison and Possibilities for Change in the United States” Cambridge Quarterly of Healthcare Ethics (2005), 14, 113–118. [PDI]

The term presumed consent poses some semantic difficulties. **The word presumed indicates a lack of personal choice or an assumption about a decision. But nothing is particularly presumed; what has changed is the action, from acceptance to refusal. The terminology, then, should follow this change** and refer to the action of opting-out. I argue that **a more appropriate designation would be specified refusal. This rightly refers to the person’s action— that of refusal—and adequately designates that this system is about choice**, not assumptions.

#### Terminology key to policy

Gundle 05

KENNETH GUNDLE, “Presumed Consent: An International Comparison and Possibilities for Change in the United States” Cambridge Quarterly of Healthcare Ethics (2005), 14, 113–118. [PDI]

The possibility of passing legislation **changing the U.S. policy is** a more **complicated** issue. **If legislation is to move forward, more research should be done** to assess the current knowledge and opinions regarding organ donation policy and specified refusal in the transplant community and on Capitol Hill. More in-depth, qualitative interviews may be more useful than surveys, **especially to examine attitudes toward presumed consent as a term. Such knowledge would allow better informed policy to be developed with a maximum probability of success.** There is also the option of trying to pass specified refusal legislation in several states as a preemptive measure to an eventual nationwide policy. This could prove the efficacy of specified refusal and provide an organizational framework for the national system.

### “Brain-Death” Bad

#### **“Brain-death” standards selfishly treat human bodies as junkyards of parts – ready to be used as soon as the mind goes – that masks problematic assumptions about identity**

Hughes 09

Paul M. Hughes, Ph.D., Professor of Philosophy, Department of Literature, Philosophy, and the Arts, University of Michigan-Dearborn, “Presumed Consent: State Organ Confiscation or Mandated Charity?” HEC Forum (2009) 21(1): 1–26 [PDI]

**The use of brain death criteria** for determining when a person’s life ends is a logical consequence of Cherry’s view that the psychological attributes definitive of persons (e.g., consciousness, rationality, etc.) are generally associated with the cerebral cortex (the higher brain). On this view, personal death is compatible with the continued functioning of the lower brain, as well as with the ability to maintain respiratory and other bodily functions artificially. I mention this because although this conception of personal death is widely accepted in medicine and law, it is not the only conception and **is not immune to the criticism [and]** that **in the context of organ retrieval and transplantation it may be problematically self-serving**. The technological ability to maintain respiration and blood circulation and maintain important transplant organs that require an oxygenated blood supply (e.g., hearts, lungs, and kidneys) even while the higher brain is “dead” **[it] encourages the view that personal death occurs with the demise of higher brain function and not with the termination of other bodily organs, which may make it easier for organ procurers, transplant physicians, and other health care personnel in the transplant industry to** view brain dead human bodies **sustained by respirators and other means** as the medical equivalent of junk yards of salvageable spare parts. Indeed, **the language in which the participants in organ procurement, retrieval, and transfer describe themselves and their work reveals conceptions** of personhood, organ procurement (a “harvesting,” with affiliated notions of seasonal renewal), organ retrieval (a mere removal of body “parts”), and transplantation (a “gift of life” from an “altruistic” donor), **that mask contested understandings of personhood, human life, human death, organ donation, and personal identity**.26

# Theory/T

### Presumed Consent

#### By definition, to presume consent means we must have sufficient reason to believe the individual would have consented

Den Hartogh 11

GOVERT DEN HARTOGH, EMERITUS PROFESSOR, DEPARTMENT OF PHILOSOPHY, UNIVERSITY OF AMSTERDAM, “Can Consent be Presumed?” Journal of Applied Philosophy,Vol. 28, No. 3, 2011 [PDI]

Opt-out systems of post-mortal organ procurement are often referred to as ‘presumed consent’ systems. **A presumption directs us, in a case in which no compelling evidence is available to hold that P, nevertheless to proceed as if P were true, unless there is sufficient evidence that it is false.** **It is recommended to presume consent in this case, because, in the absence of registered objections of the deceased, it is held to be more probable that she consented than that she did not.** Whether this suggestion makes sense, however, turns out to depend on the proper interpretation of the concept of ‘consent’. **On a mental state conception of consent we are allowed to presume it if we have reason to suppose the deceased to have been in favour of donation**. However, we should rather understand consent to be a public action of authorisation. On that view consent cannot be presumed, and the opt-out systems as we presently know them on the European continent and elsewhere do not satisfy the requirement that the deceased should have consented to the removal of his organs.

#### **Presumed consent can only be justified by a claim about the probability of the deceased person having consented, not organ supply benefits**

Den Hartogh 11

GOVERT DEN HARTOGH, EMERITUS PROFESSOR, DEPARTMENT OF PHILOSOPHY, UNIVERSITY OF AMSTERDAM, “Can Consent be Presumed?” Journal of Applied Philosophy,Vol. 28, No. 3, 2011 [PDI]

The presumption of consent, as it is normally proposed, clearly belongs to the first category.8 It is true that **a possibly valid norm could direct us to attach the normal normative consequences of consent** (i.e. that we are at least permitted to remove the consenting person’s organs) **to a constellation of evidence which makes consent less probable than non-consent. However, the justifying reason would then be a normative consideration which in itself has nothing to do with consent, e.g. the benefits to be provided to patients with organ failure, and in such conditions talk about presumed consent would be otiose, a kind of newspeak**. **The relevant normative background of the appeal to presumed consent is people’s right to dispose of their own body.** In this context the appeal is used to rebut a charge, and **the only** even faintly plausible **rebuttal is that the probability of the deceased person having consented is greater than the probability of her having refused**.

#### Presumed consent defined.

Rosenblum et al. 11, (Amanda M. Rosenblum, Division of Nephrology, Department of Medicine, London Health Sciences Centre, Lucy D. Horvat, Division of Nephrology, Department of Medicine, London Health Sciences Centre, Department of Epidemiology and Biostatistics, University of Western Ontario, Laura A. Siminoff, Department of Social and Behavioral Health, School of Medicine, Virginia Commonwealth University, Versha Prakash, Trillium Gift of Life Network, Toronto, Janice Beitel, Trillium Gift of Life Network, Toronto, and Amit X. Garg, Division of Nephrology, Department of Medicine, London Health Sciences Centre, Department of Epidemiology and Biostatistics, University of Western Ontario, “The authority of next-of-kin in explicit and presumed consent systems for deceased organ donation: an analysis of 54 nations,” Nephrology Dialysis Transplantation, 2011, http://ndt.oxfordjournals.org/content/early/2011/11/25/ndt.gfr619.full) [PDI]

Presumed consent is defined as a system that ‘permits material to be removed from the body of a deceased person for transplantation and, in some countries, for anatomical study or research, unless the person had expressed his or her opposition before death by filing an objection with an identified office or an informed party reports that the deceased definitely voiced an objection to donation’. Some nations have also proposed a ‘soft’ presumed consent law, where the next-of-kin is still involved in the donation decision [20].

### Specification

#### **The type of consent and involvement of families makes a difference**

Neades 09

Barbara L Neades, pf Napier University, “Presumed Consent to Organ Donation in Three European Countries” Nursing Ethics 2009 16 (3) 2009 [PDI]

**The findings identify a number of key issues that would require careful consideration** if PCL were to be adopted in the UK, many of which have been supported by the Department of Health task force.3 **Of most importance among these is the need to consider the form of consent that would be acceptable to society to allow organ donation under PCL.** The HCPs’ responses suggest that in **their countries the concept of presumed consent in organ donation is well accepted by the public.** The strong objections held by some that a change in the UK legislative approach could have much wider ranging consequences do, however, require to be considered carefully. **Exploration of the impact on bereaved relatives identified that the current legislation in the three countries studied demonstrated the variable need for the involvement of families in the organ donation process**.

#### Presumed consent entails some evidence or reason to believe most people have in fact granted permissiion

Hughes 09

Paul M. Hughes, Ph.D., Professor of Philosophy, Department of Literature, Philosophy, and the Arts, University of Michigan-Dearborn, “Presumed Consent: State Organ Confiscation or Mandated Charity?” HEC Forum (2009) 21(1): 1–26 [PDI]

**What is being presumed** in a policy of presumed consent? According to the Oxford English Dictionary (OED), **the main sense of the verb “presume” is “to take for granted; assume, suppose” that a specific state of affairs is as one takes it or expects it to be** (1989, volume, 12, p. 428). One may, for example, presume (in this sense) that one’s colleagues will be supportive of one’s endeavor to alter the existing philosophy curriculum to reflect new developments in the field while unaware that according to university bylaws only non-faculty administrators may initiate and implement curricular changes. A secondary sense of the term connotes the notion of reasonable supposition or probability, such that one’s expectations are not a mere taking for granted. Yet, a third sense of “presume” as “to take upon oneself, undertake without adequate authority or permission; to venture upon,” closely related to “presumptuous,” which means “to take the liberty; to venture; dare (to do something), usually associated with overconfidence. In this context, the OED notes the specialized legal sense of “presume” as “to take as proved until evidence to the contrary is forthcoming,” which closely parallels the essence of the presumption in presumed consent, albeit in the context of presumed consent it is not “evidence to the contrary” of an assumed fact but behavior (i.e., express exit) that shows dissent (i.e., no consent). **In the context of a policy of presumed consent, the state takes for granted that those who do not expressly opt out of the policy voluntarily consent to the post-mortem harvesting of their viable organs. The key question about the propriety of the state presuming voluntary consent is thus whether there are good reasons for thinking those who have not expressly exited the policy have in fact granted permission to have their viable organs harvested. This is made clear in the standard definition of “presumption,” which shares in the main sense of “presume” as “the assuming or taking of something for granted,” but refers equally as well to justified presuming in its definition as “that which is presumed or assumed to be, or to be true, on probable evidence; a belief deduced from facts or experience.”** **The reference to evidence, inference, and deduction suggests a distinction between a mere taking for granted and a taking for granted that is epistemically grounded** (though not necessarily adequate or justified). In presumed consent, it is the behavior of refraining from opting out of the policy that grounds the presumption that the donor has given voluntary permission for the state to harvest his viable organs.

The cognate “presumptive” is similarly defined as “giving reasonable grounds for presumption or belief; warranting inferences.” As noted, in law the core notion is “a legal inference or assumption that a fact exists, based on the known or proven existence of some other fact or group of facts.” A presumption in law sets or shifts a burden of proof. According to Black’s Law Dictionary, “A presumption shifts the burden of production or persuasion to the opposing party, who can then attempt to overcome the presumption” (1999, p. 1203). The canonical presumption in criminal law is the presumption of innocence, which asserts that a person cannot be convicted of a crime unless the government proves guilt beyond a reasonable doubt, “without any burden placed on the accused to prove innocence” (1999, p. 1205).

In the light of these conceptual observations, we can clarify the nature of the presumption in a policy of presumed consent. **Such a policy creates a state of affairs in which the state takes for granted a person’s permission to have her viable organs harvested upon her death unless she expressly dissents from the program. Whether this is “presumptuous” in the negative sense noted above will depend on whether the state has reasonable grounds for taking persons’ permission for granted, and this, in turn, will depend on whether failing expressly to opt out of the policy is an adequate epistemological basis for thinking such persons voluntarily consent to the policy.** The presumption in a policy of presumed consent sets a burden of proof by shifting the current requirement that the state secure the express consent of prospective organ donors to the prospective organ donor manifesting her desire to opt out of the program. In other words, a policy of presumed consent shifts the burden of persuasion to prospective donors, who can overcome the presumption via opting out of the policy. Unlike the absolute presumption of innocence in the criminal law, the presumption in a policy of presumed consent is a defeasible one.5

# Misc

### Example of Topical Cross-Framework Comparison

#### The “maximizing expected value” approach is in the topic lit – proves balancing autonomy and large-scale benefits is a necessity of applied ethics

Bird 10

Sheila Bird senior statistician, MRC Biostatistics Unit, What about mandated choice? Authors’ reply, BMJ: British Medical Journal, Vol. 340, No. 7760 (19 June 2010), p. 1320 [PDI]

Buggins doubts the need to move to presumed consent,1 but **the need is made acute by the lives needlessly lost.** Opting-out would save lives at a moral cost which is trivial compared with the benefits **and which society has demonstrated it is more than willing to pay by its acceptance of coronial postmortem examination.** We point out: "In the UK, **there are fewer than 3000 confirmed brain stem deaths a year in which presumed consent for organ donation, as a public good, would apply if the deceased had not opted-out in life.** For comparison, over 120000 coronial or fiscal postmortem examinations are done in the UK each year."2 Thus the UK already accepts a vast interference without consent with bodies after death. There is nothing dishonest or covert in opting out: **the citizen retains control and so there can be no basis for threat to patients' trust in the medical profession.**3 **If opt-out has been exercised, organs will not be used**.

#### A variety of moral reasons converge on presumed consent.

Welbourn 14, (Hannah Welbourn, School of Medicine, University of Hull, UK, A principlist approach to presumed consent for organ donation, Clinical Ethics, 2014, Vol. 9(1) 10–16, http://cet.sagepub.com/content/9/1/10) [PDI]

By examining the issue of presumed consent more closely and subjecting it to ethical scrutiny by the process of moral reasoning using a principlist approach, it appears there are many advantages and moral arguments in support of the introduction of presumed con- sent. Despite some concerns that a system of presumed consent would threaten individual autonomy, it has been argued here that as an opt-out system would reflect the wishes of the majority of the population, it is actually more respectful of the principle of autonomy than the current consent system. Individuals who object to organ donation are provided with a means to register their wish not to become a donor, which they currently do not have. Furthermore, by providing the opportunity for life-saving and life- improving organ transplantation to many more patients with end-stage organ failure, without causing harm, the system of presumed consent is also consistent with the principles of beneficence, justice and nonmalificence. Thus, presumed consent has been shown to be an ethically beneficial policy when examined by a principlist approach.

### AT Pierscionek

#### Pierscionek’s argument about reversibility is wrong – we can change our standards of evidence for presumption

Collins 09

Mike Collins, Ph.D. (Candidate), CUNY Graduate Center, Department of Philosophy, “Consent for Organ Retrieval Cannot be Presumed,” HEC Forum (2009) 21(1): 71–106 [PDI]

This analysis is mistaken. **Pierscionek’s inference from the claim that presumption involves a revisable inference** based on the available evidence **to the claim that “presumed consent for organ donation” is really a misnomer** and should be “presumption of the state’s right to bodily organs in the absence of an objection” **does not follow**. First, **while it certainly is the case that the action taken upon the presumption of consent is irreversible** (i.e., retrieval of organs), **the presumption itself is not. Second,** note that if we accept Pierscionek’s inference from the irreversibility of the action taken on the basis of the presumption to the claim that the presumption cannot be made, then **by her own account we also cannot presume that the state has a right to body organs in the absence of refusal, since the same actions would be taken on the basis of that presumption as would be taken on the basis of the presumption of donor willingness.** More importantly, what we should note is this: **the very fact that the actions taken on the presumption of willingness to donate are irreversible implies that the standards of evidence in order to make that presumption ought to be very high. It does not imply that we cannot make that presumption at all**. Let us take a look then at a paradigm case of a legitimate presumption of consent and draw out two morally relevant features of it that should generalize to all legitimate presumptions of consent.

### Methodology for Neades

[There are also some tables in the article – if anyone needs the pdf to access these, email us]

Neades 09

Barbara L Neades, pf Napier University, “Presumed Consent to Organ Donation in Three European Countries” Nursing Ethics 2009 16 (3) 2009 [PDI]

Study design This was a qualitative study employing a questionnaire and semistructured interviews. Setting The study took place in Portugal, Norway and Belgium. Participants Thirty-one HCPs from Portugal, 47 from Norway and 44 from Belgium were recruited as respondents to the initial questionnaire. In addition, semistructured interviews were undertaken with 14 HCPs in Portugal, 13 in Norway and 15 in Belgium who had responded to the initial questionnaire and consented to being interviewed (Table 1). Sampling method An initial survey of 22 European countries involved in the European Transplant Coordinators organization identified 11 countries that used a presumed consent framework. Subsequently, four countries that reported higher than average donation rates, namely, Spain, Portugal, Norway and Belgium, were invited to participate in this study; however, Spain declined the invitation. Supported by local transplant co-ordinators in the three remaining countries, doctors and nurses from critical care areas and having direct experience of organ donation were identified and invited to participate. Data collection The study participants were invited to complete the study questionnaire in their native language or English, as preferred. Returned questionnaires in Portuguese, Norwegian, French or Flemish were translated into English by a university translation service. Table 1 Questionnaires returned from each country and HCPs interviewed Portugal Norway Belgium French speaking Belgium Flemish speaking Questionnaires sent 300 450 70 53 Questionnaires returned 31 47 31 13 Doctors interviewed 5 6 5 5 Nurses interviewed 9 7 2 3 Total interviews conducted 14 13 7 8 Semistructured interviews were conducted in English or in the participant’s native language, with translator support as required. Data analysis The two methods of collection provided data relating to the professionals’ experience and were initially coded using a Qualitative Software Research International Nvivo computerized data management system.36 The data were analysed using a phenomenological framework based on Heideggerian hermeneutics37 to explore the lived experiences of these professionals related to their application of a PCL framework. An overview of the research process can be found in Figure 1. Ethics approval Permission to undertake this study was obtained from the author’s local ethics committees and from the local health ethics committees at the study sites in Portugal, Norway and Belgium.