
Presumed Consent, Autonomy, and Organ Donation

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ABSTRACT

I argue that a policy of presumed consent for cadaveric organ procurement, which assumes that people do want to donate their organs for transplantation after their death, would be a moral improvement over the current American system, which assumes that people do not want to donate their organs. I address what I take to be the most important objection to presumed consent. The objection is that if we implement presumed consent we will end up removing organs from the bodies of people who did not want their organs removed, and that this situation is morally unacceptable because it violates the principle of respect for autonomy that underlies our concept of informed consent. I argue that while removing organs from the bodies of people who did not want them removed is unfortunate, it is morally no worse than not removing organs from the bodies of people who did want them removed, and that a policy of presumed consent will produce fewer of these unfortunate results than the current system.

Keywords: Carl Cohen, mandated choice, presumed consent, transplantation, Veatch & Pitt

I. INTRODUCTION

The current American system of cadaveric organ procurement includes the default assumption that individuals prefer *not* to donate their organs for transplantation after their death. Thus, if there is no evidence that an individual either wanted or did not want to donate her organs after her death, she is currently treated as though she did not want to donate.

“Presumed consent” is the name that has been given to a proposal to change the current system.¹ A policy of presumed consent would include the default assumption that individuals *do* prefer to donate their organs for transplantation after their death. Under such a policy, every individual would

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be given the opportunity to register her desire not to have her organs removed for transplantation, and that registered desire would be respected in every case. But if a person died without leaving any indication of her desires – and if family members provided no reason to believe the individual did not want to donate – we would proceed on the assumption that she would have preferred that her organs be removed for transplantation.

I believe that a policy of presumed consent would be a moral improvement over the current American system of organ procurement. In what follows, I will try to make the case for presumed consent by addressing what I take to be the most important objection to it. The objection is that if we implement presumed consent we will end up removing organs from the bodies of people who did not want their organs removed, and that this situation is morally unacceptable because it violates the principle of respect for autonomy that underlies our concept of informed consent. I will argue that while removing organs from the bodies of people who did not want them removed is unfortunate, it is morally no worse than not removing organs from the bodies of people who did want them removed, and that presumed consent will produce fewer of these unfortunate results than the current system. The principle of respect for autonomy, I will argue, does not conflict with presumed consent but speaks in its favor.

I will proceed as follows. In section II, I will sketch Cohen's argument for presumed consent (Cohen, 1992, pp. 2168–2172), and Veatch and Pitt's argument against presumed consent (Veatch & Pitt, 1995, pp. 1888–1892); I will use Cohen and Veatch and Pitt's arguments because I take them to be among the best and clearest representatives of the opposing sides of this dispute. In section III, I will show how the dispute between proponents and opponents of presumed consent revolves around what I will call the "fewer mistakes claim." In section IV, I will explain why the fewer mistakes claim constitutes a morally powerful reason for presumed consent, a moral reason that is in accord with the principle of respect for autonomy underlying informed consent.

In section V, I will address the related question of whether basing organ procurement policy on "mandated choice" is a better option than basing it on presumed consent. I will argue that while a policy based on mandated choice has much in its favor, presumed consent with a provision for family veto is still a superior option, at least at the present time, when a significant portion of the American public lacks full information about organ donation and transplantation.

II. THE TWO SIDES: COHEN VS. VEATCH AND PITT

There is some dispute about whether a policy of presumed consent would increase the number of organs available for transplantation. I believe that it is probable that a policy of presumed consent would produce more organs, but I will not argue that point here. What I want to focus on instead is the dispute over whether or not a policy of presumed consent would do a better job than the current system at respecting people's wishes about what should happen to their bodies after death.

Cohen has given the following argument for the claim that presumed consent would do a better job than the current system at respecting people's wishes (Cohen, 1992, p. 2169).² About 70% of Americans would prefer to donate their organs for transplantation after their death. But fewer than 70% of the organs suitable for transplantation are donated. This is because many people who want to donate their organs do not leave indications of their desires that are clear enough to overcome the current system's initial presumption against removing organs for transplantation. As a result, many who wanted to donate their organs after death are buried with all their organs intact inside their bodies. This violates their wishes about what should happen to their bodies after death. A policy of presumed consent, however, would result in people's wishes being respected at least 70% of the time, and probably much more than that, so long as the policy includes a well-publicized opt-out opportunity. This would almost certainly constitute an increase over the current system in the number of decedents whose wishes are respected.

Veatch and Pitt have given the following argument for the claim that presumed consent is morally unacceptable because it violates persons' wishes about what should happen to their bodies after death (Veatch & Pitt, 1995, pp. 1889-1890).³ About 30% of Americans prefer not to donate their organs for transplantation after their death. But if presumed consent was implemented, some portion of that 30% would fail to indicate their desire not to donate. As a result, some people who wanted to be buried with all their organs intact would have their organs removed. This would violate their wishes about what should happen to their bodies after death. Under the current system, in contrast, it is very unlikely that organs will be removed from the body of someone who did not wish to donate. The current system thus does a better job than presumed consent at respecting the wishes of those who do not want to donate their organs after death.⁴

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

With that caveat in mind, let us now proceed to examine the disagreement between Cohen, on the one hand, and Veatch and Pitt, on the other. Both sides, as I've noted, operate on the empirical assumption that presuming that an American wants to donate her organs after death will be correct more often than presuming that she does not. Their disagreement centers on the moral importance they attach to the consequences of presuming incorrectly.

III. THE FEWER MISTAKES CLAIM

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

Some opponents of presumed consent may dispute the empirical component of the fewer mistakes claim, maintaining that presumed consent will in

fact lead us to contravene the wishes of more decedents than the current system does. I believe, however, that the core of the opposition to presumed consent is based on a non-empirical reason for rejecting the use of the fewer mistakes claim in the justification of organ procurement policy. This core opposition holds that the fewer mistakes claim simply cannot support the moral weight the proponents of presumed consent try to place on it, and that, as a result, we have conclusive reason to reject presumed consent even on the assumption that it would lead us to follow the wishes of a greater number of decedents than the current system.

The opposition to presumed consent that is insulated from the fewer mistakes claim is based on the idea that mistaken removals are morally much worse than mistaken non-removals. Those who subscribe to this idea hold that it would be wrong to implement a policy of presumed consent because even if it does lead to fewer mistakes overall, it will also inevitably lead to more mistaken removals. And the moral harm of increasing the number of mistaken removals is greater than – or trumps – the moral benefit of decreasing the number of mistakes overall.

We can sharpen this picture of one kind of mistake's being worse than another by comparing it to our differing attitudes toward punishing the innocent and not punishing the guilty. We all want the guilty to be punished and the innocent to go free. But we also have to acknowledge that our legal system cannot be perfect, that some mistakes will be made. We do not, however, believe that all legal mistakes are morally equivalent and that therefore we should simply try to reduce the number of legal mistakes overall. Mistaken convictions and mistaken acquittals are both bad, but mistaken convictions are worse. It's worse to punish an innocent person than not to punish a guilty one. Because of this belief that one kind of mistake is worse than (or trumps) the other kind, we have constructed a system based on the presumption of innocence. We have tried to ensure that we err on the side of not punishing the guilty so as never to punish the innocent. The core opposition to presumed consent holds that mistaken removals are worse than mistaken non-removals in much the same way that punishing the innocent is worse than not punishing the guilty. According to the core opposition, we should presume that people do not want to donate their organs, as this makes it least likely that we will commit the egregious error of removing organs from someone who did not want them removed.

Why do opponents of presumed consent believe that mistaken removals are morally worse than mistaken non-removals? Why do they believe that we are

morally required to place higher priority on preventing mistaken removals than on preventing mistaken non-removals? They believe it, I think, because they take it to be a necessary consequence of the principle of respect for autonomy underlying our commitment to informed consent.

The origin of the requirement that physicians gain informed consent from their patients is the belief that it is wrong to invade a person's body unless that person has given permission. This belief is an essential aspect of the moral principle of respect for autonomy, as a person cannot engage in autonomous decision-making if she cannot control what happens to her own body. Now it is common in medical ethics to give the principle of respect for autonomy the highest priority. Many people believe, that is, that we must reject any policy, no matter how many other things it has going for it, if it violates individuals' autonomy or undermines their capacity for self-determination. And this is why medical ethics generally takes informed consent to be a sacrosanct requirement: it is the guardian of patients' control over what happens to their own bodies.

Opponents of presumed consent seem to believe that mistaken removals violate the right of bodily control while mistaken non-removals do not. They seem to believe that when we remove organs from the body of someone who did not want them removed, we invade her body against her wishes, which constitutes a blatant violation of her autonomy. Mistaken non-removals, in contrast, merely fail to help bring about a state of affairs the individual desired. And while it is unfortunate if we fail to help a person achieve one of her goals, this failure pales in comparison to the violation of a person's right to decide whether an invasive procedure is performed on her body.

Proponents of presumed consent believe, in contrast, that mistaken removals and mistaken non-removals are morally equivalent, that each kind of mistake is morally unfortunate in the same way. Because proponents of presumed consent believe that mistaken removals and mistaken non-removals are morally equivalent, they believe that we should implement the organ procurement policy that results in the fewest mistakes overall – i.e., that we should base organ procurement policy on the fewer mistakes claim. And the fewer mistake claim (along with the empirical assumption discussed in section II) implies that presumed consent is superior to the current system of organ procurement.

I believe proponents of presumed consent are right in holding that organ procurement policy ought to be based on the fewer mistakes claim. Let me now explain why.

IV. WHY THE FEWER MISTAKES CLAIM SHOULD GUIDE ORGAN PROCUREMENT POLICY

The first thing to note about a situation in which we are trying to decide whether or not to remove organs for transplantation is that the person whose body houses the organs in question is, when we are trying to make that decision, brain-dead. It is only after a conclusive determination that the person meets all the legal criteria of death that the question of whether or not to remove her organs can even arise.

Does the fact that a person is legally dead mean that she will not be wronged if we remove her organs even though she did not want them removed? No, it does not mean that. A person *is* wronged if after her death we treat her body in a way that she did not want it to be treated. Treating a person's body after her death in a way she did not want it to be treated is a wrong done to her in the same way disposing of a person's estate in a way she did not want it to be disposed of is a wrong done to her. We have a powerful moral duty to respect a person's wishes about what should happen after her death to the things that belonged to her. But mistaken non-removals violate that duty in the same way that mistaken removals do.

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

Here's another way of putting the same point. When we are dealing with a competent, living person, we have two options: we can do something to the person's body, or we can refrain from doing anything to the person's body. When we do something to a competent person's body against her will, we violate her autonomy. When we refrain from doing anything to a competent person's body – when we do nothing to prevent a competent individual from acting on her own decisions – we do not run the risk of violating her autonomy. So if our overriding concern is not to violate autonomy, then whenever we are in any doubt at all as to whether a competent person wants anything done to her body, we ought not to do anything. But we do not have the same two options when we are dealing with a person who is brain-dead. To refrain entirely from interfering with the body of a person who is brain-dead will not allow the person to exercise the capacity to determine for herself what happens to her, as the person no longer possesses that capacity. The best we can do with regard to respecting her autonomy is to treat her body in the way that she most likely wanted it to be treated. We are not faced with a choice between a course of action that cannot possibly violate her autonomy and a course of action that may possibly violate her autonomy. Whatever course of action we take, we run the risk of committing the same kind of mistake, which is to contravene the wishes the person had when she was competent (which, it is crucial to remember, she herself can no longer fulfill). Thus, so far as respect for the autonomy of the brain-dead is concerned, our goal should be to construct a

policy that maximizes the chance that we will treat their bodies as they would have wanted.

This point will become clearer when we compare the decision of whether or not to remove organs for transplantation to the closely related decision of what to do, ultimately, with the body of someone recently deceased. Some people wish to have their bodies embalmed and displayed in an open casket before burial, while other people are religiously opposed to embalming and wish to have their bodies buried within 48 hours of death. Some people wish to be buried in family plots, while others wish their ashes to be scattered in a place of spiritual significance. We have a moral duty to try to respect these various wishes. But is failing to respect one kind of wish morally worse than failing to respect another kind of wish? I don't think so. It would be unfortunate if we cremated someone who wanted to be buried in a family plot, but it would be just as unfortunate if we buried in a potter's field someone who had a fervent desire to have her ashes scattered in the Ganges. The wrong done to a person cremated against her wishes and the wrong done to a person buried against her wishes are symmetrical or morally equivalent. If, therefore, we do not know what a particular person wanted done to her body after death, we should do what it is most likely she would have wanted done. The duty to respect persons' wishes about what should happen to their bodies after death implies that we should follow the policy that can reasonably be expected to lead to the fewest mistakes.

The same holds for disposing of a person's estate. We have a moral duty to try to dispose of a person's estate in the manner that she herself wished, and it is unfortunate if a person's money and possessions end up going to a person or institution she did not want them to go to. But there is no reason to think that one kind of mistaken inheritance is morally worse than any other. In the absence of a will, we generally presume a person wanted to leave her money to her immediate family, not because bilking family members out of their rightful inheritance is morally worse than bilking charities or beloved companions, but because it just so happens that most people choose to leave their money to their immediate family. Presuming that someone wanted to leave her money to her immediate family is the policy that can reasonably be expected to lead to the fewest mistakes, and that is why we think it's the policy that does the best job of respecting the wishes of the deceased.

The decision of whether or not to remove organs for transplantation parallels these other decisions of how to treat the things that belonged to a

person after the person has died. There is not nearly as much of a parallel between the decision of whether or not to remove organs for transplantation and the decision of how to treat a competent, living person.

It is, consequently, illegitimate to equate a mistaken removal of organs to an operation on a competent, living person against her will. For operating on a competent person against her will is a violation of the non-interference model of autonomy. But the non-interference model of autonomy does not apply to our treatment of the bodies of individuals who are brain-dead. The illegitimate equation of a mistaken removal of organs to an unwanted operation on a competent, living person is, however, just what opponents of presumed consent rely upon when they dismiss the fewer mistake claim. Veatch and Pitt, for instance, maintain that mistaken removals violate “the right of the individual not to have his or her body invaded” (Veatch & Pitt, 1995, p. 1890). And Kluge writes,

Furthermore, the very concept of presumed consent is fundamentally misguided: It undermines the principle that unless we have given explicit consent to interference with our person, our body remains inviolate. This is what underlies the right to freedom from non-consensual interference with one’s person. Therefore if the logic of the presumed consent option were to be applied consistently, it would mean that someone who did not want to be interfered with physically, whether that be sexually or in any other fashion, would have to inform potential trespassers to the individual’s person of that fact. (Kluge, 2000, p. 286)

Kluge argues here that presuming that someone wants her organs removed for transplantation is as morally repugnant as presuming that someone wants to be “interfered with physically, whether that be sexually or in any other fashion.” Just as we should presume that a person does not want to be physically interfered with and should interfere with her only if she has given us explicit permission to do so, so too (Kluge argues) we should presume that a person does not want to have her organs removed and should remove them only if she has explicitly said she wants it done. But this comparison ignores the crucially important disanalogy between the person we might physically interfere with and the person whose organs we might remove. The person we might physically interfere with is competent and living; she can be left alone to determine her own fate. But the person whose organs we might remove is no longer capable of determining the fate of her body; other people are going to have to treat her body in one way or another. And this disanalogy vitiates

Kluge and Veatch and Pitt's comparison between mistaken removals and unwanted physical interference with a competent, living person.

By distinguishing between competent individuals and the brain-dead, we can also see what's wrong with the following objection. "A policy of presumed consent is unacceptable because, by shifting the burden of proof from those who want to donate to those who do not want to donate, it implies that the state has a default right to use or interfere with our bodies. But such a shift would be repugnant since no one should have to prove that he doesn't want to be interfered with; rather, the state ought to assume that people don't want to be interfered with, with the burden of proof resting on those who would seek to interfere."⁸ The problem with this objection – at least insofar as it's directed at the justification of presumed consent I've described – is that it mistakenly tries to apply the non-interference model of autonomy to brain-dead individuals. But once we realize that the non-interference model does not apply to brain-dead individuals and that the respect-for-wishes model does, it becomes apparent that presumed consent (so long as it leads to fewer mistakes) lives up to the value of autonomy more fully than the current system. Indeed, the justification I've described for shifting the burden of proof has absolutely nothing at all to do with the notion that society has a right to use our bodies. The argument I've defended is based entirely on the idea that society ought to do its best to construct policy that respects individuals' own choices. For this argument holds that society should assume people would want to donate their organs only because such a policy does a better job than the current one of respecting people's wishes about what should happen to their own bodies. The view I've presented, in short, takes presumed consent to be more akin to legislation that attempts to ensure that deceased persons' estates are disposed of in exactly the way that they would have wanted, and less akin to conscripted government service that persons could avoid only by proving the legitimacy of their excuse.

Let me emphasize again that I do believe that our commitment to respect for autonomy implies that we have a moral duty to treat the body of a person who is brain-dead in the way she wanted it to be treated. My point is that the non-interference model of respect for autonomy does not apply to the treatment of the body of such a person. The model of respect autonomy that does apply is that of trying to fulfill a person's wishes when she is no longer capable of fulfilling them herself. And that second model coheres perfectly with the fewer mistakes claim that is at the heart of the case for presumed consent.

Moreover, even if we disregard the fact that potential organ donors meet the legal criteria of death, the moral principles underlying the requirement of

informed consent still do not imply the asymmetry between mistaken removals and mistaken non-removals upon which the core opposition to presumed consent is based. To see this, consider the decision of whether to perform an invasive procedure on an unconscious person who has arrived at the emergency room. Of course we would do everything we could to ensure that we made the decision that accorded with that person's own values and beliefs. But if the decision had to be made immediately and we had no way of determining the patient's proclivities, we would not necessarily refrain from operating. And we would not necessarily refrain because we do not think a mistaken operation is of a morally more significant kind than a mistaken non-operation. Current emergency room procedure seems to suggest, rather, that the principles underlying informed consent do not imply that the mistake of invading the body of an incompetent patient who would not have wanted to be invaded is morally worse than the mistake of not invading the body of an incompetent patient who did want to be invaded. The goal of preventing mistaken operations does not morally trump the goal of preventing mistaken non-operations in a manner that requires us to presume that all unconscious people do not want to be operated on. But if the principles of informed consent do not imply that mistaken bodily invasions are always worse than mistaken bodily non-invasions, then it's hard to see why the principles of informed consent should commit us to the idea that mistaken organ removals are significantly worse than mistaken organ non-removals.

Now I should mention that Veatch and Pitt explicitly address emergency room procedure and draw from it the opposite conclusion. They write,

In the case of the emergency room treatment of the patient incapable of giving explicit consent, the presumption of consent is surely valid. Were we to conduct a survey of the population asking its members whether they would want such a presumption made, agreement would be close to unanimous. To be sure, some small group would object. A patient who is a Jehovah's Witness may refuse blood products; a Christian Scientist may refuse treatment altogether. This reveals that on occasions the presumption of consent in the emergency room may be an erroneous presumption (it will, on occasion, yield *false positives*). But it will be accurate an overwhelming percentage of the time, and the presumption is therefore justified. By contrast if we presume consent in the case of organ procurement, we will be wrong at least 30% of the time. (Veatch & Pitt, 1995, p. 1889)

In this clear dismissal of the fewer mistakes claim, Veatch and Pitt argue that we are justified in treating a person without her explicit permission only if the chance that we are making a mistake is virtually non-existent. Their idea seems to be that if there is a non-negligible possibility that a person does not want to be treated, it is wrong to presume that the person does want to be treated. But this idea does not accord with either our current medical procedure or our moral intuitions.

To see that it does not accord with current medical procedure, consider that a non-negligible portion of elderly and terminal patients would prefer not to be resuscitated if they go into cardiac arrest. Unfortunately, many of these patients have not completed advance directives, and some of those who have completed advance directives do not have the documents on their person at the moment emergency medical teams arrive. So what do EMTs do when they encounter an unconscious patient but have no way of determining in time whether she would prefer to be treated or not to be treated? The fact is, in such a situation, EMTs treat the unconscious patient, even if they know full well that there is a non-negligible chance that the person would prefer not to have been treated, and even if the treatment involves an invasive procedure. Indeed, our current practice, which involves treating even elderly and terminal patients unless there is a clear indication that they did not want to be treated, seems to embody the idea that it is morally worse not to perform an invasive procedure on someone who wanted the procedure done than it is to perform the invasive procedure on someone who did not want it done. Now there are obvious differences between the decision to resuscitate and the decision to remove organs for transplant, and there may very well be significant problems with our current practice of treating the elderly and the terminal; these are issues I cannot explore here.⁹ My point is simply that our current practice of treating unconscious patients does not accord with Veatch and Pitt's idea that we are justified in treating a person without her explicit permission only if the chance that we are making a mistake is virtually non-existent.

To see that Veatch and Pitt's idea does not necessarily accord with our moral intuitions, consider the following scenario. You are a doctor in a community in which there is an unusually high percentage of Christian Scientists, who oppose all medical treatment. Indeed, as much as 30% of the local population are Christian Scientists. But the other 70% have no religious objections to conventional medical care. One day, a 30-year-old

adult male is brought into your emergency room. He is unconscious and will die without immediate surgery. A quick search of his wallet gives no indication of whether or not he is a Christian Scientist, and you do not have time to try to contact any of his family or friends. So what do you do? Veatch and Pitt are committed to saying that the 30% chance that the person does not want to be operated on makes operating on him the wrong course of action to take. More generally, their dismissal of the fewer mistakes claim (which is based on their notion that the goal of preventing mistaken bodily invasions is morally much more important – or trumps – the goal of preventing mistaken bodily non-invasions) implies that in the hypothetical society I have described, we should always presume that a person does not want to be operated on and should operate only if we can gain from him explicit consent to do so. But I doubt that this conclusion tracks our moral intuitions, and that is because I doubt that most of us would judge it wrong to operate on the unknown person. It's true that, if we operate, there's a 30% chance that we will invade the body of someone who would not have wanted us to do so. But there's also a 70% chance that we will treat the person's body in the way that he would have wanted. And I think that in this situation most of us would think it morally acceptable (if not morally required) to make the choice that would have the greatest chance of success. The error of mistakenly operating is not so much worse than the error of mistakenly not operating that we should follow a policy that leads us to make the wrong decision over half the time.¹⁰

I conclude, therefore, that the principles underlying informed consent do not imply that mistakenly removing organs for transplantation is morally much worse than mistakenly neglecting to remove organs for transplantation. Both mistakes fail to fulfill a person's wishes about what should happen to her body when she is no longer competent. Both mistakes, consequently, fail to live up to goal of respect for autonomy in the same way. Respect for autonomy (understood on the respect-for-wishes model, which is the only model we can use when dealing with the bodies of brain-dead individuals) does not imply that the duty to fulfill someone's wishes not to be an organ donor is more important than the duty to fulfill someone's wishes to be an organ donor; it implies, rather, that the two duties are the same.¹¹ The fewer mistake claim (combined with the empirical assumption that most people want to donate their organs) thus constitutes a powerful reason for thinking that a policy of presumed consent is morally superior to our current system of organ procurement.

VI. MANDATED CHOICE, PRESUMED CONSENT AND A FAMILY VETO

In this final section, I will briefly address the related issue of the moral status of a cadaveric organ procurement policy based on mandated choice. In so doing, I will also refine the version of presumed consent that I favor.

A cadaveric organ procurement policy of mandated choice would require all U.S. citizens explicitly to indicate whether or not they wish to donate their organs after death. This policy could be implemented by putting the question about organ donation on tax forms or driver's license applications and by refusing to accept the forms or applications as completed until the question has been answered. A potential organ donor's wishes would then be on record and doctors would need only to consult these records in order to determine whether or not to remove her organs for transplantation.

I have argued that presumed consent is morally superior to the present system of organ procurement. I have not argued, however, that presumed consent is morally superior to mandated choice. And this is important to note, not least because some of the opponents of presumed consent whom I have discussed do not seek to defend the current system but to make the case for mandated choice (Veatch & Pitt, 1995, p. 1891).¹²

It may seem, moreover, that the very argument I have given for presumed consent's superiority to the current system shows why mandated choice is superior to presumed consent. I have argued that presumed consent is superior to the current system because it can reasonably be expected to produce fewer mistakes than the current system. But mandated choice, so it might seem, can reasonably be expected to produce fewer mistakes than presumed consent. I've argued, after all, that we should presume consent for everybody only because a majority of those polled said they would prefer to donate their organs. But under mandated choice we would not need to presume anything at all; we would simply consult what each person herself explicitly indicated she wanted done to her body. With such information, it might seem we can reasonably expect to eliminate mistakes almost entirely.

My argument for presumed consent's superiority to the present system can thus be taken to be one step in a larger argument for mandated choice. My argument differs from that of other proponents of mandated choice, in that I argue that the difference between mandated choice and presumed consent is one of degree (mandated choice makes fewer mistakes than presumed consent) while other proponents argue that the difference is one of kind

(mandated choice respects autonomy while presumed consent violates it). But ultimately, it might seem, my argument ends up in the same place as theirs: in support of mandated choice.

Now I should say that I do think a policy of mandated choice would be a moral improvement over the current system of organ procurement. At the same time, I do not think it is perfectly clear that mandated choice completely supersedes presumed consent.

First of all, even if we decided that mandated choice is theoretically superior, there may be practical obstacles in implementing it. And until those practical obstacles are overcome, we should implement a policy of presumed consent instead of keeping the current system in place. Moreover, if mandated choice were implemented, we could still expect that some people would fail to register (there are some people who do not get drivers' licenses or who fail to complete tax forms), and presumed consent would be the appropriate policy to follow with regard to them.

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.

One way to solve this problem is to educate the American public about donation and transplantation. If everyone knew all the facts relevant to the issue, then everyone's mandated choice would be informed. I am certainly in favor of doing everything possible to educate the public on donation and transplantation. And I think that if such education efforts succeed at some future date, it would be correct to implement a policy of mandated choice at that time. Until that time comes, however, the non-negligible chance that the organ donation box a person checks on her tax form will be different from the box she would have checked if she had been fully informed will leave open a gap between a policy of mandated choice and the principles underlying informed consent.

One might wonder, however, whether the worry I have just raised about mandated choice doesn't apply to presumed consent as well. I argued in the previous paragraph that mandated choice does not fully live up to the principles underlying informed consent because the people whose choices are mandated may be misinformed. But the case for presumed consent is based to a large extent on how people answered poll questions about organ donation, and some of those people may also have been misinformed. So if we are unwilling to base our organ procurement policy on misinformed mandated choices, shouldn't we be at least as unwilling to base it on misinformed poll answers?

It might be worth noting that there is strong evidence that people who prefer not to donate their organs are more likely to be influenced by false beliefs about donation and transplantation; there is good reason to believe, that is, that the better informed a person is about donation and transplantation, the more likely she is to prefer to donate her organs.¹³ We should not, however, place too much weight on the fact that those who prefer not to donate are more likely to be misinformed. And that is because the more we base the case for presumed consent on this point, the closer we come to the morally problematic strategy of trying to justify treating a person contrary to her actual wishes by claiming that we are treating her as she would wish to be treated were she fully rational.

The more salient response the proponent of presumed choice can make is to acknowledge that some of the people who answered the polls may be misinformed, and thus to concede that we should not place all the weight of our organ procurement policy on the poll numbers. The poll numbers and the

existence of a well-publicized opportunity for opting out of organ donation would give us reason to presume that removing a person's organs for transplantation does not run contrary to her wishes. But they are no guarantee. A person may have forgotten to opt out, even though she meant to. Or she may have been willing to donate her organs only because she was misinformed. Because these two scenarios are possible, a policy of presumed consent must include a mechanism that can override the presumption that a person who did not opt out would not have objected to having her organs removed for transplantation.

The mechanism for overriding the presumption should be discussion with the family of the potential donor. If a person has not opted out, we should presume that removing her organs for transplantation does not run contrary to her wishes. But we should also ask her family whether they have any reason for thinking that that presumption is false in this person's case. As Caplan aptly puts it, "Families should be asked not whether they will consent to the donation of organs but whether they have any objections" (Caplan, 1983, p. 28).¹⁴ There are better and worse ways of asking the family this question, but I cannot discuss that matter here.¹⁵ One point that it is important to keep in mind, however, is that when we are asking this question, we should inform the family as best we can about the circumstances of donation and transplantation. For the principles underlying informed consent tell us that we fully respect autonomy not merely by acting in accord with persons' statements about how they want to be treated but only by acting in accord with persons' *informed* decisions.

I conclude, then, that, at the present time, the organ procurement policy that best lives up to the principle of autonomy underlying informed consent is a system of presumed consent with a provision for family veto.¹⁶ Such a system may not procure as many organs as a system of presumed consent without a provision for family veto. But living up to the principle of autonomy underlying informed consent must be our first priority. We should procure as many organs as possible only after that priority has been met.

NOTES

1. Veatch and Pitt argue that many of the proposals that go by the name of "presumed consent" are actually schemes of "routine salvaging" (Veatch & Pitt, 1995, pp. 1888–1890). My argument in this paper, I hope, does stick closely enough to the concept of consent to warrant calling the proposal I favor "presumed consent."
2. See also Caplan (1983, p. 28); Kennedy et al. (1998, pp. 1650-1651); Loewy (2000, p. 299); Matas and Veith (1984, p. 158); and Moustarah (1998, p. 232).

3. See also Erin and Harris (1999, p. 365); Kluge (2000, p. 286); and Spital (1998, p. 150).
4. Veatch and Pitt (1995, p. 1889) draw a distinction between the percentage of people who would prefer to have their organs removed for donation and the percentage of people who favor the implementation of a system of presumed consent. See also Spital (1992, p. 2422). The first percentage I take to be very relevant to the issue at hand. I am not sure, however, how much weight we should place, when we are formulating our moral position, on the percentage of people who are in favor of implementing a policy of presumed consent. There may be good moral reasons for a policy of presumed consent even if many people do not currently favor such a policy. And if there are good moral reasons for a policy of presumed consent (and we'll only find out if there are by examining the moral issues, and not merely by taking a poll), then it seems to me that we should try to convince people that they should abandon their opposition to it. This is, I take it, how we debate – and try to change – public policy in other cases.
5. The Gallup Poll is actually a relatively *conservative* estimate of Americans' desires to donate their organs after death. Other studies suggest that over 80% of Americans wish to donate (see Sade et al., 2002, p. 1145). As will become clear in the course of the argument, the case for presumed consent becomes stronger as the percentage of people who wish to donate grows higher.
6. The Council on Ethical and Judicial Affairs of the American Medical Association (C.E.J.A.) has argued that, in certain circumstances, presumed consent may actually be “more likely than systems of express consent to harvest organs against the true wishes of individuals and their families” (Council on Ethical and Judicial Affairs, American Medical Association, 1994, p. 811). Of course, if presumed consent produces more of these mistakes than the current system, then the fewer mistakes claim will constitute a powerful moral reason to think that the current system is morally superior to presumed consent. It's important to note, however, that C.E.J.A. is not opposed to presumed consent in all cases. What C.E.J.A. says, rather, is that presumed consent could produce more mistakes in circumstances in which family input is eliminated and in which the opt-out mechanism is not well-publicized. I believe the C.E.J.A. is right about this, and that therefore a policy of presumed consent must include a well-publicized opt-out mechanism and a family veto (which I discuss in section VI below).
7. There is, admittedly, something odd-sounding about the idea that we ought to choose the policy that violates autonomy less often than another policy. For such an idea seems to take a quantitative or maximizing approach toward autonomy (insofar as it tells us to choose the policy that maximizes the number of times we treat persons' bodies as they wanted them to be treated), but we tend to think of autonomy concerns as deontological or non-quantitative. That is, we tend to think we ought not to violate autonomy at all, and that any policy that leads to even one such violation must be rejected. What I have tried to show is that both the current system and a system of presumed consent will inevitably fail to respect the wishes at least some people have about what should happen to their bodies after they themselves are no longer capable of making their own decisions. Of course it would best if we could construct a policy that never violates anyone's wishes about what should happen to her body. But if our choice is between two policies, both of which violate people's wishes some of the time, the best we can do from a moral perspective is to opt for the policy that maximizes our chances of fulfilling people's wishes. Perhaps what this reveals is that the traditional notion of respect for autonomy as an inviolable deontological

duty simply does not fit perfectly onto the question of how to treat the bodies of brain-dead individuals.

8. An anonymous referee for the *Journal of Medicine and Philosophy* has raised this objection.
9. Perhaps one of the reasons we resuscitate when we are in doubt is that mistakenly not resuscitating is an irreversible mistake (while mistakenly resuscitating is in some sense reversible). The decision to remove organs for transplantation or not to remove them is, however, irreversible in both directions; the irreversibility of them is symmetrical, and thus gives us no reason to think that one kind of mistake is of a morally different kind than the other. There are undoubtedly many other disanalogies one could draw between resuscitation decisions and donation decisions, but I think they all speak against those who argue against the fewer mistakes claim by trying to assimilate mistaken organ removals to violations of a living, competent person's informed consent.
10. An anonymous referee for the *Journal of Medicine and Philosophy* has raised the objection that my analogy in the previous two paragraphs does not make its point because while treating someone in an emergency situation is not necessarily an illegitimate violation of bodily integrity, removing organs from someone without her consent is an illegitimate violation of bodily integrity. The first thing to say about this objection is that "removing organs from someone without her consent" could be taken in two different ways. It could mean, "removing organs from someone who left no explicit instructions and whose desires are unknown." Or it could mean, "removing organs from someone who would not have wanted them removed." Now whether we should remove organs from someone who has left no explicit instructions and whose desires are unknown is the central question of the debate over presumed consent. So in order not to be question-begging, the objection must be read in the second way. And of course removing organs from someone who would not have wanted them removed is a violation of bodily integrity. But treating someone in an emergency situation who does not want to be treated is a violation of bodily integrity as well. We do not think, however, that the principles of informed consent imply that, because there is a possibility that we will treat someone who does not want to be treated, we should never treat incompetent people in emergency situations. So I am unclear as to why we should think that the principles of informed consent imply that, because there is a possibility that we will remove organs from someone who does not want them removed, we should never remove organs from brain-dead people who have left no explicit instructions about whether they want to donate.
11. An anonymous referee for the *Journal of Medicine and Philosophy* has asked "why the autonomy of some should be violated on behalf of others?" What I have tried to show is that the current system of cadaveric organ procurement violates the autonomy of more people than a system of presumed consent will. Of course it is a bad thing when one person's autonomy is violated; it is a bad thing when one person's wishes about what should happen to her body are contravened. But if we are choosing between two courses of action, both of which will inevitably contravene the wishes of some people, we should choose the course that produces fewer of these bad results than the other. (For more on this point, see footnote 7.)
12. See also Kluge (2000, p. 287) and Spital (1992, p. 2423).
13. See Franz, Drachman, DeLong, Beasley, and Gortmaker (1995, pp. 51-52); Spital (1992, p. 2423); Matas and Veith (1984, p. 158); and Sade et al. (2002, pp. 1145-1146).

14. See also Council on Ethical and Judicial Affairs, American Medical Association (1994, p. 811) and Cohen (1992, p. 2170).
15. See Sade et al. (2002, pp. 1142–1146).
16. It might seem that the argument I've presented implies that the very best policy of all would be mandated choice with the opportunity of a family veto – that is, a policy that forces people to state their preferences with regard to organ donation, but which also gives family members the right to override that stated choice. The problem with this proposal is that many of those who argue for mandated choice seem to believe that once a person has stated her preference, that statement should have a kind of legal status that is incompatible with the opportunity for family veto. The stated choice, in other words, should have status similar to that of a last will and testament – something that family members have to accept whether they like it or not. That said, there is no logical barrier to proposing a policy of mandated choice with the opportunity of a family veto (the idea of mandated choice, in other words, is not necessarily incompatible with the possibility of family veto), and perhaps such a hybrid policy would be morally superior to the version of presumed consent I've been discussing. I wonder, though, about the practical wisdom of implementing a policy that tries to mandate and record the choice of every adult in the nation, and that also mandates full consultation with the family of every potential organ-donor, with each of those families' being given the opportunity to override the choice that has been mandated and recorded.

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