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ORGAN PROCUREMENT AND THE FAMILY VETO

A submission to the Nuffield Council on Bioethics consultation on
“Human Bodies in Medicine and Research”
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1. Introduction

We are academic researchers with an interest in organ procurement policy. Lindsay Stirton is Lecturer in Medical Law and Ethics and is a member of the Centre for Social Ethics and Policy (CSEP) and the Institute for Science Ethics and Innovation (iSEI) at the University of Manchester. Jurgen De Wispelaere is a Senior Fellow at the Centre de Recherche en Éthique de l'University de Montréal (CRÉUM), with expertise in moral philosophy and applied ethics. We are currently undertaking a research project to explore how the introduction of financial or other incentives to organ donation can be made compatible with solidaristic models of organ procurement.² Our research is interdisciplinary, bridging the fields of ethics, law, and administration.

In this submission we draw on our research, both published and ongoing, to draw the Council's attention to what we believe is one of the key bottlenecks concerning organ procurement for transplant purposes: the objections of family members to the removal of organs from deceased donors, even in the face of a clear intention on part of the latter to donate.³ A key claim of our research is that there exists a subtle relationship between this and other bottlenecks, and that any simple-minded attempt to eliminate the so-called “family veto” may end up increasing the number of organs lost at other bottlenecks. In this submission we first discuss our overall approach to the ethics and practice of organ procurement and indicate why the family veto must become a focus of policy attention, if the shortage of transplant organs is to be addressed effectively. The remainder of the submission briefly introduces a model of organ procurement, which in our view

1. For correspondence, please contact Lindsay Stirton at <lindsaystirton@gmail.com>.
2. We prefer the term “solidaristic” over “altruistic” and use the former throughout.
3. See Jurgen De Wispelaere and Lindsay Stirton (2010) “Advance Commitment: An Alternative Approach to the Family Veto in Organ Procurement”, *Journal of Medical Ethics* 36: 180-183; De Wispelaere and Stirton (2010), “Procuring Permission: The Case for Organ Transplant Tax Credits”, paper presented at the annual meetings of the UK Association for Legal and Social Philosophy (Edinburgh, July 2009), the UK Political Studies Association (Edinburgh, April 2010) and the Canadian Society for Practical Ethics (Montreal, May 2010), as well as academic seminars in Belfast, Manchester and Montreal. This paper is currently being revised for submission to a leading medical law journal.

has the potential to combine the introduction of effective incentives with a genuine solidaristic approach to organ procurement.

There are two parts to our policy proposal. First, we suggest a mechanism whereby families can signal their advance commitment to organ removal in the event of the donor's death through what we call a Designated Second Consenter (DSC), effectively a living advocate for the donor for the limited purpose of affirming organ donor status. Designed to reduce the burden of consenting to organ removal on the part of the family, we believe this advance commitment device to offer many practical and ethical advantages.⁴ Second, we propose a modest Organ Transplant Tax Credit (OTTC), which in the particular version of the scheme we propose would be paid to the DSC on the sole condition that the latter does not revoke the donor's decision to donate her organs once a request is made by a donor coordinator. The OTTC is designed as a way of incentivizing the DSC to perform her role as the donor's living advocate, encouraging registration to a public good scheme with considerable social benefits. Because it is not an actual market transaction, the OTTC scheme is framed to achieve a high degree of fit with our existing solidaristic organ procurement policies and maintains crucial distance from the many controversial proposals for a market in organs discussed in the literature.⁵ In principle, the two parts of the proposal are severable, and one could endorse either part of our proposal while rejecting the other; however, what we like most about our scheme is the way they work together synergistically.

Note that throughout our submission we refer to the relevant Consultation questions in margin text.

2. The Current Organ Shortage

The development in the 1980s of immunosuppressant drugs such as cyclosporine transformed organ transplant surgery from a previously experimental (and often

- 4 This proposal is outlined in some detail in De Wispelaere and Stirton (2010) "Advance Commitment: An Alternative Approach to the Family Veto in Organ Procurement", *Journal of Medical Ethics* 36: 180-183. We attach the article to this submission in Appendix.
- 5 On markets for organs, see, for instance, Charles Erin and John Harris (2003) "An Ethical Market in Human Organs" *Journal of Medical Ethics* 29: 137-138; James Stacey Taylor (2005) *Stakes and Kidneys: Why Markets in Human Body Parts are Morally Imperative*. Aldershot: Ashgate, 2005. Monetary incentives are typically regarded as anathema to solidaristic motivations for organ donation, but we believe this is incorrect. Jurgen De Wispelaere and Matthew Hunt, "Fair Reciprocity in Posthumous Organ Donation", paper presented at a CREUM seminar in Ethics and Public Health, May 2010, University of Montreal, reviews a large number of reciprocity-compatible schemes, both monetary and non-monetary. Our view is compatible with survey evidence outlining the differentiated (and quite sophisticated) evaluation of different types of monetary schemes by the general public and transplant staff. Robert Arnold, Steven Bartlett, et al (2002) "Financial Incentives for Cadaver Organ Donation: An Ethical Reappraisal" *Transplantation* 8: 1361-1367.

unsuccessful) treatment into what is practically routine surgery. As the statistics show, however, despite a gradual year-on-year increase in the number of donors, demand continues to outstrip supply. In 2007-08, for instance, 506 patients died awaiting a transplant in the UK.⁶ Many more experience a significant loss of quality of life for want of an organ transplant, for example, through having to undergo renal dialysis.

In response to this, a number of countries have begun to rethink their organ procurement policies, while academic commentators too have engaged with the problem for a number of decades.⁷ Perhaps the best-known suggestion is a shift from an opt-in system of informed consent to an opt-out, presumed consent scheme. Another approach to the problem has been to search for new sources of organs, for example through expanding the use of living kidney donors, or through elective ventilation of cadaveric donors. A third approach has been to consider how the introduction of financial incentives could encourage more people to become organ donors. In different ways, all of these proposals raise significant ethical questions, and give rise to serious discussion over whether it is appropriate to meet demand in their respective ways. To foreshadow a point we elaborate in the next section, from our point of view a major concern with most of the alternatives currently discussed is that they fail to appreciate the involvement of the family in organ procurement – both as a barrier to organ removal and as a potential solution to the current shortage.

When discussing the ethics of various alternatives to boost the organ supply it is of crucial importance to recognize that there are substantial moral and economic costs of *not meeting demand* through an established organ procurement program. Specifically, any argument against a proposal to meet the demand for organs for transplant in a particular manner must weigh the following costs in the balance, if it is to be taken seriously:

Loss of life: as noted above, official statistics report that 506 patients died awaiting a transplant in 2007-08 in the UK. In fact the true number is likely to be higher than this due to the implicit rationing that occurs when patients who are considered to be low priority for receipt of a transplant organ, or for whom a transplant operation is considered to have a high risk of failure are not admitted onto the waiting lists.

- 6 NHS Blood and Transplant (2008) *Transplant Activity in the UK*, Watford, NHS Blood and Transplant. This figure significantly underestimates the real demand for transplant organs.
- 7 Philosophers and applied ethicists often contribute quite radical ideas, but those remain typically outside the bounds of political feasibility. A good example is the literature on compulsory organ donation or mandatory harvesting. See, for instance, Cécile Fabre (2006) *Whose Body Is It Anyway? Justice and the Integrity of the Person*. Oxford: Clarendon; Jeremy Wisniewsky (2008) "When the Dead Do Not Consent: A Defense of Non-consensual Organ Use", *Public Affairs Quarterly* 22: 289-309; J. Delaney and D.B. Hershenov (2009) "Why Consent May Not Be Needed for Organ Procurement", *American Journal of Bioethics* 9: 3-10.

Impaired quality of life: this includes the symptoms of ill health that could be avoided by a transplant operation, as well as the inconvenience of alternatives to a transplant such as renal dialysis for patients with kidney failure.

Economic and productivity losses: these take a number of forms, including the increased health care costs of treating patients awaiting a transplant for an extended period, as well as the lost output of those who in the absence of an available organ suffer death or impaired ability to work.

Additional moral costs: failure to meet the demand to the maximum morally permissible extent may lead desperate patients to engage in even more exploitative practices, for example the purchase of organs on unregulated or black markets, or the forcible taking of organs from prisoners under sentence of death, as well in practices such as 'transplant tourism' which might sustain these objectionable sources of organs for transplantation.⁸

Balancing the moral objections to some of the particular ways of boosting the supply of transplant organs with the moral costs of not meeting demand, it becomes imperative to ask whether there might be ways to increase the number of available organs without substantially incurring these moral costs. Academic discussion in particular often proceeds by positing a direct conflict between competing ethical values, and much of the effort seems to go towards arguing for the moral superiority of one value over another. Instead, we propose the ethical and practical desirability of an organ procurement policy that avoids direct ethical conflict, where possible, and manages to simultaneously contribute to the realization of a number of ethical goals (including avoiding important moral costs). We believe that the scheme we sketched in the introduction has the potential to do so. ⁹

8 Nancy Scheper-Hughes (2000) "The Global Traffic in Human Organs", *Current Anthropology* 41 191-224.

9 While we recognise that it is not possible to maximise two values simultaneously, it is often possible to advance several values at the same time. While ethicists typically consider the hard choices that arise when values conflict, we question whether existing policy is at the possibility frontier at which it is only possible to advance any particular value at the expense of others.

1. The Importance of the Family in Organ Procurement

In our research, we see the organ procurement process in terms of a number of *bottlenecks*, each of which has the potential to reduce significantly the number of available organs. These occur at the point of the individual's decision to become a donor, her notification of this decision, and at various points after the death of the donor (the decision to make a request to the family for permission to proceed with organ removal, the decision of the family to grant permission, for example). From the perspective of administrative analysis, the problem is that these bottlenecks interact in complicated ways. Any attempt to alleviate one of the above-mentioned bottlenecks without regard to the effects on the others risks undermining the effectiveness of the intervention. In the worst cases, ineffective interventions may even make matters worse. Consequently, in our view, the most promising reform proposals are likely to be those which address a number of these bottlenecks simultaneously.

Viewed from this perspective, the decision of family members to assent to organ removal turns out to be of crucial importance; not only because of the number of organs for transplant that are lost through the refusal of permission, but because of the knock-on effect that this has on the other key bottlenecks in the organ procurement process. That the family veto should play such an important role may seem surprising, given that in the UK families have no legal right to object to organ removal once the donor's consent has been validly expressed. As the Consultation Paper, rightly notes, "Family members have no right in law to override this decision and refuse to permit donation after the person's death, although in practice hospitals are very unlikely to remove material in the face of family opposition."¹⁰

It is hard to get a handle on the precise number of donations that are blocked by families in the face of the deceased's wish to donate. The literature often suggests that approximately half of all organ donations are blocked because of such opposition from family members, but the evidence may be anecdotal and thus not capture the full reality. In the UK, the *Potential Donor Audit* (PDA) conducted by the NHS Blood and Transplant Authority since 2003 gives what is arguably a more reliable (as well as less alarming) sense of the scale of the problem than is suggested in the above-mentioned literature. According to the PDA, in the period between April 2007 and March 2009, 37% of families refused

10 Nuffield Council on Bioethics (2010) *Give and Take: Human Bodies in Medicine and Research*, p.24

consent when requested.¹¹ Unfortunately, of the cases in which consent was refused by the family, we have no way of knowing how many cases were refusals in the face of a donor preference and how many were cases in which the patient had expressed no preference, and so a relative was giving consent on her behalf either as nominated representative or as a person within a qualifying relationship under the Human Tissue Act.

Nevertheless, there are good reasons to think the family important, both in its own right and for instrumental reasons. Many directly involved in organ procurement or transplantation believe family grief and distress at a time of bereavement matters ethically, and they are wary to add to this burden. This last point might explain both the documented reluctance to actively request organs to be removed as well as a similar reluctance to proceed with organ removal without explicitly consulting the family.¹² To this point we can add the instrumental concern of a public backlash against organ procurement, potentially directly affecting donor registration. The worry here is that if organ procurement policy does not tread carefully when broaching organ donation with the family, this may negatively affect the supply of future donors.

In the face of this substantial loss of potential organs for transplant as a result of family refusal, some have suggested the removal of the family veto.¹³ In essence, this is the position of the Human Tissue Authority, whose guidelines on consent to organ removal requires clinicians to encourage family members and others close to the deceased to accept the wishes of the deceased, while emphasizing that *families have no legal right to veto or overrule those wishes*.¹⁴ The problem with this approach is that it seeks to eliminate one particular bottleneck without considering the knock-on effects on all the others, and the net benefit of such a strategy remain unclear. In our view, it seems likely that the additional distress caused to families in not having their views considered is likely to result in fewer patients being considered for organ removal, and possibly even fewer individuals signing onto the organ donor register. A vivid illustration of this point is the case in Singapore in 2007 of Sim Tee Hua, whose kidneys and corneas

11 NHS Blood and Transplant (2009) *Potential Donor Audit: Summary Report for the 24 Month Period 1 April 2007 - 31 March 2009*. Excluding the 142 cases in which the patient had expressed a desire not to donate organs gives an adjusted overall rate of family consent of 67%.

12 Some scholars have discussed required request policies as alternatives in this case. See Arthur Caplan (1984) "Ethical and Policy Issues in the Procurement of Cadaver Organs for Transplantation", *New England Journal of Medicine* 311:981-983.

13 Edmund Pellegrino (1991) "Families' Self-Interest and the Cadaver's Organs: What Price Consent?", *JAMA* 265: 1305-1306; Ann Klassen and David Klassen (1996) "Who Are the Donors in Organ Donation? The Family's Perspective in Mandated Choice", *Annals of Internal Medicine* 125: 70-73.

14 Human Tissue Authority (2006) *Code of Practice—Consent*, London, Human Tissue Authority

were removed against the family's objections. The resulting public outcry was accompanied by a significant number of opt-outs from Singapore's presumed consent system.¹⁵ This individual anecdote is supported by more systematic research in the US which shows that there is little evidence that the willingness of organ procurement organizations to remove organs in the face of family reservations (for example, by suggesting to families that the deceased donor's wishes should be respected) makes a difference to organ procurement rates.¹⁶ We oppose approaches that deny family members a part in deciding whether organs may be used after death, because they are likely to be ineffective: donor coordinators will in any case give weight to the family's wishes. Worse, they could easily become counterproductive because individuals will be less willing to donate if they fear the removal of their organs against their relatives' wishes. Instead, we propose a strategy that works with the grain of families' *de facto* veto over organ removal by formalizing the role of the family in organ procurement policy. We maintain this strategy is more likely to have a beneficial effect on several currently existing bottlenecks, making it easier to approach families as well as removing one reason (potential distress to family members) why donors may be reluctant to commit to donate in the first place. As well as being in our view a more effective approach, we believe that our scheme also has independent ethical appeal: while for many philosophers minimizing the distress to family members ought to be given a low priority among the ethical values related to organ procurement, particularly when compared to the distress of patients in need of an organ transplant, nevertheless respect for a grieving family ought to carry some ethical weight.

4. Procuring Permission: two practical proposals

In this final section we briefly outline our practical proposal. The first part is described in more detail in the article appended to this submission. The second part of the proposal is still being written-up for submission to a scholarly journal, but we expect to complete it shortly.

15 The family perspective offers an interesting line of criticism against a move towards presumed consent. Some scholars suggest under presumed consent families may object more to organ removal on the grounds that they do not know for certain whether the deceased effectively intended to become a donor. But ignoring the family altogether could create a public backlash, instigating a drop in donor registration rates. Our worry with the lack of full informed consent is primarily practical, not ethical, but it adds relevant considerations to recent attempts to ethically defend such a policy move. See Ben Saunders (2010) "Normative Consent and Opt-out Organ Donation", *Journal of Medical Ethics* 36: 84-87.

16 Kieran Healy (2006) *Last Best Gifts: Altruism and the Market for Human Blood and Organs*. Chicago: University of Chicago Press, Chapter 3 (and see especially pp. 63-66). One reason for this surprising result may be that individuals will be less willing to donate if they fear the additional distress to their families that a more insistent approach will cause in the event of their death.

4.1. Advance Commitment: Designated Second Consenter (DSC)

Families face two broad types of concern when a request is made to remove the organs of a deceased family member. The first concern relates to the specific circumstances in which the decision has to be made: family members are asked to consent at a moment when they are shocked and distressed, often having just found out that a loved one (typically young and healthy) was involved in a tragic, perhaps violent accident, and is now kept alive on a ventilator for the sole purpose of organ harvesting. This is the worst possible time to deliberate and decide on a matter as grave as organ donation. A second concern arises when a loved one has registered onto the donor list but failed to properly communicate this to family members, who in this case face a form of epistemic uncertainty – did the deceased really intend to be a donor? In case of doubt, the default easily becomes non-donation.¹⁷

The current policy response to these two problems is for organ procurement organizations to tell donors to discuss matters with their families – a rather cursory approach, in our view. Our approach, by contrast, is to adopt a policy that formalizes the role of the family in giving their consent through a person designated by the donor (the Designated Second Consenter, or DSC). The donor selects a DSC at the moment she becomes a donor, and the DSC is subsequently invited to endorse the donor's request – well in advance of any tragic event. Ideally this “second consent” takes place after discussion of the donor's motives and deliberation about the process of organ procurement. If, after the death of the donor, the removal of organs for transplant is considered, the DSC is the primary contact person and will be informed by the transplant coordinator of the intent to proceed with removal. The DSC effectively fulfills the role of a donor's Living Advocate for the limited purpose of organ removal for transplant purposes, ensuring that her wishes are fulfilled posthumously.

There are a number of advantages to disconnecting the process of request, information, deliberation and decision by the DSC (effectively representing the family) from the tragic event of a fatal accident in this way.

It avoids imposing an additional burden on families who at a time of shock and bereavement may otherwise be left with a feeling of loss of control or of being disrespected, and now can focus on the actual grieving process.

17 As mentioned before, policy alternatives that somehow abridge the process of informed consent (or are perceived as doing so) all produce this form of epistemic uncertainty. We already mentioned in this regard the defect of opt-out/presumed consent, but the same applies to forms of mandatory choice where relatives may suspect the donor just ticked a box rather than make an informed choice.

It becomes less stressful for medical personnel, including the donor coordinator who makes the request to families, who may otherwise be reluctant to make the request for permission to proceed with organ removal.

It reduces epistemic uncertainty as the process of donor registration is considerably more deliberate, and the donor now has a living advocate to fully convey the reasons behind his donor status.

There is less procedural uncertainty for organ procurement organizations about whether to proceed with organ removal, since second consent has already been obtained; this is particularly relevant when windows-of opportunity are small.

Fewer organs are “wasted” due to the fact that family members could not be reached in time.

The public’s understanding of organ transplant and procurement policy is improved due to the introduction of a “deliberative moment” separate from any tragic event.

Donor autonomy is promoted since the donor’s desire (to become a donor) is less likely to be overridden by family members

There is likely to be a positive effect on actual donor registration since (a) donors who have concerns about family grief will have less to worry about and (b) DSCs invited to second consent may be more inclined to sign up themselves to the donor registry.¹⁸

Of course, many details remain to be addressed, some of which are developed in some detail in the appended article. What are the proper criteria to become a DSC (family, friends, colleagues)? Should we allow for more than one person to take on the role of DSC? What obligations do transplant coordinators have in terms of contacting and informing the DSC? What happens if the DSC refuses before, but most importantly *after*, the donor has died? Does the family have any remaining standing once the DSC has consented? These questions (and many more) merit full consideration but we hope the general form of the advance commitment scheme, and the reason for proposing this policy, are clear from the discussion in this section.

18 Kieran Healy finds evidence that “being asked” is one of the most important predictors for donor registration rates. Kieran Healy (2006) *Last Best Gifts*. Chicago: University of Chicago Press.

4.2 Solidaristic Incentives: Organ Transplant Tax Credit (OTTC)

Advance commitment reduces the burdens imposed on the family in relation to having to consent to a loved one's organ removal. Quite a different approach is to add an appropriate incentive to further increase the likelihood of family members allowing organ removal to take place. Building on the advance commitment scheme, outlined before, we now add a simple provision to the policy: shortly after the death of the donor, the DSC receives a modest, refundable tax credit on the condition that she does not veto the removal of the donor's organs when informed about the procurement organization's intent to remove the donor's organs.

The OTTC will be quite modest. In part this is for budgetary reasons: we expect stringent budget considerations to apply.¹⁹ Also, we regard the OTTC as a type of registration bonus to which all DSCs who register their second consent and subsequently do not revoke it are entitled, not just those who consent to actual organ removal. In other words, the pool of OTTC recipients is considerably larger than the pool of effective organ donors, and thus the size of the individual tax credit needs to be quite small if the scheme is to be affordable. However, there is a third, important reason not to swell the OTTC to anything like a substantial credit reflecting market value: in line with what we know about the symbolic value of monetary incentives, and how recipients actively construct the meaning of different types of “money”²⁰, it is important that there is no leakage between our proposal and that of a market in organs. Part of the framing of our proposal as a solidaristic incentive mechanism, as distinct from a market transaction, depends on the OTTC not resembling a unit price-per-organ but merely a uniform registration bonus. Appropriately framed, the OTTC proposal reflects the social appreciation of a DSC's contribution to the public good of increasing the supply of organs for transplant purposes: it is what one might call a reciprocity-compatible incentive scheme.²¹

In our view, even a modest OTTC (in combination with the advance commitment mechanism outlined above) is likely to substantially reduce the number of organs lost due to families over-riding donor consent. To begin with, some DSCs will be motivated by the economic value of the OTTC – no matter how small, if the opportunity cost is negligible, even a small tax credit has some value. Others may have undertaken the role of DSC out of friendship or family

19 In one version of our proposal the OTTC could be funded in a budget neutral manner by earmarking the efficiency gains from increased transplant interventions on the overall health budget, perhaps adjusted to account for broader economic efficiency gains from returning transplant patients to a productive life.

20 Viviana Zéziler (1994) *The Social Meaning of Money*. New York: Basic Books; Kieran Healy (2006) *Last Best Gifts*. Chicago: University of Chicago Press.

21 De Wispelaere and Hunt (2010), “Fair Reciprocity in Posthumous Organ Donation”

duty in any case, but would value the OTTC either because it is seen as a gift from the donor in recognition of their service as a living advocate, or else as a public recognition of their contribution to the common good. In neither case would the payment of the OTTC give a nominated DSC a reason to refuse to perform this service.²² The OTTC in this sense represents a reciprocity-sensitive, generalizable entitlement that connects donors and DSCs to society: it is a tax credit with a high symbolic value that in most cases is likely to outweigh the economic value of a modest tax credit.²³

Of course we must beware of the danger that the economic value of the tax credit would come to dominate the symbolic value, thereby *crowding out* the solidaristic account of organ donation on which our organ procurement system depends. In particular, great care needs to be taken that the introduction of payment undermines what Richard Titmuss, in his seminal work on blood donation, described as the “fellowship relations” in which voluntary cooperation by “free and equal individuals may be facilitated and encouraged by certain instruments of social policy.”²⁴ Titmuss showed how the voluntary system of blood collection in UK in the 1960s generated a relative abundance of blood which was also safer to that generated by the commercial market that at the time existed in the United States as well as to the systems of incentives or virtual compulsion that prevailed in other countries such as the USSR or South Africa. Scholars working on organ procurement policy have drawn intelligently on Titmuss’s work, particularly on his understanding of the institutional arrangements which make a solidaristic approach possible. Kieran Healy, building on these insights, for instance argues that the decision to donate one’s organs, and the decision of family members to consent to such donation are not merely isolated acts of individual altruism: rather such decisions take place within a set of carefully constructed institutions and social practices which make donation both a practical possibility and a morally acceptable (and commendable) choice.²⁵ Central to these institutions and social practices, in Healy’s view, is a cultural account of organ donation in which donors are seen as

22 Because the OTTC is framed as the social recognition of a public service it allows those who are in fact motivated by the economic value of the tax credit to accept it without stigma or social cost. In other words, the OTTC works because it has the potential to appeal to both those economically and solidaristically motivated, while deliberately not distinguishing between the motivational basis of a DSCs acceptance of the role of a donor's Living Advocate.

23 It is for this reason we believe our proposal to be less vulnerable to the challenge that it disproportionately targets poor donors. When it comes to symbolic recognition, the OTTC applies across socio-economic divides in society.

24 Richard Titmuss (1971) *The Gift of Blood: From Human Blood to Social Policy*. New York: Pantheon Books, p. 243.

25 Kieran Healy (2006) *Last Best Gifts*. Chicago: University of Chicago Press.

acting altruistically, giving the 'gift of life' to another unknown human being. While the clumsy introduction of financial incentives to boost the supply of organs from deceased or living donors risks may seriously undermine the existing organizational and cultural basis of organ procurement, the clever design of incentive mechanisms that ensure compatibility opens many opportunities. We are aware of the need to accommodate the concerns about crowding-out and the modest size (as well as other key features) of the tax credit are deliberately designed to complement a solidaristic model of organ procurement. As with the advance commitment device outlined in the previous subsection, the OTTC deserves and requires further research, both in terms of building the case for the scheme and in working out the details for implementation. How does the ethical case compare to that for other forms of incentive mechanism, such as a futures market in cadaveric organs or monopsonistic markets in organs procured from the living? ²⁶ How well does the OTTC fit with the cultural account of organ donation on which existing organ procurement policy rests, and how can the best fit be achieved? Should a payment be made in cases where the donor's lifestyle choices or manner of death has rendered her ineligible for organ removal? Should we perhaps go further and pay the OTTC to those who act as living advocates for those who *do not* wish their organs to be donated, and under what conditions? Could the OTTC constitute a form of discrimination against those who on moral or religious grounds object to organ donation? What should be the level of the OTTC and how should it be funded? Again, though we do not address these questions here, we believe that the brief outline contained in this submission is sufficient to convey the general idea and spirit of our proposal.

4. Conclusion

In this submission, we have sought first to advance a view of the organ procurement process as a series of bottlenecks, each of which has the potential to contribute substantially to the number of "lost" organs; and second to outline a proposal which would alleviate one key bottleneck — the family veto — whilst having a beneficial effect in terms of some of the knock-on effects that cause organs to be lost at other bottlenecks in the process.

The first part of our proposal, the advance commitment device, seeks to address the reasons why families often refuse to allow organ removal, but at the same time we believe that its introduction would make it easier for donor

26 See, for example, Roger Blair and David Kaserman (1991) "The Economics and Ethics of Alternative Cadaveric Organ Procurement Policies", *Yale Journal of Regulation* 8: 403-452, proposing a futures market in which individuals can make binding contracts authorizing the removal of their organs after death; Charles Erin and John Harris (2003) "An Ethical Market in Human Organs" *Journal of Medical Ethics* 29: 137-138, proposing a monopsonistic market in organs from the living.

coordinators to approach families, and perhaps also addressing one reason why individuals do not become organ donors in the first place. Certainly, the obverse of this point seems to be correct, as illustrated by the Sim case in Indonesia: dealing with family concerns insensitively could easily lead to a rapid decline in donor registration. This, incidentally, is also the reason why under our scheme the DSC would be free to change his or her mind after the death of the donor (subject to the loss of the OTTC): while it is easy to imagine a more binding form of commitment, such a scheme could for the same reasons easily become controversial and ultimately counterproductive.²⁷ More importantly, for the same reasons we would reject any attempts to enforce the current law strictly, and to disregard family objections.

We recognize that our OTTC proposal is considerably more controversial than the advance commitment device, in large part because of the many objections to the marketization of body parts. Yet we are confident that we can design and frame the OTTC proposal in ways that breaks any potential link with a market for organs. Where markets are characterized by unit prices per organ, competition for organs on the supply side or the demand side (or both), inequalities between sellers and buyers (and indeed between each of these), and ultimately a high predisposition towards exploiting the economically vulnerable, we do not believe our proposal faces the same problems. The OTTC does not imply competitive pricing (in fact it does not put a price on organs at all), has only the smallest of differential effects between the rich and the poor, does not affect the allocation of organs, does not allow DSCs to buy themselves into the market (they have to be “designated” by the donor), and in fact does not even imply a genuine transaction between a buyer and a seller. What the OTTC “procures” is permission – permission to remove the organs of a donor, provided that donor has registered in the proper manner and has authorized a DSC – and not organs as such. This is most evidently illustrated by the fact that many DSCs will receive an OTTC without the donor being eligible for organ removal: while some will argue this is both unfair and inefficient, we in fact believe it is a key component of the solidaristic incentive mechanism we advocate.

27 This offers yet another reason to keep the OTTC at a modest level: increasing the size of the tax credit risks shifting the OTTC to an extortion device where one's subsequent veto against organ removal has punitive consequences. While incentives (even incentive payments) may be compatible with a solidaristic model, punitive burdens are most certainly not.