

TAKING FROM THE DEAD: AN EXAMINATION OF CADAVERIC ORGAN
PROCUREMENT

by

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Taking from the Dead: An Examination of Cadaveric Organ Procurement

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Abstract [342 words]

Within the last 40 years, post mortem organ transplantation has emerged as a reliable and effective life-saving medical therapy. Since an integral part of organ transplantation involves organ donors, this dissertation considers a series of interrelated ethical and policy questions on donor autonomy.

In Chapter 1, I consider presumed consent policies of organ procurement, which presume that people have consented to organ donation if they fail to “opt-out” of donation. I give and defend a novel argument, which implies that the main argument typically offered in favor of a presumed consent policy is unsound.

In Chapter 2, I discuss the often-cited “family veto” problem. This problem emerges when a person makes a decision to be an organ donor but after her death her family blocks her decision. Many have argued that the family veto is a clear violation of patient autonomy, but I develop a novel argument that the family veto does not violate the autonomy of deceased donors.

In Chapter 3, I consider one of the most fundamental questions in organ procurement policy: must we obtain a patient’s consent before removing her organs for transplantation? I argue that obtaining patient consent before organ removal is not strictly necessary because there are other ways to properly respect patient autonomy that do not involve obtaining consent. In this chapter, I also argue that the kind of consent obtained from donors by current U.S. policy fails to respect patient autonomy.

Finally, in Chapter 4, I consider the ethical merits of a conscription policy, a policy on which organs are automatically removed from a person's body after her death, regardless of whether she decided to donate or not. There is a seemingly powerful argument which demonstrates that implementing an organ conscription policy is a moral obligation, but I suggest that it can be defeated by showing that organ conscription violates at least some people's posthumous rights regarding their bodies. To do this, I develop an account of posthumous rights and argue that people's posthumous rights outweigh the interests of living patients who need organs to continue living.

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Chapter 1

“Fewer Mistakes” and Presumed Consent

1.1 INTRODUCTION

Most arguments for the moral acceptability of a policy of cadaveric organ procurement are comparative: they are arguments designed to show that one policy is better than another at respecting an important value, such as patient autonomy or well-being. When comparing the moral merits of organ procurement policies, historically the most frequent comparisons have been made between “opt-in” policies based on explicit consent and “opt-out” policies based on presumed consent.¹

Under opt-in policies based on explicit consent, people are given the opportunity to “opt-in” to organ donation by registering as organ donors.² By contrast, under opt-out policies, people

¹ See Caplan, A.L. 1983. “Organ transplants: The costs of success.” *Hastings Center Report* 13: 23–32;

² However, this description of opt-in policies needs to be qualified in two ways. First, in many opt-in countries such as the United States, England, and Australia, it is not necessary for a person to opt-in before her organs may be removed. In fact, if a person did not opt-in while she was alive, her organs may be taken if her family consents to organ removal (Wilkinson 2011, p. 92-95). Second, even if a person opts-in, this does not guarantee that her usable her organs will be removed for transplantation because her family may object to organ donation and doctors sometimes honor the family’s objection. In the United States, however, the family’s objection does not actually have legal authority. Under the U.S.’s Revised Uniform Anatomical Gift Act (UAGA), people are given the opportunity to register themselves as donors by signing an official document or registering in an online donor registry (section 4, UAGA). If a person officially registers as an organ donor, then “a person other than the donor is barred from making, amending, or revoking an anatomical gift of a donor’s body or part if the donor made an anatomical gift of the donor’s body or part...” (section 8, UAGA). Thus, doctors are legally permitted to remove the organs of a registered donor without the family’s consent. However, medical practice is not often a perfect reflection of the law and sometimes doctors do side with the family’s refusal to donate, though there is some evidence that this does not happen frequently in the U.S. For example, in their study of every Organ Procurement Organization (OPO) operating in the United States, Chon et al (2014) found that 80 percent of OPOs were compliant with First Person Authorization (FPA) legislation as it is outline

are not given the opportunity to opt-in to organ donation; instead, they are given the opportunity to refuse the removal of their organs by formally opting-out of organ donation.

The most popular justification for an opt-out policy is that of presumed consent.³ It says that if people do not opt-out, we may presume that they consented to the removal of their organs.⁴ Thus, opt-out policies based on presumed consent give people the opportunity to opt-out of organ donation but presume that they consent if they fail to opt out. This policy, however, needs to be qualified. In most presumed consent countries, even if a person fails to opt-out, her family will be asked if they approve of or consent to organ removal. For example, under Spain's presumed consent policy, if a person fails to opt-out, her family will be asked if her organs may be removed and the family does have the power to block organ retrieval.⁵

Michael Gill (2004) has developed an important argument in favor of a policy of presumed consent that appeals to respect for autonomy. This argument is known as the Fewer Mistakes Argument.⁶ According to the Fewer Mistakes Argument, given people's actual

in Section 4 of the revised UAGA. In particular, 21 percent of OPOs reported that they would inform the family of the donor's wish to donate and proceed with procurement, and 59 percent of OPOs reported that they would proceed with organ procurement even if they could not convince the family to agree to donation (Chon et al 2014, 174). By contrast, only 20 percent of OPOs indicated that they would not proceed with removing organs from a registered donor unless the family consented (Ibid).

³ While opt-out policies have traditionally been justified by appealing to presumed consent, it is important to note that it is not the only form that an opt-out policy can take. Saunders (2012), for example, has argued that opt-out policies can be justified by tacit consent: the idea is that, under certain conditions, people's failure to opt out can count as a form of tacit consent to organ donation.³ As an analogy, imagine that at a business meeting, the director of a company proposes a policy to extend lunch to two hours instead of one. She then tells her colleagues that, if they object to this proposal, they should now raise their hand. If none of the meeting attendees end up raising their hands, their omissions are a way of tacitly consenting to the new lunch policy. The same is true for an opt-out policy based on tacit consent. While opt-out policies can in principle be justified by tacit consent, this paper focuses on opt-out policies based on presumed consent, since they are the most popular.

⁴ den Hartogh, Govert. 2011. "Can consent be presumed?" *Journal of Applied Philosophy* Vol 28 (3): 295-307.

⁵ Wilkinson, T.M. 2011. *Ethics and the Acquisition of Organs*. Cambridge: Cambridge University Press, p. 14.

⁶ See Gill, Michael B. 2004. "Presumed consent, autonomy, and organ donation." *Journal of Medicine and Philosophy* 29 (1): 37-59.

preferences and wishes regarding donation, an opt-out policy based on presumed consent is preferable to an opt-in policy based on explicit consent because it would result in fewer frustrated wishes regarding organ donation. Thus, a presumed consent policy better respects patient autonomy by better respecting patient wishes regarding donation. My goal in this paper is to argue that, despite its initial appeal, we should reject the Fewer Mistakes Argument. The plan for the paper is as follows. In §2, I will explain Gill's Fewer Mistakes Argument and in §3 I will consider two different objections to the argument that have been defended by James Taylor (2012) and recently by Douglas MacKay (2015). I will argue that MacKay's argument fails to defeat Gill's Fewer Mistakes Argument. I will then argue that the success of Taylor's argument against Gill's Fewer Mistakes Argument depends on the success of his arguments for the conclusions that it is impossible to posthumously harm and posthumously wrong a person. By contrast, my own arguments against Gill's Fewer Mistakes Argument do not depend on controversial theses about posthumous harming and posthumous wrongdoing. Indeed, my own arguments depend on premises that most people, regardless of their position on posthumous harm, will be inclined to accept. Thus, insofar as my arguments are not dependent on controversial theses, they will be prima facie more effective than Taylor's argument at rebutting Gill's Fewer Mistakes Argument. Finally, in §4, I will defend two theses. First, I will argue that Gill's primary argument for the crucial premise of the Fewer Mistakes Argument is flawed. Second, I will argue that the main premise of the Fewer Mistakes Argument is false.

1.2 THE FEWER MISTAKES ARGUMENT FOR PRESUMED CONSENT

The origin of Gill's Fewer Mistakes Argument is a dispute between Cohen (1992) and Veatch and Pitt (1995) over whether a policy of presumed consent would do a better job than the current opt-in policy at respecting people's wishes regarding what happens to their organs after death. Cohen argues that a presumed consent policy would better respect people's wishes regarding what happens to their organs than the current opt-in policy.⁷ Cohen claims that polls show that, in the U.S., 70 percent of people wish to donate their organs, while only 30 percent do not wish to donate. The problem is that, under an opt-in policy, the organs of many willing donors are not removed after death because they do not leave indications of their wishes that are clear enough to defeat the opt-in policy's presumption against the removal of organs.⁸ Consequently, many people who want to donate are left with their organs intact, thus violating their wishes about what happens to their body after death. By contrast, under a presumed consent policy, people's wishes would be respected at least 70 percent of the time; in addition, with a well-publicized opt-out policy, people who do not wish to donate would have the opportunity to opt-out. Thus, according to Cohen, a presumed consent policy would respect people's wishes better than the current opt-in policy.

In opposition to Cohen, Veatch and Pitt (1995) argue that since 30 percent of Americans do not wish to donate their organs, then if we adopted a presumed consent policy, some amount of the 30 percent of people unwilling to donate their organs would fail to opt-out and mistakenly have their organs removed.⁹ By contrast, under the current opt-in policy, it is unlikely that people

⁷ Cohen, Carl, 1992. "The case for presumed consent to transplant human organs after death," p. 2169.

⁸ Cohen, Carl, 1992. "The case for presumed consent to transplant human organs after death," p. 2170.

⁹ Veatch, R.M., & Pitt, J.B. 1995. "The myth of presumed consent: Ethical problems in

who do not wish to donate will have their organs removed after death. Thus, Veatch and Pitt argue that the current opt-in policy better respects the wishes of people who do not wish to donate than presumed consent does.

Gill (2004) claims that both opponents and proponents of presumed consent should admit that mistakes regarding people's wishes will occur no matter which policy is implemented. Under an opt-in policy, there will be people who wish to donate but whose organs are mistakenly not removed; call these mistaken non-removals.¹⁰ And under a presumed consent policy, there will be people do not wish to donate but whose organs are mistakenly removed; call these mistaken removals.¹¹ Despite that fact that both policies will result in mistakes, Gill claims that presumed consent would be the right policy to implement because it would result in fewer mistakes overall by drastically reducing the number of mistaken non-removals. Gill calls this the "fewer mistakes claim" for presumed consent.¹²

According to Gill, there are two reasons why proponents of presumed consent can plausibly claim that there will be fewer mistakes overall under a presumed consent policy compared to the current opt-in policy. First, as Cohen (1992) pointed out, the majority of Americans – 70 percent of them – prefer to donate their organs, while only 30 percent of Americans do not want their organs donated.¹³ The second reason is 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".¹⁴ This is the case because most people opposed to organ transplantation have strong religious or moral objections to organ donation and

organ procurement strategies," p. 1890.

¹⁰ Gill, Michael B. 2004. "Presumed consent, autonomy, and organ donation," p. 41.

¹¹ Ibid.

¹² Ibid.

¹³ Gill, Michael B. 2004. "Presumed consent, autonomy, and organ donation," pp. 41-42.

¹⁴ Ibid.

this makes it likely that they will opt out of organ donation. By contrast, the desire to donate one's organs is usually tied to values that are "relatively unremarkable", hence making it less probable that a person with those values will opt in to organ donation.

According to Gill, the core opposition to the fewer mistakes claim is that mistaken removals, which occur under presumed consent, are morally much worse than mistaken non-removals because they violate the right of bodily control by taking organs without a person's consent.¹⁵ By contrast, mistaken non-removals only fail to bring about a state of affairs that a person desires. Thus, even if a presumed consent policy would result in fewer mistakes overall, "the moral harm of increasing the number of mistaken removals outweighs the moral benefit of decreasing the number of mistakes overall".¹⁶

Gill attempts to refute the argument for the moral non-equivalence of mistaken removals and mistaken non-removals by showing that both types of mistakes are in fact morally equivalent. To make this argument, Gill distinguishes between two different models of respect for autonomy. The non-interference model says that "it is wrong to interfere with a person's body unless that person has given us explicit permission to do so", while the respect-for-wishes model says that we ought to treat a person's body in the way she wanted it treated.¹⁷ Which model of autonomy should govern our treatment of brain-dead organ donors? According to Gill, the non-interference model should not govern our treatment of brain dead individuals because it implies that we cannot do anything to the bodies of the dead unless they had given us explicit, prior permission to do so. But this is absurd, since we must touch the bodies of the dead in some way – for example, to transport their bodies or to dispose of them properly. Therefore, with respect to organ procurement policies, we should adopt the respect-for-wishes model of

¹⁵ Gill, Michael B. 2004. "Presumed consent, autonomy, and organ donation," pp. 42-43

¹⁶ Ibid.

¹⁷ Gill, Michael B. 2004. "Presumed consent, autonomy, and organ donation," p. 44

autonomy rather than the non-interference model. And on the respect-for-wishes 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”.¹⁸ Since each type of mistake is morally equivalent, then according to the respect-for-wishes model, we ought to implement the procurement policy that leads to the fewest number of frustrated wishes regarding donation.¹⁹

Since it contains many moving parts, it will be helpful to state the Fewer Mistakes Argument more formally:

(P1) Respect for autonomy (as described by the respect-for-wishes model) requires that we implement the procurement policy that results in the fewest frustrated wishes regarding organ donation

(P2) A policy of presumed consent would result in fewer frustrated wishes regarding organ donation compared to an opt-in policy

(C) Therefore, respect for autonomy requires that we implement a policy of presumed

¹⁸ Gill, Michael B. 2004. “Presumed consent, autonomy, and organ donation,” p. 45

¹⁹ Taylor (2012) has cast doubt on Gill’s equivalence argument by claiming that Gill is mistaken in his claim that the non-interference model and the respect-for wishes model are two different, competing accounts of respect for autonomy. As Taylor notes, the non-interference model of respect for autonomy is plausible only if we are assuming that a person would not wish that others interfere with her body. Thus, according to Taylor, the non-interference model is a variant of the respect-for-wishes model “in which the plausible assumption that persons do not want their bodies interfered with has been made explicit” (Taylor 2012, p. 118). But if this is right, then merely showing that the respect-for-wishes model should govern organ procurement policy is compatible with the claim that respecting certain wishes (i.e. wishes to not have one’s organs removed) is more important than respecting other wishes (i.e. wishes to have one’s organs removed) (Ibid). Thus, merely showing that mistaken removals and mistaken non-removals both involve treating a person’s body in a way that she did not want it treated does not show that both mistakes are on a moral par. While this is correct, in Section 4 I take Taylor’s argument further by providing a positive reason to think that mistaken removals are generally much worse than mistaken non-removals.

consent.

Gill's argument for the moral equivalence of mistaken removals and mistaken non-removals is an argument in favor of (P1). Gill has shown that, since organ procurement policy should be governed by the respect-for-wishes model, mistaken removals and mistaken non-removals are morally equivalent. Since both mistakes are equivalent, we ought to implement the policy that would result in the fewest mistakes overall. And the policy that would result in the fewest mistakes overall is a presumed consent policy.

In the remainder of the paper I will consider two important objections to Gill's Fewer Mistakes Argument that have been developed by Douglas MacKay (2015) and James Taylor (2012). I will argue that MacKay's argument fails to undermine Gill's defense of the Fewer Mistakes Argument, and that the success of Taylor's argument against the Fewer Mistakes Argument depends on the success of controversial arguments which show that it is impossible for a person to be posthumously harmed and posthumously wronged, whereas my own arguments against Gill's Fewer Mistakes Argument do not depend on the success of such arguments. I will then defend an argument against Gill's Fewer Mistakes Argument that does not depend on controversial commitments regarding posthumous harming or posthumous wronging. In the course of making this argument, I will also defend an argument against Gill's argument for the moral equivalence of mistaken removals and mistaken non-removals.

1.3 EVALUATING THE FEWER MISTAKES ARGUMENT

1.3.1 MacKay's objections

According to Douglas MacKay (2015), Gill's Fewer Mistakes Argument fails because it misconstrues the problem that donor registration policies are meant to address.²⁰ Gill seems to think that the problem donor registration policies are meant to address is that of surrogate decision-making for brain dead individuals. But this is false, according to MacKay:

“Organ donor registration policies of course have implications for this type of decision making, but the question they address is a different one. These policies offer ways of ascertaining presently competent people's preferences regarding a treatment question care providers will face when these people are no longer competent, namely whether to retrieve their organs”.²¹

Thus, the question organ registration policies mean to answer is “how should we register presently competent people for an intervention that will occur—if it does—when they are no longer competent?”²² What, then, does respect for autonomy require when we are trying to register presently competent people for an intervention that will take place when they are dead and no longer competent? MacKay argues that respect for autonomy requires that we take steps to secure the actual consent of presently competent persons for an intervention they may undergo when they are not competent when the following three conditions are satisfied: (1) it is not unreasonably costly for agents to secure consent; (2) there is a real possibility that decisions regarding the treatment in question will need to be made; and (3) the choice of treatments is likely to matter to people.²³ Since organ registration policies satisfy (1)-(3), it follows that

²⁰ MacKay, Douglas, 2015. “Opt-out and consent” *Journal of Medical Ethics* 0: 1-4.

²¹ MacKay, Douglas, 2015. “Opt-out and consent,” p. 2

²² *Ibid.*

²³ *Ibid.*

obtaining people's actual consent to organ removal is required by the principle of respect for autonomy. Thus, MacKay's argument is meant to show that respect for autonomy does not require that we implement the policy that results in the fewest mistakes; instead, respect for autonomy in the specific context of postmortem organ procurement requires that we obtain people's actual consent to organ donation.

MacKay's account of respect for autonomy entails that, with respect to living competent patients, if an intervention satisfies (1)-(3), then a failure to obtain a person's actual consent to that intervention is a failure to respect her autonomy. But this claim is false, because there are other posthumous bodily interventions that satisfy (1)-(3) but for which it is implausible to claim that failing to obtain a person's actual consent to that intervention is a failure to respect her autonomy. I use the term 'posthumously bodily intervention' broadly to describe the touching, invading, handling, or the destruction of the physical body.

Consider, then, the decision to be cremated or buried intact when one dies. Surely these count as posthumous bodily interventions, and they are decisions that can be considered by living competent people. More importantly, burial and cremation seem to satisfy MacKay's three conditions. First, it does not seem to be unreasonably costly for agents to secure consent for this type of bodily invasion. One might wonder *who* the agents are that would secure actual consent from people regarding decisions about burial and cremation. While the family is typically responsible for the burial or cremation of their deceased loved ones, families need not be the agents who take steps to obtain consent. A person's consent to burial or cremation can be obtained in a variety of ways and by different agents. For example, it can be obtained by a nurse or physician in a routine medical exam, at the DMV while obtaining a driver's license, or via an online database (the U.S. does this with organ donation registration as well). The information

regarding whether people consent to burial or cremation would then be used by the person's family in deciding how to lay their loved ones to rest. Of course, obtaining consent in these contexts will require extra costs and resources, but if it is agreed that obtaining consent to organ donation is not too costly, then there doesn't seem to be an in principle reason to think that obtaining consent for burial or cremation is too costly either. Second, it is clear that decisions regarding whether to cremate or bury a person's body will need to be made. We don't just let the bodies of the dead lay where they drop. Third and finally, the decision about whether to be cremated or buried likely matters to most people. Some people may not like the idea of a proper burial and prefer to be cremated, while others would want to be buried rather than cremated.²⁴

Since the example of the decision to be cremated or buried intact satisfies MacKay's three conditions it follows that if we don't acquire a person's actual consent while they are alive regarding whether to be cremated or buried intact, we have failed to respect their autonomy. But this is implausible. For it seems clear that acting on the basis of a person's known wishes and desires regarding some posthumous intervention would be sufficient to respect their autonomy, which means that obtaining their actual consent is not necessary to respect their autonomy. Consider, for example, the case of Lisa. Lisa has told her family for the last ten years that she

²⁴ One might object that the example involving burial and cremation is flawed because it describes two different interventions, while MacKay is considering organ donation, which is a single intervention that is either performed (the organs are removed) or is not performed (the organs are not removed). My reply is that this makes no moral difference and that when redescribed as a single intervention, the intervention still satisfies Mackay's three conditions on obtaining consent. Suppose, then, that a person, let's call her Ann, told her family that she wishes to be cremated when she dies and that she finds the idea of a proper burial a waste of time and resources. Once Ann dies, the family is confronted with the decision to cremate her or not cremate her. Now, it certainly seems that the decision to cremate or not cremate satisfies MacKay's three conditions for the requirement of obtaining actual consent. First, it isn't unreasonably costly for agents (such as the family or the State) to take steps to secure consent for cremation; second, the decision to cremate or not is one that will likely need to be made because people die regularly and many of them had desires to be cremated; third, the decision to cremate or not likely matters to people, for some people prefer not to be cremated for moral, aesthetic, or religious reasons, while others do prefer to be cremated.

wishes to be cremated when she dies. In fact, she continually reminds them of her wishes almost every year. When Lisa becomes seriously ill with a rare blood disease, she reminds her family to keep her wishes regarding cremation. Shortly thereafter, Lisa dies and her family cremates her remains. It seems clear to me that if the family acts in accordance with Lisa's wishes, they have sufficiently respected her autonomy. But if MacKay is correct that obtaining actual consent is necessary when his three conditions are met, then Lisa's family have not respected her autonomy because they never obtained Lisa's actual consent (i.e. Lisa never said verbally or in writing "I give you permission to cremate me").²⁵ But this seems wrong. Indeed, there doesn't seem to be any remnant of moral wrongdoing or disrespect for Lisa on the part of her family if they act in accordance with her wishes. By contrast, if the family completely disregarded Lisa's wishes regarding cremation, we would feel as if she had been disrespected. Thus, it seems more plausible to claim that Lisa's family did sufficiently respect her autonomy because they acted in accordance with her wishes regarding cremation. Thus, since burial and cremation satisfy Mackay's three conditions, MacKay must hold that acting in accordance with the person's wishes is not sufficiently respectful of her autonomy; by contrast, I think that the more plausible position is that we *are* sufficiently respectful of her autonomy when we act in accordance with her wishes.

Thus, if a person is known to have wanted to donate (for example, she told her family this), then acting on the basis of her wishes sufficiently respects her autonomy. Now, one could

²⁵ Against my argument, one might claim that a person such as Lisa, who tells her family that she wishes to be cremated, has in fact consented to cremation. If this assumption is correct, then I cannot claim that MacKay is committed to the view that we disrespect a person's autonomy by cremating her in accordance with her wishes. But the success of this objection requires accepting a controversial view of consent as a mere wish or desire. In other words, to consent to P just means to wish or desire that P. But this view is very controversial, for consent is usually taken to be a public act of authorization whereby one party authorizes or permits another party to do something (See Kleinig 2010 and Beauchamp and Childress 2009).

in part agree with MacKay that obtaining actual consent is *sufficient* to respect people's autonomy when it comes to posthumous interventions such as burial, cremation, or organ donation. But that is not the claim at issue. The claim at issue is whether obtaining actual consent is *necessary* to respect people's autonomy. I think that obtaining actual consent is *not* necessary to respect patient autonomy, though it is likely sufficient.

One might object by suggesting that the practices of burial and cremation are not relevantly similar to organ procurement because they don't occur in a medical context. Therefore, they cannot be utilized as counter-examples to MacKay's argument. It is true that posthumous interventions such as organ procurement occur in a medical context while burial and cremation do not, but, pending a further argument, I don't see why this makes a moral difference. So long as an intervention involves the touching, invading, handling, or destruction of the cadaver, it counts as a posthumous bodily intervention. Furthermore, Gill's original examples of posthumous bodily interventions, which he uses in the course of defending the Fewer Mistakes Argument, are ones that need not occur in a medical context to count as bodily interventions. For instance, to argue against the non-interference model of respect for autonomy as an appropriate model for treating the brain dead, Gill says, "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".²⁶ Since people can become brain dead anywhere, and not necessarily in a medical context, it seems that Gill himself understands the notion of posthumous bodily interventions to be sufficiently broad.

To conclude, while MacKay is correct that organ procurement policies are meant to address the issue of how best to register currently competent patients for an intervention that will

²⁶ Gill, Michael B. 2004. "Presumed consent, autonomy, and organ donation," p. 45

take place after they are dead, this need not commit us to the claim that obtaining people's actual consent is necessary to respect their autonomy. Thus, MacKay cannot argue against Gill's argument by claiming that respect for autonomy requires gaining people's actual consent for an intervention that will take place when they are dead.

1.3.2 Taylor's Arguments against the Fewer Mistakes Argument

James Taylor (2012) argues against Gill's Fewer Mistakes Argument by attacking (P1) of the argument.²⁷ Taylor claims that (P1) rests on the view that "if one fails to take steps to ensure that persons' wishes concerning the treatment of their bodies are not likely to be thwarted after their deaths then one will have failed to respect their autonomy".²⁸ But, according to Taylor, this claim depends on the idea that in order for one person to respect the autonomy of another person, "she must act to ensure that his wishes are not likely to be thwarted".²⁹ But Taylor argues that this is an overly stringent account of respect for autonomy. He thus distinguishes three different views of respect for autonomy:

1. Strong Absolutism: the view on which a person's consent for her involvement in a procedure is necessary for it to be morally permissible for her to be involved in it.
2. Weak Absolutism: the view on which a person's involvement in a procedure is impermissible if she has refused to be involved in it.

²⁷ Taylor, James Stacey. 2012. *Death, Posthumous Harm, and Bioethics* (London: Routledge).

²⁸ Taylor, James Stacey. 2012. *Death, Posthumous Harm, and Bioethics*, p. 120.

²⁹ Ibid.

3. Proceduralism: the view on which, even if a person objects to being involved in a procedure, requiring her to be involved in it could be permissible if her interests have been given the appropriate moral consideration.³⁰

According to Taylor, if the value of a person's autonomy conflicts with the value of the well-being of others, then which account we should adopt depends on our answers to the following five questions:

(Q1) the degree of harm or wrong that a person P would incur were his decision not to be adhered to;

(Q2) the degree to which such a failure to adhere to P's decision would advantage or disadvantage the other persons that it concerned

(Q3) whether a failure to adhere to P's decision would serve to prevent harm to others, or to provide them with certain benefits

(Q4) whether failing to adhere to P's decision would result in his being required actively to provide some good or service

(Q5) whether the goods that would be produced by the failure to adhere to P's decision could be produced in another way, and if so, what the costs of doing so would be.³¹

³⁰ Ibid.

Taylor thinks that the answers to (Q1)-(Q5) support Proceduralism over the other accounts. If Proceduralism should be adopted, then, according to the Taylor, all that is necessary and sufficient to respect patient autonomy within postmortem organ procurement is (i) that we take those wishes that a patient is autonomous with respect to seriously, and (ii) give them due weight in one's considerations.³² If respect for autonomy requires only (i) and (ii), as Taylor suggests, then (P1) of Gill's argument is false, for (P1) maintains that respect for autonomy requires that we implement the policy that results in the fewest frustrated wishes regarding organ donation. Taylor has in effect denied (P1) by claiming that respect for autonomy only requires (i) and (ii).

We should thus ask: what reasons are there to accept Proceduralism in the context of postmortem organ procurement? Consider Q1. According to Taylor, the greater the degree of harm or wrong that P would incur were his decision not to be adhered to, the greater the justification for adopting an approach to respecting his autonomy that would lean more towards Strong Absolutism than towards Proceduralism.³³ But Taylor argues that it is impossible for people to be posthumously harmed and posthumously wronged.³⁴ Therefore, since people cannot be harmed or wronged when their decision regarding their organs is not adhered to, we should prefer the Proceduralist account. Taylor also thinks that the answers to Q2-Q5 also support Proceduralism. With respect to (Q2), it is clear that failing to adhere to a person's decision to not donate would greatly advantage people on the waiting list by providing them with organs. But this fact in itself does not support Proceduralism unless we are assuming that people cannot be

³¹ Ibid.

³² Taylor, James Stacey. 2012. *Death, Posthumous Harm, and Bioethics*, p. 121.

³³ Taylor, James Stacey. 2012. *Death, Posthumous Harm, and Bioethics*, p. 120.

³⁴ Indeed, Taylor argues at length in his book, *Death, Posthumous Harm, and Bioethics*, that it is impossible to posthumously harm and posthumously wrong a person. While I cannot evaluate every argument discussed by Taylor, I only note that his case for Proceduralism hinges on the impossibility of posthumous harm and posthumous wrongdoing.

harmed or wronged by the failure to adhere to their decision to not donate their organs. For even if the failure to adhere to a person's decision regarding some procedure would greatly advantage some people, if it harms or wrongs the person whose decision we have failed to adhere to, we have a reason for not adopting a Proceduralist account. Similarly, with respect to (Q3), it is clear that failing to adhere to a person's decision to not donate would prevent people on the waiting list from suffering and death. However, this fact would not support Proceduralism unless we assumed that people cannot be harmed or wronged by the failure to adhere to their decision to not donate their organs. For even if failing to adhere to a person's decision regarding some procedure would prevent harm to others, if failing to adhere to the person's decision harms or wrongs her, we have a reason against adopting Proceduralism.

Thus, in addition to Q1, whether answers to Q2 and Q3 support Taylor's Proceduralism all depend on the claim that it is impossible to posthumously harm and posthumously wrong a person. Since this is the case, much of Taylor's case for Proceduralism depends on the thesis that it is impossible to posthumously harm and posthumously wrong a person. Thus, whether Taylor's argument succeeds against Gill's Fewer Mistakes Argument depends on the claim that it is impossible to posthumously harm and posthumously wrong a person. But this is a controversial claim. Indeed, others have ably defended the thesis that people can be posthumously harmed, especially in regard to the removal of their organs.³⁵ Thus, it would be better, from a methodological standpoint, to have an argument against Gill's Fewer Mistakes Argument that did not depend on such a contested premise. Fortunately, the argument that I will

³⁵ Pitcher, George, 1984. "The Misfortunes of the Dead" *American Philosophical Quarterly* Vol. 21 No 2: 183-188; Wilkinson, T.M. 2011. *Ethics and the Acquisition of Organs*; Boonin, David. *Posthumous Wrongs*, Ms, in progress.

defend in the next section does not force us to accept or reject the view that posthumous harming and posthumous wronging are impossible. Thus, while I am not attempting to refute Taylor's argument – since doing so would require a full-blown discussion of posthumous harm and posthumous wronging – I am suggesting that there is a methodological reason to prefer my argument to his argument.

1.4 WHY GILL'S FEWER MISTAKES ARGUMENT FAILS

I have argued that MacKay's argument fails to undermine the Fewer Mistakes Argument and that the success of Taylor's argument against the Fewer Mistakes Argument depends on the thesis that posthumous harm and posthumous wronging are impossible. However, what should also be noted is that both Taylor and MacKay attempt to refute the Fewer Mistakes Argument by defending what they take to be superior views of respect for autonomy. Taylor argues against the Fewer Mistakes argument by presenting a Proceduralist account of respect for autonomy, which entails that (P1) of the Fewer Mistakes argument is false. Similarly, MacKay presents an account of respect for autonomy that says that obtaining a person's actual consent is necessary when certain conditions are met. By contrast, the two problems for the Fewer Mistakes Argument that I will defend do not hinge on accepting any particular account of respect for autonomy. In that respect, my argument is more conservative, and allows us to reject Gill's argument without any significant commitments about what is necessary and sufficient to respect patient autonomy.

To begin, I would like to confront Gill's argument that mistaken removals and mistaken non-removals are morally equivalent because both fail to treat people's bodies in the way that they wanted them to be treated. To recall, Gill argues that we ought to accept the respect-for-wishes model of respect for autonomy, which says that we ought to treat a person's body in the

way they wanted it treated. From this claim Gill argues that mistaken removals and mistaken non-removals are equally bad from the standpoint of respect for autonomy because both involve treating a person's body in a way that they did not want it treated. The problem is that, even if both mistakes fail to treat people's bodies in the way that they wanted it treated, it doesn't follow that the mistakes are equivalent. Indeed there is a positive reason to think that generally, mistaken removals are worse than mistaken non-removals. This problem is based on remarks that Gill attributes to proponents of presumed consent. As Gill remarks, proponents of presumed consent argue that a policy of presumed consent will lead to fewer mistakes overall than the current opt-in system because of two related considerations. First, a presumed consent policy will lead to fewer mistakes overall since "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".³⁶ This is the case because people who oppose organ transplantation tend to have strong religious or moral objections to organ donation. For example, Orthodox Jews, some Amish, strict Jehovah's Witnesses, and people coming from cultures with a strong Confucian influence tend to be strongly adverse to organ removal. Confucians, for example, maintain the belief that our bodies are gifts from our parents and ancestors and thus, we should maintain our entire bodies at death.³⁷ By contrast, those who want to donate typically want to donate based on values that are "relatively unremarkable".³⁸ These remarks, which Gill attributes to proponents of presumed consent, suggests that, in general, those who oppose donation do so in light of deep religious or moral convictions that are likely very important for them to fulfill. By contrast, those who support donation do not tend to base their desire to donate on deep moral or

³⁶ Gill, Michael B. 2004. "Presumed consent, autonomy, and organ donation," p. 41

³⁷ Lam, W. A., and L. B. McCullough. 2000. "Influence of religious and spiritual values on the willingness of Chinese-Americans to donate organs for transplantation." *Clinical transplantation* Vol 14 (5): 449-456.

³⁸ Gill, Michael B. 2004. "Presumed consent, autonomy, and organ donation," p. 41

religious convictions and this partly explains why many of them do not opt in to organ donation.

If people who oppose donation do so because of deep religious and moral convictions, and if people who want to donate do so based on values that are relatively unremarkable, then it is plausible that mistaken removals are generally worse, from the standpoint of respect for autonomy, than mistaken non-removals. This is because the wish to not donate tends to be far more important to the unwilling donor than the wish to donate is to the willing donor. This means that, in general, frustrating a person's wish that her organs not be removed is worse, from the standpoint of respect for autonomy, than frustrating a person's wish that her organs be removed. To illustrate the general point, consider the following two wishes: the wish to eat spaghetti for dinner; and the wish to marry one's significant other. It is plausible that, in general, the wish to marry one's significant other is far more important to the person who has that wish than the wish to eat spaghetti for dinner is to the person who wants spaghetti. It is thus plausible that frustrating the wish of the person who wants to marry his or her significant other is far worse, from the standpoint of respect for autonomy, than frustrating the other person's wish to eat spaghetti for dinner.

The more general explanation for this difference in badness is that some wishes, desires, and interests hold a more central, important place in a person's overall life plan, whereas others take a more peripheral role. The desire to marry one's significant other is the sort of desire that often is central to a person's overall life plan, and this plausibly explains why its frustration is far worse than the frustration of a person's desire to eat spaghetti for dinner. Similarly, there is good reason to think that, for unwilling donors, the desire to not donate tends to occupy a central place in their overall life plan, whereas for willing donors, the desire to donate does not occupy such

an importance place.³⁹ Therefore, in general, the frustration of the desire to not donate one's organs is plausibly worse, from the standpoint of respect for autonomy, than the frustration of the desire to donate.

Since we now have a plausible reason to think that in general mistaken removals are worse than mistaken non-removals, Gill cannot plausibly claim that both types of mistakes are equally bad from the standpoint of respect for autonomy. This is important for the following reason. Gill's argument for the moral equivalence of mistaken removals and mistaken non-removals is significant because this is his main argument in defense of (P1) of the Fewer Mistakes Argument. My first argument against Gill shows that his argument for the moral equivalence of mistaken removals and mistaken non-removals is flawed, and hence, this robs him of a plausible reason to accept the first premise of the Fewer Mistakes Argument.

While the above objection casts serious doubt on the major argument that Gill utilizes to support (P1) of the Fewer Mistakes Argument, there is another problem for the argument, namely, that (P1) is false. That is, it is false that respect for autonomy requires that we ought to adopt the policy that would result in the fewest number of frustrated wishes overall. To show this, imagine a procurement policy in which procurement personnel were required to knock on the door of every person's place of residence and force him or her to state whether they wish to donate their organs or not, or else face legal penalties such as a monetary fine. For convenience call this the "decide-or-pay policy", or the DOP policy. It is plausible that the DOP policy would lead to fewer frustrated wishes (understood as wishes in favor of donation or wishes against donation) because it would secure people's actual wishes about donation by visiting them at their places of residence and forcing them to make a decision about donation or else face legal

penalties. But recall that (P1) says that respect for autonomy (as described by the respect-for-wishes model) requires that we adopt the procurement policy that will lead to the fewest mistakes regarding people's wishes about donation. It appears, however, that the DOP policy would in fact lead to fewer mistakes regarding people's donation wishes compared to either an opt-in, presumed consent, or mandated choice policy. Therefore, if we accept (P1), we ought to adopt the DOP policy, which is absurd. It is absurd because despite resulting in the fewest mistakes regarding people's wishes regarding donation, the policy disrespects people's autonomy in significant ways.

In what follows, I will explain why the DOP policy would likely result in the fewest frustrated wishes (regarding organ donation) compared to alternative policies. First, the DOP policy would lead to fewer mistakes than an opt-in policy by ensuring that people who wish to donate and those who do not wish to donate get their preferences recorded and their wishes followed. However, opt-in policies will result in many mistaken non-removals in which people who wish to donate, but who did not opt-in, will have their organs left intact. By contrast, the DOP policy ensures that people who wish to donate have their preferences recorded and followed. Second, the DOP policy would lead to fewer mistakes than a presumed consent policy by ensuring that both willing donors and those unwilling to donate have their wishes recorded and followed. However, presumed consent policies will result in mistaken removals in which people who did not wish to donate, but who never opted-out, will have their organs removed. By contrast, the DOP policy ensures that people who did not want to donate have their preferences recorded and followed.

One might, however, be skeptical about whether the DOP policy would lead to fewer mistakes than a mandated choice policy. Under mandated choice policies, such as the one in the

U.S. state of Illinois, the obtaining or renewal of a driver's license is conditional upon making a decision about whether one wishes to donate. Thus, under mandated choice policies, one must make decision about donation in order to obtain one's driver's license, though of course there are other ways to make people make a decision about donation. However, the main reason that the DOP policy is likely to lead to fewer mistakes than a mandated choice policy is that it targets all citizens, and hence gathers the donation wishes of the entire population, rather than just that subset of people who decide to obtain driver's licenses. Furthermore, there is evidence that the amount of people obtaining driver's licenses has been significantly declining over the last several years.⁴⁰ This is especially true with respect to teens and young adults.⁴¹

It is thus plausible that the DOP policy would result in fewer frustrated wishes regarding donation than an opt-in, presumed consent, and mandated choice policy. This means that, if we accept (P1), then we ought to adopt the DOP policy. But this is an unacceptable implication of (P1), since the DOP policy is seriously disrespectful of people's autonomy. Therefore, in order to reject this unacceptable implication, we must reject (P1), and that means that the Fewer Mistakes Argument is unsound.

One might object by saying that a background assumption of Gill's Fewer Mistakes argument is that the only choices on offer are between opt-in and opt-out policies. If that is the case, then I cannot claim that (P1) of Gill's argument entails that we ought to adopt the DOP policy since that policy is not a choice on offer. In order to rebut my argument, then, Gill must reformulate (P1) as the claim that, between opt-in and presumed consent policies, respect for

⁴⁰ See M. Sivak and B. Schoettle. "Recent Decreases in the Proportion of Persons with a Driver's License Across All Age Groups." University of Michigan Transportation Research Institute 2016: 1-6.

⁴¹ Sivak and B. Schoettle. "Recent Decreases in the Proportion of Persons with a Driver's License Across All Age Groups," p. 2

autonomy requires that we implement the policy that results in the fewest frustrated wishes regarding donation.

But I think that this objection is mistaken. It is important to point out that one of Gill's goals is to provide an account of respect for autonomy that is plausible within the unique context of organ procurement on the dead. He argues that the best model of respect for autonomy is the respect-for-wishes model, which in turn entails that we implement the policy that results in the fewest mistakes about people's wishes regarding donation. Once Gill's argument is viewed in this context, it is implausible to claim that Gill is providing an account of respect for autonomy that is applicable only in the context of opt-in and presumed consent policies. Indeed, Gill's account of respect for autonomy, if it is to be plausible, should be sufficiently general so that it can be used to evaluate and construct procurement policies other than opt-in and presumed consent policies. Indeed, given his account of respect for autonomy, Gill himself says that a mandated choice policy (with a provision for a family veto) would result in fewer frustrated wishes than a presumed consent policy, and hence, would be better than a presumed consent policy at respecting patient autonomy.⁴² What the foregoing comments suggest is that (P1) of Gill's argument is a general claim about respect for autonomy within procurement policy, rather than the more specific claim that between opt-in and presumed consent policies, respect for autonomy requires that we implement the policy that results in the fewest frustrated wishes regarding donation.

Second, one might argue that Gill need not be committed to accepting the DOP policy for the following considerations. Recall that Gill accepts the respect-for-wishes model of respect for autonomy because he thinks it's the right account of respect for autonomy when dealing with the brain dead. Since deceased organ donors are brain dead, he thinks that the respect-for-wishes

⁴² Gill, Michael B. 2004. "Presumed consent, autonomy, and organ donation," p. 52

model ought to govern our postmortem organ procurement policies. But one might object by claiming that, once the situation is understood in this way, Gill's commitment to the respect-for-wishes model as expressed in (P1) does not entail that we ought to adopt the DOP policy, and this is because the DOP policy targets living, competent people, rather than brain dead people. Since the DOP policy targets living, competent people, it is open to Gill to employ the non-interference model of respect for autonomy by claiming that the DOP policy would be in tension with the non-interference model and hence, the DOP policy should not be adopted.

But this objection is mistaken for at least two reasons. First, recall that the non-interference model of respect for autonomy says that it is wrong to invade or interfere with a person's body unless that person gave us their permission to do so. Thus, Gill would only be able to argue that the DOP policy is tension with the non-interference model of respect for autonomy if the DOP policy was that we ought to interfere with or invade people's bodies while they are alive. But the DOP policy does not say that we ought to interfere with or invade people's bodies while they are alive. Rather, the policy is simply that we force people to express their wishes regarding donation so that we can act in accordance with those wishes only once they are brain dead.

Secondly, if it's true that the DOP policy targets living, competent people, then, for the same reason, so do opt-in, presumed consent, and mandated choice policies. All of these policies in some sense target living, competent people. Opt-in policies, for example, target living, competent people by giving them the opportunity to register as organ donors; in addition, presumed consent policies target living, competent people by giving them the opportunity to opt out of organ donation. And mandated choice policies target living people by forcing them to make a decision about donation if they wish to receive or renew their driver's licenses.

Third, one might object that the fact that (P1) of Gill's argument entails that we ought to adopt the DOP policy is not as implausible as it seems, since some places, such as New York, Illinois, and New Zealand, already operate on a mandated choice policy, which requires people to state their donation preferences in order to receive their driver's licenses.

However, given the significant differences between them, the DOP policy is considerably less respectful of patient autonomy than a mandated choice policy, despite the fact that the DOP policy would likely result in fewer frustrated wishes. First, the DOP policy is less respectful of people's autonomy compared to a mandated choice policy because it has a greater coercive *scope* than a mandated choice policy. While a mandated choice policy coerces only those who decide to receive driver's license, it misses a significant portion of the population that do not receive driver's licenses for whatever reason. By contrast, the DOP policy would target everybody, by visiting them at their places of residence and coercing them into stating their donation preferences. Second the DOP policy is less respectful of people's autonomy than a mandated choice policy because it is supremely invasive, whereas a mandated choice policy is not. The DOP policy requires personnel to visit the places of residence of all citizens in order to extract the donation decisions of everyone of age in each household. By contrast, mandated choice policies are not comparably invasive, since they do not require that people be visited at their places of residence to extract their donation decisions. Third, the kind of punishment that the DOP policy utilizes to coerce people to make a decision about donation is, *prima facie*, either comparably coercive or more coercive than the punishment that mandated choice policies use to coerce people to make a decision about donation. Mandated choice policies do not coerce by the threat of a severe monetary penalty or jail time; instead, they coerce by the threat of not giving people a driver's license. It should be acknowledged that the threat of not receiving a driver's

license can be very serious for many people. However, the threat of a high monetary penalty under the DOP policy can be very coercive for many people who are not financially well off, which suggests that for at least these people, the DOP policy is particularly coercive. In addition, one could imagine a version of the DOP policy, which requires people to pay a high monetary fine for every month that they do not state their donation preferences. Such a policy would be quite coercive even for people who are financially well off. Thus, in light of the three above considerations, I submit that the DOP policy is less respectful of people's autonomy than a mandated choice policy.

One might argue that the state is sometimes justified in coercing its citizens with the threat of legal punishment, and so there is nothing problematic about doing so within procurement policy. For example, U.S. citizens are often summoned by the state for participation on a court jury (often referred to as "jury duty"). Failing to respond to a juror summons may result in the issuing of a legal penalty, such as a monetary fine, and in some cases, jail time. Thus, if the state is sometimes justified in coercing people by the threat of legal punishment, then there is no reason to think that it cannot also coerce people into making a decision about their organs.

My response to the current objection is that even if there are legitimate cases of coercion by the threat of legal punishment, these cases differ in an important way from organ donation. The difference is that organ donation involves a decision that a person makes about what will be done to her own body, and it is inappropriate to coerce people by the threat of legal punishment into making a decision about how their body will be treated. Suppose, for example, that physicians were allowed to coerce their patients by the threat of legal punishment into making decisions about invasive procedures that the patients might undergo. Surely this practice would be a clear failure to respect the autonomy of patients. Similarly, I am claiming, coercing people by the

threat of legal punishment to make a decision about whether their organs will be removed would also constitute a failure to respect patient autonomy, despite the fact that it would result in fewer mistakes regarding donation.

I have argued that there is a positive reason to accept that mistaken removals are generally worse, from the standpoint of respect for autonomy, than mistaken non-removals. If this is right, then Gill cannot claim that mistaken removals and mistaken non-removals are morally equivalent. Second, I have argued that (P1) of the Fewer Mistakes Argument is false because it implausibly entails that we ought to adopt the DOP policy. We thus have a plausible case against Gill's Fewer Mistakes Argument.

1.5 CONCLUDING REMARKS

The Fewer Mistakes Argument is unique in the sense that it argues for a presumed consent policy on the basis of the claim that such policies respect the autonomy of people better than the currently implemented opt-in policy. If presumed consent policies do respect the autonomy of donors better than opt-in policies and since there is evidence that presumed consent policies can and do yield more usable organs for transplantation, whether such an argument succeeds is of great interest to both philosophers and policymakers. However, in this paper I have taken a negative view of the Fewer Mistakes Argument. I have argued that Gill's argument for the equivalence of mistaken removals and mistaken non-removals is implausible because there is a good reason to believe that mistaken removals are generally much worse than mistaken non-removals. I also argued that there is a serious problem for (P1) of the Fewer Mistakes Argument, which renders it unsound.

Chapter 2

Patient Autonomy and the Family Veto Problem in Organ Procurement

2.1 ORGANS AND FAMILIES

A question of paramount significance in the debate over organ procurement from the dead is: who should have the final authority to decide what happens to a deceased patient's organs?⁴³ Countries such as the United States, Scotland, England, and New Zealand currently operate under an opt-in system of organ procurement: on this model, the default is that a patient's organs will not be removed unless she has officially registered as an organ donor.⁴⁴ As we'll see, however, actual practice permits organ removal in various other circumstances.⁴⁵ Opt-in systems such as those in the United States, England, and New Zealand, are more reliably

⁴³ Frances Kamm. *Morality, mortality vol 1*. (New York: Oxford University Press, 1993: 205–12, 217–21); Robert Veatch. *Transplantation Ethics*, 1st edition. (Washington D.C.: Georgetown University Press, 2000); David Price. *Legal and ethical aspects of organ transplantation*. (Cambridge: Cambridge University Press, 2001); Martin (T.M.) Wilkinson. *Ethics and the Acquisition of Organs*. (Cambridge: Cambridge University Press, 2011); Martin (T.M.) Wilkinson. "Individual and family consent to organ and tissue donation: is the current position coherent?" *Journal of Medical Ethics* 2005, 31: 587-590; Paula Boddington. "Organ donation after death—should I decide, or should my family?" *Journal of Applied Philosophy* 2005, 15:69–81; Govert den Hartogh. "The role of the relatives in opt-in systems of postmortal organ procurement." *Medical Health Care and Philosophy* 2012, 15:195–205; David Shaw. "We should not let families stop organ donation from their dead relatives." *British Medical Journal* 2012, 345: e5275; Jurgen de Wispelaere and Lindsay Stirton. "Advance commitment: an alternative approach to the family veto problem in organ procurement." *Journal of Medical Ethics* 2010, 36: 180-183.

⁴⁴ Although the majority of U.S. states operate under opt-in policies, some U.S. States, such as New York and Illinois, operate under Mandated Choice policies. Under mandated choice policies, people are required to decide whether to be organ donors or not. This is usually done in the context of obtaining or renewing a driver's license at the DMV, and one cannot obtain a license without deciding one's donor status.

⁴⁵ Wilkinson, *Ethics and the Acquisition of Organs*; Den Hartogh, "The role of the relatives in opt-in systems of postmortal organ procurement."

characterized as “impure” opt-in systems because, in such systems, even if a patient has registered as an organ donor, doctors in practice often acquiesce to the wishes of the family regarding donation. Thus, if the donor’s family does not want the donor’s organs to be removed, doctors often honor this request.⁴⁶ However, within these systems, the donor herself also has the power to veto the posthumous removal of her organs.⁴⁷ Thus, most opt-in systems as we know them operate on what has been called a ‘double veto’.⁴⁸ My goal in this paper is to discuss one part of the double veto, namely, the family’s power to veto or override a patient’s registered decision to donate.

The power of the family to veto a patient’s recorded decision to donate has come under considerable criticism. One of the most common criticisms against the family veto is that when families veto the decision of their deceased family member, they fail to respect the wishes of the deceased, and this constitutes a violation of the deceased patient’s autonomy.⁴⁹ This criticism has considerable plausibility, especially when we consider other cases in which we would think it is clearly wrong for families to either override or have the power to override a patient’s decision regarding the treatment of her body. For example, imagine that families had the power to veto a competent patient’s decision to undergo surgery to treat cancer or other diseases; or suppose that the family had the power to veto a patient’s advance directive that instructed physicians to take her off life support in the event of brain death.

⁴⁶ Wilkinson, “Individual and family consent to organ and tissue donation: is the current position coherent?”; Den Hartogh, “The role of the relatives in opt-in systems of postmortal organ procurement.”

⁴⁷ This power to veto organ removal is essentially equivalent to the power to refuse consent to organ removal. See Wilkinson, “Individual and family consent to organ and tissue donation: is the current position coherent?” for discussion.

⁴⁸ Wilkinson, “Individual and family consent to organ and tissue donation: is the current position coherent?”

⁴⁹ Veatch, *Transplantation Ethics*, 1st edition; Shaw, “We should not let families stop organ donation from their dead relatives.” Walter Glannon. “Taylor on Posthumous Organ Procurement.” *Journal of Medical Ethics* 2014; Vol 40, No. 9: 637-638.

Although many find compelling the claim that the power of the family to veto a patient's decision is wrong because it is inconsistent with respect for the patient's autonomy, in this paper I defend the position that when families veto an individual's recorded decision to donate and the individual's organs are not in the end removed, neither the doctors nor the family infringe on the individual's autonomy in any morally objectionable sense. Call this the Non-Removal Thesis. The Non-Removal thesis is not simply the view that doctors and families act within their rights by not removing the organs of a registered donor. For this is consistent with the view that although doctors and families act within their rights by failing to remove the donor's organs, they do act in a morally objectionable way towards the donor. I am not merely claiming that it's morally permissible -- in the sense that it doesn't violate a potential donor's rights -- to not remove a person's organs who has registered as an organ donor; I am also claiming that not removing the donor's organs would not be doing *anything* morally objectionable in terms of her autonomy. In other words, the fact that a person autonomously agrees to donate her organs fails to ground any autonomy-based moral objection to not removing and using them after the person's death.

I'll argue for the Non-Removal Thesis in a two-step process. First, I'll consider what happens when an individual registers to become an organ donor. I will argue that registering to become a donor is best interpreted as a mere act of authorization whereby an individual gives her consent to the State to remove her organs for transplantation purposes after she has died. Second, given this notion of authorization as giving consent, I'll argue by analogy for the Non-Removal Thesis by considering analogous cases of mere authorization or consent, and suggest that not bringing about a state of affairs to which an individual has consented does not constitute a violation or infringement of her autonomy. By analogy, when families veto an individual's

decision to donate and the individual's organs are not in the end removed, they do not infringe on her autonomy in any morally objectionable sense.

2.2 INTREPETING THE ACT OF DONOR REGISTRATION

Before I begin, some clarifications are in order. One might think that, under an opt-in system, if a person does not register as a donor then her organs will not be removed, even if her family permits it. This is incorrect. In actual medical practice, even if a person has not registered as a donor, doctors will often ask for the donor's family to give consent to organ removal. In addition, if the deceased's family makes it known that the donor did in fact wish to donate, then this often suffices for organ removal as well. These kinds of cases – where no official decision regarding organ removal has been registered – are both important and interesting. However, they are starkly different kinds of cases that present different ethical issues from the cases I am in concerned with.⁵⁰ Thus, in this paper I am only concerned with cases in which (i) a person has officially registered as an organ donor, and (ii) her organs are not in the end removed.

In this section, my goal is to consider what happens when a person registers as an organ donor. In other words, what does a person *actually do* when she registers to become an organ donor? I will argue that the most plausible interpretation of what she does is that, in registering as a donor, a person gives her consent to the State to posthumously remove her organs for transplantation. I will dub this *the Authorization Account*.

⁵⁰ On the topic of family consent to organ removal, see Den Hartogh, "The role of the relatives in opt-in systems of postmortal organ procurement." For an ethical analysis of cases in which a person has not registered as a donor but has indicated to her family that she wishes to donate, see Martin (T.M.) Wilkinson. "Consent and the Use of the Bodies of the Dead." *Journal of Medicine and Philosophy* 2012, 37 (5) 445-463.

According to the Authorization Account, signing up to become a donor essentially involves consenting to the posthumous removal of one's organs for transplantation purposes. The most straightforward evidence for the Authorization Account comes from donor registration documents that use the language of consent. For example, the official website for organ donation in the state of Colorado states that, "By registering as a donor you give legal consent to donate your organs and tissues at the time of your death".⁵¹ In addition, the U.S. Department of Health and Human Services indicates that the donation process begins "when people perform the simple act of indicating their consent to be a donor by enrolling in their state's donor registry."⁵²

Thus, it is clear that donor registration documents seek people's consent to the posthumous removal of their organs for use in transplantation. Therefore, when a person registers to become a donor, the most straightforward interpretation of what they do is that they give consent.

It might be argued that the Authorization Account leaves out something important, namely, that many donors have deep wishes to donate their organs, and hence it is not mere consent that is given by registering as an organ donor. Although it is true that some people who register as organ donors also have a deep wish to donate their organs, this fact is an extrinsic one that is not present in every case of donor registration. Indeed, people who register as donors do so for a variety of reasons. According to the Authorization Account, if someone registers as a donor, all we can conclude from this act is that they have consented to their organs being removed for transplantation purposes. It does not necessarily communicate that they have a deep wish to donate. As an analogy, suppose you want to buy my car. I sign a contract that transfers

⁵¹ "Donate Life Colorado," <http://www.donatelifecolorado.org/register-now/>, accessed August 15 2015.

⁵² Organ Donation: The Process," <http://organdonor.gov/about/organdonationprocess.html>, accessed August 15, 2015.

ownership of my car to you. Now, it might be true that I really want to sell my car to you, or that I wish that you keep my car for many years to come. But all we can conclude from the fact that I signed the contract is that I legally transferred ownership of the car to you. Indeed, this fact, and not the fact that I really wanted you to have my car, is what makes it permissible for you to take the car as your own. I am suggesting something similar for donor registration: when a person registers as a donor, all we can conclude is that she has consented to organ removal.

Another reason to accept the Authorization Account involves a necessary condition on any acceptable interpretation of the act of donor registration. Any plausible interpretation must explain why it is permissible for the State to posthumously remove a person's organs for transplantation purposes if they have officially registered as a donor. The Authorization Account provides a simple and plausible answer: it is permissible to posthumously remove the organs of a registered donor because, by registering, they have given their valid consent to the removal of their organs for transplantation purposes. Consent, on the standard view, waives whatever rights the person has against unauthorized bodily invasions.⁵³ The Authorization Account thus exploits the commonly accepted view that gaining a patient's consent makes the posthumous removal of her organs permissible.

The main alternative to the Authorization Account is a view that sees the act of registration as a form of gift giving.⁵⁴ Thus, *the Gift Account* says that registering as a donor essentially involves gifting one's organs to the State or some other official procurement organization. One might object that the Gift Account is not a genuine alternative to the Authorization account since both involve the giving of consent. This worry is mistaken. Gift-giving necessarily involves

⁵³ Wilkinson, *Ethics and the Acquisition of Organs*; Wilkinson, "Individual and family consent to organ and tissue donation: is the current position coherent?"

⁵⁴ Veatch, *Transplantation Ethics*, 1st edition; Price, *Legal and ethical aspects of organ transplantation*.

features that need not be present when one is merely giving consent or authorizing the use of something that is properly yours. One of these features is that the giving of a gift involves the transfer of ownership of something, but consenting or authorizing that something be used need not involve a transfer of ownership. For example, if I have merely consented to you using my lawn mower, I haven't given it to you in the sense that it is now your property and not mine. But if I give you my lawn mower as a gift, I give it to you in the sense that it is now your property and not mine.

Second, one cannot successfully give a gift without the recipient accepting it, but this is not true for authorizing or giving consent. For example, suppose I take my old coat and offer it to a friend, who rejects the offer. In that case, I have not actually given my friend a gift because he has rejected the offer. However, suppose I tell my friend that I have consented to let him take my coat as his own. In that case, it is true that I have consented to give my friend the coat, even if in the end he turns down the offer. Thus, while giving a gift requires the recipient to accept the gift, giving consent requires no such thing.

Now that I've argued that the Gift Account and the Authorization Account are genuine alternatives, there are two additional features of the Gift Account to consider. First, in normal gift giving, it is assumed that the recipient may do what she wants with the gift once it becomes her property. If I receive a shirt from my sister as a gift, I can cut up the shirt if I please, or I can cut off the sleeves and then wear it. But it would be strange if the State or other procurement organizations were able to do whatever they pleased with people's donated organs. Suppose, for example, that transplantation surgeons removed a donor's organs but instead used them for their personal biomedical research. Although doing this is consistent with the view that in donating one gives a gift, it is tacitly assumed that if one gives organs as a gift, it is expected that they be

used for transplantation purposes. This could be viewed as a form of conditional gift giving: “you may have *X* *only if* you do such and such”. This seems to be an improvement upon the original Gift Account. Registering to become a donor might therefore entail the giving of one’s organs to the State *on the condition* that they are used for transplantation purposes.⁵⁵

The second feature of the Gift Account that we need to consider concerns how to interpret the *time* at which the gift of a person’s organs is actually given. Proponents of the Gift Account must make a choice between two different views of when the gift of a donor’s organs is actually given. On the first view, by signing up to become a donor, a person successfully gives the gift of her organs to the State or the relevant procurement organization; however, although the gift has been *given*, it can only be *used* in the future once the donor has died. Consider how a parent might give her child the gift of a college savings account that can only be used once the child grows up and goes to college. The parent gives the child the gift now, but the gift can only be used at a later time.

Alternatively, on the second view, when a person registers to be an organ donor, they are not giving the State the gift of their organs *now*; rather, the gift can only be given once the registered donor has died. Once the person has died, then the gift can be given and received.

The problem is that, no matter which view we accept, the Gift Account runs into trouble. Consider the first version of the Gift Account. The problem is that in normal gift-giving, once a person successfully gives a gift to another person, it is inappropriate for her to take back what she has given as a gift. For example, if I receive movie passes from my relative as a birthday gift, then my relative cannot simply take back what is no longer hers a day later. The problem,

⁵⁵ For a presentation of this view on conditional gift-giving, see Alida Liberman. “A Promise Acceptance Model of Organ Donation.” *Social Theory and Practice* 2015, 41(1): 131-148.

however, is that people are permitted (and should be permitted) to change their donor status.⁵⁶ Suppose I register to become a donor but then later come to realize that I wish to be buried with my organs intact. In that case, I may change my donor status and this decision will be respected. But the fact that people may change their donor status is inconsistent with the view that one gives a gift when one signs up to become a donor.

One might object and suggest that there are cases in which a person gives a gift but then later changes her mind and takes back the gift. For example, suppose I sign my will, which includes giving 500 dollars to Oxfam after my death. It seems that I am giving a gift to Oxfam, but this is consistent with me later changing my mind and altering the will to not include a 500-dollar gift to Oxfam. Similarly, it can be consistently maintained that a registered donor gives her organs as a gift, but that she may later change her mind and take back the gift. To reply, I suggest that the scenario involving the leaving of 500 dollars to Oxfam is not actually a case of gift giving. What this scenario seems more like is a case of *giving instructions*. In particular, my will gives instructions to the relevant parties on how to dispose of my property and assets. In general, a person can always change her mind about the instructions concerning how to dispose of what is rightfully hers. But the same does not hold for gift giving. Indeed, it would be a strange conception of gift giving if it turned out that every gift giver was able to give a gift to another party and then take it back whenever she pleased.

Let's now consider the second version of the Gift Account. The problem for this version occurs when a registered donor's organs cannot be used for certain medical reasons. For example, a person who has signed up to become a donor may have died in circumstances such that their organs could not be properly preserved for transplantation, and hence their organs will

⁵⁶ This is virtually the argument against the Gift Account given by Liberman, "A Promise Acceptance Model of Organ Donation."

not be used for transplantation. This presents a problem for the second version of the Gift Account. On the Gift Account, a person gives a conditional gift to the State when they register as a donor: remove my organs only if they are used for transplantation purposes. But if a registered donor's organs are not medically viable, then they cannot be used for transplantation purposes. In such cases, then, no gift is successfully given to the State because the sole condition on which the gift may be given, i.e. that the organs be used for transplantation, cannot be satisfied. This implies that registered donors, who turn out to have defective organs for transplantation purposes, did not actually give a gift to the State. But surely all registered organ donors, including those whose organs are not usable for transplantation, have done *something* that has changed the normative status of their situation in relation to the State. This is because, had a registered donor's organs been medically viable upon their death, it would have been morally permissible for the State to remove their organs and use them in transplantation. But the second version of the Gift Account cannot explain this normative change, since, in cases where the person's organs are not viable for transplantation, no gift has actually been given to the State.⁵⁷

The Authorization Account, in contrast, can easily explain the normative change that occurs in situations where the organs of registered donors are not medically viable. On the Authorization Account, even if a registered donor's organs cannot be used, he or she has previously authorized the State to posthumously remove her organs for transplantation purposes; therefore, *had* the person's organs been useable for transplantation, it would have been permissible for the State to remove and use them in transplantation.

Given this second problem for the Gift Account, one might respond by putting forth a

⁵⁷ To reply to this objection, it seems that proponents of the second version of the Gift Account must say that, although a person with defective organs does not actually give a gift, by registering as donors they signal their *intention* to give a gift at a later time. But this response is implausible since signaling an intention to give some thing as a gift to another party is not sufficient for that party to simply take that thing without your consent.

slightly different view, according to which, registering to become a donor involves merely *offering* the gift of one's organs for transplantation purposes. Call this the *Gift-Offer Account*.

On the Gift-Offer Account, a person doesn't actually transfer ownership of her organs to the State or the relevant procurement organization. In contrast, on the Gift Account, a person does transfer ownership of her organs, and this explains why it is permissible for the State to remove and use the organs of someone who has given them as a gift. The problem with the Gift-Offer Account lies in the fact that it does not involve the ownership transfer of one's property to the State. Consider the following analogous case. While conversing, I offer to give you my record collection as a gift. You tell me that you will think it over and get back to me in a couple of days. However, the next night you walk into my room while I am not there and take my records. It seems plausible that you have done something *prima facie* wrong by taking my record collection. And this *prima facie* wrongness remains even given the fact that I *offered* to transfer ownership of my record collection to you. Analogously, the mere fact that a person has offered to give the State their organs as a gift does not have the same normative force as *actually* giving one's organs as a gift. This is because merely offering one's organs as a gift does not involve a transfer of ownership or authority to another party. It seems, however, that the transfer of ownership or authority to the State is precisely what is needed on any gift account in order to make the posthumous removal of organs permissible.

Finally, let's consider a view on which when a person registers as a donor, a *promise* is made between her and the State. What I will call *the Promise Account* can be spelled out in two different ways. On the first interpretation, in registering as a donor, the State promises the individual that her organs will be removed and used *if* they are medically viable for transplantation. On the second interpretation, registering as a donor involves the individual

promising the State that she will donate her organs after death. On this second account, however, a third party, such as a transplantation surgeon, must discharge the promise, since the individual who made the original promise will be dead at the time at which the promise must be discharged.

Both versions of the Promise Account are implausible. Consider the second version of the Promise Account, which says that when an individual registers to become an organ donor, she promises to give her organs to the State if they are medically viable after death. The major problem for this account can be put as follows. By registering as a donor, a person promises the State that a third party will remove her organs after her death. But when a person makes a promise to another party (e.g. the State), this plausibly generates a prima facie obligation to discharge the promise.⁵⁸ In this case, the promise made by the individual generates a duty on her part to posthumously donate her organs. But suppose that a registered donor later decides while alive that she no longer wishes to donate her organs and so she changes her status to a non-donor. In that case, she has made a promise and broken it. By breaking it, she has failed to fulfill a prima facie obligation, and consequently, she has done something prima facie wrong. But it is surely absurd to suppose that a person has done anything prima facie wrong by deciding to change her donor status to a non-donor.⁵⁹ Since this is an implication of the second version of the Promise Account, the account ought to be rejected.

Alternatively, consider the first version of the Promise Account. The view is that, by registering as a donor, the State makes a promise to remove and use a person's organs after their death. The first problem is that it is difficult to see how an action that an individual performs

⁵⁸ See William David Ross. *The Right and the Good*, ed. Philip Stratton Lake. (Oxford: Oxford University Press 2002 (1930)).

⁵⁹ I am assuming here that there is no general duty to sign up to become an organ donor. However, there might be circumstances in which certain people have special duties to donate their organs, either because they entered into a contract with another person, or perhaps because they made a promise to another person that they will donate their organs to them, as in living donation.

(e.g. registering as a donor) entails that an entity distinct from her (the State) has made a promise *to her* about some thing (e.g. to posthumously remove her organs). In general, if some agent A makes a promise to another agent B, then A, rather than B, must do some action that generates the promise. Thus, since it is the individual herself registering as a donor, it is difficult to see how this could be understood as the State making a promise to the donor.

Second, recall that a necessary condition on any acceptable interpretation of donor registration is to explain why it is permissible for the State to posthumously remove a person's organs for transplantation purposes if they have officially registered as a donor. The problem is that a mere promise to remove a donor's viable organs may not be sufficient to permissibly remove them after death. Consider the following analogy. You own a record collection that I very much want. You show me the collection and I leave you a note telling you that I promise to take your record collection from you. Given these details alone, it seems impermissible for me to take the records from you. After all, you never signaled that you accept my promise, nor did you consent to have your records removed from your possession. Thus, my promise to you that I will take your record collection is not sufficient to permissibly take them. By analogy, the promise made to the registered donor on behalf of the State is not sufficient to permissibly remove her organs after death.

It might be argued that, in addition to the State promising to posthumously remove her organs, a person *accepts* the promise that the State makes to her when she registers as an organ donor. Call this the *Promise-Acceptance Account*.⁶⁰ The problem with this account is that it is subject to a similar problem as the second version of the Promise Account, namely, that if a registered donor later changes her donor status to a non-donor, she has thereby accepted and then

⁶⁰ For a similar account, see Liberman, "A Promise Acceptance Model of Organ Donation."

rejected a promise made by the State to her. But accepting a promise and then breaking the terms of that promise is prima facie wrong. Therefore, an implication of the Promise Acceptance Account is that registering as a donor and then changing one's status to a non-donor is prima facie wrong. But surely it is not wrong for a person to register as a donor and then change her status to a non-donor. To illustrate, suppose you are thinking of selling your car to me. I take interest and I promise you that I will buy the car in two days time. You agree to the terms of the promise. Two days later, however, you change your mind and decide not to sell me your car. Since you agreed to the terms of the promise and have now broken that agreement, what you have done is prima facie wrong. Analogously, on the Promise-Acceptance Account, when registered donors change their status to a non-donor, they break the agreement that they made to the State. And if they break this agreement, it follows that what they do is prima facie wrong. However, surely people who are registered donors do not do something even prima facie wrong when they decide to change their donor status to a non-donor. Since this is an implausible entailment of the Promise-Acceptance Account, the account ought to be rejected.

One might argue that, in the car example, breaking the promise to sell your car is not wrong because the car is your property and you can, within reasonable limits, do whatever you please with your property.

Let's grant the objector the claim that, since the car is my property, I have a right to do whatever I want with the car, including breaking the original promise. But it doesn't follow from the fact that I have a right to do whatever I want with my car that therefore it is morally right to break the promise. Indeed, it is still prima facie wrong to break the promise, despite having the right to do so. But notice that, in order for my objection against the Promise-Acceptance Account to succeed, all I need is the claim that the Promise-Acceptance Account entails that it is prima

facie wrong for registered donors to change their status to a non-donor. Therefore, the above objection fails.

Given the problems with both the Gift and Promise Accounts, and given the positive reasons to accept the Authorization Account, I submit that the most plausible interpretation of the act of donor registration is that an individual gives her consent to the State for the posthumous removal of her organs for transplantation purposes.

2.3 THE NON-REMOVAL THESIS AND THE FAMILY VETO

Now that I have argued that the Authorization Account is correct, I am in a position to present an argument from analogy for the conclusion that the Non-Removal Thesis is true.⁶¹ Before I proceed, however, some preliminary points regarding the nature of autonomy and the nature of the family veto are in order.

To understand the autonomy-based objection against the family veto, it is important to briefly discuss the concept of autonomy and how it relates to the case of organ transplantation. It should be noted that although I am not assuming any particular theory of autonomy, it is still possible to get a handle on the concept and what it entails about donors and their choices. Autonomy, most generally, is about self-rule, or living one's life according to one's own values and goals, and without the undue interference of others.⁶² The thought is that people have the

⁶¹ One might wonder whether the Gift-Account supports the Non-Removal thesis, in which case the discussion concerning the Authorization and Gift Account would have been unnecessary. First, I should note that whether the Gift Account supports the Non-Removal thesis is irrelevant because I've argued that the Gift Account is an implausible account of what happens when a person registers as an organ donor. Since the Gift Account is false, whether it supports the Non-Removal thesis is not relevant for my purposes. However, let's suppose for the sake of argument that the Gift Account were true. How would that affect the Non-Removal Thesis? I think the Non-Removal Thesis would still be a plausible thesis, assuming that the Gift Account is true. This is because, the State does not seem to be morally obligated to accept the donor's gift of her organs, just as I am not morally obligated to accept a gift from someone who attempts to give me one.

⁶² See chapter 4 in James Childress and Tom Beauchamp. *The Principles of Biomedical Ethics*, 6th edition.

right to craft their life goals and plans in the way they see fit, and to carry out these goals and plans so long as they do not wrong others in the process.⁶³ In the most general terms, a person's autonomy can be violated if others interfere with her choices or if they impose a set of goals and plans that is not the person's own.

People have an interest in what happens to their organs after they die. They have wishes that they be buried intact and wishes that their organs be removed and used in transplantation or research. Insofar as people have wishes about how their organs are used, whether a person's organs are used for transplantation purposes seems directly relevant to her self-chosen life plan and whether it has been respected or interfered with by others. For example, if I promise a loved one that I will not allow her organs to be posthumously removed, and I allow them to be removed, I have failed to respect her life-plan and I have thus violated her autonomy. Opponents of the family veto claim that the family's interference in the donor's decision to donate her organs similarly violates her autonomy because it violates her right to live her life in accordance with a particular life-plan, which includes donating her organs for transplantation purposes.⁶⁴

There is, however, a reason to be skeptical about applying the concept of autonomy to deceased organ donors.⁶⁵ One might argue that once a person loses the capacity to be an autonomous decision-maker -- in this case, because she has died -- then it no longer makes sense to appeal to her autonomy when we fail to honor her choices. Thus, to claim that it is a violation of the dead donor's autonomy when her organs are not removed against her wishes seems to be a

(New York: Oxford University Press, 2009).

⁶³ For discussion, see Wilkinson, *Ethics and the Acquisition of Organs*: Chapters 2 and 4.

⁶⁴ Speaking of the right to make autonomous decisions about one's body, Walter Glannon, for example, claims: "So if a person clearly indicated that he did not want his organs procured for transplantation after his death and they were procured, this action would thwart his wish, violate his right and wrong him. A person's wish would also be thwarted, his right violated and he would be wronged if he indicated that he wanted to donate his viable organs and the transplant team failed to procure them". See Glannon, "Taylor on Posthumous Organ Procurement," p. 637.

⁶⁵ Thanks to an anonymous reviewer for bringing this problem to my attention.

mistaken way of characterizing the situation. In other words, since the dead donor is no longer autonomous, we can no longer sensibly speak of her autonomy being violated by the decisions of others.

While this line of criticism is initially compelling, there is a possible reply to this objection that mirrors the reply to an important objection to the notion of posthumous harm. To begin, imagine that Laura has a strong desire that her children have successful careers when they grow up. However, because of her terminal illness, Laura dies when her children are relatively young. Many years later, however, Laura's children all lose their jobs and end up bankrupt. Thus, Laura's desire that her children have successful careers is frustrated. Given her frustrated desire, has Laura been harmed? Opponents of posthumous harm argue that Laura has not been harmed because, although her desire has been frustrated, there is no subject of the harm. Since all harms require subjects, and since Laura is deceased, no harm has occurred. Call this the No-Subject problem.

In a now famous paper, George Pitcher attempted to solve the No-Subject problem by drawing a distinction between the post-mortem self and the ante-mortem self.⁶⁶ The post-mortem self refers to the rotting corpse in the grave; a mere rotting body. By contrast, the ante-mortem self refers to the alive and existing person. Pitcher argues that when Laura's wish is frustrated after her death, the harm does not attach to post-mortem Laura, since post-mortem Laura is nothing but a rotting corpse. Rather, when Laura's wish is frustrated after her death, the harm attaches to Laura, the ante-mortem person; that is, the harm attaches to Laura when she was alive and had the desire that her children have successful careers. On Pitcher's view, "the sense in which an ante-mortem person is harmed by an unfortunate event after his death is this: the

⁶⁶ George Pitcher. "The Misfortunes of the Dead." *American Philosophical Quarterly* 1984, Vol. 21 No 2: 183-188.

occurrence of the event makes it true that during the time before the person's death, he was harmed -- harmed in that the unfortunate event was going to happen".⁶⁷ Thus, the fact that Laura's children have failed careers makes it true that the ante-mortem Laura was indeed harmed.

A similar response can be crafted in reply to the charge that it makes little sense to speak of a deceased person's autonomy being violated since the deceased are not autonomous beings. Suppose Julio very much wants his organs donated and when he dies, his organs are usable but they are not removed. If we accept Pitcher's reasoning above, the fact that Julio's organs were not used makes it true that ante-mortem Julio's wish was frustrated, and hence, ante-mortem Julio's autonomy was violated.

Note that it is not my concern in this paper to assess whether this reply is ultimately successful. However, the reply does show that there is at least one prima facie plausible way to think about posthumous autonomy violations. Although I am overall sympathetic to the worry that it makes little sense to talk about the autonomy of the deceased being violated, I believe it is more productive, from an argumentative standpoint, to meet opponent's of the family veto on their own terms. That is, we should assume, for the sake of argument, that it makes sense to talk about posthumous autonomy violations and then argue that it is still not the case that the family veto violates the deceased's autonomy.

Now that I have granted the idea that there can be posthumous autonomy violations, we should briefly explore the nature of the family veto. What exactly do families do when they veto a donor's recorded decision? It should be noted at the outset that, in many countries, the family has no legal power to block a donor's decision to donate, unless the family provides credible

⁶⁷ Pitcher, "The Misfortunes of the Dead," p. 187.

evidence that the patient had changed her mind about donation since signing up to be a donor.⁶⁸ Legally, doctors are permitted to ignore the family's veto and procure organs from a registered donor anyway. However, when a registered donor has viable organs that can be removed for transplantation, most doctors will, as a matter of practice, consult the donor's family on their preferences about donation. If the families have a strong preference against donating their family member's organs, doctors will typically act in accordance with the family for various political and practical reasons.⁶⁹ Thus, the family veto is better understood as the stating of a preference against donation, and doctors in practice either act against or in accordance with that preference. This understanding of the family veto as the stating of a preference against donation will play an important role in constructing my argument from analogy below.

To begin, consider the following case. Brenda has a spare car that she never uses, so one day she tells Ana that if she ever needs to use the spare car for something, she is allowed to do so. A year passes when one day Ana is babysitting a client's child and the child accidentally poisons herself by drinking a mislabeled jar of liquid. The child needs immediate medical attention or else she will surely die. Ana does not own a car but she remembers that Brenda granted her permission to use her spare car for whatever reason. Ana entertains taking Brenda's car to the hospital, but in the end she does not borrow the car. As a result, the child dies under Ana's care.

It seems clear that Ana has done something wrong by failing to take Brenda's car to the hospital. However, the wrongness of her act plausibly consists in the fact that she failed to save the life of the child under her care when it was relatively easy to do so. It seems equally clear,

⁶⁸ Wilkinson, *Ethics and the Acquisition of Organs*; Price, *Legal and ethical aspects of organ transplantation*.

⁶⁹ Wilkinson, "Individual and family consent to organ and tissue donation: is the current position coherent?"

however, that the wrongness of Ana's actions does not consist in the fact that she violated Brenda's autonomy by not borrowing her spare car. The moral innocence of Ana's actions towards Brenda's autonomy seems to be captured by the general moral principle that failing to bring about a state of affairs that someone has merely consented to is not a morally objectionable violation of their autonomy. Call this the Consent-Autonomy Principle.

That the Consent-Autonomy Principle is true is confirmed by examples in other contexts. For instance, if I decide to give my old coat away by leaving it on the side of the dumpster, I have relinquished my claim to the coat and have thus consented to others taking the coat. But the mere fact that I consented to others taking the coat does not generate an obligation on the part of other people to take the coat. The fact that someone fails to take the coat does not constitute a morally objectionable violation of my autonomy. Similarly, if I consent to my friend using my lawn mower, it doesn't follow that she now has an obligation to borrow the lawn mower. Her failing to borrow the lawn mower would not constitute a morally objectionable act of failing to respect my autonomy.

One might argue that perhaps Ana has a special obligation towards Brenda to borrow her car, and hence, failing to borrow the car would be violating this special obligation. The problem is that the sorts of actions that would normally generate special obligations are entirely absent from the Brenda and Ana case: Ana has made no promises towards Brenda, nor has she entered into an implicit or explicit contract with Brenda that could generate such a special obligation. The same, I suggest, is true for failing to remove organs from a person who has merely given their consent to organ removal. If potential donors give the State permission to posthumously remove their organs and doctors decide not to take the organs because of the family's preferences, they do not violate the autonomy of the registered donor in any morally significant

way. This is the case for precisely the reason offered above in the case of Brenda and Ana: that failing to bring about a state of affairs (in this case, posthumous organ removal) that someone has merely consented to is not a morally objectionable violation of their autonomy.

One might object that the difference between failing to procure organs from a patient who has consented and the case of Ana failing to borrow Brenda's car is that in the former, there is the *expectation* on the part of the patient that her organs will be taken and used in transplantation. After all, when patients consent to posthumous organ removal, it's plausible that many of them expect their viable organs to be posthumously removed if they do give their consent to organ removal.

Although this objection appears superficially plausible, this initial plausibility evaporates when we consider analogous cases. To borrow two examples already discussed above: If I decide to leave my coat by the dumpster so that it can be picked up by someone who needs it, the fact that I expect someone to pick it up doesn't mean that my autonomy has been disrespected or violated if it happens to turn out that nobody picks up the coat. Or, suppose I permit my neighbor to borrow the lawnmower and I expect her to borrow it as well; my neighbor failing to borrow the lawnmower does not seem to constitute a failure to respect my autonomy, even assuming that I expected her to borrow it.

Secondly, a critic might object that the case of Brenda and Ana is dis-analogous from organ procurement because the Brenda-Ana case is a transaction involving two parties. However, organ procurement is more accurately viewed as involving three parties: the donor, the State (or transplantation physician), and the donor's family. What happens is that a donor gives her consent to the State to posthumously remove her organs; then the doctor seeks the family's preferences about donating the patient's organs and then either acts against or in accordance with

those preferences. I suggest that correcting for this dis-analogy makes no difference to our assessment of whether Ana violates Brenda's autonomy in a morally objectionable sense.

Consider, then, the following variation of the Brenda-Ana case. As before, Brenda has a spare car that she never uses, so one day she tells Ana that if she ever needs to use the spare car for something, she is allowed to do so. However, Brenda's parents are also present and they tell Ana that since the car has been in their family for such a long time, they strongly prefer that the car not ever be borrowed. A year passes when one day Ana is babysitting a client's child and the child accidentally poisons herself by drinking a mislabeled jar of liquid. The child needs immediate medical attention or else she will surely die. Since Ana doesn't have a car, she remembers that Brenda granted her permission to use her spare car for whatever reason. Ana gives taking Brenda's car to the hospital some thought, and she also considers that Brenda's parents have a strong preference against anybody borrowing the car. In the end, Brenda decides not to borrow the car. As a result, the child dies under Ana's care.

Again, it seems clear that Ana does not fail to respect Brenda's autonomy by not taking the car. After all, Brenda has only granted Ana permission to borrow the car, and since the Consent-Autonomy Principle is true, failing to borrow Brenda's car is not a morally objectionable violation of her autonomy. Thus, by analogy, when doctors fail to remove a patient's organs in part because of the family's preferences against donation, neither the doctor nor the patient's family fails to respect the patient's autonomy in any morally objectionable sense.

One might object that the argument from analogy presented above is illegitimate because it involves a person's property, i.e. Brenda's car, but organs are not a person's property. But this objection is not plausible. First, this objection assumes the relatively controversial position that

organs are not one's property. This claim is not obvious, nor is there a consensus on it in the literature. Indeed, rights over organs have been called "quasi property rights."⁷⁰ Second, let's assume that organs are not one's property. Even so, merely citing that organs are not one's property is not sufficient to refute the argument from analogy presented above. For it needs to be explained why the fact that organs are not one's property is morally relevant so as to make the analogies I present illegitimate. That is, it needs to be shown that there is a morally relevant difference between one's organs and one's property that makes us unable to draw a moral conclusion about the former from the latter.

Next, one might object that, despite what the Ana and Brenda case shows, there are other cases analogous to the family veto in organ procurement which show that not honoring the decision of the donor is in fact a wrongful violation of her autonomy. Consider *the Clothing Case*: Imagine that 75 percent of people in a small town endorse the idea of leaving clothes at a clothing shelter for the poor and needy of the town. But one person, call him Rick, dislikes this practice because he thinks it encourages dependence and so he takes the clothes donated at the clothing shelter and buries them in the ground to rot. Now, surely what Rick does is wrong, and one reason it is wrong is that both the social autonomy of the community that created and endorsed this practice and the personal autonomy of each clothing donor, is violated. Since this case is analogous to the organ transplantation case, it follows that the donor's autonomy is also violated when the family vetoes her decision to donate her organs.⁷¹

My reply is to first offer a couple reasons for thinking that the Clothing Case and the organ transplantation case are not analogous. Second, given the disanalogies identified, I will tighten the analogy that allegedly holds between both cases, and this will show that the Clothing

⁷⁰ Price, *Legal And Ethical Aspects of Organ Transplantation*, p. 126

⁷¹ Thanks to an anonymous reviewer for bringing this case to my attention.

Case does not, after all, involve a wrongful violation of the clothing donors' autonomy, and hence, it does not show that the organ donor's autonomy is violated when her organs are not removed because of her family's wishes against donation.

First, it seems we have the intuition that what Rick does in the Clothing Case is wrong because he seems to be engaging in either theft or something morally akin to theft. Since theft is *prima facie* wrong, what Rick does is *prima facie* wrong, and this might plausibly explain our negative evaluation of Rick's behavior. By contrast, in organ transplantation, the family is neither stealing, nor doing something akin to stealing, from the donor. Instead, they are merely expressing a preference that the deceased's organs not be taken, and in the end, the doctors decide to either take or not take the organs. This is the first way in which the Clothing Case and the organ transplantation cases are disanalogous.

Second, whether the Clothing Case successfully tells against my main argument depends on what is meant by the term "endorsed". When we say that 75 percent of the population endorse the clothing-shelter practice, does that mean that 75 percent have a preference for donating their clothes, that 75 percent of the population really, really want to donate their clothes, or that 75 percent of people in the town consent to their donated clothes being taken by those in need? If the clothing shelter case is truly analogous to organ transplantation, then to claim that 75 percent of people endorse the clothing shelter practice must mean that 75 percent *consent* to their donated clothes being taken by those in need. The way in which the Clothing Case was originally presented seemed to suggest that endorsing the practice meant something different than merely consenting to the practice, perhaps something like having a deeply rooted wish for the clothes to be taken. However, as I argued in the first half of the paper, the act of donor registration is most

plausibly interpreted as an act of mere consent that the State may use one's organs for transplantation purposes. Thus, the Clothing Case needs to be interpreted in the same manner.

Now, given the above two points, let's re-state the Clothing Case: In a small town, 75 percent of people consent to having their extra, donated clothes taken by the needy at a clothing shelter. As a result, 75 percent of people leave their old clothes by their trash bins for them to be taken by the shelter workers. On the other hand, 25 percent of people in the town do not consent to their extra clothes being taken by the needy, but they tolerate the fact that others in the town do it. However, there is a man named Rick who does not really like the idea of the needy taking clothes from the clothing shelter. Consequently, Rick sets up a small protest sign at the clothing shelter site, which expresses his preference against the clothing shelter's practices. Indeed, he even tells some people that he does not want them to take the clothes because it encourages dependence. Some see Rick's sign, disregard it, and take clothes anyway. Others see the sign and decide that they will not take any clothes after all.

Now, it does not seem like what Rick does violates the autonomy of the people who both donated clothes and whose clothes were not in the end taken. He is merely expressing a preference against the clothes being taken and people are free to act against or in accordance with that preference by taking the clothes or not taking the clothes. In addition, it's important to keep in mind that the people who donated the clothes merely consented to have the clothes taken. If they merely consented to the clothes being taken and the clothes were not in the end taken, this is not a wrongful violation of their autonomy. Indeed, suppose that all the donated clothes were purple, but that the needy collectively hated purple, and so they all decided not to take any of the clothes. This would clearly not be a violation of the clothing donors' autonomy.

Finally, one might point to real life cases that seem sufficiently similar to the cases I have been considering, but which show that the donor's autonomy has in fact been violated by the decisions of the family. Consider, for example, a case in which a family decides to donate the organs of their deceased loved one, even though they know with absolute certainty that this individual was utterly opposed to organ donation. This, the objection goes, would surely constitute a wrongful violation of the deceased's autonomy.

For the sake of argument, let's grant that the family's actions in this case *would* be a wrongful violation of the deceased's autonomy. Despite this, the case is disanalogous from the original case in two important ways. The case under dispute is one in which the family removes the organs of a patient who (i) did not previously consent to such removal and (ii) was known to oppose organ donation. So it's a case in which a person's body is invaded without their consent. That the person's body was invaded without her consent seems to be a wrongful violation of her autonomy. But this consideration is completely absent in the cases that I have focused on: that is, in the original cases under dispute, no organs are removed without the person's consent. Rather, their organs are simply not removed even though the deceased previously consented to their removal.

The second disanalogy is that this current case is one in which the patient has a deeply rooted wish to have their organs left intact. If the family knows this and does the opposite, this is plausibly construed as a violation of her autonomy. But in the cases originally under dispute, it is assumed that all registered donors have done is given their consent to organ removal. They have not expressed a deeply rooted wish to donate their organs. Thus, if consent is all that has been given, and the organs are not removed because of the family's preference against donation, this is not a violation of the deceased's autonomy.

Now consider a different kind of case, one in which the now deceased individual is an avowed atheist who very much wants to donate in order to save the lives of others at risk of premature death. Imagine that her family refuses to permit the donation because they have a religious perspective as a basis for their refusal to donate. In this case, it seems clear that the family violates the autonomy of their deceased family member.

My reply to this religious case is the same as the second reply to the above case. That is, even if the family's refusal in this case is a wrongful violation of the deceased's autonomy, this case is disanalogous from the organ removal cases under dispute because it is one in which the person has a very deeply rooted wish to donate her organs, yet this deep wish is not honored. Indeed, suppose the religious person did not have a deeply held wish to donate but instead merely consented to the use of her organs by signing a donor card. In that case, as I have argued, it would not be a wrongful violation of her autonomy if her organs are not removed because of the family's preference against donation.

This concludes the defense of my argument from analogy for the Non-Removal Thesis.

2.4 CONCLUSION

In this paper I argued that the Authorization Account is the most plausible interpretation concerning what happens when a person registers as an organ donor. Next, I argued by analogy for the Non-removal Thesis, i.e. the view that not removing a patient's organs in part because of the preferences of their family does not fail to respect the donor's autonomy in any significant sense. Thus, if a person has registered to become an organ donor and her family's preference against donation leads transplantation physicians to not remove the person's organs, this is not a morally objectionable violation of the deceased's autonomy.

What my argument shows is that the family veto problem is not a problem about the donor's autonomy and the family's failure to respect it. Rather, the fundamental issue with the family veto problem is that too many useable organs are not removed because the family does not want them removed, and hence, many patients on the transplantation waiting list suffer or die when they would have been given a second lease on life had the organs been used. Indeed, in the United States, there are currently 120,000 men, women, and children on the organ transplantation waiting list. 8,000 of these patients die every year due to not receiving a new organ in time.⁷²

This practical problem does, however, raise some interesting theoretical questions. Among these is whether the family's autonomy, in deciding what happens to their loved one's organs, outweighs the needs of those on the waiting list. Since autonomy is considered a sacrosanct value in contemporary bioethics, arguably outweighing every other value including beneficence and non-maleficence, it might be the case that we ought to respect the family's wishes, even at the cost of not saving lives. One potential argument for this position is that, since individuals have the right to choose to not have their organs donated, and hence, the right to not save the lives of patients on the waiting list, then perhaps the families of the deceased who have merely consented to organ removal also have the right to choose not to donate their loved one's organs to help others on the waiting list. Although I do not have the space here to consider whether this argument succeeds, it is at least one prima facie plausible argument in favor of the claim that the family's autonomous decision outweighs the needs of patients on the waiting list.⁷³

⁷² See "Organ, Eye, and Tissue Donation Statistics," <https://www.donatelife.net/statistics/>, accessed May 25th, 2016.

⁷³ I'd like to thank David Boonin, Eric Chwang, and two anonymous reviewers for Social Theory and Practice for their helpful comments on this paper.

Chapter 3

Consent and Cadavers

3.1 INTRODUCTION

There are currently 120,000 people in the United States who are awaiting a new organ for transplant.⁷⁴ Given the shortage of donor organs, most of these patients will either die or continue to live lives of far less quality than they would have with a new organ. Indeed, around 8,000 patients a year die because they do not receive a new organ in time.⁷⁵ Thus, the problem of organ shortage is a serious one. But how do we retrieve more donor organs in an ethically acceptable manner? Since most organs come from deceased individuals, part of answering this question requires answering a further question: how do we retrieve organs from deceased individuals in a way that is morally acceptable? A key issue that bioethicists have focused on in regard to answering the latter question is whether obtaining a patient's consent before her organs are removed is a moral requirement or obligation. According to what I call the consent requirement, in order to permissibly remove organs from a deceased person, it is necessary that her prior, actual consent be obtained.⁷⁶ This paper considers the consent requirement in connection with the

⁷⁴ "Organ, Eye, and Tissue Donation Statistics" <https://www.donatelife.net/statistics/>. Accessed Dec 12, 2016.

⁷⁵ Ibid.

⁷⁶ For discussion of the consent requirement see, Delaney, J. and D. Hershenov 2009, "Why Consent May Not Be Needed For Organ Procurement" *American Journal of Bioethics* 9 (8): 3–10; Kluge, E.-H. 2000. "Improving organ retrieval rates: Various proposals and their ethical validity." *Health Care Analysis* 8: 279–95; Wilkinson, T.M. 2012. "Consent and the Use of the Bodies of the Dead." *Journal of Medicine and Philosophy* 37 (5) 445-463; Wilkinson, T.M. 2011. *Ethics and the Acquisition of Organs* (Cambridge: U.K.: Cambridge University Press); MacKay, Douglas, 2015. "Opt-out and consent" *Journal of Medical Ethics* 0: 1-4.

requirements and procedures for obtaining consent to organ donation that are currently legally implemented in the United States.

The United States (with a few exceptions), along with England and Scotland, operate under an opt-in procurement policy. Under opt-in procurement policies, people are given the opportunity to voluntarily “opt-in” to organ donation. In the U.S., this is done at the Department of Motor Vehicles (DMV) in the process of obtaining or renewing a driver’s license, and via various online donor databases.⁷⁷ Some U.S. states, such as Illinois and New York, operate under a Mandated Choice policy. Under Mandated Choice policies, people are presented with the choice to become an organ donor or not and are required to make a decision in order to obtain a new driver’s license.⁷⁸ One might assume that under the U.S.’s opt-in policy, the only conditions under which a person’s organs will be removed is when the individual herself registers as an organ donor. This assumption is mistaken. According to the U.S. Revised Uniform Anatomical Gift Act, in order for a person’s organs to be posthumously removed, she *or* her next of kin must give explicit consent that they may be removed. Thus, U.S. law permits organ removal even in cases in which the individual herself does not consent. However, even if the law permits organ removal without individual consent, it doesn’t follow that doing so is morally permissible.

In this paper, I consider the consent requirement and argue that it is false. I argue that it is not a moral requirement to obtain a patient’s consent before removing her organs. This

⁷⁷ See Spital A. 1999. “Obtaining consent for organ donation: What are our options?” *Balliere’s Clin Anaesth* 13:179-193; Wendler D, Dickert N. 2001. “The consent process for cadaveric organ procurement. How does it work? How can it be improved?” *JAMA* 285:329-333.

⁷⁸ Spital, A. 1995. “Mandated Choice: A Plan to Increase Public Commitment to Organ Donation” *JAMA* 273 (6): 504-506.

conclusion has broader implications for future procurement policy, for if the obtaining of patient consent is not strictly required by respect for autonomy, then we can develop or adopt new procurement policies that do not seek patient consent. In addition, I will argue that the kind of consent that is currently sought by procurement policy in the United States is not sufficient to respect patient autonomy. This implies that *if* the current policy for obtaining consent is to remain, it ought to be revised in a way that sufficiently respects patient autonomy.

Before I begin, however, some preliminary remarks are in order. First, this paper explores the ethical rather than legal merits of current consent policies. However, this does not mean that the arguments presented here have no bearing on law and policy. Second, since opt-in systems seek people's explicit consent via a formal mechanism such as registering as a donor via the online donor database or at the DMV in the process of obtaining a driver's license, I will be assuming in this paper that consent is not a mental state of mere approval or a mental state of mere desiring or wishing. Consent, as I will be using the term in this paper, refers to a public, autonomous act of authorization, whereby one party authorizes another party to perform some action or series of actions.⁷⁹ This means that consenting that P and wishing or desiring that P are distinct. Third, since U.S. law permits the family to consent to organ removal even if the individual has not officially consented, I will put to the side the question of whether a deceased individual's family has the authority to authorize the posthumous removal of her organs.⁸⁰ This is largely for convenience and scope, since the topic of family consent is controversial and opens a wide variety of ethical difficulties that aren't present in the individual consent case.

⁷⁹ Kleinig, John. 2010. "The Nature of Consent" in *The Ethics of Consent*, eds. Franklin Miller and Alan Wertheimer (Oxford: Oxford University Press); Wertheimer, A. 2003. *Consent to Sexual Relations* (Cambridge, UK: Cambridge University Press), pp. 144-52.

⁸⁰ Wilkinson, T.M. 2005. "Individual and family consent to organ and tissue donation: is the current position coherent?" *Journal of Medical Ethics* 31: 587-590; den Hartogh, G. 2012. "The role of the relatives in opt-in systems of postmortal organ procurement." *Med Health Care and Philosophy* 15:195-205.

3.2 RESPECT FOR AUTONOMY AND ORGAN DONATION

Requiring consent before invasive medical interventions take place has traditionally been justified by appealing to the principle of respect for patient autonomy.⁸¹ According to the principle of respect for autonomy, we ought to allow, and when appropriate, enable patients to make autonomous decisions about their medical care.⁸² It is natural then, to consider the principle of respect for autonomy in relation to consent requirements within organ procurement policies. One way to do this is to consider people's moral rights that are grounded in their status as autonomous persons and ask whether these rights require the obtaining of consent before organ removal can permissibly take place.⁸³ If people have moral rights against bodily invasions without consent, then this generates a duty to not invade their bodies absent their consent. However, I believe that there are plausible arguments, such as those given by Wilkinson (2012) and Gill (2004), which suggest that dead organ donors do not have a right against bodily invasion without consent.⁸⁴ Thus, in this paper, I will not focus my discussion on whether people's rights require that we obtain their consent before removing their organs. Instead, I will focus on the principle of respect for autonomy and argue that the obtaining of patient consent before posthumous organ removal takes places is not necessary to respect patient autonomy.

So what does it mean to respect patient autonomy? Most generally, to respect a patient's autonomy regarding some medical decision involves allowing a person to make a decision about

⁸¹ Childress, J. 1990. "The Place of Autonomy in Bioethics" Hastings Center Report, January/February; Childress, J. and T.L. Beauchamp. 2009. *The Principles of Biomedical Ethics*, 6th edition. New York: Oxford University Press, p. 118; Faden, R.R., and T.L. Beauchamp. 1986. *A History and Theory of Informed Consent*. New York: Oxford University Press, ch. 7.

⁸² Childress, J. and T.L. Beauchamp. 2009. *The Principles of Biomedical Ethics*, p. 118.

⁸³ See, for example, Wilkinson, T.M. 2011. *Ethics and the Acquisition of Organs*; Wilkinson, T.M. 2012. "Consent and the Use of the Bodies of the Dead"; Delaney, J. and D. Hershenov. 2009. "Why Consent May Not Be Needed For Organ Procurement."

⁸⁴ Wilkinson, T.M. 2012. "Consent and the Use of the Bodies of the Dead"; Gill, Michael B. 2004. "Presumed consent, autonomy, and organ donation." *Journal of Medicine and Philosophy* 29 (1): 37-59.

her medical care, and, when appropriate, enabling her to make that decision.⁸⁵ To understand this claim, we must get sufficiently clear on the nature of autonomous action, or what it means to act autonomously. Second, given a sufficiently clear understanding of autonomous action, it is necessary to clarify what is required of medical personnel in respecting a patient's autonomous decision to donate her organs.

An ideal starting point would be to advance a specific theory of autonomous action that is widely agreed upon in the philosophical and biomedical literature. Unfortunately, no such agreement exists. Instead, it is useful to proceed by noting what most thinkers writing on autonomy do agree upon. These conditions should be understood as necessary but not necessarily sufficient conditions for autonomous action. Thus, to act autonomously requires at least two necessary conditions: (1) Liberty, or freedom from controlling influences and (2) agency, or the capacity for intentional action.⁸⁶ Thus, on this view, a person S acts autonomously with respect to some action A only if S does A intentionally and S's performing of A is free from controlling influences (such as coercion).

While these two conditions are a decent starting point, they are clearly not sufficient to account for autonomous action. Indeed, autonomous action in a medical context seems to involve more than mere liberty and intentional action. This is because medical contexts – like research contexts -- present patients with many situations for which they are not equipped to make meaningful choices without assistance from a physician or other medical personnel. Consider, for example, a patient making a choice between three different treatment options, each of which she knows little or nothing about. Such a patient could surely make a choice about which

⁸⁵ Childress, J. and T.L. Beauchamp. 2009. *The Principles of Biomedical Ethics*, pp. 103-104.

⁸⁶ Childress, J. and T.L. Beauchamp. 2009. *The Principles of Biomedical Ethics*, p. 100; Faden, R.R., and T.L. Beauchamp. 1986. *A History and Theory of Informed Consent*, p. 238.

treatment option to pursue that is both intentional and free from controlling influences, yet, given her lack of knowledge and understanding about each treatment option, she would be unable to make an informed, autonomous choice about which treatment option to pursue. To remedy this problem, we need a better account of autonomous action that is better suited for medical decision-making. In their influential analysis of autonomous action, Ruth Faden and Tom Beauchamp argue that autonomous action involves “normal choosers who act (1) intentionally (2) with understanding, and (3) without controlling influences that determine their action”.⁸⁷ Thus, what was missing from the earlier account of autonomous action was the requirement that a person act with understanding. To act with understanding essentially involves having acquired pertinent information and to have relevant beliefs about the nature and consequences of one’s action.⁸⁸ Thus, if a person has understanding regarding some action or intervention I, she has acquired pertinent and potentially material information about I, and has relevant beliefs about the nature of I, along with its potential risks and benefits. Now, it is important to point out that acting with complete understanding is too ideal for any real-world application of autonomy. Thus, a person need only act with a sufficient degree of understanding in order to satisfy the understanding requirement on autonomous action.⁸⁹ What constitutes sufficient understanding should be determined on a case-by-case basis. It is not necessary, for example, for patients to acquire every single fact about organ donation, nor do they need to have beliefs about every such fact.

⁸⁷ Faden, R.R., and T.L. Beauchamp. 1986. *A History and Theory of Informed Consent*, p 238.

⁸⁸ Childress, J. and T.L. Beauchamp. 2009. *The Principles of Biomedical Ethics*, p. 127.

⁸⁹ As Childress and Beauchamp explain, “A person’s appreciation of information and independence for controlling influences in the context of health care need not exceed, for example, a person’s information and independence in making a financial investment, hiring a new employee, buying a new house, or deciding to attend a university” (2009, 101).

Given the account outlined above, respecting a patient's autonomous decision to donate her organs involves not only allowing her to make a decision about organ donation, but ensuring, as far as possible, that her decision is intentional, free of controlling influences, and done with sufficient understanding. But how does the notion of consent figure into this understanding of respect for autonomy? One plausible suggestion is that requiring consent would enable people to make their own decisions about organ donation. This is because a person's organs would not be taken unless she authorized them to be taken. By contrast, under a policy such as presumed consent, we would not be required to obtain a person's actual consent; rather, we would simply presume that they consent if they fail to opt-out of organ donation. Thus, if part of respecting autonomy involves allowing people to make decisions for themselves, one has good reason to prefer a procurement policy where individual consent is required as opposed to one where it is not required.

In the next section, I will argue that obtaining actual consent is not required to respect people's autonomy. I will focus on the kind of consent that is sought by U.S. procurement policy, and argue that consent is not required to respect patient autonomy because there are other ways to respect patient autonomy without the obtaining of actual consent. Before I move on, however, I'd like to briefly consider an objection that might be lingering in the reader's mind. The objection is this: is respect for autonomy really the right framework to think about the consent requirement within post mortem organ procurement? Since organs are removed from dead patients, in what sense can we apply the respect for autonomy framework if the people we are applying it to are no longer autonomous? As Jonsen (1988) remarks, "consent is ethically important because it manifests and protects the moral autonomy of persons . . . [and] it is a barrier to exploitation and harm. These purposes are no longer relevant to the cadaver which has

no autonomy and cannot be harmed.”⁹⁰ The key assumption of this general worry seems to be that, if an individual is no longer autonomous, then it is not the case that their autonomy can be respected or disrespected. But this assumption is false. Consider permanently incompetent patients, such as those in a coma or in persistent vegetative state. Suppose a patient in a permanently incompetent state had previously filled out an advance directive which stipulated that, under the conditions she is in now, she does not want to be given life-saving treatment in the event of suffering from a life-threatening illness. In this case, even if this patient is not currently autonomous, acting in accordance with her advance directive seems to respect her autonomy because it satisfies her desires about what she wants done to her. Thus, if a permanently incompetent person can have their autonomy respected or disrespected, then a deceased organ donor can as well. It is thus false that if an individual is no longer autonomous, then it is not the case that their autonomy can be respected or disrespected. The objection therefore fails.

3.3 (MERE) CONSENT AND ORGAN DONATION

In medical contexts, seeking a patient’s consent to some procedure usually means seeking her informed consent. Thus, it is necessary to begin by distinguishing giving one’s *mere consent* and giving one’s *informed consent* to some procedure or intervention. Mere consent is a technical term that denotes what occurs when a person merely authorizes that some medical intervention takes place. This is done either verbally, in writing, or via some other appropriate method. For example, suppose Oscar goes to the doctor’s office seeking a vasectomy. If the doctor fails to explain the procedure, along with its risks and benefits, and simply acquires

⁹⁰ Jonsen AR. 1988. “Transplantation of fetal tissue: An ethicist’s viewpoint.” Clin Res 36:215-219.

Oscar's authorization for the procedure, then the doctor has obtained Oscar's mere consent. Mere consent is distinct from informed consent because informed consent requires several different conditions to be legitimately given, whereas mere consent only requires that a person authorize or give permission to the relevant personnel that some medical intervention take place. To see this, consider the influential analysis of informed consent developed by Ruth Faden and Tom Beauchamp:

Action X is an informed consent by person P to intervention I if and only if

1. P receives a thorough disclosure regarding I,
2. P comprehends the disclosure,
3. P acts voluntarily in performing X,
4. P is competent to perform X, and
5. P consents to I.⁹¹

For Faden and Beauchamp, each element in the above list is jointly necessary and sufficient for someone to give an informed consent to some intervention. By contrast, giving mere consent to some procedure involves only doing the fifth condition outlined in Faden and Beauchamp's analysis of informed consent.

Organ procurement policies in the United States seek patients' *mere consent* rather than informed consent. In the United States, when a person formally registers as an organ donor in the process of obtaining or renewing a license at the DMV, she is only required to check a box or sign a document, indicating her consent to be a donor. Typically, these documents contain no

⁹¹ Faden, R.R., and T.L. Beauchamp. 1986. *A History and Theory of Informed Consent*, p. 275.

disclosure of information regarding the nature of organ procurement, its implications for one's end of life care, one's family, and those on the waiting list. In addition, when registering to be an organ donor on the Internet, it is very common for one to give one's consent to organ removal merely by filling out one's personal information, and ticking a box. Often, as is the case with registering as a donor at the DMV, basic information that might be material to a person's decision is not disclosed. For example, when registering as a donor in the state of Colorado, one is merely required to fill out basic identifying information before consenting to organ donation.⁹² Indeed, in their analysis of OPO Internet websites that are designed to obtain people's consent to organ donation, Woien et al found that such websites do not fulfill the necessary requirements required for informed consent.⁹³ They conclude that OPO websites mainly provide positive reinforcements and promotional materials regarding organ donation rather than disclosing important information about the organ donation process.⁹⁴

I will now argue that obtaining a patient's mere consent to organ removal is not necessary to respect her autonomy. Call this the No Mere Consent Claim. The No Mere Consent Claim is inspired by and exploits the plausible idea that, given the account of respect for patient autonomy outlined in Section 2, a patient's autonomous decision to donate her organs can be respected without the giving of mere consent. I will consider a case that suggests that sufficiently respecting patient autonomy does not require obtaining a person's mere consent. Consider, for example, the following case:

⁹² "Donate Life Colorado" <http://www.donatelifecolorado.org/register-now/>. Accessed 18 January 2017.

⁹³ Woien, Sandra, M. Rady, J. Verheijde, and J. McGregor. 2006. "Organ procurement organizations internet enrollment for organ donation: abandoning informed consent" *BMC Medical Ethics* 7:14.

⁹⁴ *Ibid.*

Death Before Consent. Ana is extremely interested in organ donation though she knows little about it. Given her interest, her primary physician takes steps to educate her about the organ removal procedure, what it means for those on the waiting list, and the implications of donation for her family. Ana's physician takes the time to disclose important information regarding organ donation and ensures that Ana understands it. On the basis of their conversations, Ana expresses to her physician that she wishes to donate her organs. Unfortunately, before she can sign up and officially consent to be a donor, Ana dies in an automobile accident.

In Death Before Consent, Ana expresses an informed wish to donate, and yet she dies without giving her consent to organ removal. My claim is that most of us will have the judgment that removing Ana's organs, based on her informed wish to do so, is sufficiently respectful of her autonomy, despite the fact that she never gave her mere consent.

The explanation for why we have the judgment that removing Ana's organs is sufficient to respect her autonomy goes as follows. First, since a large part of respecting autonomy involves enabling a patient in making a decision about an important medical intervention by ensuring her understanding regarding that intervention, then this is satisfied in Death Before Consent: Ana's physician took the time to discuss the nature of organ procurement with her, as well as the implications that donation has for her family and people on the waiting list. Second, since Ana is dead and hence no longer competent to make a decision or to give consent, then it is appropriate to act in accordance with what Ana wanted while she was alive and competent. This allows her to carry out her wishes regarding donation. Indeed, in other contexts involving

surrogate decision-making, doing what a permanently incompetent patient wanted or would have wanted while she was competent is standard practice.⁹⁵

To further illustrate the plausibility of the No Mere Consent claim, consider a similar situation in another context involving a posthumous intervention on a person's body. Suppose that Julia frequently tells her family that when she dies, she wants her body cremated rather than buried. Julia does a lot of research about this process, along with alternate burial procedures, and she discusses this often with her family. When Julia finally dies, her family does as she wanted and cremates her body. It seems clear that, despite not giving her explicit consent to be cremated, the family would be respecting Julia's autonomy by cremating her body. By contrast, if, knowing her wishes about cremation, Julia's family decided to not cremate her body and instead bury it, most of us would be inclined to believe that this is disrespectful of Julia's autonomy.

There are two different objections to consider at this point. The first objection is that, perhaps Ana has moral rights grounded in her status as an autonomous person, and these moral rights entail that removing her organs without her consent would be disrespectful of her autonomy, and hence, wrong. In particular, perhaps Ana has a right of bodily integrity, which precludes unconsented invasions of her body, such as organ removal.⁹⁶ Thus, if she has not given her prior consent to organ removal, we would be violating her right by removing her organs.

In response, I should note that, since organs are removed only after a patient suffers from whole brain or cardio-pulmonary death, if we do in fact violate Ana's right to bodily integrity, we violate it posthumously. However, there are persuasive arguments that have been developed by Gill (2004) and Wilkinson (2011) which suggest that the dead do not have a right against unconsented invasions of the body. Gill (2004), for example, considers what he calls the non-

⁹⁵ See Childress, J. and T.L. Beauchamp. 2009. *The Principles of Biomedical Ethics*, ch. 6.

⁹⁶ Wilkinson, T.M. 2011. *Ethics and the Acquisition of Organs*, ch. 5.

interference model of respect for autonomy. According to this model, “it is wrong to interfere with a person’s body unless that person has given us explicit permission to do so”.⁹⁷ But Gill argues that the fundamental problem with this view is that it implies that we cannot do anything to the bodies of the dead unless they had given their prior consent to do so. But this view implies that we must leave the bodies of the dead where they drop, absent their explicit consent to handle and invade their bodies. However, this is absurd, since we must handle and touch the bodies of the dead in some way -- for example, to transport their bodies or to dispose of them properly.⁹⁸ Thus, if Gill is right – and I believe that he is -- then there is no posthumous right against unconsented invasions of the body.

The second objection is that, despite what I have suggested, Ana *has* given her consent to organ removal in *Death Before Consent* and that is why removing her organs is sufficiently respectful for her autonomy. The thought is that, even if she has not uttered, “I consent to organ removal,” or signed a formal document, perhaps by the expression of her wish to donate she has implicitly given her consent.

There are three different replies to this objection. The first is to deny that Ana has actually given the kind of consent that is sought by opt-in policies. Recall that a guiding assumption of this discussion is that consent is a public act of authorization in which a person gives another person, or group of persons, permission to do some thing. In opt-in policies such as the United States, individual consent must be given officially and explicitly in the form of a written or online document that expresses that the individual in question has indeed authorized the posthumous removal of her organs for transplantation purposes. In *Death Before Consent*, Ana did not give explicit permission to remove her organs in this way. Rather, she merely

⁹⁷ Gill, Michael B. 2004. “Presumed consent, autonomy, and organ donation,” p. 44.

⁹⁸ Ibid.

expressed her informed wish to donate her organs. Therefore, it is not the case that Ana in fact consented to organ donation.

A second reply is that, if the reason that removing Ana's organs is sufficiently respectful of her autonomy is that she gave her consent, then the objector must be assuming that to consent to P is the same as wanting or desiring that P. But if the objection is assuming that consenting to P is just to want or desire that P, then this vindicates the No Mere Consent Claim since the No Mere Consent Claim maintains that acting on the basis of Ana's wish or desire to donate would be sufficient to respect her autonomy.

Finally, if, despite what I have said, the objector is adamant that Ana *has* given her consent to organ removal, it is possible to modify the original case in a way that makes it clear that Ana did not in fact give her consent when she expressed her wish to donate. Consider:

Death Before Consent*. Ana is extremely interested in organ donation though she knows little about it. Given her interest, her primary physician takes steps to educate her about the organ removal procedure, what it means for those on the waiting list, and the implications of donation for her family. Ana's physician takes the time to disclose important information regarding organ donation and ensures that Ana understands it. On the basis of their conversations, Ana expresses to her physician that she wishes to donate her organs. She then tells her physician that she intends to sign the official donor form tomorrow, at which point she will give her consent to organ removal. Unfortunately, the next day on the way to sign her donor card, Ana dies in an automobile accident.

In the above, modified version of Death Before Consent it is clear that Ana has not yet given her actual consent to organ removal. However, I suspect that despite this fact, most of us will agree that removing Ana's organs for transplantation purposes would be sufficiently respectful of her autonomy.

However, one might also object to the modified Death Before Consent case by claiming that certain ways of making the case more precise would show that the No Mere Consent Claim is false. For example, suppose Ana expresses her wish to donate and her doctor, who is also an expert on the nature of consent, claims, "Wishing to donate is not the same as consenting to donate. I know that you *wish* to donate. But do you *consent* to it?" Suppose that Ana tells the doctor that, although she wants to donate, she does not consent to having her organs removed. Later the next day, she dies. In this case, it seems clear that despite her wish to donate, Ana has refused to give her consent – indeed this act might be interpreted stronger, as an act of dissent. Therefore, according to the objection, removing her organs, even in the presence of her wish to donate, would be disrespectful of her autonomy precisely because she has refused to give her consent.

But this objection fails to undermine the No Mere Consent Claim. Proponents of the No Mere Consent claim can agree that in a case in which a person refuses to give her consent to organ donation (or actively dissents to the use of her organs), it would be disrespectful of her autonomy to remove her organs, even if she expressed a wish in favor of donation. The No Mere Consent Claim is just the view that obtaining a person's mere consent to donate her organs is not required to respect her autonomy. But this is consistent with the view that if a person is asked and refuses to give their consent to organ removal, then, despite their wish to donate, removing her organs would disrespect her autonomy. Thus, the No Mere Consent Claim is not committed

to the position that the act of refusing consent, or relatedly, the act of dissenting, is morally irrelevant to respect for autonomy.

Another related objection to my argument for the No Mere Consent Claim accepts that Ana has not actually given her consent, but that she has done something that is close enough for the purposes of removing her organs in a manner that is respectful of her autonomy. The problem with this objection is that it implicitly accepts the view that acting on the basis of Ana's informed wish or desire to donate would be sufficient to respect her autonomy. Thus, the objection is implicitly committed to the No Mere Consent Claim.

Thus far I have considered objections against my argument in favor of the No Mere Consent Claim. I'll now consider two further independent objections that attempt to undermine the No Mere Consent Claim itself.

The first objection is that almost all other invasive medical interventions require informed consent, and in these cases, the act of mere consent is essential. But if the No Mere Consent Claim is true, it seems to implausibly entail that the act of mere consent is not actually necessary in these other medical contexts, and that all we need to obtain from a patient is a wish or desire to undergo the procedure in question. Consider for example the following case:

Knee Surgery. Richard is set to undergo surgery to remove a cancerous tumor. Richard gives his informed consent to the surgeon to undergo the tumor removal and he is then put under anesthetic. As the surgery proceeds, the surgeon remembers that, prior to the surgery, she and Richard had a brief chat in which Richard told her that he wants to have knee surgery to correct a pain in his left knee that prevents him from doing sports. Knowing that Richard wants the knee surgery, the surgeon finishes removing his tumor and then proceeds to perform surgery on his knee.

Most of us will judge that performing the knee surgery on Richard fails to respect his autonomy, despite the fact that he had an informed wish to undergo the knee surgery. But if the No Mere Consent Claim is true, it seems that I am committed to the implausible view that performing the knee surgery on Richard is respectful of his autonomy.

In reply, I agree that performing the knee surgery on Richard is disrespectful of his autonomy. But accepting the No Mere Consent Claim does not commit me to the position that performing the knee surgery on Richard is respectful of his autonomy. This is because there is a morally relevant difference between Knee Surgery and organ procurement cases: in Knee Surgery, Richard is a competent living patient, whereas in organ procurement cases, the person is dead and hence no longer competent. When treating competent, living patients, mere consent is arguably necessary because it allows the patient to direct and live her life in the way she sees fit. Since a competent person is able to direct her life by the giving or withholding of consent, seeking her consent is required by the principle of respect for autonomy. By contrast, dead patients are no longer competent and hence can no longer give their consent to organ removal. Thus, respecting their autonomy does not require obtaining their consent; it does, however, require that we act in accordance with what they wanted or desired.

The second objection is that perhaps acquiring mere consent to organ removal is necessary because it is the best indicator of patient wishes and therefore should remain insofar as we are interested in honoring patient wishes. The problem, however, is that even if the mere consent requirement is an indicator of patient wishes, the wishes that they track are unlikely to be sufficiently informed given current procedures for obtaining consent to donation. And if patient

wishes are not sufficiently informed, they are unlikely to be sufficiently informed expressions of what the patient wants or envisions for herself.

Finally, one might object that mere consent should be required because it is a way to establish trust between citizens and the transplantation or medical community.⁹⁹ Since people may reasonably have fears that their organs will be taken against their will, the consent requirement might reassure them that their organs will never be removed unless they give their consent. The problem with this response is that there are other ways to establish trust between people and the transplantation and medical community. For example, one could imagine a policy under which a person's organs would not be removed unless the person discussed organ donation with qualified personnel and expressed their positive wish to donate. This requirement would indeed respect autonomy and communicate to patients that their organs will not be removed unless it is sufficiently clear that they wish organ donation to be a part of their life-plan. Indeed, such a policy might do more to establish trust between donors and medical personnel than a policy of mere consent.

To conclude, I shall suggest that the truth of the No Mere Consent claim has interesting implications for future procurement policies. The first implication is that a procurement policy that does not obtain actual consent can still be respectful of people's autonomy so long as it acts in accordance with what patients wanted or desired. Consider, for example, a presumed consent policy, which has been implemented with some success in countries such as Spain and Belgium.¹⁰⁰ Under a presumed consent policy, people are given the opportunity to opt out of organ donation by registering an objection to it; if people do not opt out, we may presume that

⁹⁹ See O, Neil. O. 2002. *Autonomy and Trust in Bioethics*. (Cambridge: Cambridge University Press).

¹⁰⁰ Abadie, Alberto and Sebastian Gay. 2006. "The impact of presumed consent legislation on cadaveric organ donation: A cross-country study". *Journal of Health Economics* Vol 25 (4): 599-620.

they consented to the posthumous removal of their organs. Thus, under a presumed consent policy, a patient's mere consent is not sought.

Some bioethicists claim that because an overwhelming majority of people (especially in the United States) desire to be organ donors, a presumed consent policy would be justified because it would do a better job than the current opt-in policy at respecting patient wishes.¹⁰¹ Thus one might claim that the No Mere Consent Claim could in principle support a presumed consent policy because the No Mere Consent Claim is that obtaining actual consent is not necessary to respect patient autonomy and that acting on the basis of a person's sufficiently informed wish or desire to donate would be sufficient to respect her autonomy.

But there is a problem for the view that the No Mere Consent Claim could support a presumed consent policy. The cases that generated the intuition that supports the No Mere Consent Claim are ones in which a person's mere consent is not obtained but whose *informed* wish or desire to donate is obtained. The problem is that, in current conditions, it is unlikely that most people who wish to donate have a sufficiently informed wish to donate. Thus, if we implemented a presumed consent policy, we would be acting on the basis of people's relatively uninformed wishes regarding donation. Thus, I submit that the No Mere Consent Claim *would* support a presumed consent policy if most people were relatively informed about organ donation. But since it is likely that most people are not relatively informed about organ donation, the No Mere Consent Claim cannot be used to argue for the claim that a presumed consent policy would be sufficiently respectful of patient autonomy. Having said that, perhaps at some point in the future, dramatic steps will be taken to educate the general public about organ donation. One

¹⁰¹ Cohen, Carl, 1992. "The case for presumed consent to transplant human organs after death." *Transplantation Proceedings* 24, 2168–2172; Gill, Michael B. 2004. "Presumed consent, autonomy, and organ donation."

could imagine, for example, a section on organ donation being part of the mandatory health and sexual education classes in middle schools and high schools. Under such conditions, it is not implausible to suggest that people could be sufficiently informed about organ donation; in that case, if most of them have sufficiently informed wishes about organ donation, a presumed consent policy would be sufficiently respectful of patient autonomy.

Finally, the No Mere Consent Claim has implications for opt-in policies and mandated choice policies. The No Mere Consent Claim has shown that an important part of respecting a patient's autonomy in regard to the decision to donate involves ensuring that the patient has a sufficient level of understanding regarding what it means to donate one's organs. Thus, since opt-in policies and mandated choice policies seek people's consent for organ donation, such policies should take steps to inform their patients about organ donation before the obtaining of consent. In the next section, I will argue that, if respect for autonomy is what justifies the consent requirement, then the kind of consent (i.e. mere consent) sought by U.S. procurement policy does not sufficiently respect patient autonomy. Thus, if we continue to seek people's consent to organ donation, then the process of obtaining their consent should be changed so that the consent is sufficiently informed.

3.4 MERE CONSENT IS NOT SUFFICIENT TO RESPECT PATIENT AUTONOMY

To begin, it is important to point out that obtaining a person's mere consent to do some action or procedure is often times sufficient to respect her autonomy. For example, if a good friend of mine wishes to borrow one of my vinyl records, obtaining my mere consent is typically sufficient to respect my autonomy. Or if a person wishes to read a paper that I am currently working on, my mere consent is plausibly sufficient. However, I claim that obtaining a person's

mere consent to some action or procedure does not sufficiently respect that person's autonomy when the procedure in question is one in which the average person is unlikely to contain the information, and therefore, the understanding needed to make an autonomous decision. Call these *Information Cases*. Consider, for example, the following two cases:

Real Estate. Ben is looking into buying a new home, so his real estate agent shows him a home on the market. However, despite being a first time homebuyer, she does not disclose anything about the condition of the house and its potential problems, nor does she ensure that Ben understands the home buying process. Despite this, when it comes time to put an offer on the house, Ben gives his consent and signs the relevant paperwork.

Research Trials. Oscar is approached by three medical researchers who are conducting human trials for a new anti-infection drug. They ask him if his willing to help save people's lives, and he agrees. He then gives his consent to participate in the research trials.

In each of these cases, the person's mere consent was obtained to do some action or procedure. However, I suspect that most people will agree that, despite giving their mere consent, the autonomy of Ben and Oscar was not sufficiently respected. The most plausible explanation for this claim is that each action that was consented to is such that the average person is unlikely to possess the information, and therefore the understanding needed to make an autonomous decision. The researchers did not disclose to Oscar even a minimal amount of information about the research trials, its implications, and potential risks. Similarly, in Real

Estate, the real estate agent did not disclose to Ben any details about the state of the house and what kind of work it might need. Thus, since the persons in each of these cases is unlikely to have the information, and therefore, the understanding needed to make an autonomous decision, obtaining their mere consent to the procedure or action in question is not sufficient to respect their autonomy.

Consenting to organ donation is akin to both Real Estate and Research Trials. They are the same in that both are what I have called Information Cases. And that means that obtaining a person's mere consent to organ donation does not sufficiently respect her autonomy. There are a couple reasons in favor of the claim that consenting to organ donation is an Information Case.

To begin, the average person who consents to be a donor likely only understands that when they die their organs will be removed and this will either save a person's life or extend it for a certain amount of time. However, this amount of understanding is inadequate in light of several considerations surrounding the procurement process and its implications. In particular, there are four relevant types of issues that are likely to be material in a person's decision to become an organ donor.

First, there are the invasive procedures that must be done to a person's body before their organs are removed. It is common, for example, for the bodies of donors to be injected with hormones to prepare the body for transplantation.¹⁰² Relatedly, when facilitating organ donation after cardiac death, common pre-transplantation procedures involve the placement of venous catheters, and administering heparin and vasodilators to patients.¹⁰³ When consenting to organ donation, either at the DMV or on the Internet, it is quite unlikely that patients were given this

¹⁰² Wilkinson, T.M. 2011. *Ethics and the Acquisition of Organs*, p. 77.

¹⁰³ Truog, Robert. 2008. "Consent for Organ Donation — Balancing Conflicting Ethical Obligations." *N Engl J Med* 358; 12.

information, yet such considerations could be material in deciding whether they consent to be organ donors. Thus, insofar as patients might not want these things to be done with their bodies in the moments before their death or immediately after their death, they should be at least minimally informed of standard transplantation procedures in order to make a sufficiently informed choice about whether to donate their organs.

Second, the donor's decision to donate has several important implications for her family or next of kin. Organ procurement is often very difficult, emotionally, for the families of donors. After a patient has been declared dead and has been determined a registered donor, representatives from the local organ procurement organization (OPO) will approach the families about transplantation. However, since authorizing transplantation is often a very difficult and emotional decision for families, they will often oppose donation and the transplantation team will often abide by the decision of the family. In fact, in some countries, it is estimated that families block a patient's recorded decision to donate in about 50 percent of cases, thus lending weight to the fact that families often find it very difficult to see their loved ones used as donors.¹⁰⁴ Thus, the decision to donate often causes the family emotional harm because they must make the difficult decision of whether to allow physicians to remove their loved one's organs. Second and relatedly, although individuals are free to give their consent to organ removal and this is sufficient according to the Revised Uniform Anatomical Gift Act to have their organs removed, often physicians will not remove organs without the family's approval or they will remove the deceased's organs only if there is no objection to organ removal from the family. This means that

¹⁰⁴ De Wispelaere, Jurgen and Lindsay Stirton. 2010. "Advance commitment: an alternative approach to the family veto problem in organ procurement." *Journal of Medical Ethics* 36: 180-183. See also Chon W.J. et al. 2014. "When the Living and the Deceased Cannot Agree on Organ Donation: A Survey of US Organ Procurement Organizations (OPOs)". *American Journal of Transplantation* 14: 172-177.

families are in practice given the final say in whether the deceased's organs are removed. Given both of these considerations regarding the family, potential organ donors should be made aware of these facts when registering so that they can consult with their family or next of kin about their donation wishes.

Third, although patients are likely to know the vague claim that organ donation can save lives, potential donors are unlikely to know facts about how many people are in dire need of new organs and how many people die per day because of the organ shortage. They also are unlikely to know how many needy patients they can save by donating their organs -- eight. These facts are likely to be material for many people in their decision about donation, yet there is often no mandatory disclosure of this information when one gives consent to organ donation.

Fourth, patients should be at least minimally aware that organ procurement does not disfigure their body in any drastic sense. Relatedly, they should be aware that their status as a registered donor will not negatively affect their end of life care. Doctors will make every attempt to preserve their lives in accordance with their interests and advance directives, and will not let them die in order for their organs to be retrieved. This kind of information might be material for a person who fears that her end of life care will be comprised by the desire for her organs.

All of these considerations point to the conclusion that consenting to organ donation is an Information Case. And that means that obtaining mere consent to organ removal is not sufficient to respect patient autonomy. I will now consider some objections to my argument.

The first objection considers how persons might waive their right to information. In particular, one might argue that when a patient gives her mere consent to organ donation, she waives her right to have information about organ donation disclosed before she makes a

decision. If this is right, then obtaining her mere consent to organ donation sufficiently respects her autonomy.

To reply, it is true that people can in principle waive their right to information in various contexts. This often happens in the case of surrogate decision-making in which a patient gives authority to a designated surrogate to make decisions for her. However, it is false that people actually waive their right to information when they give their mere consent to organ donation. This is because there must be conditions in place that make the waiving of the right to information legitimate. There are two plausible necessary conditions that must be satisfied for a person to successfully waive her right to information: first, she must know that she *has* the right to information; and second, she must know that by giving her mere consent, she is waiving her right to information. But both of these conditions are plausibly not satisfied in the case of organ donation. First, it is unlikely that most people know that they have a right to information, especially when donor registration websites or documents do not make this explicit. Given that the first condition is likely to be unsatisfied, the second condition is also likely to be unsatisfied. For if people do not know they have a right to information, then they also do not know that giving their mere consent entails the waiving of their right to information. Therefore, it is false that people waive their right to information when they give their mere consent to organ donation.

In addition, if the objector admits that people have a right to information, then it follows that we have a *prima facie* duty to give patients this information or at least give them the option to have such information disclosed, unless they indicate that they do not want it. If this is true, then current procurement procedures for obtaining consent fail to respect patient autonomy

because they fail to disclose information (or, alternatively, they fail to give people the option of having such information disclosed) before patients make their decision to consent or not.¹⁰⁵

The second objection maintains that, when it comes to respect for patient autonomy, going beyond obtaining a patient's mere consent is required only if the procedure in question is sufficiently risky to a person's health or well-being. But since organ donors are deceased, organ procurement presents them with no real risks. Hence, respecting a patient's decision to donate her organs need not involve any more than obtaining her mere consent.

But the claim that organ procurement presents no real risks to the patient's well-being is not obviously true. Indeed, some philosophes have developed coherent accounts of posthumous harm, according to which things that happen after a person's death can frustrate her wishes or desires while she was alive and thereby harm her.¹⁰⁶ Thus, if it is possible that events that occur after a person's death can indeed harm her while she is alive, then it is false that organ procurement presents no real risks to the person's well-being. Proponents of the risk objection must therefore show that posthumous harm is impossible in order for their objection to succeed.

Second, the current objection assumes that if a procedure does not present a patient with risks to her health or well-being, then respect for autonomy does not require going beyond obtaining mere consent. But this is false. Consider the following case:

¹⁰⁵ It is true that some OPO websites in which people are given the opportunity to register have, on separate pages, information about organ donation. One might argue that this gives people the option of having information about organ donation disclosed. This objection is misleading. While some OPO websites do contain information about organ donation, the information, or the option to have such information disclosed is not presented to people before they consent to organ donation. If people have a right to information about organ donation, then we have a prima facie duty to present this information, or at least present people with the option of having it disclosed, before they officially consent.

¹⁰⁶ Pitcher, George, 1984. "The Misfortunes of the Dead" *American Philosophical Quarterly* Vol. 21 No 2: 183-188; Wilkinson, T.M. 2011. *Ethics and the Acquisition of Organs*, ch. 3-5; Boonin, David. *Posthumous Wrongs*, Ms, in progress.

Mouth Swab. A nurse tells a healthy patient that she needs to do a painless mouth swab on him. The nurse tells the patient that his doctor ordered the mouth swab, and he consents. In reality, however, the doctor never ordered the mouth swab; the nurse is going to pocket the swab for her own personal collection (she collects mouth swabs).

Since the administering of a mouth swab is not a procedure that in itself presents the patient with risks to her health or well-being, obtaining the patient's mere consent is sufficient, according to the current objection, to respect her autonomy. But this is implausible, for the patient's autonomy is clearly disrespected by the nurse in the above case. Though the nurse did obtain the patient's mere consent, she also disrespected his autonomy in other ways. Thus, it is false that if a procedure does not present a patient with risks to her health or well-being, then respect for autonomy does not require going beyond obtaining mere consent.

The third objection to consider concerns the principle of respect for autonomy as a *right*, rather than a *requirement*, of patients. Thus, patients have the right to make autonomous decisions, but it is not required of them, for they may wish to designate another person as their decision maker. Thus, the idea is that, in standard medical interventions, patients ought to be able to delegate decision-making to their doctors, and when appropriate, their families.¹⁰⁷ The same is true for organ donation. Thus, if a person delegates the decision about donation to a physician or family member, they waive their right to make a first-person autonomous decision about their organs. With respect to organ procurement, some people prefer to delegate their decision about donation to their families. If this is true, then making the procedures for obtaining consent to

¹⁰⁷ Childress, J. 1990. "The Place of Autonomy in Bioethics," p. 13.

organ donation more informed by requiring people to consider potentially material information is problematic.

This objection fails to undermine my argument. This is because since respect for autonomy gives patients the right (rather than requires them) to make their own decision about their organs, it is conceivable that consent procedures for organ donation could include an option whereby a person simply delegates the decision to her family or some other appropriate surrogate. This procedure seems quite feasible and plausible, especially given the fact that families often have the final say in whether their loved one's organs are ultimately removed. Hence, if a person prefers to let her family make the decision about her organs, she should be allowed to do so. But admitting this much does not undermine my argument. Instead, it points out that, in order to respect patient autonomy, consent procedures need to be changed in yet another way: they should include the option to delegate the decision about one's organs to one's family or some appropriate surrogate decision-maker.

I have argued that obtaining a person's mere consent to organ removal in the way it is usually done in the United States is not sufficient to respect patient autonomy. So far I have considered objections to my arguments in favor of this claim. I'll now consider two objections to the thesis itself.

First, one might argue that making the consent process more informed would complicate the donor registration process in such a way that might lead to less registered organ donors, and hence, less useable organs overall. Therefore, we should not implement such a policy. After all, if people knew more about the donation process and its implications, they might decide not to become organ donors.

This first objection seems to be claiming that because my proposal may lead to less

transplantable organs overall than the current policy, it follows that my proposal is somehow wrong or problematic. This objection fails because it depends on the implausible claim that, if an organ procurement policy leads to less organs overall compared to another procurement policy, then we should not implement it. But consider a hard conscription policy, whereby useable organs are automatically removed from the dead without the possibility of a person being able to opt out of their removal. Given the objection under discussion, a hard conscription advocate could thereby argue that an opt-in policy leads to less organs overall compared to a hard conscription policy. Therefore, we should favor a hard conscription policy over an opt-in policy. But this argument would be implausible. And it is implausible precisely because the claim that, if an organ procurement policy leads to less organs overall compared to another procurement policy then we should not implement it, is false. Thus, even if my proposal has implications that might lead to less organs overall compared to current opt-in policies, this doesn't suffice to show that we should not implement it.

Let's now consider a second objection: that a more informed consent process would complicate the donor registration process by requiring more resources and trained personnel. In addition, the objector continues, it might even require that we abandon or revise the practice of registering donors at the DMV or online.

This second objection fails for two reasons. First, the mere fact that a proposal would force us to abandon or revise our current practices is not in itself a plausible reason to believe that we should not implement it. For example, when medical personnel began the practice of gaining a patient's informed consent before engaging in invasive medical interventions, this may have complicated the current practices in a way that required more time and effort on the part of physicians and medical staff. But that is not a good reason to think that we should not have

implemented informed consent procedures before medical interventions. Secondly, implementing a policy that better respects the autonomous decisions of potential donors need not be overly complicated in the way that the objection imagines. It need not, for example, be more than a short conversation with trained personnel, who are experts on organ transplantation and at speaking to potential donors about it.

3.5 CONCLUSION

In this paper I have considered the consent requirement, the view that in order to permissibly remove organs from a deceased person, it is necessary that her prior, actual consent be obtained. I argued, first, that it is not necessary to obtain a patient's actual consent prior to organ removal in order to respect her autonomy. Indeed, what I have suggested is that there are other ways to respect people's autonomy in organ procurement policy that do not involve the obtaining of actual consent and that this has implications for evaluating other procurement policies and ways in which we might revise our current policy. Second, I have argued that the kind of consent sought from patients in U.S. organ procurement policy does not sufficiently respect patient autonomy.

The two claims defended in this paper are just two pieces in a much larger puzzle about which organ procurement policies we ought to adopt. I have only considered the ethical aspects regarding consent and respect for autonomy, but there are other non-ethical policy related considerations that we must consider before making an all-things-considered judgment about policy. For instance, could a policy that did not seek actual consent be acceptable to the general public? Would the public be outraged, for example, if we implemented a presumed consent policy in which actual consent is not sought? If the public was very much against a presumed

consent policy, this is a strong practical consideration against implanting one, even if such a policy could sufficiently respect patient autonomy. Second, implementing a more informed consent process might not be the best all-things-considered option if we don't have the capacity to reach a great number of people like we currently do at the DMV and online. For example, if the consent process had to be moved to doctor's offices, then it is likely that many people, who perhaps *would* give their consent to organ removal if asked, will not end up giving their consent to organ removal because they failed to visit the doctor's office. While I do not have the space here to consider all-things-considered judgments about procurement policy, I do think the two theses argued for in this paper give us some ethical insight into which procurement policies could and could not respect patient autonomy.

Chapter 4

Organ Conscription and Posthumous Rights

4.1 INTRODUCTION

Since its inception, the institution of postmortem organ transplantation has faced the problem of organ shortage: every year, the demand for donor organs vastly exceeds supply, resulting in the tragic deaths of eight thousand individuals in the United States alone.¹⁰⁸ This is in large part due to the fact that the U.S., like many other countries, operates under an “opt-in” policy in which people are given the opportunity to voluntarily opt-in to organ donation by registering as organ donors. In the U.S., a person’s organs will not be removed for transplantation purposes unless she has registered as a donor or if her family gives their consent for organ removal.¹⁰⁹ Jointly, these policies generate a situation where we do not retrieve as many organs as we could.

Other countries, such as Spain and Belgium, have responded to the organ shortage by adopting opt-out policies based on presumed consent.¹¹⁰ Such policies are intended to increase donation by presuming that people have consented to organ donation unless they officially register an objection to donation. However, despite the adoption of presumed consent policies, organ shortage has persisted in Spain and Belgium, as well as in other countries that have

¹⁰⁸ “Organ, Eye, and Tissue Donation Statistics” <https://www.donatelife.net/statistics/>. Accessed Dec 12, 2016.

¹⁰⁹ This is the law in the United States according to the U.S. Revised Uniform Anatomical Gift Act (2006).

¹¹⁰ Abadie, Alberto and Sebastian Gay. 2006. “The impact of presumed consent legislation on cadaveric organ donation: A cross-country study” *Journal of Health Economics* Vol 25 (4): 599-620.

adopted presumed consent policies.¹¹¹ In response to the failure of both opt-in and opt-out policies to increase the number of donated organs, some bioethicists have suggested that we adopt a policy of organ conscription as a way to successfully alleviate much of the organ shortage, and consequently, save lives.¹¹² Organ Conscription is a procurement policy according to which the State takes usable organs automatically from the bodies of the dead, regardless of whether the person consented to donation, had a clear and strong preference against donation, or was at all inclined to have her organs removed for transplantation. Under such a policy, a patient's family also has no say in whether their loved one's organs are removed or not at the time of death. Such a policy would increase the number of organs available for transplantation by making organ donation automatic and routine.¹¹³

While an actual organ conscription policy is not politically feasible at this moment in time, it is important to discuss its ethical merits.¹¹⁴ In the future the public may warm up to the idea of a conscription policy, or at least regard it as a viable alternative to presumed consent and opt-in policies. Although arguments in favor of organ conscription often differ in the details and the conclusions they attempt to establish, they typically focus on and utilize the following three claims. First, it is a great good to save people's lives, and removing organs from just one

¹¹¹ Rithalia A, McDaid C, Suekarran S, et al. 2009. "Impact of presumed consent for organ donation on donation rates: A systematic review." *BMJ* 338: a3162.

¹¹² Delaney, J. and D. Hershenov 2009, "Why Consent May Not Be Needed For Organ Procurement" *American Journal of Bioethics* 9 (8): 3–10; Spital, Aaron. 2005. "Conscription of Cadaveric Organs: We Need to Start Talking About It". *American Journal of Transplantation* 5: 1170–1171; Spital, Aaron and CA Erin. 2002. "Conscription of cadaveric organs for transplantation: let's at least talk about it." *Am J Kid Dis* 39: 611–615; Harris, John. 2002. "Law and Regulation of Retained Organs: the ethical issues". *Legal Studies* 22(4): 527-49; Harris John. 2003. "Organ procurement: dead interests, living needs." *J Med Ethics* 29: 130–134; Silver T. 1988. "The case for a post-mortem organ draft and a proposed model organ draft act." *Boston Univ Law Rev* 68:681-728.

¹¹³ Spital and Erin 2002, *Conscription of cadaveric organs for transplantation: let's at least talk about it.* p. 611.

¹¹⁴ For discussion see, Veatch. Robert. 2000. *Transplantation Ethics* Washington D.C.: Georgetown University Press, ch. 10.

individual can save several lives. Second, whatever interests or moral claims the deceased (or third parties) have over their bodies, those interests or claims are outweighed by the interest that living people on the waiting list have in continuing to live.¹¹⁵ Finally, it seems that the State is often justified in performing coercive interventions (mandatory taxation, military drafts, mandatory autopsies when foul play is suspected) on its citizens by requiring their participation in some procedure regardless of their wishes.¹¹⁶ Thus, there is moral precedent for implementing a conscription policy for cadaveric organs.

Given these three considerations, one could plausibly construct a pro-conscription argument. For the purposes of this paper, I'm going to construct a pro-conscription argument whose conclusion is that conscripting organs is a moral obligation. However, one could imagine a slightly weaker argument whose conclusion is that organ conscription is morally permissible. For now, I'd like to turn my attention on the following argument:

(P1) People who need organ transplants have a great interest in continuing to live and improving the quality of their lives.

(P2) Whatever interests or moral claims that people have over what happens to their organs after they die, those interests or moral claims are outweighed by the interests of people who need organs to continue living.

(P3) We ought to act in a way that fulfills the more important interests or moral claims.

¹¹⁵ Harris 2002, "Law and Regulation of Retained Organs: the ethical issues". Spital and Erin 2002, "Conscription of cadaveric organs for transplantation: let's at least talk about it."

¹¹⁶ Spital and Erin 2002, "Conscription of cadaveric organs for transplantation: let's at least talk about it," p. 614.

(C) Therefore, we ought to conscript organs.

I will refer to this argument as *the standard pro-conscription argument*. Every premise of the standard pro-conscription argument is extremely plausible. First, with respect to (P1), it is obvious that people on the waiting list have interests in not dying and continuing to live good quality lives; many of them also have interests in improving the quality of their lives by obtaining a new organ. (P2) is also plausible. It does not claim that people do not have interests or moral claims over what happens to their bodies after they die; rather, it makes the more conservative claim that whatever interests or moral claims people have over what happens to their bodies after death, those interests or moral claims are outweighed by the interests of people on the waiting list. Finally, (P3) expresses a plausible moral principle. If we have two possible choices available to us, for example, then, all else being equal, we ought to go with the choice that fulfills the more important interests and moral claims. Thus, in such a scenario, it would be wrong to choose to fulfill the less important interests and moral claims.

While the standard pro-conscription argument seems plausible on its face, I will argue that it makes a mistake. The mistake is in the second step, for posthumous conscription violates at least some peoples' bodily rights, and this right, I will argue, does outweigh the interests of living people on the waiting list. First, I consider alternative objections to the standard pro-conscription argument but argue that none of them plausibly defeat the standard pro-conscription argument. Second, I develop an account of posthumous rights based on the combination of three popular views: the Interests Theory of rights, Joel Feinberg's account of harm¹¹⁷, and George

¹¹⁷ See Feinberg, Joel. 1984. *Harm to Others* (New York: Oxford University Press).

Pitcher's account of posthumous harm.¹¹⁸ The combination of these three views, I argue, gives us an account of posthumous rights. A coherent account of posthumous rights thus provides the resources to put forth what I call the Rights-Based Argument against Organ Conscription, which says that a policy of conscription is wrong because it violates at least some people's posthumous bodily rights. Given the Rights-Based Argument I argue for two different theses. The first, weaker thesis is that the rights-based argument is the best objection to the standard pro-conscription argument. The second, stronger thesis is that the rights-based argument defeats the standard pro-conscription argument. Thus even if I do not succeed in establishing the stronger thesis, it is possible that the weaker one is true.

4.2 OBJECTIONS TO THE STANDARD PRO-CONSCRIPTION

ARGUMENT

There are many objections to the standard pro-conscription argument. This section considers several of them, and argues that they fail to defeat the standard pro-conscription argument. Objections to the standard pro-conscription argument typically come in two kinds: first-person explanations and other-affecting explanations. Other-affecting explanations are a family of explanations which attempt to undermine the argument by claiming that it has detrimental effect on the living and that this outweighs the interests of people on the waiting list who need organs to continue living.¹¹⁹ By contrast, first-person explanations point to the fact that conscription violates some interest or moral claim of the person whose organs are posthumously

¹¹⁸ Pitcher, George, 1984. "The Misfortunes of the Dead" *American Philosophical Quarterly* Vol. 21 No 2: 183-188.

¹¹⁹ Harris, John. 2002. "Law and Regulation of Retained Organs: the ethical issues"; Wilkinson, T.M. 2011. *Ethics and the Acquisition of Organs*, ch. 7 (Cambridge: Cambridge University Press; Spital, Aaron and CA Erin. 2002. "Conscription of cadaveric organs for transplantation: let's at least talk about it."

conscripted, and that this interest or moral claim outweighs the interests of people on the transplantation waiting list.¹²⁰ I will begin by considering other-affecting explanations.

4.2.1 Other-Affecting Objections

Other-affecting explanations all center on the claim that conscription has some detrimental effect on some group of living persons. For example, one might argue that conscripting organs is detrimental to the feelings of the decedent's family: if they found out that their loved one was given no say in whether her organs were removed, they would suffer feelings of distress, anger, and fear. Relatedly, one might argue that taking organs from people automatically might be bad for society by making people unhappy, distressed, angry, or scared that they will have no choice about whether their organs are removed after death.¹²¹ Thus, one could imagine a proponent of this line of thinking arguing as follows:

(P1) Living people have an interest in not being made scared, angry, unhappy, or distressed.

(P2) But a policy of conscription would cause living people to become scared, angry, unhappy, and distressed.

(P3) It is wrong to thwart people's interest in not being made scared, angry, unhappy, or distressed.

¹²⁰ Wilkinson, T.M. 2011. *Ethics and the Acquisition of Organs*, ch. 7; Silver T. 1988. "The case for a post-mortem organ draft and a proposed model organ draft act."

¹²¹ Spital, Aaron and CA Erin. 2002. "Conscription of cadaveric organs for transplantation: let's at least talk about it."

(C) Therefore, it is wrong to implement a policy of conscription.

Call this *the argument from living sentiments*. This argument seems reasonable. After all, if a State policy caused widespread fear, anger, unhappiness, and distress among the population, this is a prima facie moral reason against it. For example, if the State decided to implement invasive spying techniques on innocent citizens by setting up video cameras outside their homes and places of work, one could imagine that such a practice would cause widespread anger and fear, even if the justification for the practice was national security from foreign or domestic threats. The fact that this policy would cause widespread fear and anger is a prima facie moral reason against implementing it. While reasonable on its face, the trouble with the argument from living sentiments is that it contains a suppressed premise; namely:

(P4) The interests that living people have in not being made scared, angry, unhappy, or distressed, outweighs the interest that people on the waiting list have in not suffering and continuing to live.

So, is (P4) true? First, it should be noted that the 120,000 people on the waiting list are suffering greatly because of their medical conditions.¹²² The health of many of these people deteriorates slowly, over a number of years, until they eventually die. Others die quickly, by suffering from acute organ failure due to various illnesses or infections. Clearly, the suffering of patients on the

¹²² “Organ Procurement and Transplantation Network” <https://optn.transplant.hrsa.gov/>. Accessed Feb 12, 2017.

waiting list and the interests they have in continuing to live is of great moral importance. But how do they compare to the interests that people have in not being made scared, angry, unhappy, or distressed? John Harris (2002) observes:

“If we can save or prolong the lives of living people and can only do so at the expense of the sensibilities of others, it seems clear to me that we should. For the alternative involves the equivalent of sacrificing people’s lives so that others will simply feel better, or not feel so bad, and this seems nothing short of outrageous”.¹²³

While I am not prepared to go as far as Harris here, I do think his claim is reasonable, and I suspect this sentiment is widely shared. That is, there is something unsettling in the claim that we should allow thousands of people continue to suffer until their deaths so that living people will not experience negative emotions. This suggests that it is at least *reasonable* to hold that the interests of people on the waiting list outweigh the interests that people have in not being made angry, scared, unhappy, and distressed. But if it is at least reasonable to hold this position, it means that the argument from living sentiments fails to defeat the standard pro-conscription argument. In order to defeat it, the argument would need to show that conscription’s effects on the sentiments of the living clearly outweighs the interests of patients on the waiting list.

Of course, there is a utilitarian-style argument to be made here in response: namely, that even if the suffering of the 120, 000 patients on the waiting list is more severe than the suffering that living people have in being made unhappy or distressed, if enough people became unhappy

¹²³ Harris J. 1992. “Wonderwoman and Superman: The Ethics of Human Biotechnology. Oxford: Oxford University Press, p. 103. See also, Harris J. 2003. “Organ procurement: Dead interests, living needs.”

or distressed by the conscription policy, not implementing it would create more net happiness overall than implementing it. Therefore, we ought to not implement the conscription policy.

Whether this objection succeeds depends on empirical facts about peoples' attitudes towards conscription, and how strong or weak these attitudes are. If most people within a society want to have their organs removed anyway, then a conscription policy would not cause widespread distress, as the objection maintains. Moreover, if most people in a society were just slightly opposed to conscription, then a conscription policy would be unlikely to cause widespread unhappiness and distress. Furthermore, as Harris (1992) and Spital and Erin (2002) claim, people will come around to conscription once it is implemented because they will realize that it benefits everyone in society.¹²⁴ What these authors seem to be assuming is that conscription would solve the organ shortage, and hence, if any particular person ends up requiring a new organ, they will get it under a policy of conscription. Whether a policy of conscription would in fact solve the organ shortage is a topic for another paper, but their general point can still be made even if conscription provides far more organs than the current policy. Thus, in order for the objection to succeed in any particular case, it must be shown that the majority of people within the particular society we are considering are opposed to the idea of conscription. In addition, in order to succeed the objection must show that the majority of people within a particular society are strongly opposed to organ conscription in a way that would cause widespread emotional distress if a policy of conscription were implemented.

Thus, I submit that *the argument from living sentiments* does not defeat the standard pro-conscription argument because it is reasonable to hold the view that the interests of patients on

¹²⁴ Harris J. 1992. *Wonderwoman and Superman: The Ethics of Human Biotechnology*; Spital, Aaron and CA Erin. 2002. "Conscription of cadaveric organs for transplantation: let's at least talk about it."

the waiting list outweigh the interests of living people in not being made scared, angry, unhappy, or distressed. In addition, the utilitarian-style argument against conscription succeeds only if we have reasons to think that most of the people within the society that conscription will be applied strongly oppose conscription and are likely to have very negative emotional reactions towards it. However, if most people are not strongly opposed to conscription, or not opposed at all, then implementing a policy of conscription would create more net happiness overall than not implementing it.

Related to other-affecting explanations are what we might call hybrid accounts, which combine other-affecting and first-person explanations that tell against the standard pro-conscription argument. Walter Glannon (2008), for example, presents two problems for conscription policies, which combine personal and impersonal considerations.¹²⁵ The first problem Glannon identifies is that removing a patient's organs without the consent of the patient or her family could undermine the incentives to fulfill the duties of care that physicians have towards their critically ill patients with viable organs. It would do this by creating a conflict of interest between the physician's "primary duty of care to critically ill patients as a potential source of organs and their secondary duty to other patients as organ recipients".¹²⁶ In other words, if we adopted a conscription policy, doctors will (consciously or unconsciously) allow their patients with viable organs to more easily die so that other patients on the waiting list might acquire those new organs.

One could construe Glannon's argument as adding an additional two premises to the standard pro-conscription in order to defeat it:

¹²⁵ Glannon, W. 2008. "The Case Against Conscription of Cadaveric Organs for Transplantation." *Cambridge Quarterly of Healthcare Ethics* 17, 330-336.

¹²⁶ Glannon, W. 2008. "The Case Against Conscription of Cadaveric Organs for Transplantation," p. 335;

(P1) People who need organ transplants have a great interest in continuing to live or improving the quality of their lives.

(P2) Whatever interests or moral claims that people have over what happens to their organs after they die, those interests or moral claims are outweighed by the interests of people who need organs to continue living.

(P3)* A conscription policy will compromise people's medical care in such a way that might lead them to die prematurely.

(P4)* But people have a moral claim against having their medical treatment compromised in such a way that might lead them to die prematurely, and this moral claim outweighs the interests of patients on the waiting list.

(P5) We ought to act in a way that fulfills the more important interests or moral claims.

(C) Therefore we ought to fulfill the moral claim that people have against having their medical treatment compromised in such a way that might lead them to die prematurely.

(C2) Therefore, we ought not conscript organs.

Call this *the Premature Death Argument*. To my mind, this argument fails because (P3)* is false.

The first problem for (P3)* is that it is plausible that if conscription compromises people's medical care in such a way that might lead them to die prematurely, then this is true for other procurement policies as well. Consider an opt-in policy. If, as the objection assumes, physicians have duties of care toward their patients but also duties to other patients who need organs, then physicians will have the same conflict of interest under an opt-in policy. If a physician's patient is known to be a registered donor, the physician may consciously or unconsciously allow this patient to more easily die so that other patients on the waiting list might acquire her organs. If this is right, then Glannon's objection is not an objection against a conscription policy per se, but rather a general problem for any policy in which physicians have duties of care to their patients and duties to patients on the waiting list.

The second problem for (P3)* is that we could imagine ways to easily avoid compromising people's medical care in such a way that might lead them to die prematurely. (P3)* seems to ignore the potential for utilizing stricter safeguards against abuse if a conscription policy were implemented. One could imagine, for example, utilizing trained medical personnel who would oversee the dealings of physicians with their critically ill patients. These personnel would ensure that doctors do all they can to treat their patients according to his or her best interests, rather than let them die or fail to treat them properly in order to harvest their viable organs. Of course, such personnel could not be taken from other areas of care that need them, since that would compromise the quality of care of a whole host of different areas. However the point is that utilizing stricter safeguards against abuse would plausibly avoid the compromising of people's care.

The second argument against conscription that Glannon defends is the claim that conscription would limit our ability to control the timing, manner, and meaning of death. As

Glannon puts it, “Eliminating choice at the margin between life and death could preclude the ability of patients and families to act in patients’ best interests. It could also prevent families from experiencing the death of a loved one as more than just a biological event”.¹²⁷ The basic claim this argument makes is that conscription eliminates some potential value, and the loss of this value outweighs the interests of patients on the waiting list. Consider, for example the claim that conscription would preclude the family from experiencing greater meaning from their loved one’s death. Under a conscription policy, the family’s consent is not sought and they have no choice in the matter of whether their loved one’s organs are donated. But as Glannon notes, some people want to have the choice to donate their loved one’s organs because it enables them to construct meaning out of the death of their beloved family member.¹²⁸

The success of this argument depends on the truth of the claim that conscription would eliminate the family’s ability to create greater meaning out of the death of their loved one. However, in reply, it appears that conscription *is* compatible with some ability to create greater meaning out of the death of a loved one. Here’s why. The objection claims that some families want to have the ability to create greater meaning out of the death of their loved one. It must be assuming, then, that the greater meaning of their loved one’s death consists in the fact their organs were able to save lives. But if a person’s death has greater meaning in virtue of the fact that it saves lives, then conscription is consistent with the goal of creating greater meaning out of a person’s’ death. Thus, even if the family is not able to voluntarily choose to donate, it is plausible that the death of a loved could still have greater meaning because their organs were removed and used to save lives.

¹²⁷ Glannon, W. 2008. “The Case Against Conscription of Cadaveric Organs for Transplantation,” p. 331.

¹²⁸ Glannon, W. 2008. “The Case Against Conscription of Cadaveric Organs for Transplantation,” p. 333.

One might object that the family can create greater meaning from their loved one's death only if they are given the choice to voluntarily donate their organs. Thus, it is the choice that gives the death greater meaning, rather than the saving of lives. But this position is implausible. Suppose Ben's family chooses to donate his organs but in the end his organs are defective and cannot be used in transplantation. If it is the choice that is key to creating greater meaning out of Ben's death, then Ben's family has created greater meaning out of Ben's death. But this is implausible, for Ben's death did not entail that other people were saved by his organs. Thus, having the choice to donate your loved one's organs does not by itself give her death greater meaning. Rather, it seems that the most plausible reason that greater meaning is created out of the death of a loved one is that her organs are in fact used to save other people's lives. Thus, I think it is plausible to claim that not much is lost under a conscription policy by way of creating greater meaning out of the death of a loved one. This, of course, means that the key assumption of Glannon's argument is false.

I submit that the other-affecting explanations I have considered as well as Glannon's hybrid position, do not defeat the standard pro-conscription argument. I will now turn to evaluating the variety of first-person explanations that might be offered to rebut the standard pro-conscription argument.

4.2.2 First-Person Objections

First-person explanations attempt to undermine the standard pro-conscription argument by showing that there is some detrimental effect that conscription has on the person whose organs are taken and that this outweighs the interests of people on the waiting list.

One explanation appeals to the fact that a conscription policy would harm people by thwarting their interests.¹²⁹ Having an interest means having a “stake” in something, such as what happens to one’s organs or how one’s body is treated. According to a popular account of harm, if one’s interest is setback by some event or state of affairs, one is thereby harmed.¹³⁰ The harm-based explanation says that people have interests in not donating their organs or having control over what happens to their bodies after they die. If a person had an interest in keeping her body intact after she dies, and her organs are removed by conscription, this would set back or thwart her interest and harm her.¹³¹ Therefore, since conscription harms some people whose organs are taken, it is wrong. Call this the Harm View.

There are two problems for the Harm View. The first problem is that truth of the Harm View depends on the claim that if some action, X, sets back a person’s interest, then it is wrong to do X. But this claim is false. A student, for example, may have an interest in passing an important exam, but if his teacher fairly gives him a failing grade, she has harmed him but she has not wronged him. Or a department store may have an interest in securing me as a loyal customer, but if I decide to take my business elsewhere, I have harmed the interests of the department store, yet what I have done is not wrong. Thus, the mere fact that an action would set back a person’s interest is not by itself a reason to think that the act is wrong. What I have argued here does not imply that no harms are also wrongs. In fact, many harmful acts are indeed wrongful – for example, physically assaulting an innocent person is both harmful and wrongful. However, in order to be successful, the Harm View needs to show why the harm of thwarting a person’s interests about her organs is wrongful. In the next section, I will suggest that the notion

¹²⁹ Harris, John. 2002. “Law and Regulation of Retained Organs: the ethical issues”; Harris John. 2003. “Organ procurement: dead interests, living needs”.

¹³⁰ Feinberg, J. *Harm to Others* (New York: Oxford University Press), Chapter 1.

¹³¹ For the ease of discussion I will understand the ‘thwarting’ of an interest to be with interchangeable with the ‘setting back’ of an interest

of harm as a setback to a person's interest does play a role in the case against conscription. However, the Harm View, as I have set it out here, does not refute the standard pro-conscription argument.

The second problem for the Harm View is that even if we grant the fact that conscription harms people by thwarting their interests, a proponent of conscription can reasonably argue that the interests of living patients on the waiting list outweigh the posthumous interests of the now deceased. Thus, even if conscription would harm people by posthumously thwarting their interests, those interests are outweighed by the fact that conscription would prevent suffering and death for thousands of people. This is not at all unique to organ conscription; for it is often the case that harms in everyday life are justified by some outweighing good that is generated by the harm. For instance, in the case of assigning grades, the harm of some students receiving a bad grade on an exam is outweighed by the good of having a functioning and fair educational system.

Next, one might argue that conscription wrongly violates patient autonomy by taking organs without a person's consent.¹³² The idea is that there are some people who do not (or would not) consent to organ removal and yet a policy of conscription would take their organs anyway. Thus, according to this view, the wrong of removing a person's organs without their consent outweighs the interests of patients on the waiting list. Therefore, the standard pro-conscription argument is false. Call this the Consent view.

To my mind, the most significant problem for the Consent view is that taking a person's organs without her consent would be wrong *only if* the person has a right to not have her organs taken without her consent. To illustrate the plausibility of this latter claim, suppose Bill tells a stranger that she cannot attend a public park without his consent. It is plausible that attending the

¹³² Wilkinson, T.M. 2011. *Ethics and the Acquisition of Organs*, ch. 7; Delaney, J. and D. Hershenov 2009, "Why Consent May Not Be Needed For Organ Procurement".

park without Bill's consent would be wrong only if Bill has a right that others not attend the park without his consent. In the absence of this right, attending the park without Bill's consent would, all else being equal, not be wrong, even if it would harm Bill by thwarting his interest.

The next natural question, then, is: do people, when they are dead, have a right to not have their organs taken without their consent? This right, if it exists, is derivative from a person's more general right to not have their body invaded without her consent after she has died. Do deceased people have such a right? If they do, then it would be wrong to invade the bodies of the dead without their prior consent. However, Michael Gill (2004) has argued convincingly that it is not wrong to invade the bodies of the dead without their prior consent.¹³³ To make this argument, Gill distinguishes between two different models of respect for autonomy. The non-interference model says that "it is wrong to interfere with a person's body unless that person has given us explicit permission to do so", while the respect-for-wishes model says that we ought to treat a person's body in the way she wanted it treated.¹³⁴ Gill considers which model of autonomy should govern our treatment of brain-dead organ donors, and he argues that the non-interference model should not govern our treatment of brain dead individuals because it implies that we cannot do anything to the bodies of the dead unless they had given us explicit, prior permission to do so. But this is absurd, since we must touch the bodies of the dead in some way – for example, to transport their bodies or to dispose of them properly.¹³⁵ Thus if it were truly wrong to invade the bodies of the dead without their prior consent, then it would be wrong to transport or dispose of people's dead bodies because such people did not give us prior consent to invade or

¹³³ Gill, Michael B. 2004. "Presumed consent, autonomy, and organ donation." *Journal of Medicine and Philosophy* 29 (1): 37-59.

¹³⁴ Gill, Michael B. 2004. "Presumed consent, autonomy, and organ donation," p. 44.

¹³⁵ Gill, Michael B. 2004. "Presumed consent, autonomy, and organ donation," p. 45.

touch their bodies. But since it is clearly not wrong to transport or dispose of the bodies of people who previously did not consent to it, it is false that deceased people have a right to not have their bodies invaded without their consent. Consequently, it is false that people have a right to not have their organs taken without their consent. Thus, the Consent View, by itself, does not defeat the standard pro-conscription argument.

4.3 CONSCRIPTION AND RIGHTS

In the previous section I considered different attempts to provide an objection that defeats the standard pro-conscription argument. I have argued that all of these objections fail to defeat the standard pro-conscription argument. Fortunately, I believe there is a satisfactory explanation that undermines the standard pro-conscription argument. My strong thesis is that a conscription policy violates people's bodily rights and that this fact defeats the standard pro-conscription argument. By contrast, my weaker thesis is simply the claim that, if a conscription policy violates people's bodily rights, it constitutes the best objection against the standard pro-conscription argument. Thus, even if my strong thesis turns out to be unsuccessful, one might still affirm the weaker thesis.

To begin, a policy of conscription violates what I call the right of bodily refusal. The right of bodily refusal is the right to refuse that some intervention be performed on one's body. It entails a corresponding duty in others to not invade a person's body if that person refuses it. Thus, if a person refuses to undergo a bodily intervention, others have a duty to not invade her body.¹³⁶

¹³⁶ One might object not to my argument per se but to my claim to have identified the right that explains the wrongness of conscription policy. The objection is that what I have called the right of bodily refusal is simply another way of putting what others have called the right of bodily integrity (Wilkinson 2011,

To clarify the content and scope of the right of bodily refusal, three comments are in order. First one might wonder how a conscription policy would violate a person's right of bodily refusal. Briefly, if a person, while alive, refuses to have her organs removed after death, others have a duty to not remove her organs after she dies. However, under a conscription policy, a person's organs will be taken regardless of the fact that she refused. This violates the duty to not remove the person's organs and hence violates her right of bodily refusal.

Second, I treat the right of bodily refusal as a right that is capable of being overridden in some circumstances. If, for example, the right of bodily refusal conflicts with more stringent rights, then the right of bodily refusal can in principle be overridden. However, despite the fact that the right of bodily refusal can be overridden, I will argue that in the case of conscription it is not overridden by the interests of living patients on the waiting list.

Third, the right of bodily refusal is violated only in cases in which a person refuses that X be done to her body and then X is still done to her body, despite her refusal. Thus, if Julio refuses that his organs be removed after death, then others have a duty to not remove his organs after death. If others remove his organs despite his refusal, they have violated Julio's right of bodily refusal. This case should be contrasted with two other possible cases: cases where a person consents, while they are alive, to have their organs removed, and cases in which a person, while they are alive, neither consents nor refuses the removal of their organs. I assume that in cases in which a person consents to organ removal under a conscription policy, her right of bodily refusal is *not* violated if her organs are removed. In addition, in cases in which a person dies but

chapter 2; Thomson 1990, p. 205). The right of bodily integrity is the right against unconsented or unwanted invasions of one's body. The difference between the two rights can be seen by making explicit the corresponding duties that they entail. If a person has a right of bodily integrity, then others have a duty to not invade her body without her consent. By contrast, if a person has a right of bodily refusal, then others have a duty to honor her decision to refuse some bodily intervention. Since their corresponding duties are distinct, the right of bodily integrity is distinct from the right of bodily refusal.

previously neither consented nor refused the removal of her organs, I assume that removing her organs does not infringe on her right of bodily refusal.

Before I move on further, I should pause to comment on how my proposal differs from a similar proposal developed by T.M. Wilkinson (2011) in his book, *Ethics and the Acquisition of Organs*. Wilkinson argues that a policy of conscription would violate people's right to control what happens to their bodies after death -- the right of bodily control, as he calls it -- and therefore it is wrong to implement a policy of organ conscription.¹³⁷ My own view is similar to Wilkinson's in that we both appeal to bodily rights to explain the wrongness of conscription, but my own view differs in two important ways. First, Wilkinson does not distinguish between different cases as I have above. That is, he seems to think that conscription would violate people's right of bodily control across the board. By contrast, my view is that conscription would not violate the rights of people who consent to have their organs removed or want to have them removed, nor would it violate the bodily rights of people who neither consented nor refused. On my view, the only case in which conscription violates a person's rights is when they refuse that their organs be removed and they are removed anyway. Second, on my view, conscription violates a negative bodily right -- the right to refuse that something be done to one's body. By contrast, Wilkinson's account does not focus on the negative right of bodily refusal; it merely focuses on bodily control. But bodily control, taken most generally, seems to imply that people have positive and negative rights to control what happens to their bodies after death. My account against conscription does not require accepting that we have both positive and negative posthumous bodily rights. It only requires that we have a negative right of bodily refusal that can be violated posthumously.

¹³⁷ Wilkinson, T.M. 2011. *Ethics and the Acquisition of Organs*, ch. 1 and 7.

Now that I have explained how my own position differs from Wilkinson's, I can continue my explication and defense of the right of bodily refusal.

That living people have a right of bodily refusal is confirmed by our intuitions in a variety of other cases. Suppose Shane's physician wants him to undergo surgery to remove a cancerous tumor. Despite the doctor's recommendation, it is uncontroversial that Shane (if he is competent) has the right to refuse that the surgery take place. That is, it is a right of Shane's that, if he refuses to undergo the surgery, others have a duty to not perform the surgery on him. Or suppose that Andrew wants to undergo cosmetic surgery to correct a birth defect on his face. However, at the last second before the operation, he changes his mind and refuses it. It is clearly permissible for Andrew to do this and doctors are obligated to respect his decision. This is because Andrew has the right to refuse that the operation take place. Finally, imagine that Alice is a tissue match for her friend John, who is awaiting a new kidney. Suppose Alice refuses to give John her kidney. It is permissible for Alice to refuse to give the kidney to her friend John. The best explanation for the permissibility of Alice's failure to give John her kidney is that Alice has a right to refuse that her body be invaded (in this case, she has a right to refuse that her kidney be removed). Despite John's wish that he be given Alice's organ, others have a duty to honor Alice's refusal to give up her kidney. Notice that we can still say about Alice that perhaps she is not a nice person, or that she is greedy and not a true friend given her reluctance to donate her kidney. But we cannot say that she acts wrongly when she refuses to give up a kidney for her friend John. She is not very generous or kind, but she does not act impermissibly.

However, to claim that living people have a right of bodily refusal with respect to interventions that might happen to them while they are alive does not entail that people have a right of bodily refusal with respect to posthumous interventions. What is unique about the right

of bodily refusal in the context of organ conscription is that, if the right of bodily refusal is violated by organ conscription, it is violated only once the person has died. This can be seen by noting that the duty corresponding to the right of bodily refusal is the duty to not invade a person's body if that person refuses. This means that the right of bodily refusal is violated only once a person fails to carry out her duty to not invade another person's body. Since conscription happens only after a person has died, the corresponding duty to not invade that person's body cannot be violated until after she has died. This means that the right of bodily refusal is violated by a conscription policy only after a person has died. But how could a person have their rights violated after death if that person no longer exists and hence is no longer the subject of rights? As Partridge (1981) observed, the existence of a right requires a subject of that right¹³⁸, and the subject of the right of bodily refusal seems to be missing once the person has died.

What the aforementioned problem shows is that we need an account of posthumous rights if we are going to claim that a policy of conscription violates at least some peoples' right of bodily refusal. That is, we need to show how a person's rights can be violated by things that happen after her death. If there are at least some posthumous rights, and in particular, a posthumous right of bodily refusal, then a conscription policy could in principle violate that right. If a policy violates at least some peoples' rights, then it is wrong; hence, a policy of conscription is wrong. If this argument is correct then we have a powerful explanation for the wrongness of a conscription policy and a powerful objection against the standard pro-conscription argument.

4.3.1 An Account of Posthumous Rights

¹³⁸ Partridge E. 1981. "Posthumous Interests and Posthumous Respect." *Ethics* 91 (2): 243-264.

The claim that there are posthumous rights is somewhat of a misnomer. The term “posthumous rights” suggests that a dead body or corpse can have rights, or that a person existing in some afterlife can have rights. These are not the claims I wish to defend in this paper. Rather, the claim I wish to defend is that people while they are alive and competent have rights that certain states of affairs obtain after they are dead and those rights can be violated by events that happen after a person’s death. In particular, people while they are alive have a right to refuse that some intervention (in this case, organ removal) be performed on their body after they are dead.

It is helpful to situate the case for posthumous rights within the context of the two leading theories regarding the function of rights: the Choice Theory and The Interest Theory. These theories answer the question: what do rights do for the individuals who possess them? In other words, what is the function of rights? If the idea of posthumous rights is coherent given these two theories about the function of rights, then we have at least one powerful reason to think that there can be posthumous rights. Of course, this does not mean that there *is* a posthumous right of bodily refusal, though I will argue for this claim later in Section 3.2. For the sake of discussion, in the next section I will focus primarily on the Interest Theory of rights, although I do think that a Choice Theory of rights is compatible with the thesis of posthumous rights.

4.3.2 Choice and Interest Theories of Rights

The distinction between the Choice and Interest theories is a distinction about the function of rights. According to the Choice Theory of rights, the function of a right is to give the

person who holds a right the power to exercise that right.¹³⁹ If a person has the power to exercise a right, she has “powers both to waive and to secure its object’s compliance with the duty or disability correlatively entailed by it”.¹⁴⁰ Thus, on the Choice theory, the function of a right is linked to having the power to waive a right or demand that it be protected, satisfied, or enforced. Thus, if the Choice Theory is correct, then something is a right if it is a claim that is exercisable by the subject of the claim.¹⁴¹ If an individual has a claim that she cannot waive, demand, or exercise any power over, then that claim is not a right.

By contrast, the Interest Theory sees the function of rights as protecting the interests of individuals.¹⁴² Since the function of rights is that of protecting interests, in order to have a right an individual must have interests. As Cecile Fabre (2008) describes the Interest Theory, a person A has a right against another person B that B do X if B’s performance of his duty to do X preserves at least one A’s interests.¹⁴³ However, interests can vary in their importance and normative strength in such a way that some interests are not plausibly protected by rights. For instance, I have an interest in winning the lottery, but obviously I have no right to win the lottery. Thus, the Interest Theory requires that the interest(s) in question satisfy a certain condition in order to be protected by a right. According to the canonical version of the Interest theory developed by Raz (1986), a person has a right if an aspect of her well-being is sufficient reason

¹³⁹ Hart, H. 1982. *Essays on Bentham: Studies in Jurisprudence and Political Theory* (Oxford: Clarendon Press); Wellman, C. 1995, *Real Rights* (Oxford: Oxford University Press); Steiner, H. 1994. *An Essay on Rights* (Oxford: Blackwell).

¹⁴⁰ Steiner, H. 1994. *An Essay on Rights*, p. 61.

¹⁴¹ *Ibid.*

¹⁴² MacCormick, N. 1982. *Legal Right and Social Democracy* (Oxford: Oxford University Press); MacCormick, N. 1977. “Rights in Legislation”. In *Law, Morality and Society: Essays in Honour of H.L.A Hart*, eds. Hacker, P., and Raz, J. (Oxford: Oxford University Press); Raz, Joseph. 1986. *The Morality of Freedom* (Oxford: Oxford University Press); Kramer, M. 2013. “Some Doubts about Alternatives to the Interest Theory” *Ethics* 123: 245–63.

¹⁴³ Fabre, Cecile. 2008. “Posthumous Rights” In *The Legacy of H.L.A. Hart: Legal, Political, and Moral Philosophy*, ed. Matthew H. Kramer (Oxford: Oxford University Press), p. 225

for holding some other person to be under a duty.¹⁴⁴ In other words, a right is bestowed on a person when one of her interests is important enough to hold others to a duty to protect or preserve that interest(s). Given this understanding of the Interest Theory, a theory of posthumous rights requires an account of posthumous interests. But it also requires an account of posthumous harm, for as Fabre (2008) notes, “the degree to which an interest of X is important enough to warrant the imposition of a duty on Y is a function of the degree to which X would be harmed if Y desisted from acting as required by the duty”.¹⁴⁵ For example, I have an interest in not being physically assaulted and this plausibly generates a duty in others not to physically assault me. It generates this duty because if others decided to engage in physical assault towards me, I would be harmed to a significant degree.

Since the Choice Theory requires that a right holder have the ability to enforce her rights by demanding or waiving them, one might argue that if the Choice Theory is true, then there can be no posthumous rights. This is because, since posthumous rights are violated or protected only after a person has died, the person no longer exists and consequently cannot waive or demand that the relevant right be enforced or waived. This objection, however, is mistaken. Consider the right of bodily refusal. One could accept the Choice Theory and claim that the demanding or waiving of the right of bodily refusal occurs while a person is still alive, although the action that they are demanding or waiving occurs after their death. In particular, people while they are alive can refuse to have their organs removed for transplantation at the time of their deaths. However, the action that they are refusing – the removal of their organs – can occur only after they have died. The point is further strengthened by noting that the Choice theory is compatible with the claim that people, while they are alive and conscious, have a right to waive or demand that

¹⁴⁴ Raz, Joseph. 1986. *The Morality of Freedom*, p. 166.

¹⁴⁵ Fabre, Cecile. 2008. “Posthumous Rights,” p. 228.

certain things not be done to them when they are unconscious but alive. For example, while I am conscious I have a right to demand that you not touch me inappropriately when I am asleep. This means that when I am conscious I can demand that my rights be protected or enforced at a time at which I am not conscious. Thus, people while they are alive can exercise their right of bodily refusal, even though the event that they are demanding or waiving will take place only once they are dead. Therefore, the Choice Theory of rights is compatible with the posthumous right of bodily refusal.

Suppose now that we accepted the Interest Theory of Rights. If the Interest Theory of Rights is true, are there posthumous rights, and in particular, a posthumous right of bodily refusal? I argue that there is a posthumous right of bodily refusal.

4.3.3 Posthumous Interests and Posthumous Harm

As was the case with the thesis that there are posthumous rights, the claim that people have posthumous interests is somewhat misleading. To claim that a person has posthumous interests does not mean that a corpse or a dead body has interests that can be thwarted or satisfied. Rather, to say that people have posthumous interests is to claim that living people have certain interests that can be satisfied or thwarted only after they have died. To show that people have posthumous interests, consider the uncontroversial fact that many people have posthumous desires: some people have the desire that their grandchildren will live happy and successful lives even after they have died; some business owners have a desire that their business will flourish even after they die; still others have a desire to have their bodies cremated after death. It is also uncontroversial that some people have posthumous desires regarding their organs. Some people, while alive, desire that their organs not be removed for transplantation after they have died,

while others have a desire that their organs be removed and used in transplantation. Others yet have a desire that when they refuse the removal of their organs, their organs will not be taken after they die.

My claim is that some desires about one's body are plausibly regarded as belonging to a person's interests. In particular, a person's desire to successfully refuse the removal of her organs after she has died is plausibly regarded as one of her interests. The argument for this is that a person's desire to refuse some bodily intervention be done to them while they are alive is plausibly regarded as one of her interests. But if a person's desire to refuse that some bodily intervention be done to her while she is alive counts as one of her interests, then a person's desire to refuse that some bodily intervention be done to her when she is dead also counts as one of her interests.

Another route to the same conclusion is to suppose that the Subjective view of Interests is true. On the Subjective view of Interests, a person's interests are just what she desires. On this view, then, we can claim that a person's desire to refuse that her organs be removed after she dies is one of her interests.

So far I have argued that people have a posthumous interest in successfully refusing the removal of their organs after death. To establish that this interest in bodily refusal is protected by a posthumous right, one must establish that the harm of thwarting the interest warrants holding others to a duty to not thwart it. Before we argue whether the harm of thwarting a person's interest in successfully refusing the removal of organs warrants holding others under a duty, it must be explained how a person can be harmed after her death by the thwarting of her interest in bodily refusal. This is because, once a person is dead, there is no subject of harm. And if there is

no subject of harm, it is false that the person was harmed by the thwarting of her posthumous interest in bodily refusal.

According to a popular account of harm, if one's interest is setback by some event or state of affairs, one is harmed by that event or state of affairs.¹⁴⁶ For example, if I have an interest in coming first in a competitive race and another person beats me, the event of that person beating me in the race sets back or thwarts my interest and harms me. Or if I have an interest in not having a life-threatening illness and I later develop cancer, the state of affairs involving my getting cancer thwarts my interest and harms me. Something similar can be said about people's posthumous interests. According to George Pitcher (1984), people can be harmed by the thwarting of their posthumous interests.¹⁴⁷ To take a simple case, suppose Ben has an interest in refusing that his organs be removed for transplantation after he is dead. Thus, he tells his wife that he refuses to have his organs removed after he has died. However, after his death his wife Lisa permits the removal of his organs for transplantation. According to Pitcher, the removal of Ben's organs thwarted his interest in refusing that they be removed and thereby harms him. Since harm requires a subject, Pitcher makes a distinction between the ante-mortem person and the post-mortem person. The ante-mortem person refers to the now dead person as she was as a living, breathing human being with interests. The post-mortem person, by contrast, refers to the remaining corpse or body of the formerly living person.¹⁴⁸ Pitcher claims that events that occur after a person's death can harm the ante-mortem person by thwarting her interests. Thus, the removal of Ben's organs harmed ante-mortem Ben by thwarting ante-mortem Ben's interest in refusing the removal of his organs.

¹⁴⁶ Feinberg 1984, *Harm To Others*, Chapter 1.

¹⁴⁷ Pitcher, G. 1984. "The Misfortunes of the Dead". *American Philosophical Quarterly* Vol. 21 No 2: 183-188.

¹⁴⁸ Pitcher, G. 1984. "The Misfortunes of the Dead," p. 184.

It is important to note that the sense in which a state of affairs harms a person is logical rather than causal. Understanding the harming relation as a logical rather than causal one sidesteps worries about backwards causation.¹⁴⁹ As Pitcher explains, “the sense in which an ante-mortem person is harmed by an unfortunate event after his death is this: the occurrence of the event makes it true that during the time before the person's death, he was harmed -- harmed in that the unfortunate event was going to happen”.¹⁵⁰ In other words, the obtaining of some event or state of affairs makes it true that a person's interest was thwarted, and hence, that he was harmed. In the case of Ben and his interest in having his body be buried intact, Pitcher is committed to saying that the fact that Lisa thwarted Ben's interest after Ben's death made it true that Ben was in a harmed state while he was alive.

It is now time to take stock. I have so far considered whether there can be posthumous rights under either the Choice Theory of rights or the Interest Theory of rights. I have focused on the Interest Theory and have argued that there are posthumous interests regarding the body, and in particular, that some people have an interest in successfully refusing that their organs be removed after death. By utilizing Pitcher's account of posthumous harm, I have also argued that a person's interests regarding her organs can be thwarted after her death, and that the thwarting of these interests can harm the ante-mortem person. This result is promising, since, in order to argue for the thesis of posthumous rights under the Interest theory, we must provide an account of posthumous interests and an account of posthumous harm. There is however a final step in

¹⁴⁹ The backwards causation worry can be put as follows: According to Pitcher, the event that harms Ben takes place after he is dead. At the same time, however, it is Ben, while he is alive, that is the subject of the harm brought about by Lisa cremating his remains. Both of these claims appear to imply that living Ben suffers harm before the event that harms him takes place. But this seems to require the possibility of backwards causation, for the cause of Ben being harmed – the event of Lisa cremating his body -- occurs temporally after Ben is alive and allegedly in a harmed state. But, the objection goes, backward causation is impossible, and hence the Pitcher account fails.

¹⁵⁰ Pitcher, G. “The Misfortunes of the Dead,” p. 187.

demonstrating that people have posthumous rights regarding their bodies, and in particular, their organs. I must show that peoples' interest in having the ability to refuse the removal of their organs is important enough to warrant holding others to a duty to not thwart this interest. To show that the interest in bodily refusal *is* important enough to warrant holding others to a duty to not thwart it, I must show that the harm imposed on a person by the thwarting of the interest in bodily refusal is sufficient to hold others to a duty to not thwart it. To that end I not turn.

4. 4 WHY ORGAN CONSCRIPTION VIOLATES THE POSTHUMOUS RIGHT OF BODILY REFUSAL

In this section I will defend the Rights-Based Argument Against Conscription. Furthermore, I will argue that the Rights-Based argument defeats the standard pro-conscription argument. I will then consider objections to my argument.

4. 4. 1 The Rights-Based Argument Against Conscription

In summary, the Rights-Based Argument Against Conscription says:

(P1) If the harm of thwarting a person's interest in refusing the posthumous removal of her organs is significant enough to warrant holding others to a duty to not thwart it, then people have a posthumous right of bodily refusal.

(P2) The harm of thwarting a person's interest in refusing the posthumous removal of her organs is significant enough to warrant holding others to a duty to not thwart it.

(C) Therefore, people have a posthumous right of bodily refusal.

The controversial premise of the argument is (P2). To defend it, I will present an argument by analogy. To begin that argument, consider the following case:

Living Mouth Swab. Researchers now have the technology to grow new organs for people in need. They do this by taking cells from a person's mouth via a painless mouth swab. The only condition is that the person whose cells are taken must have the same blood type as the recipient who will receive the organ. Suppose Maria is a blood-type match for a patient who needs a new kidney or will die within the next year. However, when asked by doctors about undergoing the mouth swab, Maria adamantly refuses. Knowing that she refused, the doctors perform the mouth swab, unbeknownst to Maria, while she is undergoing another, unrelated procedure. The doctors then use the cells taken by the mouth swab to create a new kidney, which is then used save the life of a patient who needs it. Maria never finds out that the doctors performed a mouth swab on her.

I suspect that most people will have the judgment that it is wrong for the doctors to swab Maria's mouth when she in fact refused that it be done. The reason it is wrong seems to be that the harm brought about by the thwarting of Maria's bodily interest in successfully refusing to have her mouth swabbed seems sufficient to hold others to a duty to not do it. And this is true despite the fact that Maria neither experiences the fact that her mouth was swabbed nor does she experience any effects of the swab. Since the harm of thwarting Maria's interest in successfully refusing the

mouth swab is sufficient to hold others to a duty to not do it, it follows from the Interest Theory that Maria has a right of bodily refusal against people swabbing her mouth. But now consider the following case:

Posthumous Mouth Swab. Researchers now have the technology to grow new organs for people in need. They do this by taking cells from a person's mouth via a painless mouth swab. The only condition is that the person whose cells are taken must have the same blood type as the recipient who will receive the organ. Suppose Albert has a terminal illness and he is spending his last few months of life in a hospital bed. Albert is a blood-type match for a patient who needs a new kidney or will die within the next year. Doctors ask Albert if he would like to posthumously donate cells to a patient in need by having his mouth swabbed. Oscar refuses and is adamant in his refusal. He even tells his family that he does not want his mouth swabbed after he dies. However, despite knowing that he refused, doctors swab Albert's mouth immediately after he dies.

Living Mouth Swab and Posthumous Mouth Swab are morally analogous because they share an important feature: in both cases, a competent person's interest in refusing that her mouth be swabbed is thwarted. Therefore, since they are morally analogous in this respect, if Maria has a right of bodily refusal against her mouth being swabbed, then Albert has a posthumous right of bodily refusal against his mouth being swabbed as well.

But notice that Posthumous Mouth Swab is morally analogous to cases of posthumous organ conscription in which a person refuses the removal of her organs and they are removed anyway. In both cases a competent person refuses that some invasive procedure be performed on

her body and yet that intervention is performed on her body despite her refusal. Since the cases are analogous in this respect, because Albert in Posthumous Mouth Swab has a right of bodily refusal, it follows that people who refuse to have their organs removed after death also have a right of bodily refusal. (P2) is thus true.

I have claimed that Living Mouth Swab is morally analogous to Posthumous Mouth Swab with respect to the fact that in both cases a person refuses that some intervention be performed on her body and yet it is done anyway. I have also claimed that Posthumous Mouth swab is morally analogous to cases of posthumous organ conscription with respect to the fact that in both cases a person refuses that some intervention be done to her body and yet it is done regardless. But if Living Mouth Swab is morally analogous to Posthumous Mouth Swab, and Posthumous Mouth Swab is morally analogous to cases of posthumous organ conscription, it follows that Living Mouth Swab is morally analogous to posthumous organ conscription with respect to the fact that in both cases a competent person refuses that some intervention be done to her body and yet it is done anyway. Since the two cases are analogous in this respect, since the harm of thwarting Maria's bodily interest in successfully refusing to have her mouth swabbed is sufficient to hold others to a duty to not do it, it follows that the harm of thwarting people's interest in successfully refusing the removal of their organs is also sufficient to hold others to a duty to not remove their organs. Thus, by this argument from analogy, I have established that (P2) of the Rights-Based Argument Against Conscription is true. That is, I have established that the harm of thwarting a person's interest in refusing the posthumous removal of her organs is significant enough to warrant holding others to a duty to not thwart it.

Since Living Mouth Swab and cases of posthumous organ conscription are morally analogous in this respect, we can now formulate an argument which claims that a person's right

of bodily refusal against her organs being posthumously conscripted outweighs the interests of living patients who need her organs:

(P3) If Maria's right of bodily refusal in Living Mouth Swab outweighs the interests of the living patient who needs a new kidney to continue living, then a person's right of bodily refusal in cases of posthumous conscription outweighs the interests of living patients who need her organ(s) to continue living.

(P4) Maria's right of bodily refusal in Living Mouth Swab does outweigh the interests of living patients who need a new organ to continue living.

(C) Therefore, a person's right of bodily refusal in cases of posthumous conscription outweighs the interests of living patients who need her organ(s) to continue living

The truth of (C) entails that the standard pro-conscription is unsound. We can see this by adding (C) as an additional premise of the standard pro-conscription argument:

(P1) People who need organ transplants have a great interest in continuing to live or improving the quality of their lives

(P2) Whatever interests or moral claims that people have over what happens to their organs after they die, those interests or moral claims are outweighed by the interests of people who need organs to continue living.

(C)* But a person's right of bodily refusal in cases of posthumous conscription is a moral claim that outweighs the interests of living patients who need her organ(s) to continue living

(P3) We ought to act in a way that fulfills the more important interests or moral claims.

(C2) Therefore, we ought not conscript organs.

Thus, the Rights-Based Argument against Conscription defeats the standard pro-conscription argument.

4.4.2 Objections to the Rights-Based Argument

At this point we should consider some objections to my argument. The first objection attempts to identify a morally relevant difference between Living Mouth Swab and posthumous conscription cases in which a person refuses to have organs removed yet they are removed anyway (for ease of reference I will call these "posthumous conscription cases" for the rest of the paper). One disanalogy is that in Living Mouth Swab, Maria *exists* while her interest is being thwarted, while in posthumous conscription the person whose organs are removed no longer exists. In its barest form, we might state this disanalogy as an objection about the subject of

harm: in particular, while there is an existing subject of harm in Living Mouth Swab, there is no existing subject of harm in the posthumous conscription case. Therefore, the cases are disanalogous. But this objection fails. The subject of harm in the posthumous conscription case is the ante-mortem person who had a posthumous interest in not having her organs removed. Therefore, there is no disanalogy with respect to the subject of harm, since both cases have the same subject of harm: the living person.

Another way to state this objection is that the difference between Living Mouth Swab and posthumous conscription is that in the former, the subject of the harm is alive, while in the latter the subject of harm is dead. But this objection also fails because the ante-mortem person, who is the subject of harm in case of posthumous conscription, is by definition a living person. Indeed, Pitcher's account of posthumous harm is committed to the claim that the living person is harmed by the fact that certain events or states of affairs will occur after they are dead. Thus, there is no disanalogy regarding the subject of harm, since both Living Mouth Swab and posthumous conscription cases have living persons as the subject of harm.

Another objection claims that we cannot use our judgment in Living Mouth Swab to argue for the claim that in cases of posthumous organ conscription, it is wrong to remove a person's organs when they refused. According to this objection, we judge that it is wrong to swab Maria's mouth in Living Mouth Swab because we implicitly believe that there is a risk that Maria will find out or discover that this was done against her will. And if she finds out or discovers that the mouth swab was performed, her well-being will be adversely affected. But this reason is completely absent from the case of posthumous organ conscription because a dead person cannot find out or discover that her organs were removed against her will.

But this objection is not plausible, for we can reimagine Living Mouth Swab so that the risk that Maria will find out or discover that the mouth swab was performed is eliminated.

Consider:

Living Mouth Swab 2. Researchers now have the technology to grow new organs for people in need. They do this by taking cells from a person's mouth via a painless mouth swab. The only condition is that the person whose cells are taken must have the same blood type as the recipient who will receive the organ. Suppose Maria is a blood-type match for a patient who needs a new kidney or will die within the next year. However, when asked by doctors about undergoing the mouth swab, Maria adamantly refuses. Knowing that she refused, the doctors perform the mouth swab, unbeknownst to Maria, while she is undergoing another, unrelated procedure. The doctors then use the cells taken by the mouth swab to create a new kidney, which is then used save the life of a patient who needs it. Shortly after Maria awakes from her procedure, she suffers a massive heart attack and dies.

When the case is reimaged to exclude the possibility of Maria discovering that the mouth swab was performed, it does not change our initial judgment in the original case. Indeed, we still believe that it was wrong to swab Maria's mouth when she refused. Thus, if it was wrong to swab Maria's mouth it is not because there was a risk that she would discover that it was swabbed. Rather, the most plausible explanation is that she refused that it be done to her and yet it was done anyway. Thus, the objection fails.

Yet another objection focuses on our judgments about Living Mouth Swab. The success of my argument depends on accepting the judgment that, in Living Mouth Swab, the harm of thwarting Maria's interest in successfully refusing the mouth swab is sufficient to hold others to a duty to not do it, even if doing so means not saving a person on the waiting list. But some people may not share this judgment and instead might argue that even if Maria refuses the mouth swab, it is not wrong to perform the mouth swab on her in order to save another person's life.

To reply to this objection, it is helpful to consider other cases in which a person refuses that some bodily intervention be performed on her and yet it is performed anyway to save another patient's life. Furthermore, the relevant cases are ones in which the critic would likely agree that it is wrong to perform the bodily intervention on the person, even if not doing so would result in the failure to save a person's life. With respect to these cases, if the reason it is wrong to perform the bodily intervention on the person is the *same* reason it is wrong to perform the mouth swab in Living Mouth Swab, then the critic must, on pain of consistency, commit to the view that it is wrong to perform the mouth swab on Maria in Living Mouth Swab. But if it is wrong to perform the mouth swab on Maria, then it must be because her right in refusing that the mouth swab be done to her outweighs the interests of patients who need a new organ to continue living. Consider, then, the following case:

Living Conscription. Mark is a future denizen of a country that utilizes a living conscription policy for non-essential organs. Mark has two kidneys and has no known diseases that could complicate his health with one kidney. Furthermore, the procedure is very safe. Thus, Mark is a candidate for having his first kidney removed in order to be given to another person who will soon die without a new kidney. But suppose Mark hates

the idea of having his first kidney taken and so he refuses to give it up. Despite his refusal, the State takes his first kidney.

Now, suppose the critic agrees that it is wrong to remove Mark's kidney. One prima facie plausible explanation for the wrongness of removing his kidney is that doing so might have negative effects on his health and well-being. Therefore it is wrong to remove his kidney. Since this is not the reason it is wrong to remove Maria's kidney, I cannot claim that the reason it is wrong to remove Mark's kidney is the same reason it is wrong to remove Maria's kidney. However, the problem is that what explains the wrongness of removing Mark's kidney is not the fact that doing so is risky to his health and well-being. This is because, had Mark given his informed consent to donate his kidney, nobody would reasonably object that removing his kidney is wrong because it might have a negative impact on his health or well-being. This suggests that in Living Conscription, it is not the risk of harm to Mark's health or well-being that explains why it is wrong to remove his kidney (Indeed, the case assumes that the procedure is safe and that Mark is in good health). Rather, what plausibly explains the wrongness of removing Mark's kidney is the fact that he refused that it be removed and yet it was taken, against his will, anyway. But if this is the reason it is wrong to remove Mark's kidney in Living Conscription, then the critic must also be committed to the view that in Living Mouth Swab, it is wrong to perform the mouth swab on Maria because she has refused that her mouth be swabbed and yet it was done anyway. Since it is wrong to perform the Mouth Swab on Maria, it must be because her right to refuse that the mouth swab be performed outweighs the interests of patients who need a new organ to continue living.

Thus, in order to avoid a commitment to claiming that it is wrong to perform the mouth swab on Maria because she refused it and it was done anyway, the objector must give an argument which shows that the most plausible reason it is wrong to remove Mark's kidney in Living Conscription is different than the reason it is wrong to perform the mouth swab on Maria.

In this section I have argued that the degree of harm of thwarting a person's posthumous interest in having the ability to refuse the removal of her organs is significant enough to hold others to a duty to not thwart it. Since this is the case, it follows from the Interest theory of Rights that people have a posthumous right of bodily refusal, which entails that others have a duty to not remove a person's organs if she refuses that they be removed. I have also argued that the Rights-Based Argument against Conscription defeats the standard pro-conscription argument.

Recall that my strong thesis in this paper is that the Rights-Based Argument defeats the standard pro-conscription argument, while my weaker thesis is that the Rights-Based Argument is the best objection against the standard pro-conscription argument. I have already argued in favor of my strong thesis. My weak thesis, however, is true because I have shown, in Section 2, that other objections against the standard pro-conscription argument fail to defeat it. By contrast, the Rights-Based Argument does defeat it, and hence, it constitutes the best objection to the standard pro-conscription argument.

4.5 CONCLUSION

A policy of conscription is an attractive policy if we are morally concerned with saving lives. While the temptation to focus on, and perhaps give the most weight to, saving the lives of people on the waiting list is understandable, we must also consider people's bodily rights. Once

we clarify the sense in which organ conscription violates at least some people's bodily rights, we will see that the standard pro-conscription argument fails.

This paper has considered what I have called the standard pro-conscription argument. In response to this argument, I argued for two related theses. First, I argued for the weak thesis that the Rights-Based argument against Conscription is the best objection to the standard pro-conscription argument. I argued for this weak thesis by showing how other objections to the standard pro-conscription argument fail to defeat it or seriously undermine it. I also argued for a strong thesis, which is that the Rights-Based Argument actually defeats the standard pro-conscription argument. Thus, even if one has not been convinced that I have successfully defended the strong thesis, one might still agree that I have established the weak thesis.

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