

ORIGINAL ARTICLE

Do the sick have a right to cadaveric organs?

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One way of increasing the supply of organs for transplantation is to adopt a policy giving the sick a right to cadaveric organs. Such a right would entail the coercive transfer of organs from the dead without their previous consent. Because this policy would violate individual autonomy and the special relation between humans and their bodies, it would be morally unjustifiable. Although a rights-based non-consensual model of salvaging cadaveric organs would be medically desirable, a communitarian-based consensual model would be a morally justifiable alternative way of addressing the problem of organ scarcity.

For people with end stage liver or heart failure, a transplant of the critical organ offers the only possibility of survival. People with renal failure can survive on dialysis, though a kidney transplant can lead to a much better quality of life. Assuming that there is a good tissue match between donor and recipient to minimise the likelihood of graft rejection, and there are no significant comorbid medical conditions, organ transplants can benefit people not only by saving their lives but also by restoring them to a decent quality of life. In 2002, 396 people had received a transplant in the United Kingdom and the Republic of Ireland as of March. There were 136 organ donors, but 5776 people were still waiting for an organ. In 2000, there were 1440 people on the waiting list in the Netherlands, with 569 cadaveric organs transplanted. The numbers in Germany were 10 945 waiting and 3130 transplanted. In the United States, 69 399 people were waiting for an organ in 2000. A total of 8059 organs were recovered. Living donors contributed 3268 organs, while 4791 were cadaveric organs. In that same year, 5794 Americans died waiting for an organ transplant.¹

Given the global disparity between the supply of and demand for human organs for transplantation, and given that living and cadaveric organ donation have done little to alleviate this shortage, some might argue that those who are sick due to organ failure should have a right to cadaveric organs. This right would entail the coercive transfer of organs by the state from those who have been declared dead, even if they did not consent to the harvesting of their organs while they were alive. As a matter of justice, the sick should have an equal opportunity for as many years of health and life as once healthy people who have just died. Non-consensual harvesting of cadaveric organs could significantly increase the availability of organs. Many people would benefit from more organ transplants.

But humans can have interests that survive their deaths. Failing to respect interests that humans expressed while they were alive and which survive their deaths can harm them posthumously. Unlike the idea of the coercive transfer of material resources in the form of estate taxes on the property of the deceased, the coercive transfer of cadaveric organs without express consent would violate something essential to who we are as humans. Although we are not identical to our bodies, we are constituted by our bodies and stand in a special relation to them, a relation that is deeply significant for the value of our lives. Thus the expression of an interest in how our bodies are treated after we die commands respect and places deontological constraints on what others can or cannot do to our bodies.

Because of these constraints, while non-consensual harvesting of organs from the dead is medically desirable, it is not morally justifiable. A right to cadaveric organs would entail the coercive transfer of these organs. But if the coercive transfer of organs is not morally justifiable, then there is no right to them. The negative right not to be harmed by the defeat of one's interest in dying with one's body intact overrides the putative positive right of the sick to one's organs after death. If the sick did have such a right, then it could result in unfair consequences for those who had expressed an interest in bodily integrity after death. Organs could be harvested for transplantation from some but not others on the basis of medical factors beyond their control. Against the rights-based non-consensual model, I will argue that a communitarian-based model that respects individual autonomy is a morally defensible alternative to the problem of organ scarcity. On this model, the obligation to have one's organs harvested after death is not generated by claims of the sick, but instead by the sharing of interests, needs, and values with others in a social or religious community. This will not solve the problem of organ scarcity, but it can promote increased organ donation in a morally justifiable way.

SURVIVING INTERESTS AND POSTHUMOUS HARM

The idea that the sick have a right to cadaveric organs is grounded partly in the belief that these organs are no longer of any use to the dead. Viable and therefore useful body parts can be treated as state property. This was the rationale behind what Jesse Dukeminier and David Sanders called "routine salvaging".² They reasoned that no harm could be done by salvaging organs from human cadavers, so it was justifiable for society to routinely take viable body parts without the formal permission of the dying or their families. Indeed, great good could result from saving the lives of those who would receive the transplanted organs. More lives would be saved, and none would be lost. The utilitarian argument behind this policy would appear to outweigh any deontological concerns about the rights or interests of the dead. For the dead would no longer have any interests that could be defeated or rights that could be violated.

Many philosophers hold that having interests presupposes the capacity for consciousness and other forms of mental life. Personhood consists in this capacity, which requires the structural and functional integrity of the higher brain, the cerebral cortex.³ A person dies when this integrity is irreversibly lost. But this is only one of three criteria of death that have figured

in the debate on organ transplantation. The others are the cardiopulmonary criterion, which says that death occurs when the heart and lungs permanently cease to function, and the whole brain criterion, which says that death occurs when all brain functions, including those of the brain stem, permanently cease.⁴ Unlike the first, the latter two criteria are formulated in terms of the broader concept of “human being” rather than the narrower concept of “person”. Although there may be philosophical reasons for adopting the higher brain criterion of death in deciding when to harvest organs, the whole brain criterion still forms the legal basis for harvesting. In keeping with legal precedent, I will assume that this criterion is necessary and sufficient for declaring that a human being is no longer alive. Once a human has been declared dead by the whole brain definition, there should be nothing morally objectionable about removing organs from the body for transplantation to save other human lives.

This does not mean, however, that there are no deontological constraints on taking organs from the deceased. Before dying, an individual may have expressed a conviction in the importance of bodily integrity and a corresponding wish that his body remain intact once he is declared dead. Harvesting his organs could defeat his surviving interest and thus harm him. Joel Feinberg and other philosophers have argued that humans can be harmed by the defeat of their interests after they have died.⁵ Feinberg maintains that the subject of the surviving interest defeated posthumously is the living individual before death whose interest it was. The harming relation is not causal but logical. That is, if one’s interest in bodily integrity and not having one’s organs harvested after death fails to be respected by others, then this makes it true that one’s interest fails to be respected while one is alive. This is a harm that can befall one posthumously because it is timelessly true of one. The idea of posthumous harm generates obligations for others to respect the surviving interests of the dead, and these obligations entail constraints on what we can do to their bodies after they die. Because individuals can be harmed by failing to respect their interests and values in this way, deontological considerations of what can be done to the body can outweigh utilitarian considerations of the good that harvesting organs from the body would do for the sick needing organ transplants.

Ronald Dworkin supports Feinberg’s position in distinguishing between “experiential” and “critical” interests.⁶ While the first type of interest can be fulfilled or defeated only when we exist, the second type involves interests that can survive and be fulfilled or defeated after we die. The conditions stipulated in a will would be an example of a surviving interest, as would an expressed desire that one’s body remain intact, or that one’s organs be harvested for transplantation. These interests can generate an obligation for others to respect them following the deaths of the individuals who expressed them.

The principle underlying this view is not a property right over one’s body, but rather individual autonomy, the right to live out one’s life according to a plan of one’s own making. A surviving interest in bodily integrity after death can be an integral part of one’s life plan, and it can generate an obligation for others not to interfere with the realisation of that life plan. Some might argue that, once they have been declared dead, humans no longer can have any interests regarding what is or is not done to their bodies. To insist that they can is to ignore the fact that, although we are constituted by our bodies, we are not identical to them.⁷ Nevertheless, even if humans and their bodies are distinct ontological types, humans stand in a special relation to their bodies. The body is essential to the development of a self in a life plan. Because the body is so closely associated with who we are, we can have an interest in what is done to it even after we cease to exist. The fact that my body is mine and is essential to my life plan means that I have a deep interest in what is done to it. If it is

treated in a way that does not accord with my wishes or interests, then in an important respect this can be bad for me and I can be harmed. The special relation between humans and their bodies can make it wrong for others to ignore the expressed wish that one’s organs not be harvested at death, despite their viability for transplantation.

Negative rights have more moral force than positive rights. The right not to be interfered with puts a stronger moral obligation on others than does the right to be aided by them.⁸ This is not due to the risk of harm to oneself in aiding others, but instead to the moral importance of individual autonomy. We may be morally permitted or obligated to aid others in need, depending on such factors as their degree of need and the risk of harm to ourselves in aiding them. But there is a greater degree of moral obligation not to interfere with one’s autonomy. Given the special relation between humans and their bodies, the moral importance of individual autonomy in having a life plan, and that what happens to one’s body after death is part of such a plan, the negative right to bodily integrity after death outweighs any presumed positive right of the sick to receive organs from those who did not consent to cadaver donation. This deontological constraint can be sustained despite the utilitarian good that would result from the transfer of organs from the dead to those who are dying from organ failure. The main objection to the utilitarian argument for non-consensual harvesting is that it ignores or overrides one’s basic negative right to decide what others can or cannot do to one’s body.

The motivation for a constraint on routine salvaging of cadaveric organs is that it would mistakenly presume tacit consent from a significant number of individuals who would not have given consent if they had been asked. Robert Veatch cites surveys showing that at most 69% of individuals would be either “very likely” or “somewhat likely” to consent to having their organs harvested for transplantation. He argues that presumed consent is “an ill-informed notion at best . . . and an outright deception at worst”.⁹ Further, he says that “in a society that affirms the right of the individual not to have his or her body invaded without appropriate consent, procuring organs on the basis of a presumption of consent will violate that right at least 30% of the time”.¹⁰ The concern here is with taking organs from the dead when they had made no decision about donation while they were alive. This is distinct from not allowing individuals to make such a decision. A right of the sick to cadaveric organs would mean that individuals would have no choice about what is done to their bodies. It would be more morally objectionable than presumed consent because it would entirely ignore individual autonomy and the negative right to bodily non-interference.

Individuals should have the unconditional choice of opting out of routine salvaging of their future cadaveric organs. We should follow the policy of routine salvaging with opting out. Crucially, this policy requires explicit consent to cadaver organ procurement, not merely presumed consent. In the absence of explicit consent, a wish not to donate and a decision to opt out of salvaging should be presumed. Veatch articulates the principle behind this policy:

If we are a society that insists on respecting the integrity and autonomy of the individual, we will not assume that something as closely associated with the essence of the individual as his or her body can be appropriated by the state without permission. Even with an opt-out, the assumption that those who don’t want their bodies taken must actively register their objection raises serious questions. It seems to get the priorities backward. Preserving the priority of the individual as much as possible seems like a noble and worthwhile goal.¹¹

FACTORS OF UNFAIRNESS

The idea that the sick have a right to cadaveric organs suggests a relation between two parties: the sick making a claim to

receive these organs; and the once healthy dying or deceased, whose organs can be harvested after their death without their previous consent. This relation is misleading, however, because it leaves out of the picture a critical third party: medical professionals determining who should receive an organ transplant. At issue here is not the moral question of justice, but the medical question of efficacy in assessing which potential recipients would have a better outcome with a new organ, as well as which organs would be more likely to yield such an outcome.

In the light of these third party considerations, a right of the sick to cadaveric organs could be unfair to those who have a surviving interest in bodily integrity. Suppose that each of two 30 year old individuals who have had healthy lives present with acute injuries in emergency. Although death is imminent for both, their livers are still viable and are considered potential organs for transplantation. Just before lapsing into unconsciousness, both express the wish that their bodies remain intact and that none of their organs be harvested when they die, despite any good that might result from it. One of them is a better HLA (human leukocyte antigen) match for an otherwise healthy 20 year old with acute liver failure. This match would minimise the risk of graft rejection and thus would suggest a good outcome for a liver transplant. But if only one of the two dying patients is a suitable source of the organ because of his HLA status, then it would be unfair to take his liver from his body for the transplant. The sick 20 year old's claim applies equally to the two dying individuals, each of whom has a surviving interest in bodily integrity. Yet, the decision to salvage one liver but not the other would be based on medical factors beyond their control that have nothing to do with the moral factor of justice. With the new immunosuppressive drugs, matching of donor and recipient antigens is less critical. But the long term outcomes of transplants involving donors and recipients with a different HLA status are still unknown. Transplant teams continue to match antigens, so it remains an important factor in transplantation.

In standard discussions of justice in allocating scarce organs for transplantation, the main question is which of two potential recipients should receive an organ, given that each has an equal need and thus an equal claim to it. In contrast, here the relation is between a potential recipient and a potential source of the organ. Yet in each case the moral question of justice is mediated by the medical question of how to bring about the best health outcome. This determination is made by a third party transplant team and involves assessing both the medical status of the source of the liver and the likely medical benefit to the recipient. Because such a determination would be made on the basis of medical factors beyond their control, it would be unfair to override the surviving interest of one but not the other individual by taking his liver.

A similar unfair scenario would arise in the case of two dying potential sources of a cadaveric liver who differed significantly in age. If these patients were 25 and 50 years of age and both had viable organs, the biological age of the latter might indicate less than an optimal outcome in transplantation than the former. Suppose that at an earlier time both patients clearly indicated that they did not want any of their organs harvested once they were declared dead. For the medical reason just mentioned, the liver most likely would be taken from the younger rather than from the older patient. This would be unfair to the younger patient because the decision to take his organ would be based on medical factors beyond his control. It would be unfair because the claim of the sick to receive an organ would be based on considerations of justice, and presumably justice can override the dying patient's refusal to consent to the harvesting of his organ. Yet this decision would not be based on justice but instead on the estimated medical outcome.

All of the points in this and the preceding section undermine any possible justification for the practice of taking

organs from the dead without their previous consent. A right is a claim by some entailing an obligation for others to fulfil that claim. A right of the sick to cadaveric organs would entail a strict obligation for people to give up their organs when they die. But if autonomy means that there is no strict obligation to give up one's organs, then there cannot be a corresponding right of the sick to these organs. When people express the wish that their bodies remain intact after death, this wish should be respected. Given the moral importance of individual autonomy in general and bodily integrity in particular, it would be morally unjustifiable to override such a wish, despite any benefit that might go to those needing organ transplants.

COMMUNITARIAN-BASED DONATION

Thus far, I have presented only a negative argument against a rights-based model of non-consensual routine salvaging. A positive argument is needed as a constructive alternative to address the disparity between the availability of and need for organs. I propose a model of organ donation as a form of giving back something to the community from which one has benefited over the course of one's life. The idea of donation as giving back (as distinct from simply giving) implies an obligation and accordingly should not be confused with the idea of donation as a gift or an altruistic act.¹² By definition, these actions are not obligatory but supererogatory, beyond the call of duty or obligation. The sense of obligation to donate cadaveric organs is not generated from a right or claim by others, but instead from the idea that one shares common interests, needs, and values with other individuals in a community.

"Community" can be understood in narrower religious terms (members of the same faith) or in broader social terms (constituents of a city, state, or humanity in general). Because an individual who has had a reasonably long and healthy life is likely to have had her medical needs met at some or many times over the course of her life, the benefit she has received generates an expectation to act so that the medical needs of others can be met over the course of their lives.¹³ This expectation creates an obligation to act in this way, provided that doing so does not come at a significant risk or cost to oneself. Just as one can have a surviving interest in bodily integrity after death, one can have a surviving obligation to benefit others after death, specifically in the form of cadaveric organ donation. The obligation is not rights-based but community-based; it is grounded in the concept of mutual benefit, of what we receive from and what we owe to each other as members of a community. Still, the obligation is not strict or absolute but *prima facie*. Some weight can be given to individual autonomy and the option of not donating if cadaveric donation entails too much cost to the individual by violating her interest in bodily integrity. Intuitively, the interest in surviving for those in need of an organ transplant should have more weight than the interest of the deceased in bodily integrity. Yet autonomy allows some weight to be given to the decision to die with one's body and organs intact.

In so far as interests, needs, and values are shared commonly rather than held separately, there is an obligation for those in the community to promote the common good. In this regard, community-based organ donation may be compatible with a moderate utilitarian argument for donation. It is "moderate" in the sense that promoting the good is not the only moral consideration. While individuals are encouraged to benefit others by consenting to cadaveric organ donation, they must have the choice to consent or refuse to donate. Emphasising promotion of social good while at the same time respecting the choice to opt out can be an incentive to donate by generating trust in the medical profession and organ-sharing networks. This is significant, given that public mistrust in these institutions is a major reason for people's refusal to donate. Non-consensual harvesting would likely increase this mistrust because it would ignore individual autonomy. But respecting an individual's right to choose

whether to donate would likely increase public trust in the relevant institutions. Decisions about donation would be made by individuals, not for them by the sick, the medical profession, or the state. This, combined with an emphasis on one's obligation to promote the good by aiding others in need, could encourage more donation.

There are some similarities between living organ donation and cadaveric donation. In each case, donating may be motivated by a sense of obligation to give something back to others because of what one has received during one's life. The differences between these two forms are, however, more apparent. In cadaveric donation, there is no risk of morbidity or mortality resulting from postoperative complications, as there is in living donation. Clearly, cadaveric donation does not involve the same sacrifice or risk that living donation does. But this only serves as a more compelling case for cadaveric donation: it involves no medical risk; it would be based on an autonomous decision by the donor, and it would promote the good by saving the lives of others in the community.

As I have noted, consensual opt-in harvesting thus far has done little to alleviate the shortage of organs for transplantation. Still, a consensual communitarian model is morally preferable to a rights-based non-consensual model allowing the coercive transfer of body parts from the dead to the living. This would obviate the need for consent to cadaveric donation. But it would be morally unjustifiable because it would offer individuals no choice regarding the treatment of their bodies once they had died. In practical terms, donation could be promoted by broad education encouraging people to consent to donate on drivers' licenses, specialised donor cards, or in a medical file following discussion with a primary care physician. Moreover, it could be promoted by not allowing families to override an individual's expressed wish to donate. Overriding such a wish is equivalent to ignoring the conditions stipulated by an individual in a living will. This occurs frequently; yet it is a violation of autonomy and respect for the deceased.

Some might point to religious communities as a counter-example of what I have been proposing. They could cite the belief of some religions in the inviolability of the body and the corresponding prohibition against the desecration of the corpse as an obstacle to donating organs. Yet what most religions object to is not organ donation, but the coercive procurement of organs. Although some religions prescribe an obligation to die with one's body parts intact, this obligation may be overridden when an organ can save a human life. In these cases, it is permissible for one to donate an organ and thereby pass on life to another. Most religions permit the use of cadaveric organs for transplantation, provided that it is consented to in accord with religious beliefs and values.¹⁴

CONCLUSION

Those who are sick from organ failure do not have a right to cadaveric organs. Such a right would entail the coercive transfer of organs from the dead to the sick and a strict obligation for the living to give up their organs after death. Strictly obligating one to give up one's organs, or salvaging them without consent, would violate individual autonomy and the special relation between humans and their bodies. For these reasons, non-consensual harvesting of cadaveric organs is morally unjustifiable. So there is no strict obligation to give up one's organs and therefore no right of the sick to them. If there were such a right, then the selection of organs salvaged from the dead would be based on the estimated medical outcome of a

transplant. This would have nothing to do with morality or justice, which presumably motivates the rights-based model of non-consensual harvesting.

In the future, therapeutic cloning might go some way toward solving the medical problem of organ scarcity and obviate most of the moral problems surrounding non-consensual harvesting. There would be no need for the transfer of tissue or organs between people. Therapeutic cloning would enable the use of tissue derived from one's own somatic cells to create a new organ that would minimise the likelihood of graft rejection as it replaced a dysfunctional organ. The first use of cloned skin, veins, myocardium, and neural tissue has already occurred. Indeed, some would argue that this is the only way that the tissue shortage will be overcome. It will be some time, however, before a fully functional kidney, liver, pancreas, or heart can be created in this way. Until then, a communitarian-based model emphasising donation as a form of giving back something to a community from which one has benefited over the course of one's life is morally preferable to a rights-based model of coercively transferring organs from the deceased without their previous consent. Encouraging people to donate, while allowing them the choice to opt out of salvaging, would respect autonomy and thus promote trust among the public in the medical profession and organ-sharing networks. The trust thereby promoted could motivate people to consent to the harvesting of their organs after death. Having had one's medical needs met over the course of one's life entails a *prima facie* obligation to donate cadaveric organs in order to meet the medical needs of others, provided that it does not violate one's belief in the value of the body. Although this policy is not the most medically desirable way to address the problem of organ scarcity, it offers a morally justifiable alternative to the policy of non-consensual harvesting.

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- 11 See reference 4: 160.
- 12 See reference 4: 171. My position differs from Veatch's on this point. As Veatch notes, the distinction between "giving" and "taking" in organ procurement was introduced by Ramsey P. *The patient as person*. New Haven: Yale University Press, 1970.
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