

Guest editorial

Presumed consent or contracting out

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In the United Kingdom, we have become habituated to an opting-in system of cadaveric organ procurement. It is becoming of increasing concern that this system is failing to meet the demand for organs for transplantation, with 5,349 people on waiting lists for solid organ transplants at the end of 1998.¹ Manifestly, such a tragic statistic alarms us all, and calls for urgent attention, and, perhaps, for radical action. And, at one level, this is what we have witnessed in the British Medical Association's (BMA) recent reversal of its historical opposition to a system of so-called presumed consent for the procurement of cadaver organs.^{2,3} The BMA's overwhelming vote in favour of changing to an opt-out system at its annual conference in early July followed, almost immediately, publication of the results of a government survey which showed a lack of public support for such a system,⁴ and it thus came as no great surprise that the government later rejected the BMA's proposal.^{5,6} Bad timing perhaps, but, whilst any necessary change in legislation might be minimal, if the United Kingdom was to adopt a system of cadaveric organ donation based on presumed consent, this would clearly represent a major overhaul of social policy in this area, and an overnight tidal change in public opinion is hardly to be expected.

For the sake of argument, let us accept the general view that presumed consent legislation does increase the yield of cadaver organs for transplantation.^{7,8} However, there is more than efficiency to consider, and here we will be concerned with arguments from moral principle, not from statistics.⁹

Presumed consent is a fiction

The first point to note is that presumed consent is a fiction. Without the *actual* consent of the individual, there is *no* consent. This is an important point in the context of cadaver organ procurement, particularly in the face of legal instruments adopted in various jurisdictions to increase the number of cadaver organs available for transplantation.

Many see presumed consent as synonymous with contracting out.¹⁰ And it is, of course, intuitively attractive to do so. The underpinning message of the system to which the conflation of these terms refers is something like this: "unless you make it clear during your lifetime that you would refuse to donate organs on death, we will presume that you consent to organ removal, even though you do not actually consent". Even ignoring the question of whether presumed consent represents a contradiction in terms, there is a significant and worthwhile distinction to be drawn between the notion of presumed consent and contracting or opting out, and the distinction speaks to what is at the basis of social policy in this area, and how that policy sells itself, and is interpreted.

Are we not, in adopting the language of *consent*, attempting to disguise what we are actually doing in a way which, however well motivated, appeals to the now well recognised principle of respect for individual autonomy? In reality, by *presuming* consent, we are acting against that principle; we are being disrespectful of individual autonomy. However it might be perceived, in formalising a contracting-out approach for the removal of organs from cadavers, we are, in essence, articulating a particular society's view of what it is morally supportable to do with the body of a dead person,¹¹ where that person has not consented prior to death¹² to such treatment of her body after death. Effectively, we are saying: "where citizens do not explicitly make known their refusal to donate organs when dead, we feel that it is morally justifiable to remove them in order to improve the quality of life of living citizens and to save lives". It seems that, however we care to represent it, if we are prepared to remove organs from the dead in the absence of prior consent, we do so simply because we believe it is the right thing to do; and we believe that it is the right thing to do because we know it is in the best interests of those patients in need of an organ, and that not to remove these organs would be to harm those patients and to

respect no values of moral significance comparable to respect for the lives that are at risk.^{13 14}

Two final points seem apposite. Presuming consent is an affront to the moral principle that is the foundation of consent itself. That said, as fictions go, this is a very popular fiction, having the support of, for example, the Declaration of Helsinki, and the Council for International Organisations of Medical Sciences (CIOMS) guidelines.^{15 16} Nevertheless if we are to presume anything, we should presume that people would wish to do the morally right thing in the particular situation. In the case of cadaver organs this is certainly to make them available for life-saving or life-enhancing use.

We must also remember that while people talk of their ownership of their own organs and their rights to dispose of them as they wish, the normal incidents of ownership are lacking in the case of cadaver transplantation. There is no one who gets to keep the organs. If they don't go for donation, the worms or the fire, or sometimes the coroner, will have them. Of course there are such things as wills for disposal of property after death, but there are also such things as death duties. Perhaps best of all would be to think of cadaver donation in such terms, as a duty the dead owe to the living, which costs them little or nothing to pay and which does huge amounts of good.

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References and notes

- 1 United Kingdom Transplant Support Service Authority (UKTSSA) figures, taken from <http://www.argonet.co.uk/users/body/DoH.html>. The figure of 5,349 represents the active waiting list; including the suspended figure, the total is 6,500. And this is despite there having been 2,694 solid organ transplants from cadavers during 1998.
- 2 Anonymous. Doctors back organ donation reform. *BBC News Online*. http://news.bbc.co.uk/1/hi/english/health/newsid_3890000/389043.stm posted 8 July, 1999.
- 3 Beecham L. BMA wants presumed consent for organ donors. *British Medical Journal* 1999;319:141.
- 4 Department of Health. Press release 1999/0405. Survey shows that public prefers existing organ donor scheme. 2 Jul 1999.
- 5 Anonymous. Opposition to changing organ donor scheme. *BBC News Online*. http://news.bbc.co.uk/1/hi/english/health/newsid_384000/384401.stm posted 3 July, 1999.
- 6 Anonymous. Organ donor reform rejected. *BBC News Online*. <http://news.bbc.co.uk/1/hi/english/health/newsid%5F396000/396430.stm> posted 16 July, 1999.
- 7 Compare with: Sells RA. Radical options for improving the supply of cadaveric organs, presented at *Multi-cultural ethical issues in transplantation*. International Conference, Institute of Medicine, Law and Bioethics (IMLAB), University of Manchester, and University of Tel Aviv, Manchester, 21-22 February, 1999 (unpublished observations).
- 8 Though, as Michielsen warns, we should be careful in comparing national statistics. See Michielsen P. Informed or presumed consent legislative models. In Chapman JR, Deierhoi M, and Wright C, eds. *Organ and tissue donation for transplantation*. London: Arnold, 1997:349-354, esp. 349.
- 9 For what it is worth, however, the successful Spanish experience suggests that a change of law alone is insufficient and, whether we are to go this route or not, it seems that greater resourcing for transplant co-ordinators, for example, is called for.
- 10 For example, see reference 8:344.
- 11 A dead person? There is something self-contradictory about this.
- 12 That is, where an express consent was not obtained, and there is no relevant, reliable advance directive, whether in the form of a living will, or a record on the National Organ Donor Register, or an organ donor card.
- 13 Compare with Harris J. Research, transplantation and the duty to others. (unpublished observations).
- 14 We assume the moral and causal symmetry of acts and omissions. See Harris J. *Violence and responsibility*. London: Routledge & Kegan Paul, 1980.
- 15 World Medical Association. *Declaration of Helsinki*, as amended by the 48th General Assembly, October 1996: basic principle 11.
- 16 Council for International Organisations of Medical Sciences (CIOMS) in collaboration with the World Health Organization (WHO). *International ethics guidelines for biomedical research involving human subjects*. CIOMS and WHO: Geneva, 1999: guideline 1.