

Legal Solutions to Ontario's Organ Shortage: Redrawing the Boundaries of Consent

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[I]f a gift-of-life ethic is preferred and policy makers cannot solve the philosophical dispute over emotion in morality, a dispute that divides proponents of altruism and of routine procurement, then policy makers could judge whether the prevailing model of altruism has received a fair and sufficient test. This judgment would flow from an initial endorsement of altruism as a preferred public policy, a policy that may be modified or abandoned when it proves ineffective or too costly. —*Law Reform Commission of Canada*¹

We thought we were off to a great, great first step. ... Now looking back at everything, nothing has changed. ... I'm doing this alone and I shouldn't have to do this alone ... Deep, deep down they know they aren't getting it right. ... They need a general that will set the tone, lead the charge and address the issues and get the job done. —*George Marcello, transplant recipient*²

Introduction

In the 2000 Throne Speech, then-Premier Harris' government "accepted as a millennium challenge the goal of doubling the organ donation rate by 2005."³ Following the recommendations of the Premier's Advisory Board, the government proceeded by revising and renaming the *Human Tissue Gift Act* (HTG Act).⁴ Repackaged as the *Trillium Gift of Life Network Act* (TGLN Act),⁵ Ontario's new legislation created a new, independent organ procurement organization (OPO) that would follow the example of successful OPOs in other jurisdictions by installing and supervising transplant coordinators in donor hospitals, reimbursing hospitals for costs associated with organ procurement, and by engaging in massive public and clinician education campaigns.

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¹ Canada, Law Reform Commission, *Procurement and Transfer of Human Tissues and Organs*, (Ottawa: The Commission, 1992) at 61.

² Valerie Hauch "Vital Signs Weak for Transplants: Harris Promise to Double Rate Flops; Political Leadership Lacking Say Critics" *The Toronto Star* (28 September 2004), online: The Toronto Star <<http://www.thestar.com>>.

³ Ontario, Premier's Advisory Board on Organ and Tissue Donation, *Organ and Tissue Donation in Ontario: A Plan for Change and Action: Report of Premier Harris' Advisory Board on Organ and Tissue Donation*, (Toronto: The Board, May 2000) at 18.

⁴ R.S.O. 1990, c. H.20.

⁵ R.S.O. 1990, c. H.20.

The government's response to the organ shortage has been essentially managerial. While it undoubtedly has a legal component, i.e. the establishment of an independent body with delegated statutory powers, this body is intended to work within already-established legal boundaries that structurally limit the potential for increased organ donation. In this paper I will review the advisory process leading up to the establishment of Ontario's new OPO (the Trillium Gift of Life Network (TGLN)), and the decisions that followed from that advisory process. I will assess TGLN's progress to date, and review the prospects for improvement in donor rates under the new regime. I will then examine in detail one potential legal solution that was left off the table from the beginning but which, if considered, could have brought about – and still could bring about – a dramatic improvement in organ availability in this province.

From *Tissue Gift* to *Gift of Life*

Don Cherry's Recommendations and Mike Harris' Response

Premier Harris' government signalled its interest in the organ shortage at the beginning of its second term in office. Lieutenant Governor Hilary Weston's Speech from the Throne gave the issue pride of place on its legislative agenda, appearing near the beginning of the new government's commitments for the coming term:

The miracles of modern medicine help many live well, but some patients' survival depends on the selflessness of others. George Marcello waited years for a donor before his life-saving transplant in 1995. This year he walked across Ontario to increase awareness of organ donation.

In response to Mr. Marcello's mission, and on behalf of the people of Ontario, Premier Harris has accepted as a millennium challenge the goal of doubling the organ donation rate by 2005. Your government is developing an organ donor action plan that, through outreach and education, will raise public awareness and improve registration. A new Premier's Advisory Board on Organ Donation, headed by hockey legend Don Cherry, will recommend complementary initiatives.⁶

"Challenge" was an appropriate choice of words. The situation in Ontario at that time, as the Premier's own Advisory Board would observe in its report, was bleak:

There are currently approximately 1,731 people on Ontario's waiting lists for organ transplants. It is estimated that in 1999 over 100

⁶Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, 2 (21 October 1999) at 1510 (Hon. Hilary M. Weston (Lieutenant Governor)).

Ontarians died waiting for a transplant. All predictions are that the waiting lists will continue to grow, the wait for a transplant will become longer and more people will die waiting if nothing is done to improve organ and tissue donation in our Province.⁷

The Advisory Board succeeded in painting a dire picture of the state of voluntary donation in Ontario, noting not only that supply fell woefully short of demand, but that by comparative measures, Ontario's performance was sub par. The provincial rate of organ donors per million of population (dpmp), comparable in 1999 to the national rate of 13.9, was put to shame by rates in jurisdictions such as Spain (33.6), Pennsylvania (33.8), and Texas (26).⁸ It is worth noting, though, that before the Board began its research, its horizons had been limited by its mandate. As the Throne Speech made clear, with its focus on "education," "public awareness," "registration," and "complementary initiatives," a radical rethinking of the legal regime in which organ donation occurs was not in the offing. For a small "c" conservative government the attraction of a circumscribed approach was in part ideological, as a news report following the release of the Advisory Board's report suggests:

"The long arm of the law is not going to get involved," Harris said during a visit to the Hospital for Sick Children. "It will be individuals first and family members who will always have the last say and I haven't seen anything in the recommendations that is in any way obtrusive."⁹

The Advisory Board's recommendations were, indeed, unobtrusive. These included legislation requiring hospitals to create organ donation protocols, implement "routine referral" of all imminent potential cadaveric donors, and to make "required requests" to the families of potential donors.¹⁰ All sites receiving potential cadaveric donors would have professional in-house donor coordinators,¹¹ and the cost of these, as well as the medical and administrative costs associated with facilitating organ donation from these sites, would be reimbursed by the Ministry of Health.¹² The farthest-reaching of the Board's recommendations was for the creation of the TGLN to "lead and manage organ and tissue donation in the Province of Ontario."¹³

⁷ *Supra* note 3 at 17.

⁸ *Ibid.* It should be noted that the reliability of the "dpmp" standard is questionable as a standard for international comparison because different jurisdictions use different definitions for "donor" in calculating their rates. David Baxter, The Urban Futures Institute Report 51, *Beyond Comparison: Canada's Organ Donation Rates in an International Context* (Vancouver, B.C.: Urban Futures Institute, 2001) at 4-16, online: The Urban Futures Institute <<http://www.urbanfutures.com>>.

⁹ Canadian Press, "Families Will Still Have Final Say in New Organ Donation Laws: Harris" *Canadian Press NewsWire* (13 July 2000).

¹⁰ *Supra* note 3 at 12 (Recommendation One).

¹¹ *Ibid.*

¹² *Ibid.* at 13 (Recommendation Two).

¹³ *Ibid.* at 13 (Recommendation Three).

The legislative response to the Advisory Board's recommendations was favourable. As of February 2001, the former *HTG Act* was restyled the *TGLN Act*, with enabling provisions creating the TGLN and assigning it a broad mandate that included duties to "co-ordinate and support the work of designated facilities in connection with the donation and transplant of tissue,"¹⁴ "manage the procurement, distribution and delivery of tissue,"¹⁵ and "establish and manage waiting lists for the transplant of tissue."¹⁶ The remainder of its mandate focuses on promoting educational initiatives, collecting data, and advising government as needed.

Not surprisingly, the bulk of the *HTG Act* remained untouched, with conditions surrounding issues of consent for post-mortem donation remaining as they had been drafted in the mid-1980s.¹⁷ The significance of this choice will become clear shortly.

Donation Rates in 2005: Double or Nothing?

We are now several months past the year by which the former Premier had forecast a doubling in the provincial rate of organ donation. How close have we come to fulfilling his "millennium challenge"? In July, 2003, the TGLN published its annual report.¹⁸ This report documents considerable progress in meeting the *administrative* milestones suggested by the Advisory Board. Donor coordinators had been recruited and trained,¹⁹ participation agreements between TGLN and referring hospitals were put into place,²⁰ and Ministry reimbursement of hospitals for donation-related costs had been implemented.²¹ Most of the organization's accomplishments centred on designing future programs and establishing more detailed plans.

In terms of an appreciable increase in donation, the *Annual Report* has remarkably little to say. The Message from the CEO that introduces the report states frankly: "We did not expect TGLN's efforts to result in an increase in donations during this start-up year,"²² and the remainder of the report may well have been calculated to manage expectations in this regard. Statistics on living and cadaveric donations are provided but are relegated to three pages in an appendix.²³ These give

¹⁴ *Supra* note 5 at s.8.8(2).

¹⁵ *Ibid.* at s.8.8(3).

¹⁶ *Ibid.* at s.8.8(4).

¹⁷ The only significant revision to these provisions from 1986 to 2001 appears to have been the addition of "same-sex partner" to the list of persons capable of giving consent to the post mortem donation of a loved one's tissues. *Ibid.* at s.5(1).

¹⁸ Ontario, Trillium Gift of Life Network, *Annual Report 2002-2003*, (Ontario: Trillium Gift of Life Network, July 2003).

¹⁹ *Ibid.* at 8.

²⁰ *Ibid.* at 5.

²¹ *Ibid.* at 6.

²² *Ibid.* at 4.

²³ *Ibid.* at 32-34.

the actual numbers of transplants performed, referrals, and persons on waiting lists, but only for the year 2002-2003; no comparative data from previous years is presented to show progress, nor is the dpmp rate given.

TGLN's *Annual Report 2003-2004* was not publicly available at the time of writing, but will reportedly hold few surprises and will report little improvement in donation rates.²⁴ Significantly, TGLN has abandoned altogether Premier Harris' "millennium challenge" goal of doubling the transplant rate by 2005 – the goal that, it should be remembered, inspired the consultation process and the legislative change that brought TGLN into being in the first place – and is currently engaged in the process of determining how much improvement may reasonably be expected through TGLN's efforts.²⁵

Media reports since the 1999 Throne Speech reveal that little if anything in the way of quantifiable results has been achieved in the intervening five years. In the first year of the *TGLN Act*, "the number of organ donors in Ontario plummeted by 30 per cent in 2001 to hit the lowest total in a decade," bottoming out at a dpmp of 10.6 and slipping below the national average for that year.²⁶ A recent series of human-interest stories in the *Toronto Star* revealed that the donation rate had grown slightly from 12.5 dpmp at the end of 1999 to 13.5 dpmp by the end of 2003.²⁷ It also reported that the TGLN's CEO had resigned after just two years at the helm, and revealed (in the second introductory quote above) the frustration of George Marcello – the transplant patient whose recovery inspired the "millennium challenge" of 1999,²⁸ and who has been a standard-bearer for the cause ever since.²⁹

At worst, it appears to be the case that the province's approach to managing the organ shortage has stalled at the starting gate. At best, it is likely that this bureaucratic approach to the problem will not be enough to solve – or even keep pace with – the crisis. The number of patients dying on waiting lists nationwide continues to climb steadily.³⁰ Some experts have predicted that over the next three decades the shortfall between organ supply and demand will increase by 291%.³¹

²⁴ Interview of Nadine Saby Vice President, Operations and Community Relations, Trillium Gift of Life Network (15 September 2004).

²⁵ *Ibid.* Saby told me in the course of a telephone conversation that TGLN is no longer using this yardstick to measure its progress, and remarked that she and others at TGLN "don't know where that [figure] came from in the first place." Saby reports that TGLN is currently engaged in assessing the actual potential for increased donations from each hospital, and hopes to have this calculated within the next fiscal year.

²⁶ Canadian Press, "Organ Donations Hit 10-Year Low in Ontario; Down by 30 Per Cent in 2001" *Canadian Press NewsWire* (12 April 2001).

²⁷ *Supra* note 2.

²⁸ *Supra* note 6.

²⁹ *Supra* note 2.

³⁰ Canadian Institute for Health Information, "A Decade of Organ Donation in Canada: 1993 to 2002" (April 2003), online: Canadian Institute for Health Information <<http://www.cihi.ca>>.

³¹ David Baxter & Jim Smerdon, The Urban Futures Institute Report 46, *Donation Matters: Demographics and Organ Transplants in Canada, 2000 to 2040* (Vancouver, B.C.: Urban Futures Institute, 2000) at 52, online: The Urban Futures Institute <<http://www.urbanfutures.com>>.

Others forecast a 500% increase in demand for liver transplants over the next decade alone.³² Moreover, the current approach alone is unlikely to reach the levels of success enjoyed in the countries Ontario has sought to emulate because our age demographics and mortality patterns are less conducive to high rates of potential cadaveric donors.³³ If the crisis is to be ended or at least managed for the future, a combination of radical legal solutions will be required. This paper will argue in favour of one such solution.

Cadaveric Donation: From Opting In to Opting Out

Current Law and Objections to Change

Express vs. Presumed Consent

Ontario's current regime with respect to cadaveric donation is premised on a form of "express consent." This is just one of several possible policy choices.³⁴ Here, as in other provinces and the United States, no procurement of solid organs for transplant occurs without explicit consent.³⁵ Adults are free to signal their willingness to donate organs after death (typically in writing, on a card that is issued with their driver's license),³⁶ or they may make no decision at all. If a person fails to record a preference before their imminent death, it falls to transplant professionals to obtain the permission of the decedent's family, according to a scheme that ranks family members in a descending order of closeness to the decedent starting with spouses or the equivalent.³⁷ Officially, the consent of the family cannot be used to override the express wishes of the decedent,³⁸ and the existence of a recorded consent makes it unnecessary to consult with the decedent's family. Pragmatically, medical personnel have no way to verify whether a decedent who has at some point recorded a willingness to donate has subsequently changed his mind, since such a

³² *Supra* note 26.

³³ Relative to Spain, from which the Ontario model is largely drawn, Canada has a lower proportion of its population in the age range that provides the most potential donors. Canada also has proportionately fewer motor vehicle, gun and "intra-cranial event" deaths than Spain; these are the types of death that produce the most potential donors. See generally *supra* note 31.

³⁴ For brief overviews of the various forms of consent regimes, see Carol J. Roberts, "Presumed Consent for Organ Procurement Does It Have a Future in the U.S.?" (2003) 35:2 *Journal of Neuroscience Nursing* 107 [*Roberts*]; Denise Mackey & Maria Kjerulf, "The Ethics of Organ Donation: Examining Consent Policies and Donor Criteria" (2000) 78:1 *University of Toronto Medical Journal* 51 [*Mackey & Kjerulf*].

³⁵ Pituitary glands and corneas are exceptions to this rule, under particular circumstances and only in some jurisdictions. See *infra* note 107.

³⁶ *Supra* note 5 at s.4(1).

³⁷ *Ibid.* at s.5(2).

³⁸ *Ibid.* at s.5(4):

Upon the death of a person in respect of whom a consent was given under this section the consent is binding and is, subject to section 6, full authority for the use of the body or for the removal and use of the specified part or parts for the purpose specified except that *no person shall act on a consent given under this section if the person has actual knowledge of an objection thereto by the person in respect of whom the consent was given or by a person of the same or closer relationship to the person in respect of whom the consent was given than the person who gave the consent* [emphasis added].

wish is revocable at any time³⁹ and may be made orally rather than in writing.⁴⁰ Moreover, there is statutory liability for a transplant professional who proceeds with procurement when he “has reason to believe” that a consent was withdrawn,⁴¹ but there is no correlative penalty for families who lie about a change in the decedent’s recorded intentions. One doctor has summarized the practical effect of these policies as follows:

People who procure organs continue to seek permission from next of kin even though consent has already been given. ... Under our current system, there is little incentive for anyone to sign a donor card. As a potential donor I have to foresee my death, realize the need for organs and sign my donor card as a goodwill gesture, all the time realizing that my family’s wishes might be given precedence over mine.⁴²

This might still work fine if people in general could be counted on to signal their intentions in writing *and* communicate these intentions to their families.⁴³ However, TGLN’s ongoing research reveals the central defect of our – or any other – express consent policy: an extreme disconnect between potential donors’ understanding and intention with respect to donation on the one hand, and their willingness to act accordingly on the other. Most Ontarians support organ donation in principle:

A strong majority of Ontarians (77%) indicate they are willing to donate their own organs for transplant purposes. A majority (66%) of Ontarians indicate that they would be likely to consent to donating a family member’s organs even if they were unsure of the family member’s donation wishes. An overwhelming majority (94%) are either *very likely* (85%) or *somewhat likely* (8%) to donate a family member’s

³⁹ *Ibid.* at s.4(3).

⁴⁰ *Ibid.* at s.4(1).

⁴¹ *Ibid.* at s.4(3).

⁴² Fady Moustarah, “Organ Procurement: Let’s Presume Consent” (1998) 158:2 *Can. Med. Assoc. J.* 231 at 233 [*Moustarah*]. Even the Premier’s Advisory Board acknowledged the prevalence of this policy of family consent regardless of decedent’s wishes in its report. Advisory Board, *supra* note 3 at 57.

⁴³ It would appear that the Conservative government began to acknowledge the shortcomings of this policy toward the end of its tenure. In May 2003, a Private Member’s Bill was introduced by Conservative MPP Steve Gilchrist that would have amended the *TGLN Act* and other statutes so that a person’s last valid written consent would prevail, regardless of the wishes of family members. Note, though, that this is how the *TGLN Act* is *supposed* to be interpreted, and the wording of Bill 17 does not appear to make the Act any more explicit in this respect. The Bill evidently died on the order paper after Ernie Eves’ government was voted out of office. See Canadian Press, “Ontarians Need More Education About Organ and Tissue Donation” *Canadian Press NewsWire* (22 April 2003) [*Canadian Press*, “More Education”]; Bill 17, *An Act to amend various Acts with respect to organ or tissue donation on death*, 4th Sess., 37th Parl., Ontario, 2003 (as at 1st Reading May 5, 2003). Online: <[http://64.233.167.104/search?q=cache:Kqf8-i-5kCgJ:www.giftoflife.on.ca/1](http://64.233.167.104/search?q=cache:Kqf8-i-5kCgJ:www.giftoflife.on.ca/1>)>.

organs when they are aware of the family member's desire to be a donor.⁴⁴

However, the majority of Ontarians fail to take *both* of the steps necessary to ensure their intentions are acted upon in the event of their deaths:

Just over half of the province (53%) report [*sic*] having signed an organ donor card. Just under half (45%) of those who have not signed an organ donor card claim they would be willing to do so.

Ontarians are *virtually unanimous (96%) in their belief that it is important to tell their families* whether or not they would want their organs to be donated after death. However, *only 44% report actually having a family discussion*. There is no particular barrier to family discussion. Most of those who have no had such a discussion just never had an occasion to talk about organ donation.⁴⁵

Decades of public education, including Trillium's recently intensified efforts, have not changed the fundamental failing of express consent: people are unwilling to expend the small effort required to translate good intentions into actions.⁴⁶

The main alternative to express consent is a policy of "presumed consent." This comes in various forms. The most extreme of these is "conscription," under which "[a]ll usable organs would be removed from recently deceased people and made available for transplantation; consent would be neither required nor requested and, with the possible exception of people with religious objections, opting-out would not be possible."⁴⁷ A more reasonable variation is an "opting out" policy under which everyone would be presumed to consent to the donation of their organs after death unless they registered an express wish to the contrary. "Opting-out" regimes may be further divided into "hard" and "soft" laws, the former of which takes a lack of recorded objection by the decedent to indicate consent *regardless of the family's wishes*, while the latter includes consultation with the family even if no objection by the deceased has been declared.⁴⁸

⁴⁴ Ontario, Trillium Gift of Life Network, *Executive Summary* (Ontario: Trillium Gift of Life Network, 2004), online: Trillium Gift of Life Network <<http://www.gifttolife.on.ca/images/ExecutiveSummary.pdf>> [emphasis in original].

⁴⁵ *Ibid.* [emphasis added].

⁴⁶ Even Trillium's now-former CEO, after two years at the helm, has expressed exasperation at the continuing problem: "It's frustrating that almost 90 per cent of people say they'd be willing to accept a transplant if they needed it, but fewer than half say they have signed donor cards." Canadian Press, "More Education"; *supra* note 43.

⁴⁷ Aaron Spital & Charles A. Erin, "Conscription of Cadaveric Organs for Transplantation: Let's at Least Talk About It" (2002) 39:3 Am. J. Kidney Diseases 611 at 612, cited in Roberts, *supra* note 34 at 108.

⁴⁸ Mackey & Kjerulf, *supra* note 34 at 52.

A middle ground between these positions is the notion of “mandated choice,” which requires all persons to indicate, on a form they would normally complete anyway, such as a driver’s license application or income tax return, their wishes for or against donation.⁴⁹ A further variation of this position is “modified mandated choice,” in which the individual is again required to consent or decline, but is encouraged, via a more propagandist variety of the awareness-raising of the sort the TGLN undertakes, to choose in favour of donation.⁵⁰

For the remainder of this paper, I will use “presumed consent” to refer specifically to the “hard” variation of the “opt-out” form of consent, and will argue in favour of this type as a preferred policy option for Ontario. Space does not permit a full weighing of the merits of presumed versus mandated consent, or of the subspecies of each against one another; I will, however, articulate my reasons briefly here. Conscripted and opting out are subject to identical ethical arguments about autonomy and individual rights (canvassed below), but the latter, by virtue of the fact that it still gives the individual a choice, is legally and morally more defensible and more likely to accord with the values of a free society. “Soft” presumed consent, in giving family members a veto over the decedent’s intentions, imports the inherent dysfunction of express consent, and is a misnomer since it doesn’t “presume” anything at all. Mandated choice invites reactionary negative responses in that it forces people into a decision which they may not have had time to consider properly and to which they may thus react to with a conservative refusal to donate; it may be that asking people for their organs at the same time you are collecting their taxes invites pique rather than civic virtue. Moreover, it is easier and more cost effective to maintain a register of explicit objections – which statistics regarding organ donation suggest would be relatively few⁵¹ – than a register recording a choice for every adult in the country.⁵²

Presumed consent has been a lightning rod in the transplantation and medical ethics communities for decades, and has inspired myriad objections as well as arguments in its favour. Surprisingly, the Premier’s Advisory Board had little to say about which objections and arguments informed its own recommendation to maintain the status quo. The topic merited less than two pages in its report, and the Board’s response was at once vague, sentimental and crassly instrumentalist:

The Advisory Board has read a great deal about the issues surrounding consent and the alternatives to consent. We have also heard the frustration of many persons we consulted because the expression of their intent to donate ... is not binding on family members. But along with

⁴⁹ Roberts, *supra* note 34 at 108.

⁵⁰ P. Chouhan & H. Draper, “Modified Mandated Choice for Organ Procurement” (2003) 29:3 J. Med. Ethics 157 at 161.

⁵¹ See *supra* note 44 and accompanying text.

⁵² British Medical Association Medical Ethics Committee, *Organ Donation in the 21st Century: Time for a Consolidated Approach*, (London: British Medical Association, June 2000) at 15, online: BMA <<http://www.bma.org.uk/ap.nsf/Content/Organdonation21stapproach>>.

these expressions of frustration, we have also heard emotional pleas that this right not be taken away from donor families. And we heard almost unanimous discomfort with presumed consent legislation.

On balance, the Advisory Board has decided that it will not recommend changes to the practice that the consent of families be obtained prior to donation. We recognize the risk of serious harm to a grieving family who choose not to donate a loved-one's organs and recognize the negative effect that these families' complaints could have on organ and tissue donation. In addition, it is clear that to do otherwise would be highly controversial and would create the risk that discussion of this issue will take precedence over implementation of the recommendations in this Report.⁵³

The final statement is a triumph of circularity: we will not recommend presumed consent in our report because it may detract from the attention given to recommendations in our report (including, of course, presumed consent). Even more troubling is the subtext of the other reasons given: we have weighed the frustration of (i) donors whose wishes are not respected by express consent against those of (ii) families who wish to refuse consent, and have sided with the latter because their complaints are *potentially* damaging to our short-term goals. From the perspective of legal rights this argument is untenable, as it amounts to choosing the rights of families – the standing of whom is by no means certain – against those of the potential donors themselves, whose claims are presumably greater since *their organs* are at stake. This aspect of the problem is taken up in greater detail below in the discussion of potential legal obstacles to change.

Judging from the Report's bibliography, the more principled objections causing "unanimous discomfort" are of the usual sort: presumed consent is unethical, it may be unworkable, and could open floodgates to litigation. I will address each of these in turn.

Ethical Objections

An earlier, and intellectually more rigorous, examination of presumed consent formed part of a report by the Law Reform Commission of Canada (LRCC) in the early 1990s.⁵⁴ In a discussion of the ethics of procurement, the LRCC sets out competing arguments in favour of altruism (the concept that underlies express consent), utilitarianism (which, in valuing life over sentiment, tends to favour presumed consent), and other competing values, and concludes ultimately that these are irresolvable, and endorses a philosophical posture that favours the status quo.⁵⁵ The LRCC justified its recommendation in this way:

⁵³ *Supra* note 3 at 57-58.

⁵⁴ *Supra* note 1.

⁵⁵ *Ibid.* at 37-61.

In its favour, it encourages voluntarism and altruism. It also accommodates religious preferences and the surviving family's wishes. ... On the negative side, particular weaknesses in the model result in missed opportunities for donation. There has also been undue legal uncertainty over whether surviving family members may override the express wishes of a deceased declared donor.⁵⁶

That scepticism about the legality a family veto is "undue" is not at all obvious, but I will address this concern further on.⁵⁷ Note also that the "missed opportunities," i.e. continuing high death rates on waiting lists, are dismissed out of hand. This passage does, however, hit on two common ethical arguments against presumed consent: religious freedom and the value of altruism.

The argument that presumed consent offends religious preferences may well be a straw man, as few religions oppose organ transplantation in general.⁵⁸ Moreover, a system of presumed consent that allows the individual to, with minimal effort, opt out respects these preferences by allowing the person to decline consent. In this way the only persons whose preferences are offended are relatives who are unwilling to respect a decedent's wish to donate, and decedents who hold those preferences to be of so little value that they are unwilling to spare the small effort required to make their preferences known.

The argument in favour of altruism is less concrete and equally spurious. It has been summarized as holding that "altruistic tissue transfers nurture community bonds and generosity" and "become the material and symbolic gifts of life that bond strangers to our communities."⁵⁹ Even assuming this proposition survives outside the realm of speculation and sentimentality, it may be that altruism is a virtue that is too costly in human life to warrant protection. It presumes, as well, that giving is only giving – or as it has been put elsewhere, that consent is only 'real' consent – if the person giving or consenting does so with an affirmative gesture as opposed to by default through silence. This is to quibble over semantics. The essence of giving, or of consent, is the decision to give or consent; the mechanism by which the decision is communicated is unimportant. So long as the decision is an informed one and the person has a reasonable opportunity to make it, a presumed gift or consent is as ethically valid as an express one.⁶⁰

Finally, there is the problem of autonomy: it is argued that presumed consent robs the individual of the opportunity to make choices about his or her own body. The pragmatic rejoinder to this concern is that self-determination "obviously

⁵⁶ *Ibid.* at 177 [footnotes omitted].

⁵⁷ See below at 156-157.

⁵⁸ David P. T. Price, *Legal and Ethical Aspects of Organ Transplantation*, (New York: Cambridge University Press, 2000) at 35-36.

⁵⁹ *Supra* note 1 at 39.

⁶⁰ See Tom L. Beauchamp & James F. Childress, *Principles of Biomedical Ethics*, 4th ed. (New York: Oxford University Press, 1994) at 129; discussed in *supra* note 58 at 106-07.

requires a 'self'⁶¹ and that it is probably nonsensical to speak of exercising autonomy once one has ceased to be, since "the dead have no moral autonomy."⁶² Some maintain, however, that part of autonomy for the living is the ability to control what becomes of their bodies after death.⁶³ Accepting that this is true, our current system is no better than conscription, and may be worse, at ensuring the wishes of the deceased are honoured. As it stands, even an express consent in our system may be overridden by the decedent's family; under presumed consent, those who wished to decline could, and those who didn't would say nothing, and that choice would stand regardless of the family's opinion. Surely this better preserves individual if not familial autonomy. Moreover, some have argued that since in Canada and many other countries the number of people willing in principle to donate outstrips the proportion of those who actually communicate an intention to do so, presumed consent – even without the option of opting out – would give effect to the wishes of most people better than the current system does.⁶⁴ This argument fails in the cases of those who are either unaware of the policy of presumed consent,⁶⁵ or are aware of it but unable to muster the effort to signal their refusal. An ethically defensible (and politically viable) implementation of presumed consent would ensure that no-one was ignorant of the policy and would thus avoid the former case. As for the latter, the social value of defending the autonomy of persons over a choice they are so utterly uninterested in making is simply lesser than the social value of saving more lives.

Efficacy and Problems of Implementation

Objections under this heading fall into three categories: first, that a system of presumed consent in which individual objections were recorded would be impossible to implement in practice. Second, that there is no evidence that presumed consent increases donation rates. Third, that even if it works elsewhere, it would be an impossible 'sell' in Canada. I will address these objections in turn.

The argument that such a system is impracticable was, until a few years ago, entirely valid. To work properly, a refusal to donate must be easy to file with the government, must be processed immediately (to avoid the possibility of a lag between the time it was made and the time it might be needed, should the person

⁶¹ V. English & A. Sommerville, "Presumed Consent for Transplantation: A Dead Issue after Alder Hey?" (2003) 29:3 J. Med. Ethics 147 at 149.

⁶² *Supra* note 1 at 44.

⁶³ *Ibid.* at 45; *supra* note 58 at 145-46; *supra* note 61 at 149.

⁶⁴ *Ibid.* at 109-10; Moustarah, *supra* note 42 at 232. For an opposing view, see Robert M. Veatch, *Transplantation Ethics* (Washington, D.C.: Georgetown University Press, 2000) at 169-70.

⁶⁵ This has been a problem in the case of U.S. statutes applying presumed consent to corneal and pituitary extractions. The root of the problem has been that these statutes were implemented with no attendant attempt to educate the public about them, and appear to have been administered in near-secrecy. See Michele Goodwin, "Rethinking Legislative Consent Law?" (2002) 5 DePaul J. Health Care L. 257 [Goodwin]. Obviously, this approach is ethically indefensible, invites the sort of public-relations backlash against transplantation feared by opponents of presumed consent, and would rightly doom such a policy to failure.

die in the interim), and must be available for immediate access by transplant professionals faced with the imminent death of a potential donor (since the window of time for successful organ procurement after brain death begins is so short).⁶⁶ Before the advent of the internet, such a system would likely have been prohibitively expensive if it were possible at all. Indeed, a lack of proper infrastructure continues to be a barrier to the prospect of successful presumed consent laws in many places.⁶⁷ In Ontario today, however, individuals could register their intentions with the same ease with which they access health information on the government's websites (with certain security precautions to ensure no-one opted anyone other than themselves out of the system) or replace driver's licences at computer kiosks. The British Medical Association (BMA) recently argued that such a system could be implemented in Great Britain, and has endorsed its use.⁶⁸

The success of presumed-consent systems is difficult to measure in that in most countries where they appear to succeed they are accompanied by other proactive measures, while in countries where they fail they are plagued with other systemic problems.⁶⁹ For example, it appears that donation rates have risen under presumed consent in countries such as Belgium, Austria, and Singapore (in Belgium, they nearly doubled); they have not under similar systems in the Netherlands in Germany. Denmark switched from presumed to express consent and its donation rates were halved.⁷⁰ Scholars examining the data in this area note that, on balance, there is "a general tendency for countries with presumed consent to have higher donation rates"⁷¹ and that "there would appear to be substantial *prima facie* evidence that presumed consent laws are a major factor in increasing organ donation," though they are obviously much more effective in the context of a "highly organised and well-resourced system, employing large numbers of transplant co-ordinators in a decentralised system."⁷² The reason frequently cited for the failure of presumed consent to greatly increase organ donations *on its own* is that

⁶⁶ For a description of such a system, see *supra* note 52 at 16.

⁶⁷ Presumed consent was a disaster in Brazil, where the lack of infrastructure of even the most basic kind – i.e. serviceable roads joining rural towns to the cities where transplant programs were located – meant that only 10% of organs arriving at hospitals were suitable for transplant by the time they arrived. The country furthermore lacked the technology to keep a proper electronic register of recipients and to notify them when organs became available. The policy was a poor fit for a country that *already had a surplus* of organs and long recipient waiting lists simply because it was unable to effectively connect the supply of organs with the demand. The policy was abandoned in 1998. See Claudio Csillag, "Brazil Abolishes 'Presumed Consent' in Organ Donation" (1998) 352:9137 *The Lancet* 1367; Troy R. Jensen, "Organ Procurement: Various Legal Systems and Their Effectiveness" (2000) 22:3 *Hous. J. Int'l L.* 555 at 558-59.

⁶⁸ *Supra* note 52.

⁶⁹ Moreover, comparisons between countries are difficult to interpret because of the myriad other factors that are necessary to ensure a successful transplant program but are highly variable from country to country, such as the availability of intensive therapy beds and staff, the "number, efficiency, and enthusiasm of transplant coordinators" and the availability of transplant surgeons; *supra* note 61 at 151.

⁷⁰ *Supra* note 58 at 87-91; LRCC, *supra* note 1 at 151.

⁷¹ *Supra* note 61 at 151.

⁷² *Supra* note 58 at 91-92.

transplant professionals in many countries ignore the letter of the law of presumed consent and refuse to procure organs without seeking the permission of the decedent's family.⁷³ In other cases, it is due to the frequent failure of medical personnel to report potential donors.⁷⁴ Neither of these constitutes a failure of presumed consent *per se*; they are, rather, failures of implementation, and most probably evidence of reticence in the medical community rooted either in an unfounded fear of legal consequences of following presumed consent, or discomfort at the prospect of telling donor families that that procurements will occur regardless of their feelings. Such failures are not truly arguments against presumed consent, but are rather arguments in favour of educating both the medical community and the public at large so that there are no ambiguities or surprises when doctors and families meet. Education of this sort falls squarely within the mandate of the TGLN and should become a natural extension of its current work.

In rejecting presumed consent, the LRCC noted among its reasons that it was "unlikely to enjoy wide public support in Canada."⁷⁵ Interestingly, the Commission cited no particular source or data for this conclusion. Years later, a Report of Parliament's Standing Committee on Health reached a similar conclusion, again, without presenting any data to support its contention.⁷⁶ This argument is often advanced as though self-evident, but there appears to be no empirical evidence either way as to the actual state of public opinion. We do know that Ontarians support donation of their own organs and those of family members when they know the family members' wishes.⁷⁷ There is no particular reason to assume Ontarians would reject presumed consent as the mechanism for making those wishes known and actionable, so long as the concept was explained fully and tactfully; after all, the BMA believes that an increase in public awareness and debate will change public opinion in favour of presumed consent in the UK.⁷⁸ It is worth noting that presumed consent has been endorsed in Canada by columnists in both the leftist alternative press⁷⁹ and the conservative mainstream⁸⁰ and has been raised in debates

⁷³ *Ibid.*

⁷⁴ Bela Blasszauer, "Hungary: The Ethics of Presumed Consent" in Peter J. Morris, ed., *Ethical Eye: Transplants* (Strasbourg: Council of Europe, 2003) 91 at 100.

⁷⁵ *Supra* note 1 at 177.

⁷⁶ This report, several chapters long, granted just four sentences to the topic of presumed consent, noting that "[i]t was suggested that, not only would Canadians resist such a system, there was no evidence from countries where this method has been enacted to show a substantial increase in organ donor numbers." No mention is made of evidence supporting the first conclusion, and we know from the foregoing discussion that the second conclusion is incorrect. Canada, Parliament, "Organ and Tissue Donation and Transplantation: A Canadian Approach" by House of Commons Standing Committee on Health (April 1999) at c.3, online: Parliament of Canada <<http://www.parl.gc.ca/InfoComDoc/36/1/HEAL/Studies/Reports/healrp05-e.htm#toc>>.

⁷⁷ See *supra* note 44 and accompanying text.

⁷⁸ *Supra* note 52 at 17.

⁷⁹ "Transplanting Consent," Editorial, *Eye Weekly* (7 August 2003), online: *Eye Weekly* <http://www.eye.net/eye/issue/issue_08.07.03/op/editorial.html>.

⁸⁰ Jeffrey Simpson "Want to Save Lives? Just Say Presumed Consent" *The Globe and Mail* (13 December 2002) A25.

of the Ontario Legislature.⁸¹ That at least some of those who shape and serve public opinion are amenable to the logic of presumed consent suggests it cannot entirely be anathema to the public imagination.

Moreover, it is worth remembering that public opinion is not static. Unpopular laws, such as the mandatory wearing of seatbelts, are often imposed by government where “the initial public irritation [is] seen as of lesser importance than the overall societal benefit.”⁸² Over time, as people become accustomed to the laws, they concede their importance and comply more willingly. Public opinion is also shaped by generational effects. A study in Belgium ten years after presumed consent was introduced found higher levels of awareness and support among young people than older people; thus, even a moderate-to-high level of resistance to the policy at the time of introduction appears to lessen over time and give way to majority support.⁸³ While its speculation about a lack of public support may or may not be founded, the LRCC was certainly correct in suggesting that successfully implementing presumed consent would require the assistance of “broad, persistent educational initiatives” to ensure the understanding and support of the general public. This, in turn, will make compliance with the policy by transplant professionals easier and more likely.

Liability for Transplant Professionals

Daniel Jardine notes that “first and foremost” among the reasons U.S. doctors tend to solicit the consent of the families of potential donors, even where the deceased has registered an express consent, is “the fear of being sued by the next of kin.”⁸⁴ He notes further that the structure of donation legislation in the U.S. is such that the fear is unfounded. While there are differences in U.S. and Canadian legislation in this respect,⁸⁵ the history of organ donation acts suggests that there, as here, this concern is largely misplaced and rooted in misunderstanding. There is almost no case law, concerning personal injury or otherwise, under either the *TGLN Act* or its predecessor *HTG Act*; perhaps incredibly, in the twenty-four years since the law in its modern form was enacted in Ontario, only one case has even cited the Act in any of its iterations.⁸⁶ This phenomenon is not peculiar to Ontario, as electronic searches suggest that there is no body of litigation concerning the

⁸¹ Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, 31 (4 June 1992) at 1040 (Allan K. McLean).

⁸² *Supra* note 61 at 148.

⁸³ L. Roels, *et al.*, “A Survey on Attitudes to Organ Donation among Three Generations in a Country with 10 Years of Presumed Consent Legislation” (1997) 29 *Transplantation Proceedings* 3224. Interestingly, this study was listed in the bibliography of the Premier’s Advisory Board Report, though its implications were evidently not heeded; *supra* note 3.

⁸⁴ Daniel G. Jardine, “Liability Issues Arising out of Hospitals’ and Organ Procurement Organizations’ Rejection of Valid Anatomical Gifts: The Truth and Consequences” (1990) *Wis. L. Rev.* 1655 at 1666.

⁸⁵ See below at 157.

⁸⁶ *Pittman Estate v. Bain* (1994), 112 D.L.R. (4th) 257 (Ont. Gen. Div.) (in which the *TGLN* definition of “tissue” was mentioned for a purpose irrelevant to the Act or to transplantation in general).

equivalent Acts in other provinces, which mirror Ontario's in most respects except for Ontario's provisions creating the TGLN.⁸⁷ Even in the far-more litigious United States, transplant-related litigation is relatively rare. One author noted in 1987 that, up to that time, "there [had] been virtually no litigation against parties involved in the organ procurement and transplantation process."⁸⁸ T.D. Overcast offers several plausible explanations for the dearth of suits against transplant personnel:

The low incidence of litigation may be related to social factors; providers and recipients and their families often develop a close relationship, one that contrasts markedly with the often impersonal nature of relationships in other areas of highly technological medical practice. Moreover, most of the surgeons and the centers involved in transplantation at this time have solid reputations for skill and expertise. Additionally, patients and their families may view a transplant with lowered expectations of success, and therefore, are better prepared for less than satisfactory results.⁸⁹

These factors speak primarily to the feelings of *recipients* and their families. There is no reason to believe that a change from express to presumed consent would affect the relationship of this group toward the transplant community, for the obvious reason that it would be the families of presumed-consent *donors* who felt the organs of loved ones were wrongfully procured who would be aggrieved. One might object, however, that public perception in general of the transplant community would be harmed, and that this might sully the trust of recipient families that staves off recipient-side legal actions. This needn't be the case. Public confidence in transplantation in general is a matter of public education and a history of positive results; this is why transplantation enjoys widespread public acceptance while, for instance, genetically modified foods are equated with Frankenstein-esque irresponsibility⁹⁰ even though the metaphor might be applied far more aptly to the former. This suggests a role for which the TGLN, with its large budget for advertising and

⁸⁷ Every common-law jurisdiction in Canada has passed similar Acts: see generally *Human Tissue Gift Act*, R.S.A. 2000, c. H-15 and the related but not yet proclaimed *Human Tissue Donation Procedures Statutes Amendment Act*, R.S.A. 2000, c. 15 (Supp.) (Alberta); *Human Tissue Gift Act*, R.S.B.C. 1996, c. 211 (British Columbia); *Human Tissue Gift Act*, C.C.S.M. c. H-180 (Manitoba); *Human Tissue Gift Act*, S.N.B. 2004, c. H-12.5 (New Brunswick); *Human Tissue Act*, R.S.N.L. 1990, c. H-15 (Newfoundland and Labrador); *Human Tissue Act*, R.S.N.W.T. 1988, c. H-6 (Northwest Territories and Nunavut); *Human Tissue Gift Act*, R.S.N.S. 1989, c. 215 (Nova Scotia); *Human Tissue Donation Act*, R.S.P.E.I. 1988, c. H-12.1 (P.E.I.); *Human Tissue Gift Act*, R.S.S. 1978, c. H-15 (Saskatchewan); and *Human Tissue Gift Act*, R.S.Y. 2002, c. 117 (Yukon). In point of fact, Quicklaw searches, verified by a manual noting-up of each statute using the *Canadian Statute Citations (Canadian Abridgment, Carswell)*, confirm that not a single case has been litigated under any one of these statutes.

⁸⁸ Elizabeth S. Spencer, "Maximizing Use of a Scarce National Resource: An Analysis of Alternatives for Establishing Uniform Standards of Conduct for Organ Procurement Agencies" (1987) 42 Food Drug Cosm. L.J. 430 at 459.

⁸⁹ Thomas D. Overcast, Karen J. Merrikin & Roger W. Evans, "Malpractice Issues in Heart Transplantation" (1984) 10 Am. J.L. & Med. 363 at 387.

⁹⁰ CBC News Online Staff "Canadian Activists Protest GM Foods" (2000), online: CBC News <<http://www.cbc.ca/story/news/national/2000/04/03/Consumers/gmofight000304.html>>.

awareness-raising, is particularly well-suited: public support for presumed consent should be cultivated just as public support for donation has.

There are also a number of practical difficulties involved in suing transplant professionals for malpractice, even on the recipient side. The relatively small size of the speciality makes standards of care difficult to assess and willing expert witnesses hard to come by; causation is hard to prove given the number of variables inherent in complicated surgical procedures on already-very sick patients; and arguments about damages based on loss are problematized by the fact that most organ recipients would die anyway without the procedure.⁹¹ While it was thought decades ago that these barriers to litigation might recede as the practice of transplantation matured,⁹² the continued dearth of Canadian cases suggests that they have not done so here.

While it has had relatively little experience with transplant litigation, the United States does offer some insight into the shape of donor-side transplant malpractice. Many of the circumstances under which such litigation has arisen are arguably no longer an issue in Canada. For instance, cases in which organs were removed where there was confusion as to whether the patient was legally dead are less of a concern now that Canada, like the United States, has universally adopted an entire-brain death standard.⁹³

Other circumstances continue to arise, and could also be expected under a regime of presumed consent. Michele Goodwin cites two relatively recent American cases in which the families of cadaveric donors signed forms that were subsequently misread and miscommunicated to the OPOs, resulting in the removal of tissues without consent of the families.⁹⁴ In both *Lyon* and *Ramirez*, summary judgements were granted against the plaintiffs.⁹⁵ In *Lyon*, a new resident who was unfamiliar with the hospital's forms asked the family to execute a eye donor authorization as a formality after being told by the family that they did not consent to eye donation. Both the doctor, who had misunderstood the form, and the hospital staff, which acted on the authorization without inquiring further, were exempt from liability on the basis of a statutory "good faith" exemption contained in s. 11(c) of the *Uniform Anatomical Gift Act* (1987) (*UAGA*), which has been adopted in every state in either its 1987 incarnation or its 1968 predecessor.⁹⁶ A similar conclusion was reached in *Ramirez*. The "good faith" exemption under *UAGA* guarantees that

⁹¹ *Supra* note 89 at 459-60.

⁹² *Ibid.* at 387.

⁹³ Overcast notes such a case in which death was declared while the donor's heart was still beating. Despite this fact, the jury found in favour of the surgeon. *Ibid.* at 368.

⁹⁴ *Lions v. United States*, 843 F. Supp. 531 (D. Minn. 1994) [*Lyon*] and *Ramirez v. Health Partners of S. Ariz.*, 972 P. 2d 658 (Ariz. App. Div. 2 1998) [*Ramirez*] cited in Goodwin, *supra* note 65 at 297-98.

⁹⁵ Goodwin, *supra* note 65 at 297.

⁹⁶ The exemption in the 1968 version contained at s.7(c) is substantively identical.

[a] hospital, physician, ... technician, or other person, who acts in accordance with this [Act] ... or attempts in good faith to do so is not liable for that act in a civil action or criminal proceeding.⁹⁷

Since family preferences would be irrelevant under a presumed consent regime, malpractice cases of this nature could arise only where organs were procured against the expressed wishes of the *deceased*. American critics of presumed consent claim that “[i]t would require guaranteed legal immunity for healthcare providers who act in good faith,”⁹⁸ but it would appear that such immunity is already nearly guaranteed under the current American legislation:

Absent a clear indication that a health care provider did not act in “good faith,” courts generally uphold this limitation on liability as necessary to promote UAGA’s goal of increasing the supply of organs available for transplantation.⁹⁹

Logically, the same “good faith” exemption would protect transplant professionals so long as the procurement was the result of mistake rather than malfeasance. All that would change under presumed consent is that the process of ascertaining willingness to donate would be simplified from two steps – determining whether the deceased recorded an express consent or not, and then determining whether the family is willing to honour the deceased’s choice or to give consent in its absence – to a single step in which the electronic registry was consulted to determine the deceased’s recorded objection to donation, if such objection existed. The potential for miscommunication, and thus for liability, would be reduced.

Presumed consent would also protect transplant professionals from another form of tort liability that, although only theoretical, could prove a genuine danger in the hands of enterprising personal injury lawyers in express consent jurisdictions. Daniel Jardine makes a convincing case that the current practice of transplant programs in the United States – in which the express consent of a deceased to donate is “almost always” rejected unless affirmed by the deceased’s next of kin¹⁰⁰ – violates the primacy of the deceased’s wishes over those of his or her kin under the UAGA, and that potential organ recipients may have a cause of action negligence against the hospital, doctor or OPO that rejects a gift under such circumstances.¹⁰¹

⁹⁷ UAGA, s.11(c).

⁹⁸ Roberts, *supra* note 34 at 110.

⁹⁹ Christine E. Edwards, “Giving Virginia’s *Anatomical Gift Code* Life: Creating Liability for a Hospital’s Failure to Determine Individual Donative Intent” (1995) 47 Wash. U.J. Urb. & Contemp. L. 185 at 197 [Edwards]. Moreover, Overcast was able to report that after sixteen years under UAGA, “No reported cases have held that a physician acted in bad faith and thus was not immune” under the “good faith” exemption, see *supra* note 89 at 366. In 1990, Jardine was similarly able to claim that “since the enactment of the UAGA in 1969, no physician has ever been successfully sued because of involvement in organ procurement.”, see *supra* note 84 at 1666.

¹⁰⁰ *Supra* note 84 at 1657-58.

¹⁰¹ Jardine sets out the breach of duty, standard of care, causation, and an argument for establishing damages, *ibid.* at 1675-80.

Moreover, he suggests that the recipient might have cause of action *against the deceased's family* for tortious interference in those instances where the family has overruled the express consent of the would-be donor.¹⁰²

Legal Obstacles to Reform

Tort Liability

The *TGLN Act* differs from the American *UAGA* in one potentially important respect: it lacks an explicit “good faith” exemption from civil (and criminal) liability. Thus, while an American transplant professional (whether a doctor or any “other person” involved in the process) will only be held to a standard of “good faith” observance that precludes liability for mistakes, a doctor in Ontario would be expected to meet the standard of care of “a prudent and diligent doctor in the same circumstances,”¹⁰³ while other transplant professionals – nurses, technicians, or clerical staff – would be held to equivalent professional standards or to the “reasonable person” standard of ordinary negligence. This difference could prove significant under presumed consent in cases in which a person responsible for verifying a potential donor’s lack of express objection either (i) failed to properly follow established procedures in doing so (through a simple mistake, as in *Lyons* and *Ramirez*), or (ii) properly followed a “standard practice” that a court might hold “fails to adopt obvious and reasonable precautions which are readily apparent to the finder of fact.”¹⁰⁴ Nor can it be safely assumed today, as it once was, that a claim by the donor’s family for “emotional distress” – such as was made in *Lyons* and *Ramirez* – would fail in the absence of a recognized psychiatric illness or more-than-minor mental distress¹⁰⁵ caused by wrongful organ procurement.

Of course, the danger of suits of this nature might as easily arise under the current situation, since under express consent, the transplant team must still correctly ascertain the status of the deceased’s wishes. However, if Jardine is correct that an unfounded fear of donor-family litigation prevents practitioners from correctly implementing even express consent, it may be that a presumed-consent regime would function more efficiently with the addition of a “good faith” exemption to a revised *TGLN*.¹⁰⁶ Properly educated as to the effect of such an exemption, transplant professionals might proceed with their work without fear of prosecution by families of donors who feel slighted by the policy of presumed consent.¹⁰⁷

¹⁰² *Ibid.* at 1686.

¹⁰³ *ter Neuzen v. Korn*, [1995] 3 S.C.R. 674 at para. 33.

¹⁰⁴ *Ibid.* at para. 51.

¹⁰⁵ *Mason v. Westside Cemeteries Ltd.* (1996), 135 D.L.R. (4th) 361 (Ont. Gen. Div.) cited in *Bastien v. Ottawa Hospital (General Campus)* (2001), 56 O.R. 3d 397 (Ont. S.C.J.) at para. 41.

¹⁰⁶ Maureen McTeer echoes Jardine’s concerns on this point, arguing that successful implementation of even express consent requires that doctors, hospital administrators, and other health care professionals must be protected so that valid donor consents will be respected. Maureen McTeer, *Tough Choices: Living and Dying in the 21st Century* (Toronto: Irwin Law, 1999).

¹⁰⁷ One competing consideration is that the absence of liability for persons involved in verifying the status

Charter Challenges

The United States has some experience with litigation against presumed consent; cases of this description appear to take the form of constitutional challenges to the law rather than tort litigation against those who act under it. This experience confirms the intuitions of the LRCC, which speculated in its conservative examination of the topic that the routine-inquiry approaches it advocated above presumed consent “seem less likely to provoke legal challenges for infringement on religious freedom, autonomy and privacy.”¹⁰⁸

Several states have passed “presumed consent” statutes specifically with respect to the removal of corneas for transplant. While there are some variations, the “pure” presumed-consent statutes require no family consent and no search for family members to verify the deceased’s donative intent.¹⁰⁹ As of 2002, these statutes had been subject to relatively few court challenges.¹¹⁰ However, three such challenges are illustrative of the approach American courts have taken to the constitutionality of presumed consent in this narrow context.

In *Tillman v. Detroit Receiving Hospital*,¹¹¹ a constitutional challenge to corneal harvesting without consent of the family based on the right of privacy was dismissed out of hand by the Court of Appeals of Michigan:

The privacy right encompasses the right to make decisions concerning the integrity of one’s body. *Roe v. Wade*, *supra*. This right is, however, a personal one. It ends with the death of the person to whom it is of value. It may not be claimed by his estate or his next of kin.¹¹²

of consent might lead to carelessness and unauthorized procurements; it has been suggested that statutory liability should be imposed on those who fail to properly determine donative intent. See *Edwards, supra* note 99. I would argue, however, that such a liability might have the far worse consequence of preventing transplant professionals from properly implementing presumed consent. I believe for the sake of the larger goal (i.e. increased donation) it is best to assume that such people are aware of their responsibilities and will generally conduct their duties with due caution.

¹⁰⁸ *Supra* note 1 at 179.

¹⁰⁹ Daphne D. Sipes, “Legislative Update on the State Adoption of the 1987 Revision to the *Uniform Anatomical Gift Act of 1968*” (1990) 4 B.Y.U. J. Pub. L. 395 at 429-30. Similar statutes enacted in Canadian provinces allow for an extremely weak form of presumed consent in which consent to donation is presumed for a decedent with no recorded donative intent and no identifiable family to either consent or reject. For the history of these Acts, see LRCC, *supra* note 1 at 129-30. There are several provincial Acts allowing for presumed consent extraction of pituitary glands and corneas under specific circumstances, but at the time of writing, it appears that none of these has been litigated; thus, there is no Canadian judicial pronouncement on their constitutionality. The LRCC speculated that these provisions “may afford models for broader legislative reforms intent on increasing the general supply of scarce tissue and organs,” although the Commission ultimately rejected expansion of presumed consent in its recommendations. See *ibid.* at 133, 181-82.

¹¹⁰ Goodwin, *supra* note 65 at 271.

¹¹¹ 360 N.W. 2d 275 (Mich. Ct. App. 1984); 138 Mich. App. 683 (1984).

¹¹² *Ibid.* at 687.

The Supreme Court of Georgia reached a similar conclusion in *Georgia Lyons Eye Bank, Inc. v. Lavant (Georgia Eye Bank)*,¹¹³ concluding that “there is no constitutionally protected right in a decedent’s body” and citing an earlier case for the proposition that “among all the objects sought to be secured by governmental laws, none is more important than the preservation of the public health.”¹¹⁴

Finally, the Supreme Court of Florida in *State v. Powell (Powell)*¹¹⁵ upheld the law on the grounds that it “rationally promotes the permissible legislative objective of restoring sight to the blind”¹¹⁶ and that the decedent’s family had no right of “free choice in decisions of fundamental importance to the family,” grounded in freedom of religion or otherwise:

The cases cited recognize only freedom of choice concerning personal matters involved in existing, ongoing relationships among living persons as fundamental or essential to the pursuit of happiness by free persons. We find that the right of the next of kin to a tort claim for interference with burial ... does not rise to the constitutional dimension of a fundamental right traditionally protected under either the United States or Florida Constitution.¹¹⁷

Both *Powell*¹¹⁸ and *Georgia Eye Bank*¹¹⁹ rely on W.L. Prosser’s pronouncement with respect to family rights to the bodies of the deceased:

It seems reasonably obvious that such ‘property’ is something evolved out of thin air to meet the occasion, and that in reality the personal feelings of the survivors are being protected, under a fiction likely to deceive no one but a lawyer.¹²⁰

This “U.S. position” on the right has been contrasted with Canadian jurisprudence.¹²¹ The leading Canadian case of *Edmonds v. Armstrong Funeral Home Ltd.*¹²² suggests we have maintained the “fiction” of a quasi-property right of custody and possession vested in the decedent’s family for the purpose of arranging burial,¹²³ but reminds us that “these rights are subordinate to the demands of justice

¹¹³ 335 S.E. 2d 127 (1985); 255 Ga. 60 (Sup. Ct.).

¹¹⁴ *Ibid.* at 61-62. Obviously, this right is of limited application in Canada where there is no constitutional protection of property rights of any sort, but the public policy argument is certainly applicable.

¹¹⁵ 497 So. 2d 1188 (Fla. Sup. Ct. 1986), cert. denied, 107 S. Ct. 2002 (1986).

¹¹⁶ *Ibid.* at 1193-94.

¹¹⁷ *Ibid.* at 1193.

¹¹⁸ *Ibid.* at 1192.

¹¹⁹ *Georgia Eye Bank*, *supra* note 113 at 61.

¹²⁰ Page Keeton & William Lloyd Prosser, *Prosser and Keeton on the Law of Torts*, 5th ed. (St. Paul, Minn.: West Publishing Company, 1984) at 63.

¹²¹ *Supra* note 1 at 67, n. 389.

¹²² [1931] 1 D.L.R. 676, 1930 Carswell Alta 53 (Alta.S.C.A.D.) [*Edmonds* cited to CarswellAlta].

¹²³ *Ibid.* at para. 10.

or public good.”¹²⁴ Again, the lack of a Canadian constitutional property right precludes a claim based on family property in the deceased from arising, but the principle that a family right with respect to the decedent is subject to the dictates of public policy is suggestive of the manner in which a constitutional claim phrased in non-property terms would likely be decided. A challenge launched under the *Charter of Rights and Freedoms*¹²⁵ based on freedom of religion¹²⁶ or on the right to life, liberty and security of the person¹²⁷ – seemingly the only grounds on which family members might ground a constitutional challenge to the law – would be subject to a section 1 analysis and would have to demonstrate that presumed consent was not a “reasonable limit” on such a right as could be “demonstrably justified in a free and democratic society.”¹²⁸

But these challenges have been answered in previous *Charter* jurisprudence in other circumstances. To begin, it has been decided in Ontario, and affirmed by the Supreme Court of Canada, that “there is no guaranteed right to ‘family autonomy’”¹²⁹ under section 7. In *B.(R.)* it was denied that there was a constitutionally protected right of a family to make health care decisions on behalf of children, and even if there were, it was beyond the scope of this right or the parents’ individual section 7 liberty to make decisions that would result in the death of their children:

Section 7 addresses itself also to ‘the principles of fundamental justice’. It can hardly be said that the principles of fundamental justice could be invoked to deny a child a chance to live.¹³⁰

The absence of a right of “family autonomy” with respect to the living would extend, in principle, to the dead as well. Just as the section 7 individual right of family members with respect to children cannot be exercised to deny life to a child, such a right of family members in respect of the deceased potential donor – even if such right exists – would surely be subject to the “reasonable limit” that it could not be exercised at the cost of the lives of potential recipients waiting for organs.

The Court of Appeal went on to hold that the parents’ section 2(a) freedom of religion was protected “only so long as it does not impede the vital and overriding state concern with the life and health of a child,” thus life-saving medical treatment

¹²⁴ *Ibid.* at para. 18.

¹²⁵ Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982 c. 11 [*Charter*].

¹²⁶ *Ibid.* at s.2(a).

¹²⁷ *Ibid.* at s.7.

¹²⁸ *Ibid.* at s.1.

¹²⁹ *B. (R.) v. Children’s Aid Society of Metropolitan Toronto* (1992), 43 R.F.L. (3d) 36; 10 O.R. (3d) 321, 96 D.L.R. (4th) 45, (sub nom. *Sheena B.*, Re) 58 O.A.C. 93, 1992 CarswellOnt 301 (Ont. C.A.) at para. 36. [*B.(R.)* cited to CarswellOnt].

¹³⁰ *Ibid.* at para. 44, quoting from the unreported trial decision. Note that on appeal to the Supreme Court, the majority agreed that “s. 7 of the *Charter* does not afford protection to the integrity of the family unit as such” but instead recognized the possibility of a narrower “parental liberty.” [1995] 1 S.C.R. 315 at paras. 72, 83-85.

administered against their wishes did not violate this freedom.¹³¹ If such treatment did indeed violate a section 2(a) right, it was justified under section 1 and the *Oakes* test.¹³²

Logically, presumed consent provisions in a revised *TGLN Act* would survive a section 2(a) challenge for the same reason as did the medical treatment at issue in *B.(R.)*: the primacy of preserving life over the exercise of a conditional though fundamental freedom. In the event that such provisions were held to violate sections 7, 2(a), or any other *Charter* provision, the family of the decedent would have the unenviable task of convincing the court that their rights in respect of the decedent – which, as we have seen, are at best highly qualified and circumscribed – were of such great importance as to be worth their weight in human life.

So far I have considered only the possibility of challenges brought by the families of potential donors. However, it is also theoretically possible that such a challenge might be brought by a living person who objects to the prospect of his or her organs being donated without express consent. Such a claim would, again, be premised on the exercise of some fundamental right and would be subject to the same reasonable limitations inherent in each right and reaffirmed by the section 1 override. It would arguably be a stronger claim, as it would be in respect of the plaintiff's own body and beliefs. Nevertheless, the arguments in favour of presumed consent would be the same – the legislative objective of preserving life, weighed against the fullest possible exercise of one's individual rights, in this case, from beyond the grave – and were such provisions held to violate sections 7, 2(a), or any other *Charter* provision, the only likely difficulty they would face in passing the *Oakes* test would be the objection that they did not constitute a "minimal impairment" of the right.

While a conscription-style variant of presumed consent in which organs were procured regardless of the express wishes of the deceased might encounter difficulty at this stage – though I would argue that even such an extreme variant is still a justifiable limit on any *Charter* right – it should be recalled that the version of presumed consent I endorse entitles the decedent to opt out of donation with a minimum of difficulty. In order to succeed in challenging the law, a plaintiff would

¹³¹ *Ibid.* at para. 82.

¹³² *R. v. Oakes*, [1986] 1 S.C.R. 103 [*Oakes*]. The Supreme Court majority in *B.(R.)* held that the provision at issue did indeed violate s.2(a) but was, as the Court of Appeal had ruled, saved by s.1, *supra* note 130 at para. 98. The *Oakes* test was concisely summarized in *R. v. Chaulk*, [1990] 3 S.C.R. 1303 at 1335-56:

1. The objective of the impugned provision must be of sufficient importance to warrant overriding a constitutionally protected right or freedom; it must relate to concerns which are pressing and substantial in a free and democratic society before it can be characterized as sufficiently important.
2. Assuming that a sufficiently important objective has been established, the means chosen to achieve the objective must pass a proportionality test; that is to say they must:
 - (a) be 'rationally connected' to the objective and not be arbitrary, unfair or based on irrational considerations;
 - (b) impair the right or freedom in question as 'little as possible'; and
 - (c) be such that their effects on the limitation of rights and freedoms are proportional to the objective.

have to argue that the requirement of filing an express objection to the procurement of his or her organs more than minimally impaired his or her right to determine what became of them at death. Given the ease with which such an objection could be filed,¹³³ it is difficult to imagine a less onerous limitation on a right.

While there is no case law precisely on point with respect to constitutionality of schemes in which the rights bearer must actively opt out of a legislative scheme to give effect to that right, it appears that the courts have tacitly accepted such arrangements. In *Taylor v. Rossu*,¹³⁴ for instance, the Alberta Court of Appeal actually *recommended* such an opt-out option as a less intrusive alternative to a measure it had struck down as violating section 15 and which could not be saved under section 1 of the *Charter*.¹³⁵ While the possibility of opting out may not to save a law where the possibility is more illusory than real, the notion that a person might have to take positive action to exercise a fundamental freedom does not appear to have been considered enough in itself to invalidate the law.¹³⁶ Moreover, the Supreme Court of Canada has upheld even schemes that *refused* to allow individuals to opt out where such an option would weaken the purpose of the legislation, even where the purpose was arguably less compelling than the saving of lives.¹³⁷

For these reasons, it is difficult to view constitutional challenges, any more than tort litigation, as legitimate impediments to a more proactive legal regime for organ procurement.

Conclusion: Conservative Choices, Modest Prospects

The LRCC commented in its recommendations that “[l]aw is ill-equipped to solve the technical dilemmas of medicine or the philosophical divides of ethics.”¹³⁸ While I would not presume to argue with this proposition¹³⁹ by suggesting that the

¹³³ See above at 15.

¹³⁴ [1998] A.J. No. 648, 161 D.L.R. (4th) 266 (Alta. C.A.) [*Taylor* cited to A.J.].

¹³⁵ *Ibid.* at para. 152.

¹³⁶ See e.g. *Waldman v. British Columbia (Medical Services Commission)*, (1997) 150 D.L.R. (4th) 405 (B.C. S.C.). In this case, a doctor’s *Charter* mobility rights were held to be infringed by provincial regulations restricting his ability to obtain a physician’s billing number after moving to the province from another jurisdiction. That the doctor could still technically practice medicine in the province without such a number by “opting out” of the provincial health insurance plan did not save the restrictions, since it was unrealistic to expect that patients insured by the universal health care system would be willing to pay a doctor working outside of the plan in cash.

¹³⁷ See e.g. *Lavigne v. Ontario Public Service Employees Union*, [1991] 2 S.C.R. 211, S.C.J. No. 52 [*Lavigne* cited to S.C.J.] (in which the Court upheld under s.1 the application of the Rand formula in a collective agreement (which violated the plaintiff’s s.2(d) freedom of association) because allowing individuals to opt out of the provisions in question would weaken the “spirit of solidarity which is so important to the emotional and symbolic underpinnings of unionism” – at para. 269).

¹³⁸ *Supra* note 1.

¹³⁹ I have argued elsewhere about the folly of expecting law alone to ameliorate social problems: see H.W. Arthurs & B. Arnold, “Does the *Charter* Matter?” (2005) 11:1 Rev. Const. Stud. 37.

complexities of the organ shortage may be resolved with legislative “tweaking,” I *would* argue that law should at least not hinder its resolution. Like any social problem, it must be met with a combination of adequate funding, cooperation, coordination and innovation, within a framework of laws suited to achieving the goal. The provincial government and the Premier’s Advisory Board laid the groundwork for such an approach by creating the TGLN. What they failed to do, whether out of an abundance of caution or political expedience, was to tackle the legal barriers – from express consent in cadaveric donation, to contentious classes of living donors, to the whole-brain-death standard – which limit the ability of any OPO, no matter how well funded or organized, to make an appreciable difference. Presumed consent is only one of many ways in which law must be made amenable to the efforts of groups like the TGLN if the challenge of organ shortage is to be met. Twelve years ago, the LRCC also suggested that we should try to make express consent work and consider abandoning it “when it proves ineffective or too costly.”¹⁴⁰ The numbers suggest that, after several years, millions of dollars and thousands of lives lost, it is time.

¹⁴⁰ *Supra* note 1 at 61.

