

Priority Systems in the Allocation of Organs for Transplant: Should We Reward Those Who Have Previously Agreed to Donate?

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Introduction

Organ transplantation has been described “with only slight exaggeration [as] usher[ing] in the age of bioethics”¹ as it has focused public attention on the practice and its associated ethical issues. These compelling ethical issues have inspired a voluminous body of writing in the medical, legal and philosophical literature. These authors debate the intrinsic morality of transplantation.² Long-standing prohibitions against the mutilation of the body compete with the suggested moral duty to assist those in need.³ Although it is now commonly accepted, the ethics of voluntary living donation are sometimes questioned given its lack of benefit to the donor and the medical ethical requirement of non-maleficence.⁴ Another issue arises from the definition of death.⁵ The old definition relied on the cessation of cardio-respiratory function but was not satisfactory from the perspective of organ donation as oxygen deprivation damages the organs. The move to a brain-death definition permitted organs to be preserved through life support.

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¹ Albert R. Jonsen, “Ethical Issues in Organ Transplantation” in Robert M. Veatch, ed. *Medical Ethics* 2nd ed. (Sudbury Massachusetts: Jones and Bartlett Publishers, 1997) 240.

² See e.g. *ibid.* at 242-244.

³ H.E. Emson, “It is immoral to require consent for cadaver organ donation” (2003) 29 J. Med. Ethics 125 [Emson], (Emson suggests that the idea of property in the human body during life and after death is “biologically inaccurate and morally wrong” and that “[t]he body should be regarded as on loan to the individual from the biomass, to which the cadaver will inevitably return”); John Harris, “Organ procurement: dead interests, living needs” (2003) 29 J. Med. Ethics 130 [Harris].

⁴ James Neuberger, “Should Liver Transplantation be Made Available for Everyone?” (2003) 163 Arch. Intern. Med. 1881 (Live donation of liver tissue is associated with increased risk of longer term morbidity and mortality for adult donors); Irwin Kleinman & Frederick H. Lowy, “Ethical Considerations in Living Organ Donation and a New Approach: An Advance-Directive Organ Registry” (1992) 152:7 Arch. Intern. Med. 1484 at 1484 [Kleinman & Lowy] (“Living organ transplantation should be recognized as an ethical compromise to the principle of non-maleficence (doing no harm), given the risks health donors are allowed to assume. Living organ donation is not completely safe”).

⁵ See e.g., *supra* note 1 at 244-246.

In addition to these basic questions about whether we can and at what point we can take an organ and transplant it into another person, a group of thorny ethical problems are driven by the fact that the supply of organs for transplant is inadequate to meet the need. As a result, stronger measures, many of which raise ethical problems, have been proposed to try to meet the shortfall.

On the supply side, troubling questions are raised regarding the acceptability of using unorthodox sources of organs such as anencephalic infants,⁶ animals,⁷ fetuses,⁸ and non brain-dead persons.⁹ The inadequacy of the supply of organs has also raised questions about the propriety of more coercive methods to increase cadaveric donation.

Despite vigorous arguments for the state "nationalization" of cadavers,¹⁰ most are unwilling to abandon the requirement of some form of consent by the individual or his or her next-of-kin. A range of methods short of state ownership of cadavers have been proposed to increase donation rates, including the suggestions that (1) everyone should be required to register either consent or refusal to donate ("mandatory choice"), (2) physicians should be required to ask the next-of-kin to consent to donation ("required request"), and (3) consent to donate should be presumed and those unwilling should be required to register their refusal ("opt-out" or "presumed consent").

A large variety of proposals seek to obtain consent by offering incentives. These range from the neutral reimbursement of expenses (e.g., live donors might receive reimbursement of lost wages and travel expenses, while the estates of dead donors might receive reimbursement of funeral expenses), to positive financial and non-financial inducements. These suggested incentive-based systems are that (1) people be permitted to sell organs (either privately or to the state) receiving payment while alive or posthumously via their estates, (2) people who donate or register to donate should receive tax breaks, (3) people ought to be able to make conditional

⁶ *Supra* note 1 at 254 ("Anencephaly is a genetic anomaly in which the higher portions of the brain and the skull remain undeveloped in the fetus; after birth, an anencephalic infant may live for a few hours or even a few days but will inevitably die...Although lacking higher brain portions, the anencephalic infant has a functioning brain stem and, thus, is not legally brain-dead").

⁷ Xenotransplantation, or the transplant of animal tissues into humans, raises ethical questions about animal rights, about the importance of the human-animal distinction, and the transfer of diseases and the development of new diseases.

⁸ See *supra* note 1 at 255 (discussing the debate over the use of aborted fetuses, and the possibility of using such tissue to treat parkinsonism and diabetes).

⁹ J. Savulescu, "Death, us and our bodies: personal reflections" (2003) 29 *J. Med. Ethics*. 127 at 129-130 (Savulescu suggests that we may not need to wait until a donor satisfies the criteria for brain death or cardiorespiratory failure if we believe that what is critical to life is mental state. Although we may be uncomfortable in declaring that all patients with severe brain damage or permanent unconsciousness are available for donation, he suggests that we should permit people to complete advance directives that direct that organs may be removed at that point).

¹⁰ See e.g. Emson, *supra* note 3.

donations, specifying the class of permitted recipients,¹¹ (4) people should be able to set up “paired organ exchanges,”¹² (5) people who donate should be able to designate a charity to receive a cash award,¹³ and (6) people who donate should receive medals or other forms of public recognition and gratitude.

Another proposal that has been made sporadically for some years is what has been called a “solidarity model,”¹⁴ a “reciprocity policy,”¹⁵ a “priority incentive,”¹⁶ or “preferred status.”¹⁷ In such a system, those who register as donors receive some degree of preference later on should they require an organ. The terminology chosen may be significant, as the labels emphasize different aspects of the proposed approach and might affect how it is received.¹⁸ The terms solidarity and reciprocity emphasize the values of community and interdependence, while priority and preference emphasize the appeal to individual self-interest, as do the terms incentive and status. In this paper, I will call the approach a priority system.

A priority system was suggested as early as 1967. Joshua Lederberg recognized the problem of supply very soon after the first heart transplant was performed and wrote about the idea of a priority system for organ donation and allocation.¹⁹

¹¹ Stephen J. Wigmore & John L.R. Forsythe, “Incentives to Promote Organ Donation” (2004) 77:1 *Transplantation* 159 at p. 160 [Wigmore & Forsythe] (Wigmore and Forsythe describe the kinds of problems that may occur with conditional donation, such as the attachment of racist conditions to the allocation of the donated organ. Although “[t]he notion that cadaveric donation and allocation can be made conditional (by the donor or the donor’s family) to attributes of the recipient is not a generally accepted premise,” living-donor transplants are usually directed to a specific recipient. For a discussion of using directed donation as a means to increase the rate of donation within racial minority communities, see Wayne B. Arnason, “Directed Donation: The Relevance of Race” (1991) 21:6 *Hastings Center Report* 13.

¹² A paired organ exchange permits a live donor who wishes to donate to a loved one but cannot due to tissue incompatibility to find another live donor in the same situation. The two live donors then donate to the other’s loved one. See e.g. Francis L. Delmonico *et al.*, “Ethical incentives – Not Payment – For Organ Donation” (2002) 346:25 *N. Engl. J. Med.* 2002 at 2003 [Delmonico].

¹³ This is mentioned in Dilip S. Kittur *et al.*, “Incentives for organ donation?” (1991) 338:8780 *The Lancet* 1141 at 1442.

¹⁴ G. Gubernatis, “Solidarity Model as Nonmonetary Incentive Could Increase Organ Donation and Justice in Organ Allocation at the Same Time” (1997) 29:8 *Transplantation Proceedings* 3264 [Gubernatis]; Gundolf Gubernatis & Hartmut Kliemt, “A superior approach to organ allocation and donation” (2000) 70:4 *Transplantation* 699 [Gubernatis & Kliemt].

¹⁵ Mark S. Nadel and Carolina A. Nadel, “Using Reciprocity To Motivate Organ Donations” (2005) 5 *Yale J. Health Pol’y L. & Ethics* 293.

¹⁶ Adam Kolber, “A Matter of Priority: Transplanting Organs Preferentially to Registered Donors” (2003) 55:3 *Rutgers L. Rev.* 671.

¹⁷ James F. Burdick *et al.*, “Preferred Status for Organ Donors: A Report of the United Network for Organ Sharing Ethics Committee” (30 June 1993), online: United Network <<http://www.unos.org/resources/bioethics.asp?index=5>>.

¹⁸ Abdallah S. Daar, “Altruism and Reciprocity in Organ Donation: Compatible or Not?” (2000) 70:4 *Transplantation* 704 at 705 [Daar] (“It might be easier to explain to the public if it were labeled the “reciprocity” proposal, because of the association of the latter term with the Golden Rule, which everyone understands and accepts (“do unto others as you would others do unto you”). The emphasis should be that the Golden Rule is not based on altruism or charity, but on reciprocity, with implicit reciprocal duties and obligations”).

¹⁹ Gubernatis, *supra* note 14 at 3264 (“Commenting on the first heart transplantation, *The Washington*

Since then, many proposals, which are described below, have been made. There is a priority system in operation in Singapore and elements of a priority system exist elsewhere, as is discussed below.

Priority systems raise ethical concerns with respect to both the donation side of organ transplantation as well as the allocation side. From the perspective of donors, some suggest that the system is coercive and erodes altruism. With respect to allocation, the system would prefer some potential recipients over others. While this is necessary in any non-random system of rationing scarce resources, critics suggest that the criterion of previously-expressed willingness to donate would operate unfairly and also reflects an impermissible method of allocation according to adjudged social worth. Other concerns exist regarding deviation from allocation according to need or medical utility, as well as with respect to the commodification of body parts.

This article will consider the advisability of using a priority system. Part I of this article will provide some necessary background on the current Canadian organ transplant system, particularly with respect to Canadian attitudes toward donation. Part II will outline the elements of the various forms of priority system. Part III will consider the advantages and disadvantages of priority systems, and will offer some suggestions about how an ethically acceptable priority system might be designed.

Part I Organ Transplantation in Canada

The number of Canadians awaiting an organ transplant has been steadily increasing, and reached 4054 people in 2004.²⁰ In the same year, 224 people died while on the waiting list. Between 1993 and 2002, the Canadian national donation rate hovered between 405 and 470 cadaveric donors (or 13 and 15.3 per million).²¹ In 2004, 1347 organs²² were transplanted from 414 cadaveric donors.²³

Post stated on December 19, 1967, 'Moribund patient's trust is at stake – Heart transfer poses grim decisions.' At this early date, the author, Joshua Lederberg, had already proposed 'a mutual club' of potential organ donors. He anticipated that this scheme could help to solve the two major problems from which organ transplantation is now suffering: organ shortage and rationing in organ allocation. He had already understood that the two problems are closely linked to each other").

²⁰ CIHI, "eQuarterly Report on Transplant, Waiting List and Donor Statistics, 2004 Summary Statistics, January 1 to December 31, 2004: Figure 1: Transplants, Patients Waiting for Transplants and Patients Who Died While Waiting for a Transplant, Canada, Summary Statistics, January 1 to December 31, 1998-2004", online: CIHI

<http://secure.cihi.ca/cihiweb/en/downloads/CORRQ404_Figure_1_C_e.pdf>.

²¹ CIHI, "Cadaveric Donors, Canada 1993-2002 (Number and Crude Rate per Million)", online: CIHI <http://secure.cihi.ca/cihiweb/en/reports_corrinsites_apr2003_nat_fl_e.html>.

²² CIHI, "eQuarterly Report on Transplant, Waiting List and Donor Statistics, 2004 Summary Statistics, January 1 to December 31, 2004", online: CIHI

<http://secure.cihi.ca/cihiweb/en/downloads/CORRQ404_Table1A_C_e.pdf>.

²³ CIHI, "eQuarterly Report on Transplant, Waiting List and Donor Statistics, 2004 Summary Statistics, January 1 to December 31, 2004: Figure 2 Procured Deceased Donors, Canada and Provinces, Canada and Provinces, Summary Statistics, January 1 to December 31, 2000-2004", online: CIHI

<http://secure.cihi.ca/cihiweb/en/downloads/CORRQ404_Figure_2_C_e.pdf>.

The donated organs are allocated using various allocation algorithms, which vary according to the organ in question. The Trillium Gift of Life Network maintains the allocation algorithms applied in Ontario.²⁴ In Ontario, patients awaiting a heart or liver transplant are placed in one of a list of classes according to the urgency of their need, and organs are allocated to blood-type compatible recipients in the most urgent class first. Within a class, recipients in the donor region are ranked ahead of others, and recipients are ranked by time on the waiting list. The kidney allocation algorithm similarly prefers local high urgency patients and considers wait list time. The U.S. United Network for Organ Sharing (“UNOS”) similarly considers tissue compatibility, urgency of the need, time spent on the waiting list, and the likelihood of a successful outcome.²⁵ As in Canada, substantial preference is given to recipients from the donor’s region.²⁶

Canadian donors can register in a variety of ways. Some provinces operate specific organ donation registries,²⁷ while in other provinces willing donors express consent through their driver’s license, health card or by carrying a donor card from an organ procurement organization.²⁸ Most donors die from cerebrovascular accident and head injuries, and a declining number die as a result of motor vehicle accidents.²⁹ The actual organ retrieval rate from potential donors appears to be quite low, at approximately 16% of potential donors who die as a result of head injury and 10% of those who die as a result of cerebrovascular accident.³⁰

The relevant legislation in Ontario is the *Trillium Gift of Life Act*.³¹ The *Act* provides that any person over age 16 may consent to donation in writing at any time or orally during the person’s last illness in the presence of two witnesses.³² The *Act* provides that consent so given is “binding and full authority” for the use of the body

²⁴The author is grateful to the Trillium Gift of Life network for sending the allocation algorithms as of June, 2005 to her for review. These remain on file with the author. Interested readers should contact the Trillium Gift of Life network for updated versions of Ontario’s allocation algorithms.

²⁵*Supra* note 16 at 681.

²⁶*Ibid.*

²⁷See e.g. British Columbia Transplant Society, “Organ Donor Registry”, online: British Columbia Transplant Society <http://www.transplant.bc.ca/odr_process_main.htm>.

²⁸Parliament, House of Commons, Standing Committee on Health, “Organ and Tissue Donation and Transplantation: A Canadian Approach, Report of the Standing Committee on Health” (April 1999) ch. 3 at 5, online: <<http://www.parl.gc.ca/InfoComDoc/36/1/HEAL/Studies/Reports/healrp05-e.htm>>.

²⁹CIHI, “Distribution of causes of death among deceased donors, Canada, 1994-2003”, online: CIHI <http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=statistics_results_source_corr_e>.

³⁰CIHI, “Actual donors for every 100 potential donors by cause of death category, Canada, 1992 and 1997”, online: CIHI <http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=statistics_results_source_corr_e>, (Potential donors are defined as people up to 69 years old who died in hospital from a cause of death that would permit them to be suitable donors). CIHI, “New Method to Compute Organ Donation Rates Shows Donation Rates are Up in Canada, Reports Canadian Institute for Health Information,” (18 April 2001), online: CIHI <http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_18apr2001_e>.

³¹R.S.O. 1990, c. H.20, online:

<http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/90h20_e.htm>.

³²*Ibid.*, s.4(1).

or specified body parts of the decedent, except if there is reason to believe that consent has been withdrawn.³³

Transplantable organs are lost for various reasons. Some are lost due to a failure by medical personnel to approach the families of potential donors. A 1998 study of 15 Canadian hospitals indicated that families of only 158 of 232 potential donors that were identified were approached.³⁴ Some provinces have amended their legislation to require that the organ procurement organization be notified of any death or impending death of a potential organ donor and to provide that family consent to donate must be requested.³⁵

Notwithstanding a donor's consent, physicians will not remove organs without the consent of family members. In Ontario, the Trillium Gift of Life Network asks donors to speak with their families.³⁶

"When you sign a donor card, you give doctors permission to recover your organs and tissue upon death. This does not mean that the doctors must recover your organs. Out of respect for the feelings of grieving families, hospital staff will talk with the next-of-kin about their feelings regarding donation and what their loved one would have wanted. That is why it is important that you talk with your family and loved ones about your wishes..."³⁷

Not only do hospital staff feel a duty to respect the emotions of a grieving family, but they depend upon the family to provide information that is essential for ensuring the quality and safety of the donated organs.³⁸ Family consent depends critically upon whether the family is aware of a decedent's wishes. A survey conducted for Health Canada in 2001 indicated that 83% of families were very likely to consent to the donation of a family member's organs if the family member had registered to donate and discussed donation with the family, and another 13% were somewhat likely to consent.³⁹ If the family member had registered but not discussed the matter with the family, the numbers slipped to 65% who were very likely to consent and 26% who were somewhat likely to consent.⁴⁰ If the family member had not registered to donate, only 25% were very likely to donate and 31%

³³ *Ibid.*, s.4(3).

³⁴ *Supra* note 28 at ch. 3, p. 11.

³⁵ See e.g. British Columbia, *Human Tissue Gift Act Consent to Donation Regulation*, B.C. Reg. 65/99, s.4-6; *Trillium Gift of Life Network Act*, R.S.O. 1990, c. H-20, Part II.1).

³⁶ Trillium Gift of Life Network, FAQ, online: Trillium Gift <<http://www.giftoflife.on.ca>>.

³⁷ *Ibid.*

³⁸ *Supra* note 28 at ch. 3, p. 13.

³⁹ Environics Research Group Ltd., "Organ and Tissue Donation: Canadian Public Awareness, Knowledge and Attitudes," prepared for Health Canada (November 2001) at 37.

⁴⁰ *Ibid.* at 37.

somewhat likely to donate.⁴¹ Unfortunately, approximately one third of potential donors are lost due to family refusal.⁴²

Given the critical importance to families of knowledge about the deceased's willingness to donate, improved registration rates would be helpful. The 2001 Health Canada poll noted the importance of increasing the numbers who sign organ donor cards, as this would "encourage more next of kin to agree to a donation, since next of kin are strongly supportive of agreeing to a donation if their loved one has signed a card."⁴³

The overwhelming majority of Canadians are aware of the need for donated organs.⁴⁴ Although a large majority of Canadians support organ donation and transplantation, and say they are willing to donate, far fewer actually discuss the matter with their families or register their commitment to donate. Contrary to the belief of many Canadians, Canada has one of the lowest donation rates among industrialized countries, at less than half of the 31 donors per million achieved in Spain.⁴⁵

The 2001 Health Canada poll reported that 96%⁴⁶ of Canadians approve of organ and tissue donation, but only 46% have decided to donate, while 45% are undecided and 9% have decided not to donate.⁴⁷ The poll shows that women, those aged 45-54 years, better educated and more affluent respondents are more likely to decide to donate, while those older than 65, the least educated and least affluent respondents, those whose religion is non-Christian, those whose ethnic background is either non-European or European other than French or British, and those born outside Canada are more likely to be undecided. Non-Christians older than 65 years are most likely to have decided not to donate. Of those who have made a decision either to donate or not, most (85% of respondents) say they have told their families about their decision.⁴⁸

The number of respondents who have actually signed a donor card is 45%.⁴⁹ The poll shows a similar demographic pattern as those who say they have decided to donate.⁵⁰ It is quite possible that the survey overstates the number of Canadians

⁴¹ *Ibid.* at 38.

⁴² *Supra* note 28 at ch. 3, p. 6

⁴³ *Supra* note 39 at 48.

⁴⁴ *Ibid.* at 29 (stating that 82% of respondents reported that there is a great need, and 14% said there is some need).

⁴⁵ Health Canada, "Organ Donation in Canada" (April 2001), online: Health Canada

<http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2001/2001_36bk1_e.html>; *supra* note 28 at ch. 3, p. 10.

⁴⁶ *Supra* note 39 at 13 (67% strongly approve and 29% somewhat approve).

⁴⁷ *Ibid.* at 13.

⁴⁸ *Ibid.* at 14.

⁴⁹ *Ibid.* at 12.

⁵⁰ *Ibid.* at 12 (Those most likely to have registered to donate are "[w]omen, especially working women, those aged 35-44 years, married people, better educated and more affluent respondents." Registration is

who have actually registered to donate.⁵¹ The current number of registered donors indicated on the British Columbia Transplant Society's website is only 551,189⁵² in a population of about 4.2 million, suggesting a registration rate closer to 13%.

The tendency for high public support for donation, but much lower personal willingness to donate and even lower registration to donate is mirrored in American and UK surveys. A 1993 American poll reported that 85% of Americans supported donation for transplantation, but only 55% reported they were willing to register to donate. In fact, only 28% reported having formally committed to donate on a driver's license or donor card.⁵³ A 1990 poll in the UK found that 73% of respondents said they were willing to donate organs, but only 27% actually had signed a donor card and only 7% carried it with them.⁵⁴

Of the respondents to the Canadian survey who were unwilling to donate an organ, 59% would willingly accept an organ and 16% would consider accepting an organ.⁵⁵ Of those undecided about whether to donate, 81% would willingly accept an organ and 9% would consider it.⁵⁶ The 1993 American poll also indicated that nearly half of those who were opposed to donation would accept an organ transplant if they needed one.⁵⁷

Of those who decided not to donate, the reasons for refusing to donate were: poor health (18%), "body should be whole" (12%), "too old" (12%), religious reasons (10%), "don't feel like it" (9%), fear or discomfort regarding donation (4%), "body would not be useful" (3%), and concern about premature harvesting or less effort in saving donor's life (3%).⁵⁸

Of those who were undecided about donation, the reasons for indecision were: not having thought about donation (27%), needing more information (8%), procrastination (7%), being too old (6%), health (4%), simply undecided (4%), "body parts no good" (4%), "too young to decide or think about it" (4%), feeling it is a family decision (4%), religious issues (3%) and discomfort thinking about

lower among those "aged 65 years or more, those who have never married, those whose ethnic background is either non-European or European other than French or British, and those born outside Canada").

⁵¹ Respondents may offer what they perceive is the more socially acceptable response.

⁵² British Columbia Transplant Society, online: <<http://www.transplant.bc.ca/>>. The number of registrants is current as of April 10, 2006.

⁵³ Gallup, "The American Public's Attitudes Toward Organ Donation and Transplantation" (1993), online: <http://www.transweb.org/reference/articles/gallup_survey/gallup_index.html>.

⁵⁴ Rupert Jarvis, "Join the club: a modest proposal to increase availability of donor organs" (1995) 21:4 J. Med. Ethics 199 at 199.

⁵⁵ *Supra* note 39 at 11.

⁵⁶ *Ibid.* at 11.

⁵⁷ *Supra* note 53 at Table 8.

⁵⁸ *Supra* note 39 at 17 (Eleven percent mention other reasons and 13% have either not thought about it, have no reason or don't know why they have decided not to donate).

the topic (3%). A large number don't have a reason for their indecision (17%) or offer other reasons (11%).⁵⁹

The 2001 Health Canada poll also included questions about the respondents' beliefs about the justice of the organ donation system. Opinion was divided among those willing to donate as well as those unwilling to donate on whether the rich are more likely to receive donations.⁶⁰ Most respondents rejected the idea that doctors might prematurely declare someone dead in order to harvest organs.⁶¹ The poll found that women and better educated and affluent respondents are more likely to reject these ideas, while those of non-European ethnic background and those born outside Canada are less likely to reject these ideas.⁶²

Despite the widespread recognition of the need for organs and the widespread social approval of transplantation, the actual willingness to donate is far lower. There are various reasons for this including widespread psychological resistance to thinking about the subject, religious objection, and mistrust of the medical system particularly among certain ethnic communities.

It seems likely that in many cases a key impediment is the psychological discomfort of thinking about death and with contemplating the dissection of one's own remains (as well as perhaps the minor inconvenience of registering).⁶³ These psychological impediments might arise from distaste for bodily mutilation, concern that brain-dead patients are not really dead (and so would be killed by organ removal, would suffer during organ removal, or would be allowed to die in order to access organs), belief in resurrection (either religious in nature or not), discomfort with the identity-related implications of moving one's own body parts into another person, and distrust of medicine and the medical profession.⁶⁴ Emerson draws on historical burial practices to emphasize the long-standing and widespread human uncertainty about the finality of death. He notes that there are ample examples of the belief that,

“... death is not the end of the soul and that the life of the body can somehow persist or be restored. This was expressed in the burial practices of the earliest humans ... Such practices have been elaborated

⁵⁹ *Ibid.* at 18.

⁶⁰ *Ibid.* at 32 (Definitely true (15%), probably true (29%), probably not true (30%), definitely not true (21%) and don't know (5%)).

⁶¹ *Ibid.* at 32 (Definitely true (6%), probably true (13%), probably not true (30%), definitely not true (47%) and don't know (5%)).

⁶² *Ibid.* at 32.

⁶³ S. J. Youngner, “Psychological Impediments to Procurement” (1992) 24:5 *Transplantation Proceedings* 2159 at 2159 (Youngner emphasizes the psychological impediments to donation, writing “I think that along with a recognition of the wonders of transplantation, many persons have feelings of uncertainty, fear, and even horror. These feelings are deep-seated, often irrational, but extremely powerful. They are difficult to talk about or even think about. Many may exist at preconscious or unconscious levels”).

⁶⁴ *Ibid.* at 2159.

by many different cultures, as in preservation and veneration of the bones of ancestors; burial with grave goods, food, slaughtered animals, and slaves; and mummification and embalming, to retain a simulacrum of continuing life, the last a common practice in many contemporary societies..."⁶⁵

It is, perhaps, not surprising then that so many supporters of donation cannot bring themselves to decide to donate and to register their decision.

Only a fairly low number of Canadians indicate religious reasons for their unwillingness or indecision regarding donation. Furthermore, most religions endorse organ donation and/or leave the decision to individual choice.⁶⁶ Nevertheless there are cultural and religious traditions that strongly emphasize respect for human remains and so are uncomfortable with donation as it is considered a desecration of a family member's remains.⁶⁷ Furthermore, many religions express a belief in a form of bodily resurrection, although perhaps not strictly in the form in which the body existed at the time of death.⁶⁸

"Jewish religious law explicitly prohibits mutilation of the dead body. Contemporary developments have refined that position and allowed it to be interpreted as permitting removal of an organ when the life of another can thereby be saved ... Islamic beliefs about resurrection require bodily integrity at the time of death. Buddhism also abhors mutilation of the body and transplantation has been viewed skeptically. Nevertheless, in most Islamic and Buddhist countries, donation after death has been permitted if the explicit consent of the donor has been obtained..."⁶⁹

As suggested by the 2001 Health Canada survey, there are ethnically-based differences in willingness to donate, and in whether or not respondents were concerned that doctors would be more likely to declare them dead prematurely if they were known to be donors. The same pattern is reflected in American comparisons of the attitudes of non-white and white survey respondents. For example, Siminoff and Mercer found that "non-whites were far more concerned that if doctors knew they were organ donors, they would do less to save their lives: 51.9% of non-whites agreed as opposed to only 20.8% of whites."⁷⁰ A comparison of

⁶⁵ Emson, *supra* note 3 at 125.

⁶⁶ Trillium Gift of Life Network, "Cultural and Religious Perspectives on Organ and Tissue Donation," (20 April 2005). Online: Trillium Gift of Life Network <<http://www.giftoflife.on.ca/page.cfm?id=7D37BE22-0BC5-4F8D-AA9A-5F3BAA6BDF5F>>.

⁶⁷ *Ibid.*; Anita E. Molzahn, Rosalie Starzomski & Janice McCormick, "The supply of organs for transplantation: Issues and challenges" (2003) 30:1 Nephrology Nursing Journal 17.

⁶⁸ Emson, *supra* note 3 at 125.

⁶⁹ *Supra* note 1 at 249.

⁷⁰ Laura A. Siminoff & Mary Beth Mercer, "Public Policy, Public Opinion, and Consent for Organ Donation" (2001) 10 Cambridge Q. Healthcare Ethics 377 at 384.

African-American with white respondents found that African-American respondents were almost twice as likely to agree with a statement of concern that doctors won't do as much to save the life of a person known to be an organ donor.⁷¹ African-Americans are also more likely (40%) than white respondents (31%) to think that allocation is unfair.⁷² Various studies also report a lower willingness to donate among African-American than white respondents.⁷³ Siminoff and Saunders Sturm note that "[m]ultiple studies have reported mistrust of the medical community to be a primary reason for refusal to donate among African Americans."⁷⁴ This mistrust is driven by both historical abuses, as well as continued disparities in the provision of health care to African Americans.⁷⁵

Part II Overview of priority system proposals

A "priority system"⁷⁶ is one in which those who indicate their willingness to donate are rewarded by an increased likelihood of receiving an organ should they need one in the future. The problem with the current system, according to the proponents of priority systems, is that while people are healthy, organ donation is not an appealing option.⁷⁷ What is needed is an additional incentive to induce people to overcome the apparently widespread psychological hurdles that impede donor registration. The priority system personalizes the decision to donate so that it is no longer solely an abstract, impersonal and distant benefit to some unknown person, but instead also a decision directly relevant to oneself and one's own best interests.⁷⁸

Opting-in

Most of the priority system proposals envisage a system in which people will be invited to register using whatever registration system is currently used in the relevant country to record willingness to donate, such as the driver licensing or public health insurance system.⁷⁹ Other suggestions have been to use the electoral rolls or the offices of family physicians to present people with the option to register.

⁷¹ Laura A. Siminoff & Christina M. Saunders Sturm, "African-American Reluctance to Donate: Beliefs and Attitudes about Organ Donation and Implications for Policy" (2000) 10:1 Kennedy Institute of Ethics Journal 59 at 63.

⁷² *Ibid.* at 63.

⁷³ *Ibid.* at 62.

⁷⁴ *Ibid.* at 64.

⁷⁵ *Ibid.* at 64.

⁷⁶ As noted above, the system is sometimes called a solidarity model, a reciprocity policy, a priority incentive or preferred status system.

⁷⁷ S. Giles, "An antidote to the emerging two tier organ donation policy in Canada: the Public Cadaveric Organ Donation Program" (2005) 31 J. Med. Ethics 188 at 190.

⁷⁸ *Ibid.*; Stephanie Eaton, "The subtle politics of organ donation: A proposal" (1998) 24:3 Journal of Medical Ethics 166 at 168 [Eaton].

⁷⁹ Gubernatis, *supra* note 14 at 3264.

People would be eligible to register upon reaching the age of majority.⁸⁰ The proposals vary in how they would treat children and incapable persons.⁸¹ In some proposals, children and incompetent persons could be registered by their parents and substitute decision-makers respectively. Other proposals would exempt children from the priority scheme altogether. Exemption would mean that children neither receive a priority for donating, nor would they be passed over by other recipients with priority.

Most authors recognize the danger that people might be inclined to register only once they become aware that they need an organ, and they propose a variety of methods to counteract this.⁸² One option is to provide a priority reward that increases with the amount of time a person has been registered to donate.⁸³ Another is to impose a delay before priority vests. In other words, if a person registered at the first possible occasion, the priority would vest immediately, but if a person delayed registration then the priority would only vest after a waiting period (e.g. 1 or 2 years).⁸⁴ A third option is to provide a priority reward that depends upon the length of time between registering to donate and the date of entry onto the waiting list for an organ, with a greater length of time producing a greater reward.⁸⁵ A fourth option is to provide a priority that depends upon the length of time between eligibility to donate and registration to donate, with a shorter period of time producing a greater reward.⁸⁶ A fifth option is that the delay before priority vests would be the same length as the delay between the dates of eligibility to register and actual registration.⁸⁷

In my view, the best of these options, assuming that priority systems are acceptable – a point that will be discussed further below, is the last option. It is better to consider the delay between the ability to register to donate and the date of actual registration to donate, and to apply an equivalent delay before priority vests. This would have the advantage of not penalizing immigrants to Canada who may

⁸⁰ See, e.g., Kleinman & Lowy, *supra* note 4 at 1486; *supra* note 16 at 702; *supra* note 17.

⁸¹ Kleinman & Lowy, *supra* note 4 at 1486; Raanan Gillon, "On giving preference to prior volunteers when allocating organs for transplantation" (1995) 21:4 J. Med. Ethics 195 at 195 [Gillon]; Daar, *supra* note 18 at 705; Gubernatis, *supra* note 14 at 3265.

⁸² Aaron Spital, "Should people who commit themselves to organ donation be granted preferred status to receive organ transplants?" (2005) 19:2 Clinical Transplantation 269 at 270 [Spital]; Eike-Henner W. Kluge, "Improving Organ Retrieval Rates: Various Proposals and their Ethical Validity" (2000) 8 Health Care Analysis 279 at 281 [Kluge]; Wigmore and Forsythe, *supra* note 11 at 160 (Wigmore and Forsythe suggest that "preferred status" systems would attract old and infirm registrants since they are the ones who are most likely to think of their need of organs).

⁸³ *Supra* note 15 at 315.

⁸⁴ *Supra* note 16 at 702; Burdick *et al.*, *supra* note 17.

⁸⁵ Gubernatis, *supra* note 14 at p.3265; Gubernatis & Kliemt, *supra* note 14 at 700.

⁸⁶ Gubernatis & Kliemt, *supra* note 14 at 701 (Gubernatis and Kliemt mention an approach under which priority points would be assigned according to the age and state of health of a person if they opt in after a certain age (such as 18 years)).

⁸⁷ Kleinman & Lowy, *supra* note 4 at 1486.

not have been able to register at age 18, and who may not have had the time in Canada to build up a lengthy time period during which they were registered. It would also have the advantage of not favouring older over younger recipients because older recipients have been able to accrue a longer period during which they were registered.

Furthermore, a delay in vesting of a full priority status is preferable to a system that decreases the priority the more a person delays registering. The former approach offers a continuing incentive to register, whereas the latter provides an increasing disadvantage (as more and more time passes between the date of ability to register and the date of actual registration) that may discourage very late registrants from bothering to register. The latter approach does constitute a stronger incentive because the size of the priority decreases as a person delays in registering, and so it might be better able to encourage the young and healthy registrants who would most benefit the system. However, in my view, the countervailing need to maintain a strong incentive for late registrants and to offer a strong incentive to those who may have been unaware of the system and so failed to register, prevails.

The priority system proposals vary in their approach to persons whose organs are already known to be unsuitable for transplant (e.g. because of infections disease).⁸⁸ One proposal would ignore the suitability of a person's organs as well as whether he or she is at high-risk for requiring a transplant.⁸⁹ In contrast, Nadel and Nadel suggest that those who are already known to be unacceptable donors would access the same priority if they were willing to donate their bodies to medical research on transplantation, or were willing to make other efforts to increase the supply of organs such as by assisting with public education.⁹⁰ Another would not permit those with known disease threatening the relevant organ to sign up to donate, although they do not explain whether this would apply to patients whose disease became known before they reached the age of majority and would otherwise have been able to register.⁹¹

Several proposals recognize the problem of persons whose religions forbid cadaveric donation, but not receipt of an organ. Daar suggests that they might be permitted to make some other public contribution in order to avoid being disadvantaged in the receipt of an organ.⁹² He draws an analogy to military service, noting that many countries permit conscientious objectors to do other forms of peaceful public service. Daar suggests that those who cannot donate organs could compensate by "playing a role in public education to raise donor awareness, raising funds

⁸⁸ *Supra* note 15 at 315-316 (noting that some jurisdictions, such as Illinois, permit HIV positive patients to donate to other HIV positive patients).

⁸⁹ Kleinman & Lowy, *supra* note 4 at 1486.

⁹⁰ *Supra* note 15 at 316.

⁹¹ *Supra* note 17 (The authors also deal with this problem by imposing a 1 year waiting period, which would encourage people to register before they become seriously ill).

⁹² Daar, *supra* note 18.

to help patients, and so forth.”⁹³ Singapore, which has adopted a priority system, permits Muslims to refuse cadaveric organ donation but still access the priority reward if they instead register to donate their bodies for medical education or research instead. It is unclear whether this solution would satisfy all religious requirements, such as a religious proscription against bodily mutilation or a religious requirement that a body be buried intact. In any event, the principle remains that it might be possible to find a substitute contribution to the public welfare for those who cannot donate organs but can receive them.

Allocation of Organs

The proposals vary widely in the weight that they assign to the priority received for registering to donate. At one extreme, Jarvis suggests a very strong version of a priority system, namely that only those who opt-in to donate would be eligible to receive an organ.⁹⁴ A slightly less draconian version would require that all registrants receive an organ before non-registrants can be considered.⁹⁵ The most modest effect suggested is that prior registration would be relevant only to break a tie between recipients who were otherwise exactly equally eligible (in terms of waiting time, tissue compatibility, medical urgency etc.). Evidently, this situation would be extremely rare, reducing the effect of the priority to nearly nothing.⁹⁶

Between these extremes of complete disqualification of non-registrants and the rare use of donor registration as a tie-breaker between exactly equal recipients, there are a number of options.

Burdick *et al.* suggest that the priority granted ought to be “modest but definite.” It must be sufficient to offer an effective incentive, but not so great as to result in the preference of patients with less critical need (*e.g.* elective cases having spent a short time on the waiting list) over those about to die or who have been waiting for years.⁹⁷ Spital says priority should be considered only where the “medical needs of competing recipients are approximately equal.”⁹⁸

Several U.S. and European proposals suggest modifications to the point systems used in the allocation of kidneys. Under the current point systems, a candidate is assigned points for a variety of criteria (such as time on the waiting list, tissue compatibility, urgency of need, previous live donation, and regional

⁹³ Daar, *supra* note 18 at 705.

⁹⁴ *Supra* note 54 at 202; Spital, *supra* note 82 at 270.

⁹⁵ *Supra* note 16 at 704-707 (Kolber describes this as the most extreme version along a spectrum of priority systems).

⁹⁶ Eaton, *supra* note 78 at 167-168 (recommends that priority apply only in clinically neutral situations, and recognizes that this means that priority will rarely come into play. She is more interested in the political value of priority as a means to defend a system of presumed consent); *supra* note 16 at 704-707.

⁹⁷ *Supra* note 17.

⁹⁸ *Supra* note 82 at 270.

donation rates), and it is suggested that willingness to donate could be worth several points toward the candidate's total.⁹⁹

For example, Gubernatis would replace the criterion of regional donation rate with the criterion of registration to donate.¹⁰⁰ He points out that regional donation rate, which gives points to candidates who come from regions with a high donation rate, is a kind of collective preference based on the region's collective willingness to donate. He suggests that the preference operate at the individual instead of the collective level.

Sackner-Bernstein and Godin suggest that willingness to donate should replace the criterion of time spent on the waiting-list.¹⁰¹ They would rank those who are willing to donate according to the amount of time since making a commitment to donate.

Some proposals would protect certain classes of patient from the operation of the priority under some circumstances. Under Gubernatis's proposal, high urgency cases, highly immunized patients (who have a very low chance of finding a compatible donor) and children would receive high priority.¹⁰² Gubernatis and Kliemt suggest, however, that a high urgency case might be preferred over another higher urgency case on the ground of willingness to donate.¹⁰³

Several authors have suggested that the priority system might increase the organ supply so much that even those who did not opt-in would benefit by a reduced waiting time.¹⁰⁴ Kolber suggests that the actual priority reward could be carefully calibrated to produce this very effect, leaving all patients (registrants and non-registrants) better off – a Pareto optimal outcome.¹⁰⁵ Kolber prefers this option because, he says, it would “reduce the concern that a priority incentive scheme will harm those who are simply unaware of the priority program...since they will still share in the priority scheme's benefits, albeit less than if they had registered to donate.”¹⁰⁶ This would work by splitting between registrants and non-registrants the reductions in waiting time that arise from the increase in the pool of organs brought about by

⁹⁹ See e.g., Gubernatis, *supra* note 14 at 3265 (referring to the Wujciak-Opelz model for the allocation of kidneys); *supra* note 15 at 314; Spital, *supra* note 82 at 270.

¹⁰⁰ *Supra* note 14 at 3265.

¹⁰¹ Jonathan Sackner-Bernstein & Seth Godin, “Increasing Organ Transplantation – Fairly” (2004) 77:1 *Transplantation* 157 at 158.

¹⁰² *Supra* note 14 at 3265.

¹⁰³ *Supra* note 14 at 700.

¹⁰⁴ Gillon, *supra* note 81 at 196; Kleinman & Lowy, *supra* note 4 at 1487; *supra* note 16 at 704-707; J. Muyskens, “Should receiving depend upon willingness to give?” (1992) 24:5 *Transplant Proceedings* 2181 at 2182 [Muyskens]; *supra* note 15 at 319 (“Although non-donors on the waiting list would sometimes be bypassed by a patient with a bonus, a substantial increase in the total supply of organs triggered by this policy should more than offset that loss, actually increasing even non-donors' chances to receive an organ. Of course, one's chances would still be better if one committed to donate”).

¹⁰⁵ *Supra* note 16 at 704-707.

¹⁰⁶ *Ibid.* at 705.

the priority incentive.¹⁰⁷ Kolber admits it would be challenging to calibrate the system this finely, but suggests that the objective is worthwhile since it would ensure that all would benefit to some degree from the system.¹⁰⁸

One proposal notes that the priority reward might go to the first degree relatives or spouse of the registrant.¹⁰⁹ In that way, family members might together be able to sign up to increase the chances that a family member in need will receive an organ. Presumably the preferences would be cumulative. Such a system obviously works to the disadvantage of recipients without families. Furthermore, it is unclear what would happen if someone who had transferred his or her priority later required an organ. It is possible that conflicts might emerge within families if priority is transferable. In my view, the preference should not be transferable due to these problems, and also because the relatives and spouse of someone in need of an organ may be likely to opt into the system in any event given the close example of need in a loved one. In any event, a precedent for a transferred reward is the U.S. "Hope through Sharing" program. This program permits a live donor (who cannot donate to his or her loved one, but donates to another recipient) to increase the priority of the loved one for receipt of an organ.

Nadel and Nadel note the problem specific to the U.S. health care system that the uninsured and poor likely have no realistic hope of receiving an organ. They suggest that funds be set aside to cover some number of "free" transplants per year for those who cannot afford a transplant.¹¹⁰ Poor patients would thus "be given a contingent status on the waiting list – only considered for a transplant if funds were available at the time an organ was available."¹¹¹

Daar would give even more priority points to a living donor than to a person who registers to donate posthumously. He notes that a living donor does good to the transplant recipient and to society, removing a person from the waiting list for an organ.¹¹² One might add that the living donor has dramatically and irrevocably manifested their willingness to donate, and has tolerated the risk, inconvenience and discomfort of living donation to do so.

Role of family members under priority systems

Most of the proposals for various types of priority system emphasize that family members cannot be permitted to override a decedent's previous registration

¹⁰⁷ *Ibid.* at 705-706 (Kolber suggests that if wait time can be reduced from 50 months to 40 months, registered donors might be given kidneys at a rate such that they wait on average 35 months while non-registrants might wait 45 months).

¹⁰⁸ *Supra* note 16 at 707.

¹⁰⁹ *Supra* note 17.

¹¹⁰ *Supra* note 15 at 315.

¹¹¹ *Ibid.* at .315.

¹¹² *Supra* note 18 at 705.

to donate.¹¹³ However, given the evidence that families are much more willing to consent where the decedent has registered his or her willingness to donate, this concern may not actually be warranted. Although some families may override a registered donor's wishes, the majority will not. Nadel and Nadel suggest that families may be even more willing to respect a deceased's wishes under the "quid pro quo" arrangement of a priority system than an apparently unilateral and altruistic commitment made by their family member.¹¹⁴

The renegeing recipient

Wigmore and Forsythe also wonder how "preferred status" could be enforced.¹¹⁵ They note that registrants are permitted to change their minds. This does not seem to me to be a fatal objection. It is true that registrants may change their minds and withdraw from the list, and it is consistent with personal autonomy that they be able to do so. They would also lose their preferred status, shifting the advantage to the remaining registrants.

If the concern is that registrants might withdraw after having received an organ, I also suspect that this possibility would not do significant damage to the priority system. This is because (a) most organ recipients will never donate, in any event since the chances of dying under circumstances amenable to donation are low, (b) the number of recipients who would renege, one suspects, would be low, and (c) the number of actual beneficiaries in relation to the number of possible donors is low. The incentive to participate therefore remains – even if a small number of beneficiaries withdraw from the donor pool, many other possible donors remain. The real cost of the withdrawal of beneficiaries is a "public relations" cost. To the extent that potential registrants perceive the system as being abused, they may not be interested in participating even if the system nonetheless offers them a real and valuable incentive in the form of improved access to the remaining pool of donated organs.

The need for intensive public education

Proponents of priority systems agree that extensive education would be required to ensure that the failure to register is not due to lack of awareness.¹¹⁶ Kolber suggests that educating the public may be simpler in the context of a priority system as people are more likely to pay attention where they feel it might affect their own well-being. The possibility that certain people are more likely to learn of the system than others is addressed below in the context of the potential discriminatory effects of priority systems.

¹¹³ Gubernatis, *supra* note 14 at 3264; *supra* note 16 at 704; Spital, *supra* note 82 at 270.

¹¹⁴ *Supra* note 15 at 318 ("Most would probably understand that it would be wrong for them to try to renege on the donor's death-triggered promise").

¹¹⁵ *Supra* note 11 at 160.

¹¹⁶ Spital, *supra* note 82 at 270; *supra* note 17; *supra* note 16 at 703.

Hybrid Priority Systems

Certain proposals blend elements of a priority system with other systems such as mandatory choice¹¹⁷ (i.e., requirement to register consent or refusal to donate) or presumed consent.¹¹⁸ These proposals add an element of coercion, but they do have the advantage that they reduce the chance that a failure to register is treated as a refusal to donate when in fact it reflects a lack of information or opportunity to register.

Eaton argues for the presumed consent system, and uses a priority reward to address some of the criticisms of the presumed consent system. Her proposed presumed consent system assumes consent to donate and at the same time gives each person a corresponding benefit in the form of allocation priority. Eaton argues that the acceptance of the priority reward provides a justification for the presumption of consent.¹¹⁹ In other words, if a decedent had not opted out and would have been likely to accept an organ, one can “safely [assume] that he or she would have consented to be a donor, given the charitable – and not unreasonable – assumption that this person is not a free-rider.”¹²⁰ I am not sure that this adds much to the fiction at the heart of presumed consent. One suspects that many people under a simple presumed consent system may not have considered the matter, and so removal of organs might often proceed without actual consent. It seems likely that under Eaton’s system many people would similarly not have considered the matter despite the addition of a priority reward. Furthermore, an unsettling number of people do appear willing to be free-riders, weakening her assumption that they would have consented.¹²¹

Nevertheless, the combined priority/presumed consent system may be preferable to either system alone. From the perspective of a priority system, the addition of presumed consent might answer some of the concern that the ill-informed or incapable may be disadvantaged because they do not know about the priority system and so lose the benefit of priority. The default position under a combined priority/presumed consent system is to grant the priority reward. The downside, of course, is that disadvantaged persons lose autonomy because they are less likely to know about and exercise their right to opt-out. From the perspective of the presumed consent system, the attachment of a priority reward might soften the objection that disadvantaged persons are less likely to know about and use their right to opt-out because they are at least receiving something valuable in return.

¹¹⁷ Kleinman & Lowy, *supra* note 4 at 1486.

¹¹⁸ Eaton, *supra* note 78.

¹¹⁹ *Ibid.* at 168.

¹²⁰ *Ibid.* at 168 (Eaton suggests that this reasoning may provide comfort to families who are asked to make decisions for deceased relatives. “Thus, families who accept that their prematurely dead would have wished to continue living [and so would have accepted an organ], and who believe that their relative was not a free-rider, might be satisfied that their relative would have consented to organ donation as part of this broader web of rights, duties, obligations and fairness”).

¹²¹ *Supra* notes 55-57 and associated text.

Precedents for Priority Systems

There are already some priority systems in place in various countries. In the U.S., live kidney donors receive a preference should they later require a kidney.¹²² This may serve to meet the fear of living donors of kidneys that they may be in trouble if their one remaining kidney fails. The preference given to previous donors reduces their waiting time from a median of 1115 days to a median of 499 days based on data from 1993-2002.¹²³

In 2001, the American United Network for Organ Sharing (UNOS) approved the "Hope through Sharing" program, which permits a person who cannot donate to a relative because of incompatibility to donate to another person on the waiting list in exchange for a higher priority on the waiting list for the relative.¹²⁴

Singapore's *Human Organ Transplant Act 1987*¹²⁵ applies an opt-out (presumed consent) regime to all non-Muslim citizens between the ages of 21 and 60. Muslim citizens can opt-in to donate if they wish, and non-Muslims can opt-out if they wish. A person who has not opted-out receives an organ in priority.¹²⁶ A person who has opted-out can withdraw the objection and two years later will again have the same priority as a person who never opted-out over those who have opted-out.¹²⁷

However, this priority system is subject to several exceptions. A Muslim who does not wish to opt-in to donate can still have priority to receive an organ over those who opt-out if they register to donate the relevant organ to medical education or research upon death.¹²⁸ Registration to donate for medical education or research must take place upon attaining the age of 21 or within 6 months of becoming a citizen or permanent resident of Singapore. Where registration does not take place at the specified time, it can be done later but priority status only vests after 2 years.¹²⁹

Singapore's combination of presumed consent and priority status appears to have been somewhat successful.¹³⁰ The voluntary system produced an insufficient

¹²² UNOS, United Network for Organ Sharing Policies: 3.0 Organ Distribution, 2001, section 3.5.11.6 "Donation Status" online: <www.unos.org/PoliciesandBylaws/policies/docs/policy_70.doc>.

¹²³ U.S. Dept. of Health and Human Services, Advisory Committee on Organ Transplantation, *Summary Notes from Meeting* (6-7 May 2004), online: <<http://www.organdonor.gov/acot5-04.htm>>.

¹²⁴ *Supra* note 16 at 699-700; See UNOS, "New initiatives may shorten wait for kidney transplant" (10 August 2001), online: UNOS <<http://www.unos.org/news/newsDetail.asp?id=160>>.

¹²⁵ The text of the statute is available at: Singapore, Attorney General's Chambers, *Singapore Statutes Online* <<http://statutes.agc.gov.sg/>>.

¹²⁶ *Ibid.* at s.12(1)(a).

¹²⁷ *Ibid.* at s.12(1)(b).

¹²⁸ *Ibid.* at s.12(2)(a).

¹²⁹ *Ibid.* at s.12(2)(c).

¹³⁰ Bernard Teo, "Organs for Transplantation: The Singapore Experience," (1991) 21:6 *Hastings Center Report* 10 [Teo]. For further commentary on the Singapore legislation, see B. M. Dickens, "Legal and judicial aspects of postmortem organ donation" in G. M. Collins *et al.*, eds., *Procurement, Preservation and Allocation of Vascularized Organs*, (Kluwer Academic Publishers, 1997) at 351.

and unpredictable supply, and in fourteen years of effort the National Kidney Foundation was able to recruit only 27,000 registrants, which was far below the estimated 800,000 required to meet transplant needs. After the enactment of the new law, the kidney supply became steadier and also increased significantly although it did fall short of its target.

Gubernatis points out that some allocation systems already consider non-medical criteria in a manner similar to a priority system. For example, under the Wujciak-Opelz kidney allocation algorithm that was adopted by Eurotransplant, points are assigned to individual recipients based on the net national organ donation rate and the regional donation rate.¹³¹ As a result, individuals are penalized or rewarded for collective willingness in one's region to donate organs. Given that the individual has control only over his or her own willingness to donate, the priority system might be fairer at the individual level.

LifeSharers, a United States-based group, is attempting to implement a private form of "preferred status" organ allocation.¹³² Members of the group pledge to donate their organs upon their death, and sign a card expressly stating that they wish their organs to be offered first to qualified members of LifeSharers. The system relies on the next-of-kin to ensure that the deceased member's wish to donate first to LifeSharers members is respected. LifeSharers began in May, 2002 and now has over 3000 members.¹³³

Part III Should we adopt a priority system in order to improve the organ donation rate?

Priority systems have been defended and attacked on multiple grounds. There seems to be no approach to improving the organ donation rate that does not raise ethical concerns. Yet, the status quo, a voluntary system that produces an inadequate supply of transplantable organs does not seem to be morally neutral either.¹³⁴ Accordingly, an answer to the question of whether we should adopt a priority system in order to improve the organ donation rate will depend upon the nature and strength of the arguments for and against it, as well as on a comparison of the approach with other proposed methods to improve the organ donation rate. While a comprehensive comparison with all other possible methods is beyond the scope of this article, I will proceed to sketch some of the arguments for and against priority systems with references from time to time to some of these other methods.

¹³¹ *Supra* note 14 at 3265.

¹³² See the LifeSharers website, online: <www.lifesharers.com>.

¹³³ LifeSharers, "Frequently Asked Questions" online: LifeSharers <<http://www.lifesharers.com/faq.asp>>.

¹³⁴ Emson, *supra* note 3; Harris, *supra* note 3 at 133 ("[I]t is surely implausible to think that having one's body remain whole after their death is an objective anyone is entitled to pursue at the cost of other people's lives! It is implausible to the point of wickedness, not least because the objective is irrational and impossible of achievement"); *supra* note 77.

Among the arguments in favour of priority systems are that (1) they will produce a higher donation rate, thus reducing human suffering and loss of life, and saving health care resources, and (2) it is unjust that persons unwilling to donate their organs are currently receiving organs ahead of those who are willing to donate their own.

Among the arguments against priority systems are that (1) they are coercive, (2) they are contrary to laws banning trade in organs because the priority reward is a form of consideration for the organ, (3) any incentive-based or exchange system commodifies the human body and its parts, (4) organs should be allocated solely on the basis of medical considerations of need and utility, (5) the use of willingness to donate as an organ allocation criterion is akin to using a judgment of a potential recipient's social or moral worth in allocating medical resources, which is unacceptable, (6) priority systems would have discriminatory effects on the basis of religion, race or socio-economic status, and (7) any incentive-based system will undermine social altruism, which has inherent value.

Several of these arguments raise important questions of medical ethics. The principles of medical ethics usually embrace the following moral considerations: individual autonomy (the obligation to respect the wishes of competent persons), non-maleficence (the obligation not to harm others), beneficence (the obligation to benefit others), utility (the obligation to produce a net balance of benefits over harms), justice (the obligation to distribute benefits and harms fairly), fidelity (the obligation to keep promises), the obligation to be truthful, the obligation to disclose information, and the obligation of confidentiality.¹³⁵ Different authors advance different sets of primary and derivative moral obligations. For example, Beauchamp and Childress identify autonomy, non-maleficence, beneficence (including utility) and justice as primary principles, while the rest are derivative principles.¹³⁶ None of these four principles are, however, absolute.¹³⁷ Instead, they are only *prima facie* binding, and must be weighed and balanced in particular situations.¹³⁸

¹³⁵ James F. Childress, "The Normative Principles of Medical Ethics" in Robert M. Veatch, ed., *Medical Ethics* 2nd ed. (Sudbury Mass: Jones and Bartlett Publishers, 1997) at 33.

¹³⁶ *Ibid* at 33, referring to Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 4th ed. (New York: Oxford University Press, 1994). R. Gillon, "Ethics needs principles – four can encompass the rest – and respect for autonomy should be 'first among equals'" (2003) 29 *J. Med. Ethics* 307 at 307-308 [Gillon]: The so-called "four principles approach" is the subject of debate among ethicists, some of whom regard it as "the four moral nucleotides that constitute moral DNA – capable, alone or in combination, of explaining and justifying all the substantive and universalisable moral norms of health care ethics and [the author suspects] of ethics generally" or as "a useful checklist approach to bioethics for those new to the field, and possibly for ethics committees without substantial ethical expertise."

¹³⁷ *Supra* note 135 at 36.

¹³⁸ *Ibid.* at 36-37 ("The approach of Beauchamp and Childress suffers from the limitations of any pluralistic approach that does not assign weights or priorities to various principles in advance. Much rests on what has been variously called prudence, practical moral reasoning, or discernment in the situation.").

The medical ethical principles that appear to be most directly at issue in the analysis of priority systems are those of autonomy, beneficence (utility) and justice. The respect for autonomy underlies the concern about coercion. The requirement of beneficence (which includes utility) suggests that organs should be allocated solely on medical criteria such as need and likelihood of successful outcome rather than other criteria. The principle of beneficence can be invoked in defense of priority systems, however, since it is arguable that efforts to improve the supply of organs reflect this commitment to beneficence as well.¹³⁹ Finally, the distributional implications of priority systems raise clear and important questions of justice. The possibility that priority systems may have discriminatory impact also raises the question of whether a priority system would be consistent with the requirements of the *Charter of Rights and Freedoms*.

Arguments in favour of priority systems

A higher rate of donation

The main motivation behind priority systems is to increase the rate of donation of transplantable organs in order to save more lives, to improve the quality of life of sick patients (some of whom are subjected to extremely burdensome alternative treatments such as dialysis), and to save health care resources that could then be devoted to other health care needs. Health Canada stated in 2001 that the cost of a kidney transplant is about \$20,000 plus \$6,000 per year thereafter, whereas the cost of dialysis costs about \$50,000 per year.¹⁴⁰ American statistics also suggest that kidney transplantation is much more economical than dialysis.¹⁴¹

“Transplantation has been recognized to be cost-effective in many settings. For example, in developing and developed countries alike, kidney transplantation not only yields survival rates and quality-of-life that are far superior to those obtained with other treatments for end-stage renal disease, such as haemodialysis, but is also less costly in the long run.”¹⁴²

Critics of priority systems question whether they will be effective in increasing donation rates. Both proponents and critics rely on their intuitive sense of how individuals will react to the priority system. A number of surveys have inquired into whether a priority system would be acceptable to the public. The surveys, which cover a wide time span and also vary according to the constituencies polled, suggest widely different levels of acceptance of priority systems. The acceptance

¹³⁹ Gubernatis & Kliemt, *supra* note 14 at 700.

¹⁴⁰ Health Canada, “Organ Donation in Canada” (April 2001), online: Health Canada <http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2001/2001_36bk1_e.html>.

¹⁴¹ Theodore I. Steinman, “Economics of Transplantation,” in Douglas J. Norman & Laurence A. Turka, eds., *Primer on Transplantation*, 2nd ed., (Mt. Laurel, N.J.: American Society of Transplantation, 2001).

¹⁴² World Health Organization, “Human Organ and Tissue Transplantation,” EBI12/5, (2 May 2003), online: World Health Organization <http://www.who.int/gb/ebwha/pdf_files/EB112/eeb1125.pdf>.

rate appears to vary from a low of about 25%¹⁴³ up to 75%,¹⁴⁴ with several surveys showing a slight majority of the public would accept a priority system.¹⁴⁵ Although the public acceptability of a priority system is relevant to the question of whether such a system would be likely to increase the donation rate, and is certainly relevant to the political feasibility of instituting such a system, it does not directly answer the question of whether the priority incentive would cause people to register to donate their organs in greater numbers.

Another survey of transplant surgeons, transplant coordinators and critical care nurses asked whether they thought an allocation preference would be likely to increase the donation rate. All groups thought that an allocation preference would increase donation rates to some extent, although they thought that paying funeral expenses or offering a cash award of \$1500 would be more effective.¹⁴⁶ Nevertheless, only 45% of surgeons, 34% of coordinators and 40% of nurses advocated the adoption of a priority system.¹⁴⁷

The limited experience that has developed so far in using priority systems makes it difficult to judge their effectiveness. It would be useful in future polling to include questions designed to determine whether the priority incentive would cause respondents to register to donate rather than asking them if they think a priority system is acceptable. The survey would likely have to provide a fair bit of context so that respondents would have a reasonable understanding of how the proposed system would work. Spital suggests that the level of acceptance of priority systems shown in his survey might have been higher had his question made it clear

¹⁴³ *Supra* note 70 at 380 (reporting that only a quarter of the survey group (families who had been asked to donate the organs of a deceased relative) agreed that “[p]eople who have signed a donor card should receive an organ transplant before others do”).

¹⁴⁴ Spital, *supra* note 82 (cites a 1987 U.S. survey that found 75% support for priority status for the members of families that agree to organ donation); H.L. Batten & J.M. Prottas, “Kind strangers: the families of organ donors” (1987) 6 *Health Affairs* 35; *supra* note 15 (citing contradictory survey evidence at footnote 96); A. Bruce Bowden & Alan R. Hull, *Controversies in Organ Donation: A Summary Report*, (1993: National Kidney Foundation) (reporting that 70% of 18-24 year-olds were supportive of a preference system); Marlies Ahlert et al., “Common Sense in Organ Allocation,” (2001) 23 *Analyse + Kritik* 221 (reporting a study that found that a majority of German students oppose a preference).

¹⁴⁵ *Supra* note 13 at 1442 (describing a UNOS survey from the early 1990s in which respondents were asked whether some form of financial or non-financial compensation should be offered to increase donation. Fifty-two percent of respondents said there should be some form of compensation. They were asked to rank various compensation options with the preferred status option first. Preferred status was the top-ranked option); Spital, *supra* note 82 at 271 (conducted a survey in 2003 that asked the survey respondents whether people who agree to donate should be given priority to receive organs over those who have not agreed to donate. Thirty-three percent of respondents answered “yes,” 20% “probably yes,” 30% “no,” 11% “probably no” and 5% “don’t know.” Spital concludes that there is a reasonable degree of support for “preferred status” in the U.S. and suggests that support would likely have been higher had the survey question made it clear that willingness to donate would affect allocation only where the needs of the competing recipients were similar).

¹⁴⁶ J.D. Jasper et al., “Altruism, Incentives, and Organ Donation: Attitudes of the Transplant Community” (2004) 42:4 *Medical Care* 378 at 383.

¹⁴⁷ *Ibid.* at 384.

that the preference would operate only when the competing medical needs were similar.¹⁴⁸ Nadel and Nadel suggest that a small-scale pilot priority system should be tried in order to gather data that would demonstrate whether the approach is likely to be effective.¹⁴⁹

Critics of priority systems also suggest that the proposed priority incentive would be most successful in attracting older and sicker people who are more likely to require an organ and less likely to be able to supply a "high-quality" organ for transplant. It is true that those who are ill, who anticipate becoming ill, or who are more prudent, might be more likely to register than young persons who are less likely to think about illness or to contemplate needing an organ. Supporters of priority systems counter this objection by imposing various forms of penalties for delay in registering, as discussed above. Educational efforts may also be helpful in encouraging the young and/or healthy to think about registering.

It is unjust that people unwilling to donate receive organs before those willing to donate

Another argument that is advanced in favour of priority systems is that the current system is unjust because it permits those who refuse to donate (who are often described as free riders) to take organs ahead of people who are willing to donate to the community.¹⁵⁰ Proponents argue that registered donors have demonstrated their support for the community and their commitment to those in need, while those who refuse to donate not only have not contributed to reducing the shortage, they worsen the shortage for those who have.¹⁵¹ They argue that it is not for proponents of priority systems to defend the morality of priority systems, but for detractors to explain why willingness to donate should not be considered.¹⁵²

Jarvis suggests that the current system invites free riding.¹⁵³ However, it is unlikely that most non-registrants have deliberately considered the matter and

¹⁴⁸ *Supra* note 82 at 271.

¹⁴⁹ *Supra* note 15 at 319 (They are particularly interested in gathering four types of data. First, driver's licensing records should be reviewed to see if a short statement regarding the priority system had any effect on registration. Second, family doctors should be asked whether the priority system caused them to make a greater effort to encourage their patients to register. Third, hospitals should monitor family decisions to determine whether the priority system led fewer to override a decedent's prior consent to donate. Fourth, they wonder whether a priority system would encourage a different demographic group to register than currently makes up the group of donors. In particular, they wonder whether the system encourages people to register who are more or less likely to die in a manner conducive to organ donation).
¹⁵⁰ Spital, *supra* note 82 at 270; Muyskens, *supra* note 104; Gubernatis, *supra* note 14 at 3266; *supra* note 17.

¹⁵¹ Muyskens, *supra* note 104 at 2183.

¹⁵² Gubernatis & Kliemt, *supra* note 14 at 700-701.

¹⁵³ *Supra* note 54 at 200 ("A...problem with the current system by which donor organs are rationed is that it takes no account of, indeed it encourages, the 'free rider': the individual who hopes to benefit from cooperation of others even though he does not himself contribute to the socially desired end. Although it is in each individual's interest that donor organs should be available, it is in nobody's interests to make his/her own organs available: the choice to donate post mortem is an entirely altruistic one").

decided to take advantage of this invitation. Most people are likely simply to be avoiding the psychological discomfort and other inconveniences that appear to be involved with taking a decision to donate and formalizing it through registration. Jarvis is correct that the current system permits access to the pool of organs while avoiding the costs of contributing, a situation that an economist would predict would not lead to much donation.

However, there are some responses to the argument that a willing donor should not be passed over by someone unwilling to donate. Some critics suggest that in seeking to reward those who live by the “Golden Rule” (i.e., those who are willing to assist people from whom they seek the same assistance), proponents of a priority system are awarding organs on the basis of moral desert.¹⁵⁴ The critics then ask why we would choose only this criterion of moral desert.

“Consider the scenario of two medically similar patients, for whom preferred status would be the tie-breaker. One patient has signed an organ donor card, but has had a life of doing harm to society, robbing and beating others. The other patient has lived an exemplary life, has contributed financially and personally to medical causes including transplantation, and therefore has directly benefited many other people, but has not felt comfortable with agreeing to organ donation. Is there justice in the former person receiving the organ, allowing the one arbitrary fact of opting into the system to override all the other comparative points, which would tend the choice toward the latter.”¹⁵⁵

This argument, which asks why we would choose one criterion of moral desert over another as the allocation criterion, is distinct from the argument also raised by critics of priority systems that no criteria of moral desert are permissible in allocating scarce medical resources.¹⁵⁶ One response to the question of “why this criterion and not another” is that it is directly relevant to the key problem of organ scarcity. A person who does alternative good works may be a good and deserving person, but is doing nothing to reduce the scarcity problem (unless the good works directly affect the supply or demand for organs by, for example, convincing others to register or promoting preventative medicine). Someone who does harm by robbing and beating others, but has registered to donate *is* doing something to reduce the scarcity problem. This criterion of willingness to donate *is* relevant to the key problem of organ scarcity that is targeted by priority systems, while the other aspects of moral desert cited above (living an exemplary life, good works or criminality) are not relevant to the key problem. It does not make sense for a priority system to attempt the complicated and dangerous reckoning of all the possible aspects of whether someone is morally deserving of an organ, even if it were

¹⁵⁴ See e.g. A.M. Capron, “More blessed to give than to receive?” (1992) 24:5 *Transplant Proceedings* 2185 at 2186.

¹⁵⁵ *Supra* note 17 citing Capron, *ibid*.

¹⁵⁶ This argument is discussed in more detail below.

possible. None of it would assist with the problem that is the very *raison d'être* of the priority system, namely the scarcity of organs.

Another criticism that is, in my view more powerful, is that the willingness to receive an organ when one would not give an organ is not necessarily an inconsistent and selfish position. If it is not inconsistent and selfish, perhaps it is not unjust for such a person to receive an organ ahead of someone who is willing to donate.

For example, one person may believe that doctors would be less energetic in saving his life if he registered to donate, and he may believe that another person (with greater social status or power) would not face this risk.¹⁵⁷ Accordingly, he holds back hoping that these more advantaged persons will supply the necessary organs. Under these circumstances, a refusal to give an organ while being willing to receive an organ seems more defensible. Nevertheless, the problem remains that people taking this position worsen the problem of organ scarcity even if they have a better reason to do so than it might have seemed at first. It is unclear how far we ought to go in recognizing these types of arguments. Another way to state this situation is that certain groups may actually face higher burdens in registering to donate than others, and so a system that predicates receipt of an organ on the basis of registration to donate imposes differential burdens that may be discriminatory. The possibility of a discriminatory impact of priority systems will be addressed in more detail below.

Arguments against priority systems

Priority systems are coercive

One of the key principles of medical ethics is respect for individual autonomy or self-determination.¹⁵⁸ This principle is commonly understood to require that a person have the right to control his or her body during life and "within reasonable limits after that life has gone as well."¹⁵⁹ It is on this ground that proposals for state ownership of cadavers are often rejected.¹⁶⁰ A policy that ignored the need to obtain prior consent to the postmortem removal of organs would violate the autonomy rights of all those whose organs might be removed after their death.

¹⁵⁷ As will be discussed further below, American studies suggest that white survey respondents are much less concerned that doctors would do less to save their lives if they were registered donors than non-white survey respondents.

¹⁵⁸ Gillon, *supra* note 136.

¹⁵⁹ David Lamb, *Organ Transplants and Ethics*, (London: Routledge, 1990) at 144, quoting R. M. Veatch, *Death, Dying and the Biological Revolution*, (New Haven: Yale University Press, 1976) at 268-269.

¹⁶⁰ *Ibid.* at 141 (The loss of the opportunity for social altruism is also raised in opposition to the nationalization of cadavers).

While autonomy is respected where a person freely and independently consents to bodily interference, various factors can undermine that freedom and independence and, thus, the validity of the consent. The question in the context of priority systems is whether the penalty for refusing to register is so great that consent is coerced rather than free.

One critic describes a priority system as “an offer you can’t refuse,”¹⁶¹ and asks why we do not simply eliminate the “pretense of consent” and automatically harvest the organs of the deceased.¹⁶² If, however, we are unwilling to force people to donate their organs, we must reject priority systems.¹⁶³ Another critic argues that consent is coerced if people are motivated to donate by fear of a reduced chance of access to an organ if they would not otherwise have donated.¹⁶⁴

These critics of priority systems may put their point too strongly. First, the priority system offers a very small benefit, namely a small increased chance of receiving an organ.¹⁶⁵ It also threatens a small penalty for those who refuse to donate, namely a decreased chance of receiving an organ in the unlikely case that an organ will be required.¹⁶⁶ If the system is successful in generating more donations, the penalty may decrease even further, perhaps reducing waiting lists for everyone including non-registrants. The issue is perhaps not the imposition of a penalty, but whether it is so overwhelming that consent is vitiated. Second, we already violate autonomy by interfering with cadavers without prior consent when post-mortem examinations are conducted¹⁶⁷ in the public interest to investigate a possible crime or to identify a disease.¹⁶⁸ One wonders why the infringement of autonomy in post-mortem examination is acceptable while the application of some pressure to consent to a similar post-mortem bodily interference for organ donation is an unacceptable infringement of autonomy.

Jarvis, arguing in favour of priority systems, writes that “the proposal seems no more coercive than any other arrangement which offers a valued future goal as a reward for some sacrifice. Indeed, the coercion involved looks to be particularly thin, given that all the benefits accrue to the individual while s/he is alive while the

¹⁶¹ *Supra* note 154 at 2186.

¹⁶² *Ibid.*

¹⁶³ *Ibid.* (“On the other hand, if we are unwilling, as I believe we should be, to force people to “give” their organs because we recognize that some people have “acceptable” objections to being cadaveric organ donors, then we must reject Muyskens’ means of reaching the same result”).

¹⁶⁴ Teo, *supra* note 130 at 12.

¹⁶⁵ The high value of receiving a life-saving organ is discounted by the remote chance that a given person will require an organ as well as by the chance that an appropriate organ will become available at the necessary time.

¹⁶⁶ The penalty is somewhat larger under priority system proposals that would disqualify those who refuse to donate from receiving an organ at all.

¹⁶⁷ See e.g. *Coroners Act*, R.S.O. 1990, c. C-37, s.28.

¹⁶⁸ Harris, *supra* note 3 at 131; *supra* note 159 at 141.

costs are exacted exclusively after his/her death."¹⁶⁹ In my view, this puts the point too strongly as well. The problem is not so much the incentive award that one can choose to forego, but the penalty of being disadvantaged in receipt of an organ. Non-registrants cannot just opt to retain a neutral position. Furthermore, the costs are not exacted exclusively after death. The costs that matter (ignoring religious objections) are those felt during life, and they are the psychological consequences and other inconveniences associated with committing to donate.

The effects on autonomy of priority systems can be compared with systems of presumed consent. In a "presumed consent" system, everyone is presumed to consent to the posthumous removal of their organs. Those who object can opt out by registering their refusal to donate. A presumed consent system seems, on its surface, to be more of a violation of individual autonomy since it is likely that the failure of many to opt out is not due to consent but to a failure to think about the matter. The consent is fictional. As Gillon puts it, presumed consent involves a form of "coercion by inertia."¹⁷⁰ Furthermore, it exposes those who do object to organ removal if some error is made in processing or communicating their refusal.

However, I think that a priority system may, in one way, violate autonomy more than a presumed consent system because the priority system does impose a "sanction" that cannot be avoided except by agreeing to donate. This arguably constrains free consent more than a presumed consent system, which provides an obvious initial violation of freedom of consent, but one that can be undone fairly easily without major consequences. Like a presumed consent system, an opt-in priority system also exposes people to a risk of a mistake in the registration of their wishes. If someone's willingness to donate is not registered, the default is to not remove the organs absent family consent, which would not violate autonomy as one surely cannot have an autonomy right to demand removal of one's organs. However, the failure to register a person's willingness to donate would disadvantage the person should they later need an organ. The consequences of an error are arguably more severe with the priority system, where someone is disadvantaged in receiving life-saving treatment, than with presumed consent, where someone undergoes post-mortem organ removal that the person would have objected to in life. Presumably, under a priority system, a person could attempt to prove that he or she did in fact consent, and that a registry error was made.

It is unclear which of a priority system or a system of presumed consent would be more acceptable to the public. The key distinctions between the two approaches are the use of a fictional consent, the default position for those who are unaware of the system or whose registration is lost, and the existence of a sanction for refusing to donate. A presumed consent system potentially infringes upon autonomy in only

¹⁶⁹ *Supra* note 54 at 203; *supra* note 16 at 707 and Spital, *supra* note 82 at 270, also take the position that priority systems are not coercive.

¹⁷⁰ *Supra* note 81 at 195.

the first two ways. A priority system possibly undermines autonomy in the last way, but may also disadvantage people who are unaware of the system or whose registration is lost by reducing their chances of receiving an organ.

In conclusion, a priority system can be said to be somewhat coercive, particularly when compared to the present system. The point is to induce consent with both a carrot and a stick in order to increase the donation rate. The key question is whether the inducement is so overwhelming that consent is illusory. As will be discussed below, I believe it is necessary to provide an alternative method to receive priority status due to concerns regarding the discriminatory impact of a priority system. This alternative would help to reduce concerns about coercion as well. However, I suspect that if the alternative were not available, a priority system would still not be impermissibly coercive. As noted above, we seem to have accepted that post-mortem examination may be conducted in the public interest.

Priority systems are an illegal or immoral form of “trade” in organs

Another argument against priority systems is that they involve the offer of valuable consideration for an organ, contrary to laws banning trade in organs.¹⁷¹ The trade at the heart of the priority system is the exchange of a fairly remote albeit improved chance of receiving an organ for a remote chance of giving up one’s organs after death. The exchange of these commitments may be captured by the legislation even though, strictly speaking, the exchange of these contingent and revocable promises seems somewhat removed from the letter of the legislation. The fact that the U.S. “Hope through Sharing” program, which trades a live donation for priority for a relative, is permitted suggests that consideration in the form of priority status may not offend the spirit of this type of legislation. In any event, I will not address this argument in detail because, should a priority system be judged useful, it would be possible to amend the legislation to address any ambiguity.

However, there still remains the concern that any incentive or exchange-based system, including priority systems, commodifies bodies and body parts.¹⁷² The two main classes of objection to commodification are, first, that it leads to exploitation (the poor supply the commodity under duress, and are themselves unable to afford to buy it), and, second, that it corrupts or denigrates the thing that is commodified.¹⁷³ In other words, once we can exchange body parts for other

¹⁷¹ See e.g. *Trillium Gift of Life Network Act*, R.S.O 1990, c. H.20 (Section 10 provides that “No person shall buy, sell or otherwise deal in, directly or indirectly, for a valuable consideration, any tissue for a transplant, or any body or part or parts thereof other than blood or a blood constituent, for therapeutic purposes, medical education or scientific research, and any such dealing is invalid as being contrary to public policy”). Contravention of the act is an offence under s. 12); Arguments that priority systems do not violate such legislative bans can be found in *supra* note 16 at 699 and *supra* note 15 at 320.

¹⁷² Discussed in *supra* note 16 at 728; Kluge, *supra* note 82 at 281 (Kluge argues that a priority system is ethically abhorrent because it is equivalent to the sale of organs).

¹⁷³ Note: “The price of everything, the value of nothing: Reframing the commodification debate” (2004) 117: 2 Harv. L. Rev. 689 at 690-693.

things, the body and its parts become things that can be used, promoting the view of a human as a “means” rather than an “end,” and perhaps paving the way to serious violations of human dignity and integrity.

Priority systems do not exploit poor persons as would financial incentives.¹⁷⁴ This is because the system asks the poor and wealthy alike for an identical commitment to donate organs after death. This commitment is equally within the capacity of all people to give, and does not seem to be more or less burdensome depending upon wealth alone.¹⁷⁵ For this reason, Capron’s criticism that priority systems imply that “...if someone else has “paid” more, that person’s moral claim would be judged superior...”¹⁷⁶ seems unfounded because no one can “pay more.”¹⁷⁷ The priority system would offer, in exchange, a reward that has the same value to the poor or wealthy recipient. Clearly, the chance at a life-saving organ is not more or less valuable depending upon the wealth of the recipient.¹⁷⁸ As a result, the possibility that the incentive offered has a differential impact according to a person’s wealth, and so might bring forth greater donation from the poor to benefit the rich should not exist. This conclusion evidently depends upon a medical system that offers equality of access to organ transplantation.

With respect to the corruption or denigration of the thing commodified, many and perhaps most people feel that there is something about human bodies and their parts that makes the idea of trading them offensive while donating them is not.¹⁷⁹ However, part of the offensiveness of commodification lies in the translation into monetary value of something that we consider cannot be valued in such terms. This does not occur in a priority system. Of course, commodities can be bartered, and so value can be described in non-monetary terms, by comparison with the value of other objects.¹⁸⁰ The priority system does not ascribe any value to a donated organ other than that of a donated organ. In other words, what must be exchanged for a chance to receive a donated organ is a chance that one will give an organ. The

¹⁷⁴ See also the discussions in Spital, *supra* note 82 at 270; Gubernatis & Kliemt, *supra* note 14 at 700.

¹⁷⁵ As discussed below, there is a possibility that the burden may vary on other grounds such as race or religion.

¹⁷⁶ *Supra* note 154 at 2186.

¹⁷⁷ However, some have suggested that live donors should receive greater priority status than those who consent to cadaveric donation. This option is not more available to wealthy than non-wealthy people. No one has suggested that one commitment to donate posthumously should be viewed as more valuable than another.

¹⁷⁸ I am setting aside the possibility that some wealthy recipients might purchase organs illegally, while a less wealthy person is limited to the national organ donation system and so the priority incentive may actually have greater value to non-wealthy persons.

¹⁷⁹ *Supra* note 16 at 730, citing Leon Kass, “Organs for Sale? Propriety, Property and the Price of Progress,” (1992) 107 *Pub. Int.* 65 at 83 (“The idea of commodification of human flesh repels us, quite properly I would say, because we sense that the human body especially belongs in that category of things that defy or resist commensuration – like love or friendship or life itself”).

¹⁸⁰ *Supra* note 16 at 731 (discusses the typical indicia of commodification including commensurability (the ability for a thing to be compared in value with others), monetizability (the ability for a thing to be converted into dollar value), and fungibility (the ability for a thing to be substituted for by another)).

congruence of the things exchanged avoids the offensiveness of describing their value by reference to other tradeable objects. This is not a complete answer since the offensiveness of commodification is not solely related to the manner in which it expresses a value for things we feel are beyond value. For example, the trade of a child for money or goods is offensive, but the trade of one child for another is also offensive. This is so because the children are unique, and to treat them as fungible denies this uniqueness. Organs, however, are fungible and Kolber points out that this very fungibility makes transplantation possible.¹⁸¹

Nevertheless, some may insist that an exchange is in itself debasing in its insistence on the quid-pro-quo of an exact value exchange (i.e., an organ for an organ), which is perhaps why there is such enthusiasm for “symbolic incentives” such as the recognition of donors through plaques or memorials.¹⁸² Many would prefer that the transfer of organs take place by way of altruistic gift rather than by exchange because it is ennobling. However, if it is true that priority systems do not lead to exploitation of donors, that they do not denigrate a human body part by treating it as equal in value to a sum of money or some other object like a car, and do not denigrate a unique aspect of a human being by treating it as interchangeable with that of any other human being, it is possible that the insistence on altruistic gift is unnecessarily cautious.

Priority systems undermine altruism

Another argument against the priority system, and indeed against the use of any incentives, is that it undermines the current altruistic foundation of organ donation. One set of arguments suggests that the use of incentives will reduce donation because it will take on mercenary connotations that are distasteful to those who would otherwise have donated altruistically.¹⁸³ However, the 1993 U.S. Gallup poll suggests that most people would not be affected by financial incentives, but of those that are affected more would be motivated to donate than would be less likely to donate.¹⁸⁴ Another argument sees value in the social demonstration of altruism. It provides an opportunity to affirm bonds of support throughout the community.¹⁸⁵ This is likely true, and the public example of altruism is deeply inspiring and affirming of one’s belief in humanity and of the mutual interdependence of human beings.

¹⁸¹ *Ibid.* at 732.

¹⁸² *Supra* note 146 at 382 (found that large majorities of transplant surgeons (78%), coordinators (88%) and critical care nurses (75%) polled endorsed the adoption of such a system); See also Delmonico *supra* note 12.

¹⁸³ See the discussion in *supra* note 16 at 716-717.

¹⁸⁴ *Supra* note 53.

¹⁸⁵ See the discussion in *supra* note 16 at 717-718.

Two possible responses may be made to this altruism argument. First, accepting the value of altruism, the purely altruistic system is demonstrably unable to motivate a sufficient level of organ donation. It is unclear that the social benefit we derive from an altruistic organ donation system should outweigh the benefit that might accrue to those waiting for an organ should an incentive-based system be able to produce more organs for transplantation.¹⁸⁶ Furthermore, it is difficult to ask those waiting for organs to pay the price for the social benefits we all derive from a purely altruistic donation system. After all, as Nadel and Nadel point out, we offer tax deductions for charitable donations although this arguably undermines the social benefits of a purely altruistic system of charitable donation.¹⁸⁷ Muyskens questions the morality of clinging to an altruistic system for organ donation where a morally acceptable alternative would be more effective.

“It would be regrettable, perhaps inexcusable, if uncritical or nostalgic insistence upon altruism as the only morally acceptable way to procure organs resulted in an acute shortage when another morally acceptable way could yield far more organs.”¹⁸⁸

The second response to the argument about the loss of altruism is that a priority system could still leave room for altruism. Recipients would be free to forego the priority reward associated with registering to donate.¹⁸⁹ Where priority would otherwise break a tie between an altruistic donor (who is giving up priority) and someone who had not registered to donate, the priority could be ignored and some other means to break the tie could be found. Where an altruistic donor (who is giving up priority) is competing with another donor who has priority, it is also possible to ignore the priority since this would not have been the deciding factor had the altruistic donor not given up priority and so ignoring priority is not unfair to the donor who is continuing to claim his or her priority status. In this way, altruistic donation can be preserved without actually disadvantaging the altruistic donor by placing him or her behind those with priority status.

In any event, even accepting that there is great social value to altruism, it is unclear that this value should outweigh the importance of finding ways to save lives and resources and to reduce suffering. If incentives would increase donation rates, it may be worthwhile leaving our efforts to promote altruism to other social contexts that do not inflict such heavy expense.

¹⁸⁶ See e.g. Daar, *supra* note 18 at 705.

¹⁸⁷ *Supra* note 15 at 320.

¹⁸⁸ *Supra* note 104 at 2183.

¹⁸⁹ *Supra* note 16 at 703, 721; Muyskens, *supra* note 104 at 2183 (Muyskens suggests, perhaps a bit unfairly, that “[p]resumably current advocates of altruism would be in the vanguard of such a movement, were the proposal of this essay adopted....”).

Organs should be allocated solely on the basis of the medical criteria of need and utility

Another key argument against priority systems is that allocation must be made solely on the basis of medical criteria of need and utility, and some versions of the priority system might permit allocations that deviate from these principles. Gillon, commenting on the Jarvis system that would disqualify all non-registrants from receiving an organ, wrote that,

...even if such non-volunteers can properly be said to have only themselves to blame for their predicament; even if they can properly be said to have deliberately and autonomously made their choice and rejected the opportunity to give themselves priority for receipt of transplanted organs; even if they can properly be said to have been selfish, and or inconsiderate and or foolish, even immoral, in refusing to pre-volunteer their own organs, nonetheless there is an important countervailing moral tradition in medicine. It is that patients should be given treatment in relation to their medical need, and that scarce medical resources should not be prioritized on the basis of a patient's blameworthiness.¹⁹⁰

While need is a compelling criterion for allocation, we already derogate from a pure needs-based allocation system to accomplish other objectives. For example, considerations such as time spent on the waiting list and prognosis¹⁹¹ may run contrary to a purely needs-based decision. Preferences for local recipients, which represent both medical considerations (such as the need to transplant donated organs quickly) and a form of collective preference that rewards regions with high donation rates, are also contrary to a solely needs-based system.¹⁹²

In any event, a priority system can be designed to minimize the inconsistency with a needs-based method of allocation. As discussed earlier, many of the priority system proposals would exempt highly critical cases from the operation of the priority, or would use prior registration only to break ties between cases that are roughly similar in terms of urgency and expected outcome.

Priority systems allocate organs by judging the social worth of the recipient

Another argument against the priority system is that it allocates organs on the basis of a judgment about the social worth of the recipients. This is properly rejected as an acceptable basis for allocating medical resources given the lack of

¹⁹⁰ *Supra* note 81 at 196.

¹⁹¹ Kleinman & Lowy, *supra* note 4 at 1487 ("At times a patient with a greater likelihood of benefiting from a transplant is given preference over a patient with a more urgent need but a very poor prognosis").

¹⁹² *Supra* note 15 at 322; Gubernatis & Kliemt, *supra* note 14 at 701.

any consensus on what would constitute worthiness, as well as the considerable dangers of subjectivity, bias and arbitrariness.¹⁹³ The so-called American "God Committees" of the early days of renal dialysis illustrate the danger of bias in judging social worth. The Committees were lay boards that chose patients partly on the basis of judgments about social worth, which was assessed in accordance with the class and cultural beliefs of the decision-makers.¹⁹⁴

Critics of priority systems suggest that those who fail to opt in to donate are being judged as less socially or morally worthy.¹⁹⁵ They suggest that if this is acceptable then "all other prior faults and inconsiderateness of equal or greater weight could, logically, also be regarded as morally relevant and potentially justificatory for withholding scarce life-saving medical resources from patients."¹⁹⁶ Instead, they argue, lifesaving programs should "rest simply on the equal worth of each human life."¹⁹⁷

The question then is whether a priority system, in preferring someone who has agreed to donate over those who have not, is making an allocation decision on the basis of social worth. Gubernatis and Kliemt, arguing in favour of a priority system, seem to accept that it incorporates a social value judgment. "The solidarity model expresses some resentment against the behavior of those who by their own lack of solidarity are co-responsible for the tragic scarcity of organs."¹⁹⁸

Other proponents of priority systems reject the concern that the system allocates organs on the basis of social worth. They emphasize the incentive rather than the penalty and point out that everyone is free to participate. Kolber characterizes priority not as a reward for virtue but as an incentive to join a mutual insurance pool.¹⁹⁹ The priority system can also be viewed, not as a statement of moral worth, but as a form of social contract that everyone can make if they wish.²⁰⁰

¹⁹³ *Supra* note 1 at 261 (discussing the debate between utilitarian and egalitarian approaches to allocating organs); *supra* note 159 at 129-130; Gillon, *supra* note 81 at 196 ("Fault, past or present, is widely rejected as a 'morally relevant inequality' by currently accepted substantive principles of distributive justice for scarce medical resources")

¹⁹⁴ *Supra* note 1 at 258; *supra* note 159 at 129 ("[T]he most widely discussed was the screening process for kidney patients at the Seattle Artificial Kidney center, whose decisions to allocate scarce resources in the early days of renal dialysis were based, to a certain extent, on a notion of "social worth," of which in practice the least offensive charge was that it exalted middle class values. Critics have pointed out that it assumed that scout leadership, Red-Cross activities, and religious and social teaching were eternal verities").

¹⁹⁵ Robert A. Sells, "Donation: Will the principle of "do as you would be done by" be enough?" (2000) 70:4 *Transplantation* 703 (Sells argues that the organ allocation system should not allocate on the basis of "responsible past behaviour," and emphasizes the fundamental principle that medical treatment be available to all regardless of social worth).

¹⁹⁶ Gillon, *supra* note 81 at 196; *supra* note 154 makes the same point at 2186.

¹⁹⁷ *Supra* note 154.

¹⁹⁸ Gubernatis & Kliemt, *supra* note 14 at 699; *supra* note 17 (Burdick *et al* agree that it is disingenuous to suggest that there is not some sort of moral judgment implied by preferred status, and that this might lead to the use of other moral judgments in allocating organs).

¹⁹⁹ *Supra* note 16 at 737.

Nadel and Nadel argue that the priority system does not raise the danger of subjectivity and bias because it assesses only one objective fact.

“[W]hile some might perceive a preference policy as favoring committed donors due to their moral superiority over non-donors, that is not the case: the preference is based solely on a person’s willingness to participate in a reciprocal system designed to increase donor incentives and thus the supply of organs. Thus an unemployed ex-convict who committed to donate would get the preference, while a Nobel Peace Prize winner who did not commit to donate would not. It is not an inherently subjective, and thus problematic, policy; it is objective and treats all individuals on the same terms.”²⁰¹

In my view, this does not completely answer the objection. The fact that a person’s registration is an objective, simple fact (the person either registered or did not) is not an answer to concerns about using criteria of social worth. Granted, using an objective fact is likely less amenable to abuse than asking open-ended, subjective and imprecise questions such as whether a person was a good or a kind person or a productive member of society. However the choice of which “objective facts” are to be used contains a latent moral judgment that ought to be carefully scrutinized. For example, whether a person has been convicted of a criminal offence is also an “objective fact” that could be ascertained by reviewing a person’s criminal record. The apparent objectivity of these “objective facts” does not save them from the charge that they reflect moral judgments.

It may be acceptable, nevertheless, to choose one such criterion after careful reflection on its meaning and impact. It may be true that some of the dangers of allocation on the basis of judgments about worth may not exist in the context of priority systems. It is a single fact rather than an open-ended inquiry into social worth, and it need not be permitted to expand to a consideration of other aspects of worth. The choice of willingness to donate is not an arbitrary criterion having nothing to do with the central problem of the scarcity of organs. As discussed above, the criterion of willingness to donate *is* relevant to the key problem of organ scarcity that is targeted by priority systems, while the other aspects of moral desert (living an exemplary life, good works or criminality) are not relevant to the key problem. A priority system, the *raison d’être* of which is to increase organ donations rather than to improve the average social worth of the population, has no reason to attempt the summation of all the various aspects of whether someone is morally deserving of an organ, even if it were possible.

²⁰⁰ *Supra* note 17.

²⁰¹ *Supra* note 15 at 323

Another key consideration is whether it is fair to use the particular criterion of willingness to donate. As noted above, supporters of priority systems emphasize that everyone can opt in. Whether or not this is the case will be discussed below in the context of the potential discriminatory impact of priority systems.

Priority systems have discriminatory effects

Autonomy and distributive justice are two central ethical concerns in organ procurement and allocation.²⁰² The allocation of scarce organs raises the question of whether fairness demands random allocation or whether there are permissible distinctions that may be drawn between potential recipients. Within some limits, certain distinctions are currently permitted including, for example, tissue compatibility or urgency of need. Recipients are also distinguished geographically, as allocation algorithms favour local recipients.

The question is which grounds of distinction are permissible. The *Canadian Charter of Rights and Freedoms* enumerates the following impermissible grounds of discrimination: "race, national or ethnic origin, colour, religion, sex, age or mental or physical disability."²⁰³ This is not an exhaustive list, as analogous grounds of discrimination may and have been recognized by Canadian courts.²⁰⁴

Some of the grounds of distinction used in certain current allocation algorithms, such as tissue compatibility, have the effect of distinguishing among recipients upon impermissible grounds such as ethnicity. In the U.S., African-American patients encounter a higher rate of end-stage renal disease and so are over-represented (given their proportion within the population) among patients requiring kidney transplant. However, the donor pool contains far more kidneys from white donors, leading to a greater likelihood that the kidneys will match the immunological characteristics of a white recipient. "Due to the HLA matching requirements and the large white donor pool, fewer of the kidneys available for transplant will match persons of African descent."²⁰⁵ Similarly, distinctions drawn on the basis of prognosis may disadvantage those with other significant illnesses or aged patients,²⁰⁶ raising questions about whether the effect of the distinctions is discrimination on the basis of disability or age.

The Charter guarantee of equality captures not just direct discrimination upon enumerated or analogous grounds, but also facially neutral laws that have discriminatory effects.²⁰⁷ The purpose of the equality guarantee in the Charter "...is to

²⁰² See *supra* notes 135-139 and associated text.

²⁰³ *Canadian Charter of Rights and Freedoms*, s. 15, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c.11.

²⁰⁴ *Law v. Canada* [1999] 1 S.C.R. 497 at para. 29.

²⁰⁵ Siminoff & Saunders Sturm, *supra* note 71 at 60.

²⁰⁶ Sackner-Bernstein & Godin, *supra* note 101 at 158.

²⁰⁷ Differential, and potentially discriminatory, treatment may exist where "the impugned law (a) draw[s] a formal distinction between the claimant and others on the basis of one or more personal characteristics,

promote ‘a society in which all are secure in the knowledge that they are recognized at law as human beings equally deserving of concern, respect and consideration’. The provision is a guarantee against the evil of oppression ... designed to remedy the imposition of unfair limitations upon opportunities, particularly for those persons or groups who have been subject to historical disadvantage, prejudice, and stereotyping.”²⁰⁸ Not all differential treatment is discriminatory, but differential treatment that tends to fall along lines of pre-existing “disadvantage, vulnerability, stereotyping, or prejudice experienced by the individual or group,” is more likely to be found to be unconstitutional, although this is neither a necessary nor determinative criterion.²⁰⁹

Potential discrimination arises in the context of priority systems because of the dependence of organ allocation upon willingness to donate. As a result, if an individual or a group has a particular reason to be unable to donate, or to face a greater burden in donating, then the individual or group will be disadvantaged when compared to the rest of the population. There are at least three potentially problematic forms of discrimination at work in priority systems.

First, adherents of religions that discourage donation will be disadvantaged. Some proponents of priority systems suggest that this will not be a difficulty as religions that forbid donation are likely to forbid the receipt of organs as well.²¹⁰ It is unclear whether this is true in all cases. Some religions may discourage donation while remaining silent on the propriety of accepting organs, thus leaving the receipt of an organ as a matter of individual choice. In deference to our strong commitment to religious pluralism and respect for freedom of religion, one must nevertheless acknowledge that a priority system would likely disadvantage particular groups on religious grounds, potentially constituting impermissible discrimination.

Second, as noted earlier, members of certain racial or ethnic groups show a greater tendency to fear abuse by the medical system (i.e., that they will be declared dead prematurely, or that doctors will do less to save their lives if they are declared donors). These individuals will face a greater burden (either actual or psychological depending upon whether the fear is accurate). They also show a greater tendency to believe that organs will not be allocated fairly (e.g., will be allocated to wealthy recipients, and also perhaps to white recipients rather than to those from racial or

or (b) fail[s] to take into account the claimant’s already disadvantaged position within Canadian society resulting in substantively differential treatment between the claimant and others on the basis of one or more personal characteristics”; *supra* note 204 at para. 88.

²⁰⁸ *Supra* note 204 at para. 42.

²⁰⁹ *Ibid.* at para. 63 (“These factors are relevant because, to the extent that the claimant is already subject to unfair circumstances or treatment in society by virtue of personal characteristics or circumstances, persons like him or her have often not been given equal concern, respect, and consideration. It is logical to conclude that, in most cases, further differential treatment will contribute to the perpetuation or promotion of their unfair social characterization, and will have a more severe impact upon them, since they are already vulnerable”).

²¹⁰ *Supra* note 15 at 324.

ethnic minorities). To the extent that this is true, once again, these individuals are being asked to assume a greater burden because it carries less of a reward than would be forthcoming to the rest of the population.

Third, another concern is that the priority system would be most likely to disadvantage those who remain ignorant of the policy. One might expect that this population would be disproportionately comprised of people already marginalized and who have reduced access to medical information due to mental illness, poverty, lack of education and other such disadvantages.²¹¹

Given these concerns, can a priority system still be defended? I suggest that it can, but only if an alternative route to obtaining the priority status is made available. A partial analogy may be drawn to religious or conscientious objection to military service, where objectors are able to perform public services instead. There is a distinction between organ donation and military service. In the military service context, the objector is not actively seeking the benefit provided by the self-sacrifice of his or her compatriots (i.e., national security) and cannot avoid the benefit as it is a public good.

Another partial analogy might be drawn to the refusal of vaccinations. In this case, an objector obtains a reasonable assurance of avoiding the diseases (because most others are vaccinated and epidemics unlikely) while avoiding the risks associated with vaccination. The objector may not be seeking to benefit at others' expense and also cannot avoid the benefit of existing in a well-immunized population unlikely to be subject to a disease outbreak.²¹²

In the context of organ donations, the objector differs from the pacifist or refuser of vaccination in that he or she actively consumes a scarce resource and reduces the resources available to others, rather than merely passively benefiting from a public good generated by those others without reducing it. It would be appropriate, perhaps, for those who do not wish to donate to perform some other public service that would assist in reducing the shortfall between the supply of organs and the demand for organs. Anyone who does not wish to donate should be able to perform some suitable public service that would (a) assist with reducing the demand for organs, for example by helping to promote disease prevention efforts, or (b) help to increase the supply of organs, for example, by assisting with public education about transplantation. It would be necessary to calibrate this appropriately so that it is not unduly onerous, but so that the contribution remains meaningful. Singapore offers a precedent for a priority system that offers an alternative route to priority status. Singapore offers priority status without donation for transplant if

²¹¹ *Supra* note 17, at para 11: "As is generally the case with anything, those who are well-read and living above the survival level would be more likely to benefit, since they would be better informed about the option and have better medical care..."

²¹² In Ontario, a parent may refuse to vaccinate a child on religious grounds, but the child may be suspended from school if an outbreak takes place. See *Immunization of School Pupils Act*, R.S.O. 1990, c.11.

a person donates his or her body for medical education or research instead. This particular alternative route to priority does not seem adequate as it does not answer the concern of religious or cultural groups that insist upon non-interference with the cadaver.

Although an alternative route would meet the concerns about discrimination on the basis of religion or ethnicity, as long as the contribution demanded is not unduly onerous, it would not meet the objection that poorer and less educated persons, as well as those with disabilities may be disproportionately disadvantaged because of their reduced access to health information. Various options could be adopted to attempt to address this problem. The option that is least invasive of autonomy interests would be to devote significant effort to education. Another, perhaps preferable, option is that priority status should be instituted along with a mandatory choice regime. In other words, everyone would be forced to choose one of three options: to opt in, to opt out or to decide later. The option of deciding later is included to offer the undecided something other than opting out, which would cause their families to be less likely to consent on their behalf perhaps than an expression of indecision. The mandatory choice would ensure that the existence of the program is brought to everyone's attention, hopefully under conditions where questions could be asked and answered. Furthermore, in this way, the failure to register would not be treated as a refusal to donate, and people for whom no registration exists could be asked why they have not registered. Those who were genuinely unaware of the system could thus avoid the disadvantage of failing to register. As noted earlier, Eaton suggests that a priority system be adopted along with presumed consent, so that those who are unaware of the system would have a default priority status. Canadians are, however, very divided about presumed consent, and it may be perceived as too much of an encroachment on individual autonomy.²¹³

In summary, if a decision is taken to use a priority system, it should offer an alternative route to priority status in the form of a reasonable level of public contribution aimed at assisting with the organ shortage problem. In addition, it likely ought to be instituted in conjunction with a mandatory choice regime.

Conclusion

One of the various proposals to modify the current organ donation and allocation regime in order to alleviate the chronic shortage of organs is to adopt a form of priority system. Under such a system, people would choose whether or not to opt in to donate, and those who did so choose would receive a preference in the allocation of organs should they later need one. Since families are more likely to consent to the donation of a deceased's organs if there is evidence that the deceased had previously expressed willingness to donate, an increase in registration to donate would be helpful. The priority system is preferable to a presumed consent system

²¹³ *Supra* note 39 at 45.

in this regard. However, evidence from carefully designed surveys or from pilot projects is necessary in order to establish whether a priority system would in fact bring forth a greater rate of donor registration as well as family consent.

However, priority systems have been defended and attacked on many grounds. One of the most serious arguments against priority systems is that they may have discriminatory effects. They may disadvantage certain religious and ethnic communities, and may also disadvantage those who tend to have less access to medical information, including perhaps people with mental disabilities or less affluent or educated people. If a priority system is to be adopted, it should offer an alternative route to obtaining priority status. This alternative route should not be unduly burdensome, and should take the form of public service that would assist in reducing the shortage of organs (e.g. through support for preventative medicine programs, or public education about donation). In order to reduce the risk that persons who are unaware of the program would be disadvantaged, a priority system should be instituted along with a mandatory choice regime (i.e., agree to donate, refuse to donate, undecided). In that way those people for whom no choice is recorded will not be assumed to have refused donation and so automatically suffer the priority disadvantage. Instead, they will have an opportunity to request priority where they had a genuine lack of awareness of the priority system.