

ARTICLE

Full Reciprocity: An Essential Element for a Fair Opt-Out Organ Transplantation Policy

Leonard Fleck

Center for Ethics and Humanities in the Life Sciences, Michigan State University, East Lansing, MI, USA
Corresponding author. Email: fleck@msu.edu

Abstract

In this paper, I argue for the following points. First, all of us have a presumptive moral obligation to be organ donors if we are in the relevant medical circumstances at the time of death. Second, family members should not have the right to interfere with the fulfillment of that obligation. Third, the ethical basis for that obligation is reciprocity. If we want a sufficient number of organs available for transplantation, then all must be willing donors. Fourth, that likelihood is diminished if individuals are entirely free to refuse to be organ donors but still would demand to be organ recipients. Fifth, although individuals would be ethically obligated to be organ donors, we still need to permit them to refuse to be organ donors. Sixth, to encourage individuals to stay within the organ donation system, we should have as a just and ethically justified policy denying individuals an organ transplant in the relevant medical circumstances if they have chosen to exit the organ donation system. Individuals would not be permitted to be organ recipients if they were unwilling to be organ donors. This is what it means to be part of what Rawls in *Political liberalism* (15–22) would refer to as a “fair system of social cooperation.” We refer to this as the “reciprocity requirement.”

Keywords: duty of easy rescue; reciprocity requirement; opt-out policies; opt-in policies; presumed consent; fair system of social cooperation; cadaveric organ retrieval

Introduction

Are we, citizens in a society that aspires to be just and caring with respect to meeting healthcare needs, *ethically obligated* to maximize, or at least substantially increase, the supply of major organs available for transplantation? Alternatively, would it be praiseworthy and ethically sufficient if we made a significant social effort to educate and encourage the broad public to sign donor cards that would allow their organs to be taken for transplantation at the time of death if they were medically suitable? In other words, should we be ethically satisfied if we could increase a bit the supply of transplantable organs, recognizing that success depended on the voluntary choices of citizens? This latter question captures actual practice in the United States today as well as several EU countries. The expectation is that the practice must be thoroughly voluntary. The donor and/or the donor’s family must consent to the removal of those organs at the time of death, knowing that their consent or refusal will have either lifesaving or deadly consequences for some unknown patient needing a major organ transplant. This is what is known as an “opt-in” policy. Individuals must make an explicit choice to offer themselves as potential organ donors at the time of death. Individuals in these circumstances are typically commended for their altruism, which clearly implies that they were not ethically obligated to make this choice.

Transplant Organ Shortfall Statistics

The literature for the past 40 years has repeatedly emphasized that the opt-in approach to organ donation has failed to meet the need for this life-prolonging resource. In the United States, 107,000 individuals are on waiting lists (2021), and ~6,200 individuals will die on those lists while waiting for an organ transplant.¹ In 2019, there were 39,719 organ transplants in the United States and 34,221 in the European Union.² In the European Union, ~155,000 patients are on waiting lists (2021) with ~8,000 who would die on the waiting list.³ We should also note some donor-related statistics. There are three types of donors. These are 2019 U.S. statistics: (1) living donors (mostly kidneys and some partial livers; 7,400), (2) deceased donors based on neurologic criteria (3,726), and (3) deceased donors based on circulatory death (3,223). The relevance of these numbers is discussed below.

A statistic frequently cited by organ procurement agencies is that each deceased donor represents eight potential lives that could be prolonged. More relevant than that is the number of deceased patients whose death is determined by neurologic criteria. These are potential donors. Ellen Sheehy et al. (2003) review several studies aimed at determining that number.⁴ They ultimately conclude that the most likely annual number of potential donors whose death is determined by neurologic criteria is between 10,500 and 13,800. If we take the higher end of the spectrum as our starting point, that suggests there might be 10,000 additional donors who could be converted each year to being actual donors. In the vast majority of these cases, either consent for organ procurement was not obtained, or consent was denied. In theory, that represents the loss of 80,000 lives that could have been prolonged. The conclusion of many writers is that something must be done, that this is an ethical imperative, given the potential number of lives and life-years that could be saved. What many see as the obvious obstacle is the need for consent, either by the individual who becomes a donor or representatives of that donor (most often family members). Others see consent, not as an obstacle, but as a bulwark against the violation of the rights or interests of an individual.⁵

The Opt-Out Option and Presumed Consent

What many researchers have proposed as a response to this situation is an opt-out policy regarding organ transplantation. In other words, everyone is presumed to consent to being an organ donor after death unless they explicitly choose to opt out of that system by, for example, signing some legal document that says they are opposed to donating their organs after death. What justifies making this assumption regarded presumed consent? Some survey research has suggested that as many as 85% of those surveyed indicate that they would be willing organ donors after death. An opt-out policy captures that willingness to donate along with fulfilling the societal expectation for a major increase in organ donation. If some individuals are very strongly opposed to having their organs used for transplantation (for whatever reasons), they have the option of indicating their opposition and exiting the system.

The survey research, however, might be misleading. Telling a survey researcher that one is willing to be an organ donor is psychologically easy. It involves no actual commitment. If anything, self-esteem considerations might motivate an individual to tell a researcher that they would be a willing donor. It would feel selfish and irrational to refuse to be a donor. Although that survey respondent is talking to a stranger and knows their responses will be entirely anonymous, still, they would not want to be perceived as being ungenerous. Consequently, in some countries where opt-out is the established policy, as many as 30% of individuals will opt out.

Even with a substantial percent of opt-out decisions, that should still result in an overall increase in the availability of donor organs. However, in actual practice, physicians will most often still ask family members for permission to retrieve those organs after death determined by neurologic criteria. This is not something they are legally obligated to do. Perhaps these physicians see this as some sort of moral obligation, so they are not seen as violating that body. Perhaps they just see it as a matter of social courtesy. The net result is that some number of those families deny permission, which results in a further diminution of available organs for transplantation. How should we think about that loss?

Is that loss merely unfortunate, ethically speaking? How would individuals on those waiting lists think about that loss? I think it is clear that individuals on the waiting list do not have a right to those organs such that they are unjustly harmed by being denied access to those organs. Those organs are not like unowned gold in the ground, available to anyone who would make the effort to retrieve that gold. To use those organs justly, some sort of permission is required. That, of course, is the point and purpose of presumed consent. Individuals have the option of denying consent, but they must make an affirmative effort to accomplish that.

What needs to be noticed is that presumed consent is about consent from the individual who is the owner of those organs. It says nothing at all about family members. An opt-out policy does not say that family members have the right to remove one of their living members from the opt-out system, perhaps without even informing that individual he or she has been removed through some sort of family decision.⁶ Likewise, these policies do not give families permission to deny retrieval of organs from individuals who have not themselves exited the system.⁷ That would undermine the point of presumed consent and the goal of increasing the supply of transplantable organs. What can be done to correct this situation?

My Key Claims

I want to argue for the following points. First, all of us have a presumptive moral obligation to be organ donors if we are in the relevant medical circumstances at the time of death. Second, family members should not have the right to interfere with the fulfillment of that obligation. Third, the ethical basis for that obligation is reciprocity. Each of us, when thinking about a possible future in which we would need a transplanted organ to gain several additional years of life, would want a sufficient number of organs available to maximize the likelihood of actually receiving that transplant. Fourth, that likelihood is diminished if individuals are entirely free to refuse to be organ donors but still would demand to be organ recipients, were they to be faced with major organ failure. Fifth, although individuals would be ethically obligated to be organ donors, we still need to permit them to refuse to be organ donors. Sixth, to encourage individuals to stay within the organ donation system, we should have as a just and ethically justified policy denying individuals an organ transplant in the relevant medical circumstances if they have chosen to exit the organ donation system. Individuals would not be permitted to be organ recipients if they were unwilling to be organ donors. This is what it means to be part of what John Rawls would refer to as a “fair system of social cooperation.”⁸ We will refer to this as the “reciprocity requirement.”

In the remainder of this essay, I wish to defend two specific claims. First, the opt-out system is ethically preferable to either the opt-in system or more stringent systems that would legally compel organ donation at death in the relevant circumstances without any form of consent. Second, the efficiency and effectiveness of the opt-out system in increasing the supply of transplantable organs is likely to be most successful if the reciprocity requirement is part of that system. Furthermore, the reciprocity requirement is not intrinsically ethically flawed. On the contrary, it is a fair and reasonable requirement. However, the reciprocity requirement is extrinsically ethically flawed in the United States since at least half of the population lacks the financial capacity to be organ recipients while still ethically expected to be donors.

Opt-Out Is Ethically Preferable to Opt-In

In brief, the major ethical considerations that would support the legitimacy and preferability of an opt-out system would be the following. (1) More lives will be saved more efficiently through an opt-out system. This is obviously an empirical claim, about which there is some conflicting evidence.⁹ However, 20 states within the European Union have adopted an opt-out system, which would suggest the utility and acceptability of the practice. (2) The good of saving those additional lives is not accomplished through any violation of anyone’s rights, such as a right of autonomy, since individuals have the right to opt out of the system for any reason at all. (3) Some individuals who might have been inclined to exit the

system might fail to exit the system in a timely way, perhaps as a result of laziness or indifference. Their organs might then be taken. However, this would not be a harm to them, nor would any of their rights have been violated. (4) We might wish to applaud the efforts of living organ donors as highly altruistic and reflecting absolute voluntary informed consent, although we must also realize that those donors are at significant risk to themselves from the necessary surgery. Those risks are assumed, often for the benefit of friends or relatives who are unlikely to receive a cadaver organ in a timely way. Increasing the supply of transplantable organs through an opt-out system helps to decrease the need for others to take such risks. (5) There is a strong ethical obligation to be a cadaveric organ donor, given the easy rescue argument, the no harm after death argument, and the desperate need of others.^{10,11} Having said all that, substantial objections to an opt-out system must be addressed.

We can start with the objection, at the heart of an opt-out system, that presumed consent is not real consent. It is at best a shadow of consent. Consequently, presumed consent cannot count as an ethically sufficient authorization for the removal of my organs after death. The critic asks this question: "What would motivate any individual in the course of their everyday life to give a thought to endorsing or rejecting their inclusion in an opt-out system?" This is just too remote a decision to elicit sufficient thought to either endorse staying in the system or to exit the system. We might imagine a friend in casual conversation asking an individual if they wanted to remain in this opt-out system. A very likely response might be, "Why is that something I need to think about now? I am perfectly healthy." How could a response such as that count as (presumed) informed consent to remain in the system? Alternatively, we can imagine requiring physicians to ask patients at an annual visit whether they wished to remain in the opt-out system. This would likely be a tense interaction in which most patients would respond with "I guess so." Could that really be regarded as an instance of autonomous (thoughtful) consent, our critic asks? Surely, some bit of psychological coercion is there, much more than in the case of some random researcher asking my opinion on the phone. This is my personal physician. I am not going to tell her that I would prefer to be selfish and not allow some stranger to benefit from my death. The conclusion of the critic is that these are the reasons why presumed consent is not ethically sufficient as a form of consent; an opt-in system requires genuine consent. Is the last portion of this sentence really true?

Consider the typical way in which individuals opt into the system. They check a small box on their driver's license that says they are willing to be organ donors. Some individuals may have given serious thought to the matter before they check that box. Most will either ignore the box or casually check it, perhaps with the thought "Do I really care?" or alternatively, "I guess this is what is expected of me." In either case, this would appear to be a rather nebulous or marginal form of consent, which may well be one major reason why "real consent" is sought from family members at the time that death is about to be declared on the basis of neurologic criteria. The net result is that thousands of fewer organs are available for transplantation than might have been the case in an opt-out system because of family refusals.

Is Mandated Choice Better than Opt-Out or Opt-In?

A deficiency of the opt-in system is that too many individuals can procrastinate, be indifferent, or just busy with lots of other more relevant life choices. The net result is the loss of thousands of potentially lifesaving transplantable organs. The suggestion is that we should endorse "mandated choice" practices.^{12,13} When getting a driver's license, or at an annual medical visit, or filling out tax forms, one would be required to check one of the two boxes: (1) I am willing to donate my organs at death, or (2) I am not willing to donate my organs at death. No one would be allowed to check a box saying that they were unsure what they really wanted to do. To enforce making a choice, the relevant document would not be processed without a choice.

This approach has the apparent virtue of including virtually everyone (as in opt-out) but with actual choices being made (no presumed consent). However, ethically speaking, this would be a very flawed form of bare consent as well as anything that could be called informed consent. There is something of a mild form of coercion present, which is not compatible with true informed consent. In addition, there is little opportunity for thoughtfully assessing what one might regard as ethically relevant considerations

for deciding either way. Finally, it might result in many more negative choices and the loss of transplantable organs because of “feeling pressured.”

How Ethically Essential Is Consent for Cadaveric Organ Retrieval?

The above reflections might prompt this question: how ethically necessary is some form of consent for purposes of removing the organs of an individual declared dead on the basis of neurologic criteria?¹⁴ Some writers will respond that consent is ethically irrelevant, unnecessary, and sometimes counterproductive. Imagine that three children are at risk of drowning several hundred feet from shore. You see the only boat available with the owner nearby. You quickly tell the owner that you must use his boat to rescue those children, but he refuses to allow you to take his boat. Perhaps he thinks you will steal it and not rescue the children. Taking the boat without his consent to save the children is ethically justified. The same is true when it comes to a legitimate medical authority appropriating the organs of an individual declared dead on the basis of neurologic criteria. Unlike the boat situation, there is no longer an owner of those organs. Furthermore, no harm is done to the former owner of those organs, even if that former owner wanted to be buried intact. Likewise, no harm is done to the boat owner. In addition, an enormous good is accomplished in both cases because some numbers of lives are saved that otherwise would have been lost.

Consider, if that original boat owner had himself been near drowning out there, he would hope that a nearby Good Samaritan would commandeer someone else’s boat to save him. Consequently, he would not be justified in pulling out a gun to prevent our original Good Samaritan from appropriating his boat to save those children. These are the ethically relevant considerations that justify taking the organs of the neurologically dead to save the lives of many others. Seeking specific consent from anyone is unnecessary and risks a refusal.¹⁵

Is Conscription of Cadaveric Organs Ethically Justified?

If we move away from requiring any form of consent for the retrieval of cadaveric organs, then we are really endorsing what Aaron Spital has described as the “conscriptio” of cadaveric organs.^{16,17,18} Spital recognized that there would be considerable public pushback against any such proposal. Still, he contended strong ethical arguments would justify giving the proposal thoughtful consideration, especially if the alternative was permitting some form of payment for organ donation. He began by noting that “under conscription, there would be no need for expensive ongoing public education programs, no need to train requesters, no need to maintain donor registries, and no concerns about abuse or commodification of the human.”¹⁹ Spital then added that concerns regarding distributive justice would be satisfied by this proposal. That is, this would eliminate “free riders,” individuals who would be happy to receive an organ transplant if medically necessary but be unwilling to have their cadaveric organs available for donation to others.²⁰

Other concerns addressed by Spital pertain to the feelings of the relatives of the deceased who would have no say regarding the disposition of the organs of their loved one. Having those organs conscripted would likely result in strong feelings of anger and grief among those relatives, which might be regarded as a harm to them. However, Spital quoted John Harris who concluded that it would be “outrageous” to sacrifice “people’s lives so that others would simply *feel* better or not feel so bad.”^{21,22,23} Spital himself did a somewhat informal survey to assess the acceptability of his proposal. He found that 34% of his respondents would be supportive, whereas 66% would be opposed. He was undeterred by those results, arguing instead that if individuals were born into a society where his proposal was already in place, there would likely be unremarkable acceptance. This is hardly a compelling argument since the same could be said with regard to racial segregation and discrimination at the beginning of the twentieth century.

Apart from this argument, are there other ethical and political considerations that would speak against the conscription of cadaveric organs? Probably the most compelling consideration would be the inability of an individual to exit this system, that is, respect for individual freedom. There might not be

very many ethically commendable reasons that would justify exiting the system. Individuals might feel psychologically traumatized at the thought of having their body “carved up” at the time of their death. Alternatively, they might imagine that their organs would go to some individual of a different racial/ethnic group, or religious group, or a different political persuasion. In all those cases, these individuals would prefer that those individuals die rather than benefit with additional life from the receipt of their organs.

Those psychological anxieties and socially objectionable attitudes are clearly not worthy of legitimation or endorsement of any kind. Still, no one can doubt such attitudes and anxieties shape how some individuals vote and spend their money. Furthermore, as long as no one else’s rights are violated, a liberal society will need to tolerate (reluctantly) these social attitudes and behaviors. We will be reminded of the lives that will be lost as a result of a shortage of donated organs. However, that reminder is neither ethically nor politically compelling because being denied the opportunity to access the organs of *this* ungracious individual has no connection to the premature death of any other individual who had need of a major organ transplant. The likelihood that *this dissenting individual* would end up in medical circumstances that could otherwise yield cadaveric organs is an extremely remote possibility, which is to say that the social loss associated with his dissent will be largely inconsequential. In other words, the loss would be so tiny that we could hardly justify denying him the right to exit the system for any reason whatsoever. What really concerns us (societal leaders seeking to maximize the supply of transplantable organs) is that tens of millions of other individuals would seek to exercise that same liberty right to exit the system, the result being a very consequential shortage of cadaveric organs and related premature deaths. What then is the appropriate response?

The Reciprocity Requirement

If you wish to drive a car, you will be required to pass a driving test and pay a fee to acquire a driver’s license. This is not an infringement on your liberty. You have the liberty to exit the system. You are free to hire a cab to get around or to use public transportation. The roadway system is a public good that facilitates efficient and speedy travel to distant places for everyone. This is a very substantial complex benefit that requires assessing driving ability for the sake of the safety of everyone. This benefit actually represents a very substantial practical increase in liberty acquired at the very small cost of passing a driving test. This is one example of a fair system of social cooperation. No one is allowed to be a free rider. This is a common feature of complex societies today.

The above example suggests a similar resolution to the problem of increasing the supply of transplantable organs without conscripting those organs, contrary to the wishes of some individuals. If individuals wish to be organ recipients, should they be faced with the threat of premature death due to organ failure, then they must agree to be organ donors if they are in the unfortunate situation of being declared dead on the basis of neurologic criteria. A very substantial benefit, many extra years of life with a transplanted organ, is what would be available to an individual in exchange for agreeing to the removal of their organs after neurologic death. That is a very small (potential) price to pay for a very substantial (potential) social benefit. Furthermore, it should be noted that providing such a benefit requires a very complex social system that itself represents a fair system of social cooperation. Individuals would be free to exit the system, but at the potential cost of giving up access to that substantial benefit.

In this scenario, no one is conscripted into the system. There is no violation of the liberty rights of individuals. No one is coerced into being altruistic. On the contrary, individuals are free to assess what they judge to be in their best self-interest. If they judge that it is better to give up the opportunity to be an organ recipient because they are especially opposed to the thought that someone of the wrong religious or political or cultural persuasion might be a recipient of their organs, then they are free to make that trade-off. What they are not free to do is to expect to be an organ recipient without being available as an organ donor. That is the free rider problem. It is essentially unfair to be part of a system of social cooperation where one would expect to receive significant benefit without having to pay the costs required of everyone else. The problem we identified above, allowing individuals to exit the system might

significantly diminish the availability of transplantable organs, is likely reduced as a result of altering the incentives for remaining within the system. Overall, considerations of self-interest, fairness, and social utility would strongly support the stability and desirability of this system, which would suggest that the number of likely defectors from the system would be small.

Reciprocity in Practice

What do we imagine the system as a whole would look like in practice? First, it would be an opt-out system. Consent would justifiably be presumed. Rational self-interest would justify that presumption. Everyone would be included in a fair system of social cooperation. No autonomy rights would be violated since individuals could exit the system (just as U.S. citizens can relinquish their citizenship). No harm would befall any individual since the retrieved organs would be useless to that individual after death. Second, no relative could refuse to permit the retrieval of those organs. No relative has an ownership claim to those organs, nor could they offer an ethically compelling reason for refusing organ retrieval, given the consequent deaths of several individuals who would need those organs. Third, healthy individuals would be free to exit the system *and to reenter the system* as long as they were in good health at reentry. In other words, they would not be allowed to reenter the system if they were in the very early stages of kidney failure or if genetic testing revealed that they were very likely to die in midlife from some form of heart failure. Permitting that would be unfair to everyone else since these individuals would be likely beneficiaries of the system and very unlikely contributors to the system. Fourth, current UNOS [United Network for Organ Sharing] criteria would continue to govern where someone was on the waiting list and whether, ultimately, one actually received an organ transplant. In other words, assuming an increased organ supply was still insufficient to meet actual need, some individuals would continue to die on the waiting list, despite the fact that they were willing donors.

Objections to the Reciprocity Requirement

Is the reciprocity requirement excessively harsh, coercive, or unjust? I will give a negative answer to this question. We can start by considering arguments in support of the reciprocity requirement. James Nelson has argued that what justifies this requirement is a duty of easy rescue.²⁴ The well-known example in the philosophic literature is the individual walking on a beach in his Sunday suit seeing a small child starting to drown in about 4 feet of water. If that individual simply ignored the plight of that child, perhaps thinking, “I am not a lifeguard; I will be late for church,” he would be open to serious and justified moral criticism. He had a duty to rescue that child. It was an easy rescue. He did not need the skills of a lifeguard; there was no danger at all to him. Likewise, after I am declared dead, I can suffer no harm from having my organs removed to save the life of another. Granted, no one has a right to my organs, but it would be indecent to refuse to allow their removal for the sake of saving the life of another.²⁵

My critic might point out an important disanalogy regarding the duty of an easy rescue in the case of transplantation. Part of what makes the beach rescue obligatory is that no one else is on the beach who could rescue the child. In the case of organ donation, an individual can correctly claim that there are thousands of other individuals available to donate their organs. He is not uniquely available to achieve that goal. We (a just and caring society) can accept that response as reasonable. Just as reasonable is the response to that individual that there are thousands of people who need transplanted organs, that he might be one of them in the future, and, if that were the case, he would not be considered for an organ transplant. After all, he has no just claim to an organ transplant. He does have a serious healthcare need, but thousands of other people have a comparable need. He is not uniquely needy in some ethically relevant sense. There are not enough organs to meet that need for everyone who has that need. Various criteria might be used to reduce the size of that pool of needy patients. One such criterion would be this reciprocity criterion. If an individual was unwilling to be an organ donor, then they could not be an organ recipient.

Is the reciprocity criterion unkind or excessively harsh? This question gets raised because individuals who have chosen to opt out could be faced with premature death if they find themselves in late-stage organ failure and are denied access to the UNOS system. If we were to engage in a bit of rhetorical exaggeration, we could say that it is not as if they have committed a capital crime by exiting the system, but they are being condemned to death for their choice. Some writers have suggested that a more reasonable response to their problematic choice to exit the system would be to allow them to be listed (assuming relevant medical criteria have been met) but assign them lower priority. In other words, their choice would have consequences, but not the harshest consequences. I have to wonder what this would look like in practice.

What are the practical implications of “having lower priority”? It could mean that as long as there were individuals on the list who had not opted out from the system, no matter what their level of urgency, those individuals would have a prior right to that available organ. The practical implication in that situation is that “lower priority” would be the same as “no priority.” Ethically speaking, this would be a sham. In addition, it could have as a consequence more individuals choosing to opt out believing that they would still have some access to transplantation. That would diminish the supply of transplantable organs, contrary to the intent of opt out and reciprocity.

Alternatively, individuals with “lower priority” but high urgency on the list could claim an available organ ahead of someone who had not opted out but was of somewhat lower urgency on the list. This would have the unjust consequence of denying that organ to someone slightly lower on the list who had been faithful to the reciprocity requirement. This rewards the free rider and punishes the faithful reciprocator, which would not only be unfair but also undermine the utility of the system as a whole.²⁶

There are arguments in the transplant community regarding whether marginal organs ought to be used at all. Some might argue that such organs should go to these “lower priority” individuals who had opted out of the system rather than just wasting the organ. This proposal could be ethically tolerable in my judgment, but only if no one on the transplant list were reciprocators who wanted that organ.

I return to my rhetorical exaggeration comment above. It is rhetorical exaggeration because individuals who had opted out of the system would still have the option in some cases (not heart transplant) of trying to find a voluntary living donor, most likely, a friend or relative. A liberal society could not justly forbid individuals from pursuing that option since it would not threaten either the justness or the utility of our opt-out policy with the reciprocity criterion. This would obviously also be an option for those who remained within the opt-out system.

Another objection that might be raised to the opt-out system with the reciprocity criterion is that it is coercive. This strikes me as a very strained use of the concept of coercion. If my family were faced with extreme poverty and starvation (no social welfare options), and if I were offered 5 million dollars to give up my heart to an extraordinarily rich person in end-stage heart failure, that would be a coercive bargain. However, from a statistical perspective, the likelihood of my being in the medical circumstances where I would be a suitable recipient for a major organ transplant, or alternatively, the potential donor of my cadaveric organs, would be exceedingly remote. Consequently, it is difficult to imagine feeling coerced to remain in the system. Moreover, if I were to opt out, it is not as if that would be an irrevocable choice. As long as I remained healthy and was not unjustly trying to manipulate the system to my advantage, I would be permitted to reenter.

Might an individual claim that the use of the reciprocity criterion was unfair, that having a life-threatening medical need ought to be sufficient for his being placed on the organ transplant list (assuming relevant medical criteria are satisfied)? However, in the United States, one of the criteria that must be met is what is sarcastically referred to as a “wallet biopsy.” Individuals must have the financial ability to pay for the transplant itself as well as the very expensive anti-rejection medications that will be needed for years into the future.²⁷ Failure to meet this criterion means an individual will not be listed for a transplant. If our aggrieved individual passively acquiesces to this criterion because he is well-off financially, he could hardly object on ethical grounds that the reciprocity criterion was unfair.

The reciprocity criterion is ethically well-founded, whereas his acceptance of financial criteria for inclusion on the waiting list is fundamentally a matter of self-interest. That is, the financial criteria would reduce by at least 50% the number of people competing for transplantable organs. Alternatively, if there

were public funding such that no one would be denied access for financial reasons to a waiting list for a medically indicated organ transplant, that would at least double the competition for an organ transplant from the perspective of individuals who were financially well-off. They might further object that they were paying taxes for that public support for poorer individuals who otherwise would not be eligible for a transplant, thereby diminishing their own opportunities for a successful transplant. However, that makes even clearer that their objection is merely a matter of self-interest, not any credible moral consideration.

If we wish to see where there is a genuine problem of unfairness with the reciprocity criterion, then we should consider the prior scenario from the perspective of those who are financially less well-off, at least in the United States. They might be quite willing to be organ donors because they would not want to die prematurely from organ failure. However, the wallet biopsy would mean that it was impossible for them to be organ recipients as a practical matter. Of course, they would have the right to opt out. If they did opt out, they would not be open to justified moral criticism because it would be unfair to require them to be available to donate organs for the financially well-off although they themselves would be denied that benefit. That would be a clear case of exploitation.

To illustrate that last point, we might imagine the financially well-off saying to the financially less well-off who might be tempted to exit the opt-out system, “You realize that you have a stringent ethical obligation to be organ donors. It would be the pinnacle of selfishness to insist on taking viable organs to the grave with you when those organs could yield many extra years of life for desperate patients. You suffer no harm in having those organs removed after you are dead. Your financial circumstances are unfortunate, but it would be vengeful in the worst sense to deny your organs to others simply because they happened to be more fortunate. We have remained committed to the opt-out system and our reciprocal obligations to one another. We freely accept our obligations to be organ donors.” I hope my readers would see such a speech as representing a most reprehensible use of ethical language for the unethical exploitation of vulnerable others. However, this is the awkward ethical reality of organ transplantation in the United States. The opt-out proposal with the reciprocity criterion is intrinsically ethical superior to any other proposal for fairly and efficiently increasing the supply of transplantable organs and then assuring their equitable distribution. In its ideal form, as in 20 countries in Europe, everyone is included as potential donors and potential recipients of lifesaving organs. No financial barriers interfere with genuine reciprocity, fair terms of cooperation for all. Unfortunately, that is precisely what is not true in the United States.

In conclusion, and to be fair, the End-Stage Renal Disease amendments to Medicare in 1972 will pay for both dialysis and kidney transplantation for all U.S. citizens, no matter their economic circumstances. In 2020, roughly, 23,400 kidney transplants were performed along with 15,000 non-kidney transplants (livers, hearts, and lungs). The latter surgeries are more than twice as expensive as a kidney transplant. If publicly funded, that would roughly be an additional \$12 billion per year, hardly a major financial burden in a \$22 trillion economy, \$4 trillion of which is currently spent on healthcare. Those additional sums would support a more equitable and more just out-opt policy for increasing the availability of transplant organs. However, as noted already, assured access to non-kidney organs for transplantation for the relatively wealthy would be reduced by about 50%, given public funding for all. That is hardly a compelling ethical reason for remaining committed to an opt-in policy for organ donation. More importantly, and unfortunately, it represents a powerful ethical argument against shifting to an opt-out policy that included a reciprocity requirement that would be used to exploit the financially less well-off. Rather than giving up the opt-out policy option with a reciprocity requirement, we ought to correct the injustices it would otherwise legitimate.

Notes

1. Organ Procurement and Transplantation Network 2021; available at <https://optn.transplant.hrsa.gov/data/> (last accessed 22 Sept 2021). The waiting list includes 90,230 patients needing a kidney, 11,746 needing a liver, 3,471 needing a heart, and 985 needing a lung. These numbers would be misleading if we really believed that they represented the number of patients who actually had these

needs. For example, more than 100,000 patients each year could benefit from a heart transplant each year, but a majority of them would not have the financial capacity to pay for a transplant. Furthermore, it would be ethically unmanageable and psychologically disheartening for both patients and health professionals if tens of thousands were dying very visibly on the waiting list.

2. Organ Procurement and transplantation Network 2021. *For the US statistics*; available at <https://optn.transplant.hrsa.gov/news/annual-record-trend-continues-for-deceased-organ-donation-deceased-donor-transplants/> (last accessed 22 Sept 2021).
3. For the EU statistics, see European Parliament. *Organ Donation and Transplantation: Facts, Figures, and European Union Action 2021*.
4. Sheehy A, Conrad SL, Brigham LE, Luskin R, Weber P, Eakin M, *et al*. Estimating the number of potential organ donors in the United States. *New England Journal of Medicine* 2003;**349**:667–74.
5. A standard undergraduate example of a violation of basic rights is the drug-intoxicated skid row bum sleeping in the alley behind the hospital who is promised an extraordinary (deadly) drug high in the OR just before his organs are taken to save the lives of five outstanding community members with organ failure.
6. I am referring to the removal of a clearly competent family member. I would assume that someone with the relevant legal authority could remove someone as a potential organ donor if that person were incompetent.
7. Mark Cherry would defend the right of families to consent or refuse consent for organ donation. “The trust families place in the medical establishment may be seriously eroded if the usual standards of medical practice, such as informed consent, are set aside to support the harvesting of organs.” See Cherry MJ. Contested organ harvesting from the newly deceased: First person assent, presumed consent, and familial authority. *Journal of Medicine and Philosophy* 2019;**44**:603–20, at 611.
8. Rawls J. *Political Liberalism*. New York: Columbia University Press; 1996, at 15–22.
9. VanHolder *et al*. cite research documenting increased donor rates under an opt-out system in the 23%–61% range. This is disputed by others who see no significant increase. From a methodological perspective, it is very difficult to get reliable numbers either way because of the number of variables involved. VanHolder R, Dominguez-Gil B, Busic M, Cortez-Pinto H, Craig JC, Jaber KJ, *et al*. Organ donation and transplantation: A multi-stakeholder call to action. *Nature Reviews Nephrology* 2021;**17**:554–68, at 562.
10. Hester DM. Why we must leave our organs to others. *American Journal of Bioethics* 2006;**6**(4): W23–28. See also Hester DM. Opting-out: The relationship between moral arguments and public policy in organ procurement. *Cambridge Quarterly of Healthcare Ethics* 2009;**18**:159–65.
11. See [note 10](#), Hester 2009.
12. Spital A. Mandated choice: A plan to increase public commitment to organ donation. *JAMA* 1995;**273**:504–6. Spital is a defender of mandated choice.
13. For a view contrary to Spital, see Klassen AC, Klassen DK. Who are the donors in organ donation: The family’s perspective on mandated choice. *Annals of Internal Medicine* 1996;**125**:70–3.
14. I assume it is obvious that fully informed consent would be ethically necessary in the case of living individuals who would agree to donate a kidney or a portion of their liver to another individual who had that medical need. The same would be true for individuals who agree to be non-heartbeating donors. In both cases, individuals are the rightful owners of their organs. No one else can give permission for the risks associated with organ removal for them.
15. A stronger position is taken by Emson HE. It is immoral to require consent for cadaver organ donation. *Journal of Medical Ethics* 2003;**29**:125–7.
16. Spital A. Conscriptio of cadaveric organs for transplantation: A stimulating idea whose time has not yet come. *Cambridge Quarterly of Healthcare Ethics* 2005;**14**:107–12.
17. Spital A. Conscriptio of cadaveric organs: We need to start talking about it. *American Journal of Transplantation* 2005;**5**:1170–1.
18. See Truog RD. Are organs personal property or a societal resource? *American Journal of Bioethics* 2005;**5**(4):14–16. Truog asks the question whether organs should be thought of as personal property or a societal resource. He defends the latter view, which is too close to Spital’s view. Characterizing

cadaveric organs (including those from individuals who have opted out of the system) as a societal resource is not congruent with the fundamental commitments of a liberal society which, in this case, would be to respect the choice and consequences associated with an opt-out decision. Keep in mind that such individuals have accepted the potential risk of being denied an organ transplant, were they faced with that need.

19. See [note 17](#), Spital 2005, at 1170.
20. The distributive justice issue is more complex than this, as discussed below. What Spital asserts with regard to his proposal is that “all people would stand to benefit should they ever need an organ transplant.” This assertion would be true in a country with universal healthcare coverage (most of Europe), but would certainly not be true with fragmented and uncertain coverage in the United States. See [note 16](#), Spital 2005, at 108.
21. See [note 16](#), Spital 2005, at 109.
22. Spital cites Harris J. *Wonderwoman and Superman: The Ethics of Human Biotechnology*. Oxford: Oxford University Press; 1992, at 101.
23. Glannon W. The case against the conscription of cadaveric organs for transplantation. *Cambridge Quarterly of Healthcare Ethics* 2008;17:330–6, at 331. Glannon is a critic of both Spital and Harris. He rejects both presumed consent and the conscription arguments of Spital. He defends the rights of families to have the final say, which he sees as a “deontological constraint” on the organ procurement process.
24. Nelson JL. Internal organs, integral selves, and good communities: Opt-out organ procurement policies and the “separateness of persons.” *Theoretical Medicine and Bioethics* 2011;32:289–300.
25. Thomson JJ. A defense of abortion. *Philosophy & Public Affairs* 1971;1:47–66. Thomson tells the story of the Good Samaritan from the Gospels. Such behavior is supererogatory. She then goes on to explain what a minimally decent Samaritan would be ethically obligated to do, even though the individual beset by robbers would not have “a right” to receive that basic care. Refusing to provide my organs after death to save the life of another would be similarly indecent.
26. Nadel MS, Nadel CA. Using reciprocity to motivate organ donations. *Yale Journal of Health Policy, Law, and Ethics* 2005;5:293–325. Nadel and Nadel defend the view that individuals who have opted out of the system should still be able to access the transplant list but have lower priority relative to others on the list who met the reciprocity criteria. However, even though that would mean they would have a lower chance of receiving an organ transplant, their receiving a transplant at all means it was denied to someone who was a “faithful” reciprocator. That seems clearly unjust. An interesting social experiment would be to see whether a fair and inclusive process of rational democratic deliberation would endorse such a concession as just and reasonable.
27. Aleccia J. No cash, no heart. Transplant centers require proof of payment. *Kaiser Health News* 2018 Dec 5; available at <https://khn.org/news/no-cash-no-heart-transplant-centers-require-proof-of-payment/> (last accessed 5 Oct 2021).