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HOW TO REVERSE THE ORGAN SHORTAGE

Simon Rippon

ABSTRACT: Thousands of lives are lost each year because of a lack of organs available for transplant, but currently, in the UK and many other countries, organs cannot be taken from a deceased donor without explicit consent from the donor or his or her relatives. Switching to an “opt-out” (or “presumed consent”) system for organ donation could substantially increase the supply of organs, and save many lives. However, it has been argued in some quarters that there are serious ethical objections to an opt-out policy, and that it would be better to adopt a different policy known as the “presumptive approach”, that requires explicit consent while also attempting to sway the choices of potential donors and family in the direction of donating, using various persuasive techniques. This paper shows how reflection on the impact of a well-known cognitive bias known as “status quo bias” can explain (i) why moving from the status quo to an opt-out policy might be effective in increasing organ availability, even without impinging on anyone’s autonomous choices, (ii) why we might have overestimated the strength of the objections to an opt-out policy, and (iii) why the presumptive approach is morally objectionable, while an opt-out policy is not.

Introduction

The chronic shortage of organs available for transplantation in developed countries results in tens of thousands of deaths of patients on waiting lists each year. Rates of cadaveric organ donation could be increased in many of them, including all of the major English-speaking countries, by instituting an “opt-out” (or “presumed consent”) system for organ donation. In

an opt-out system, which is already in place in many European countries and planned in Wales, people do not have to opt in as organ donors by providing explicit consent, but must rather place their name on an opt-out register before their deaths if they prefer not to donate their organs.

Various moral, legal and practical objections have been raised to the opt-out system. It has been argued that it is an intrusive policy that would violate the rights of individuals to refuse to donate their organs, and the rights of relatives over the body of the deceased. It has been claimed that it makes an illicit presumption that there is a state right to distribute our body parts as the state sees fit.¹ It has further been argued that because of these questionable moral implications of opt-out policies, the introduction of an opt-out policy may undermine public confidence in the transplant system as a whole, thereby producing a paradoxical decline in organ availability.² The latter might occur even if the public were mistaken in their moral objections to the policy.

An alternative policy for increasing donation rates, which has been used in parts of the United States, is known as the "presumptive approach".³ This approach might at first appear to offer a milder, less coercive "nudge" in order to improve organ donation rates than the introduction of an opt-out scheme would. Under the presumptive approach, explicit consent from the donor or, more usually, next of kin is required in order for organ donation to take place, but this consent is not requested in a wholly neutral way. Instead, counsellors who are charged with increasing donation rates emphasize the benefits of organ donation to dying patients or their next of kin, and present the option to donate as the "normal" choice made, and as a morally good choice to make. Because the presumptive approach requires that those who donate explicitly provide their consent, it might be thought to provide additional protection for individual autonomy, and thus represent a morally preferable alternative to an opt-out policy.

These first appearances are, however, misleading: I will show that the presumptive approach actually raises serious ethical difficulties, whereas an opt-out policy, properly

implemented, would protect the value of respect for autonomy that we hold dear. While recent studies show that opt-out legislation has already been practically efficacious (in particular, a recent ten-year study of donation rates in twenty two countries concluded that it has a “positive and sizeable effect” on organ donation rates)⁴, the public acceptance of the legitimacy of an opt-out system, and thus its potential effectiveness, would only be enhanced by a better understanding of the ethical issues at stake. Therefore, setting out the relevant ethical issues is of practical as well as moral and philosophical importance.

An opt-out system promises to increase the supply of organs for transplantation partly because even though a large majority of people support the practice of organ donation, many supporters fail to ever register to become donors under opt-in systems.⁵ In these cases the decision usually falls on the decedent's family, who quite often refuse to donate organs because they are not sure what the decedent themselves would want.⁶ But this behaviour itself raises a question: why do families often choose refusal rather than donation because of a lack of information about the decedent's wishes? After all, families in this position are generally just as unsure that the decedent would *not* want to donate as they are that the decedent *would* want to donate, so families risk choosing against the decedent's wishes either way. And even most people *not* on the organ donor register would, it seems, prefer to donate. Why not, then, consent to organ donation in these circumstances? The high rate of such refusals appears to be influenced by an irrational cognitive bias known as “status quo bias”.

Status Quo Bias and its Significance

I use the term “status quo bias” to refer to an irrational cognitive bias which tends to produce a preference for the status quo, or default. It is not, of course, always irrational to prefer the status quo: it might simply be better than any of the alternatives. Even when it is not, one may have some reason to prefer to stick with the status quo. It might be risky to attempt any changes to the status quo, or the transaction costs of making changes might be high. There might also be other kinds of reasons to prefer the status quo. For example, if I promise to

stay where I am until my you arrive, it would not generally be irrational for me to prefer to stay, even if being somewhere else would be more pleasant. But a large number of observational and experimental studies in the social sciences literature provide strong evidence that we have a pervasive bias toward the status quo even when no such reasons for preferring the status quo exist.⁷

Status quo bias was first demonstrated by William Samuelson and Richard Zeckhauser.⁸ In their early experiments, they gave questionnaires in which similar options were presented to different subjects with differing ways of describing, or framing, the status quo. In the neutral framing condition, the options were presented without a default. Under the status quo framing conditions, in contrast, one of the choices was presented as the status quo. For example, in one of the questions, subjects were told that they were serious readers of the financial pages who had inherited from their great uncle either (in the neutral condition) a sum of cash, or (in the various status quo framings) a portfolio of cash and securities in which a significant portion of the portfolio is already invested in one of the options. Subjects were then asked to choose from a set of up to four investment options, such as: “Invest in [Retain the investment in] moderate-risk Company A. Over a year’s time , the stock has .5 chance of increasing 30% in value, a .2 chance of being unchanged, and a .3 chance of declining 20% in value”, and, “Invest in [Retain the investment in] municipal bonds. Over a year’s time, they will yield a tax-free return of 6%.” The prompt also specified that the transaction costs of any switches would be negligible. It was found that, in general, each option was chosen much more frequently when framed as the status quo, less frequently when the choice was framed neutrally, and much less frequently when the option was framed as a change from the default. But given the negligibility of transaction costs, and the concrete information provided about the relative risks and rewards of the investment options, it is difficult to see how the default status of an option in this context could provide any reason at all to choose it. Samuelson and Zeckhauser also noted that in the real world, status quo bias appears to similarly affect people’s decisions, including very important

decisions such as those respecting asset allocations in their pension plans, or choice of health insurance plans. This occurs even in cases where free transfers are possible and would be advantageous in various respects (for example, in the case of moving pension plan allocations into safer securities to reduce risk as one nears retirement age). The vast majority of people tend to stick with the default option or with what they started with, even when they admit to having had no particular reason for the initial choice they made.

Status quo bias seems to have a number of different psychological sources, including simple inattention, but one of the more interesting sources of status quo bias is loss aversion. This term is Daniel Kahneman and Amos Tversky's name for a seemingly pervasive phenomenon in which losses loom larger than gains when people assess their options. Some irrational instances of loss aversion can be demonstrated just by framing the exact same set of options differently, either in terms of potential losses or potential gains, and showing that this changes people's preferences between them. One real world example is in credit card marketing. Credit card companies would prefer retailers not to charge higher prices to credit card users, thereby discouraging credit card use. But when required by law to permit this, they have lobbied for the right to demand that any difference in price is labelled as a "cash discount" rather than a "credit card surcharge". They recognize that people are more willing to forego what they think of as a cash discount than to pay what they think of as a credit card surcharge, even when the final price either way would be equivalent.⁹

Perhaps a more striking example of loss aversion comes from a Kahneman and Tversky study in which respondents were asked to choose between two potential programs for combating what was described as a disease that is expected to kill 600 people.¹⁰ Some respondents received two options framed in positive terms:

If program A is adopted, 200 people will be saved.
If program B is adopted, there is 1/3 probability that 600 people will be saved, and 2/3 probability that no people will be saved.

Others respondents received two options framed in negative terms:

If program C is adopted 400 people will die.

If program D is adopted there is 1/3 people that nobody will die, and 2/3 probability that 600 people will die.

It is easy to see that options A and C, and options B and D, are numerically equivalent. But the researchers demonstrated that people become substantially more risk-seeking when attempting to avoid what they perceived as unacceptable losses under the negative framing: support of 72% in favour of program A in the first condition became support of 78% in favour of program D in the second! Similar loss aversion effects have been demonstrated across a wide range of contexts, and even experts (such as doctors choosing between treatment options) have been shown to be subject to it when they make decisions.¹¹ Because significant changes from the status quo often involve both gains and losses, and because loss aversion leads to irrational emphasis of potential losses over potential gains, loss aversion can help explain pervasive status quo bias.

Under an opt-in system for organ donation, there is a built in default of the following kind: if donors and their families do nothing, the organs will not be used for transplantation. On the plausible assumptions that status quo bias is genuine and is as pervasive as the social science literature indicates, it is likely that this default adversely affects the availability of organs. Loss aversion may underlie status quo bias in this kind of case, because a decision to donate organs involves both gains and losses compared to the default. Organ donation and organ donors save lives, but the practice also comes with costs, such as that of surgical mutilation and loss of organs from the body of the decedent, and the fact that the family cannot stay with a brain dead donor to say goodbye as circulation finally ceases (the donor needs to be in surgery before the tissues are starved of oxygen). Because donors and families are subject to loss aversion, and these negative aspects of donating may tend to loom larger than the positives, we can predict that status quo bias will probably influence people's decisions, resulting in irrational reluctance to consent.

Status quo bias, then, may exacerbate organ shortage under an opt-in system. Even if relatives were still provided with an absolute option to veto the decision to donate under an opt-out system, moving to that system could address some of the negative effects of status

quo bias by altering the built-in default of an opt-in system. Given that there is status quo bias, fewer relatives should be expected to choose what might then be called an option to “veto donation” than to exercise what is now called their option “not to donate”; likewise, fewer relatives should be expected to choose the option of non-donation if they recognize that had they done nothing at all (i.e. had they not opted out), donation would have occurred. Moreover, a move to an opt-out system could address negative effects of status quo bias among donors themselves, as well as relatives. Our evidence of status quo bias shows that all things being equal, people are less likely to sign up to any register that would alter our treatment of them irrespective of the options offered *simply because doing so alters what would otherwise happen by default*. The choice between an opt-in system and an opt-out system should be made with this factor in mind, since status quo bias would produce a reduction in the availability of organs and cost to public health if an opt-in policy is chosen, whereas it would produce an increase in organ availability and a benefit to public health if an opt-out policy is chosen.

These points about the likely effects of the direction of the opt-in/opt-out default and status quo bias remain true even if there are some respects in which it is unclear what “the” status quo *is* in cases of potential organ donation (these cases do, after all, often arise in extraordinary circumstances, after a very unexpected death of a healthy individual). They also remain true even if there are certain respects in which aspects of the status quo in the organ donation process are unalterable.¹² For example, the fact that the organs are situated in the body of the donor at the time of death makes it natural for us to think that, in one respect, the status quo persists whenever the donor’s organs are *not* surgically removed. This “natural” default cannot be altered simply by changing the policy about what we do with the bodies of those who die without explicitly choosing whether or not they wish to be donors: indeed, it cannot be altered at all. As a result, status quo bias might still discourage donation to some extent, even under an opt-out system. The point here is just that the difference between an opt-in and opt-out system provides us with one important respect in which the

status quo is manipulable, and manipulating it could reverse the direction of status quo bias in one context, turning it to the general advantage.¹³

The theory that changing the default from opt-in to opt-out could change organ donation rates is supported by some direct experimental evidence, as well as the kind of real world data mentioned earlier. Eric J. Johnson and Daniel Goldstein ran an online experiment in which respondents were asked whether they would be organ donors on the basis of questions that provided a varying presentation of the default.¹⁴ For example, the opt-in condition asked respondents to imagine that they had just moved to a new state where the default was not to be a donor, and they were given the choice of either confirming their status as a non-donor or changing it with a simple mouse click. The researchers found that the form of the question had a “dramatic impact”, with consent rates jumping from 42% to 82% between the opt-in and opt-out conditions.

The Ethics of an Opt-Out System

One cannot make the case for an opt-out system on the basis of its practical effectiveness alone: we must also take into account any potential ethical objections to it. It might be objected that an opt-out system would be morally undesirable because it threatens an important aspect of individual autonomy. We have an important interest, it might be supposed, in not having our body parts removed and distributed to others after our deaths whenever we have not explicitly consented to this. The choice of an opt-out system for its public health effects might appear to be a good one on the basis of a certain kind of utilitarian judgment, but arguably only because such a judgment is a crass one that leaves out consideration of some of the important moral implications of the choice. When seen in its true light, perhaps an opt-out system should be rejected because it would violate important human rights or otherwise produce great harms to some of those whose organs would be taken.

This sort of objection is not, I think, as rationally compelling as it may at first appear. In fact, I will argue that it only appears compelling because of a further manifestation of

status quo bias. Those of us living in opt-in countries view the opt-in system as the status quo. And because changing to an opt-out system would produce both gains and losses, the preceding argument has already indicated why we might hold an irrational bias against switching.¹⁵

But how are we to tell whether our objections to a proposal are based on a sound rational evaluation of its merits and demerits, or rather are fuelled merely by our irrational status quo bias? I will focus on two proposals for detecting and eliminating our status quo biases that have been offered. Confusingly, both proposals have been called the “Reversal Test” by their proponents, although they are in fact quite different. I will first consider a proposal found in some of the medical ethics literature which, to disambiguate, I will call the “Switching Test”. I will argue that we have no good reason to believe that the Switching Test is effective. Then I will introduce by way of alternative a test proposed by Nick Bostrom and Toby Ord that I shall refer to as the “Reversal Test”. I will argue that employing the Reversal Test as a reflective exercise can help us detect and eliminate status quo bias that may be implicit in our intuitive objections to opt-out systems of organ donation.

Detecting Status Quo Bias I: The Switching Test

First, then, consider the Switching Test, which has been advocated by Dominic Wilkinson in connection with opt-out systems of medical testing and organ donation, and by Scott Aberegg et al. in connection with decisions made by doctors in critical care and other medical practice.¹⁶ According to proponents of the Switching Test, in order to eliminate status quo bias in our objections to a proposal, we should simply imagine the option under consideration as if it were the status quo and consider whether, from that perspective, we would then think that there is sufficient reason to change *to* what is in reality the status quo. For example, a doctor finding herself opposed to the release of a patient from the Intensive Care Unit to the medical floor because of his elevated blood glucose level should imagine whether, if the patient were now on the medical floor, she would consider the patient’s blood glucose level a sufficient indication for transfer to the ICU. Similarly, if we find ourselves

opposed to an opt-out policy for organ donation, we should imagine that we already have an opt-out policy, and ask whether the reasons to move to an opt-in system seem strong enough to make the switch to it. It should be noted that if there are significant costs involved in making the switch itself, they could make it irrational to switch in either direction, even if one option is clearly superior to the other. For example, the costs involved in making changes to which side of the road people are required to drive on may provide decisive reason not to switch. To simplify the presentation here, I shall assume for the time being that there are no such costs involved in the cases we are considering.

The main problem with the Switching Test is that it is highly doubtful that we human beings can perform the kind of imaginative feat it demands in order to free ourselves from the undue influence of our existing beliefs and biases. To see why this matters, it is important to understand that the collected evidence of status quo bias has not been gleaned by presenting the same group of individuals with a set of options twice over while varying the status quo slant that they are presented with, but rather by randomly sorting a set of individuals into two different groups who each receive the options presented with only one status quo slant.¹⁷ Once a customer has rejected the idea of paying your “credit card surcharge” on a particular transaction, it would be an impressive feat of salesmanship indeed to get the same customer to change his mind and to forgo what you *only then* start calling your “cash discount” on a higher price! Unless an individual can be made to either forget the judgment already made, or to imaginatively enter into the perspective of having never made any judgment at all, there can be little hope of expunging the status quo bias that has already been manifested in reaching a decision. A relevant analogy here is to be found in the observed behavior of juries who are told by the judge that they must disregard some piece of evidence that has already been exposed to them in court. Research shows that even when jurors are motivated to comply, they still tend to be influenced by the inadmissible evidence in rendering their verdicts.¹⁸ These considerations should lead us to doubt that the Switching Test is likely to produce a change of mind, even if status quo bias is present. Of course, if

performing the Switching Test *did* in fact produce a change of mind, it would be good evidence of status quo bias having distorted our initial judgment. But the Switching Test seems likely to produce a large proportion of false negatives (i.e. undetected instances of status quo bias) and thus to falsely appear to vindicate many judgments that are in fact irrational.

Detecting Status Quo Bias II: The Reversal Test

Bostrom and Ord's Reversal Test uses a different method, which (as I will show) produces rather more useful results. If you find yourself opposed to a proposal to change a certain parameter in one direction, Bostrom and Ord suggest, then consider the option of changing it in the opposite direction instead. If you think that that change too would be a bad thing, then this could be true either because there is some good reason that counts against changing the parameter at all (such as transition costs, or significant risks involved in meddling with the parameter), or else because the value of the parameter as it is currently set is optimal. If you cannot provide good reasons in support of either of these grounds for rejecting the proposed changes, then it is not your rational assessment of the reasons but your irrational status quo bias that underlies your opposition to changing the parameter.^{19,20} In this section of the paper, I will indicate how Bostrom and Ord's Reversal Test prompts us to re-examine our reasons for having an opt-in system from a more neutral perspective, and leads to the conclusion that opposition to an opt-out system for organ donation is produced by irrational status quo bias rather than recognition of good reasons.

In the case at hand, the relevant parameter that could be moved in either direction would be the *relative ease* of donating organs versus not donating them. Under the status quo opt-in system, there is the slight burden on donors (or next of kin) of having to register their preference to donate, whereas non-donors need not register any preference. An opt-out system would make it slightly easier to donate and slightly more burdensome not to donate your organs after your death than the current opt-in system does. If you find yourself opposing this idea, the Reversal Test asks that you consider the following question: should

we instead make it relatively *more* burdensome to donate and easier *not* to donate your organs after your death than it is under the present, opt-in system? We might accomplish this, for example, by introducing bureaucratic hurdles such as requiring valid opt-in statements to be witnessed by a lawyer or minister of religion, or by instituting mandatory counselling sessions that would be directed toward discouraging opting in (this might be called the “aversive approach”, in contrast with the presumptive approach). We could legally require explicit consent from next of kin as well as that from donors themselves before donation can take place, and we could additionally require that the aversive approach and various bureaucratic hurdles be applied to next of kin before their consent can be accepted as valid.

Most people will agree that making it more burdensome to donate in such ways would be clearly bad, for both consequentialist and deontological reasons. In terms of consequences, the burdensome procedures proposed would reduce the availability of donor organs, and thereby produce negative public health consequences. Additional burdens would also reduce the ability of donors to satisfy their preferences, and could lead to painful experiences of frustration for many of those who try to do so.

Note also that this consequentialist objection need not depend on features of the particular examples I have used to illustrate how donating could be made relatively more burdensome. Since non-donation is the default option, there is no real burden on non-donors which could be reduced – so the only way to make donating relatively more burdensome than not donating would be to increase burdens on would-be donors. But any significant additional burden on donors can be expected to produce the negative consequences of reducing the supply of organs, and making it more troublesome for would-be donors to satisfy their considered preference to donate.

In terms of deontology, increasing the difficulty of donating threatens to infringe on people's autonomy by hindering their ability to put into effect their own, meaningful choices. Although I have indicated some ways in which people may be subject to pervasive irrational

biases, these do not, of course, constitute a complete story about anyone's choices – I have only described an irrational influence on otherwise rational decisions. While admitting the possibility of biases, we can still consistently hold that protection of individual autonomy is important, for example because it enables individuals – as far as possible – to express and enact their deepest preferences about their own lives, or their judgments about what matters. Increasing the difficulty of donating, however, would impinge on such capacities in respect of organ donation. For example:

(i) Legally requiring the explicit consent of next of kin as well as that of donors themselves (as is already the case in practice in many countries) in effect prioritizes a next of kin preference not to donate above a personal preference to do so. But, given some plausible assumptions, our autonomous personal preferences before death concerning what will happen to our bodies posthumously should have more weight than those of others. These assumptions are: first, that living people have a right to autonomous control over a self-regarding sphere of interest; second, that this self-regarding sphere extends to posthumous matters, when these are sufficiently well connected to how well the person's life turns out (for example, matters such as whether one's reasonable preferences concerning the disposal of one's body or possessions are met); third, that whether or not a person's organs are donated posthumously according to their preference is sufficiently well connected to how well their life turns out; and fourth, that no other person has other-regarding rights that trump these self-regarding rights.²¹ In any case, it is also worth remembering, in connection with this proposal, that not everyone enjoys a relationship of respect and trust with their next of kin, and that the legal requirement in question might inflict significant harm on those who do not.

(ii) Legally requiring witness by a minister or lawyer would place a significant practical, and possibly financial, burden on an individual's freedom to choose to donate. This burden cannot be justified (in the way that we might justify some similar burdens on other choices,

e.g. on making a valid will) by pointing to some potential harm to other people that might result from one's choice being incorrectly made or unreliably recorded.

(iii) Adoption of the "aversive approach" would not only place a practical burden on any individual wishing to donate, but would additionally threaten to undermine *entirely* a person's capacity to make a properly informed autonomous choice about the matter at hand. There is an important distinction between: on the one hand, providing someone with information that would assist them in making informed, autonomous choices; and on the other hand, influencing the autonomous choices that a person would make by browbeating or using other non-rational methods. Even if the counsellors employed under the aversive approach were banned from engaging in high pressure sales tactics, and even if they were strictly limited to providing factual information, they would necessarily focus on the partial information that speaks against donation. Individuals confronted with only one-sided, partial information are vulnerable to making decisions that are *less* rather than *more* expressive of their fully-informed subjective preferences, since the relative vividness of the case on one side can easily exert an irrational influence on one's decision making.

Arguably, a paternalistic approach that would place such obstacles in the way of making a decision to donate organs *might* be justifiable if there were clear grounds for thinking that those who decide to donate organs under the status quo often make a terrible mistake. But there are no good grounds for holding this. Cadaveric organ donation indisputably saves many lives; it is permitted and even encouraged by the mainstream interpretations of all major religions; and although we may certainly fear encroachments upon the bodily integrity of our corpses or those of our loved ones, such fears seem more to be based on an irrational imagining of our living selves experiencing the disintegration of our dead bodies than on sound, justifying reasons. There are genuine costs to the donor and the donor's family of organ donation, such as the mutilation of the donor's body, and the impact on the grieving relatives of not being able to stay with their loved one during and after circulatory cessation. But because these costs pale into insignificance in comparison to the

interests of those who desperately need organs, it cannot be plausibly claimed that many of those who have decided to donate were seriously irrational or mistaken in doing so.

I have not examined all possible means of increasing the relative difficulty of donating versus not donating here. It might be argued that there is some other means available that would place burdens on donors, but not on non-donors, yet does not invite the kind of deontological objections raised here. But we can respond that while it is true that not all means of increasing burdens on would-be donors would necessarily be equally bad, any possible means would infringe on autonomy to some degree, by moving us further away from the state in which people are maximally able to put into effect their considered preferences either to donate or not to donate.

The Reversal Test sets a challenge to the opponents of an opt-out system who would agree about the badness of making donation more difficult, then, to either offer some good reason for why changes to the organ donor system would be bad things in themselves, or else explain why the current level of relative ease of donation and difficulty of not donating should be thought to be the optimal level. It is difficult to see how the first claim could be supported. There would be some one-off transition costs associated with making and implementing any new legislation, but we are concerned here with goods (saving lives of potential transplant patients; avoiding violations of autonomy) that are of such enormous significance that they could easily outweigh such costs, especially when the stakes over the longer term are considered. There are no other reasons obvious to me for thinking that changes to the status quo organ donation system would be bad in themselves. If the first claim cannot be supported, then the opponent of an opt-out system has only one rational option left to defend the status quo. It is to explain why we should think that the relative ease of donation and difficulty of not donating is already set at exactly the optimal level.

Note that there are two distinct kinds of argument available in support of the claim that the status quo is optimal. A *normative* argument would cite justifying reasons for the status quo state of affairs, thereby explaining directly why the status quo ought to be

maintained. But one could also examine the *explanatory* reasons for why the status quo happens to be as it is. Some possible explanations of the status quo might be *justifying* explanations; that is, on learning the explanation, we would have reason to believe that the status quo is optimal in virtue of the way in which it has been brought about. We need not be able to cite any specific justifying reasons for why the status quo ought to be as it is in order to recognize a good justifying explanation. For example, suppose I learn that the mathematical proof I see in a notebook was written by a famous, brilliant mathematician. Then all other things being equal, I will have some reason to believe that the proof is correct, even if I am unable to understand and assess the mathematics that justifies each of its steps. A more pertinent example here is the following: according to Condorcet's jury theorem, if a public policy has come about by a majority vote between two options, if each voter is more likely than not to vote correctly, and if each voter comes to his decision independently of the others, then the probability that the group as a whole will reach the correct decision approaches one as the group size increases. So if we learned that these idealizations were approximately true of the way in which the organ donation system actually came about, we might have found good reason to believe that the status quo system is the best one.

Having said this, there are several reasons to doubt the existence of a satisfying justifying explanation of the opt-in organ donation system as it exists in the major English-speaking countries. Condorcet's assumptions are unrealistic as descriptions of the way in which the policy for the current organ donation system in opt-in countries has come about. Since there were in fact more than two options available (e.g. the various options which would make donation particularly burdensome), we would need to assume that voters individually performed *much* better than random to each have probability greater than 0.5 of choosing the correct option, and we have no good grounds for this strong assumption. Perhaps more importantly, it seems *prima facie* likely that whatever the best explanation of the opt-in systems in these countries is, much the same explanation will also account for the existence of opt-out systems in other developed countries. If the optimal answer to the

choice between opt-in and opt-out is not relative to the particular country it is in (and we have been offered no reason to believe that it is), this indicates that the explanation could just as easily have produced a sub-optimal system as the optimal one, and so is not a *justifying* explanation at all.²² Finally, we must note that even the best justifying explanations of the status quo system would only produce a *prima facie* presumption of its optimality (going back to the example, we should recognize that even the most brilliant mathematician could have made a mistake). So the claim that an explanation is justifying can always be overridden by our direct consideration of the normative reasons for having one system or another. At this point, then, let us turn to consideration of the normative argument for the status quo.

We think that the practice of cadaverous organ donation in general has good consequences, and we also care about allowing people to make free and effective choices about the disposal of their bodily organs. These concerns inform our argument for not making it more burdensome than it already is to donate them. But then it is hard to see how an argument for the status quo, under which it is slightly easier not to donate than to donate, can be made – at least in societies where a majority of people support organ donation and would choose it for themselves, as in the UK.²³ Under the current system many people who, if they had to make a choice, would choose to donate their organs after their deaths, do not register and, as a result, do not donate. Because of status quo bias, we can predict that there are many others who irrationally will not choose to donate, but who would choose to donate under a different system that made donation the default option. And many people on transplant waiting lists die as a result of the unavailability of all of these organs. If there is going to be a default option at all, all these reasons weigh in favour of making donation rather than non-donation the default.²⁴

Improving on the Status Quo

Because the opponents of an opt-out organ donation policy cannot meet the burden of explaining why the current opt-in system is the best one, we should look for an alternative.

Let's consider, then, our two competing policy alternatives for improving the rates of organ donation. The first is the presumptive approach. Under this system, explicit consent is necessary, but the choice of whether or not to donate would be presented to still-living donors, or to their next of kin, by counsellors who would present the options in a non-neutral way, with the aim of encouraging assent to donation. Our reflection in accordance with the Reversal Test has already highlighted a number of serious objections to the mirror image of the presumptive approach, which I called the "aversive approach". Now all we need to do is to see whether they would also apply here. Is there a danger that the presumptive approach could threaten a person's ability to make a properly informed autonomous choice about the matter at hand? It is rather clear that it could, since the counsellors used under the presumptive approach are charged with encouraging assent to donate, and their subjects, exposed to a unidirectional persuasive influence (without having chosen to be so exposed), are consequently vulnerable to making decisions that are less likely to reflect their own fully-informed reflective preferences.

Proponents of the presumptive approach may protest that it could be instituted without infringing on people's ability to make autonomous choices. Perhaps they will renounce unfair browbeating methods and high pressure sales tactics. Perhaps they would even require the counsellors to provide, on request, the sort of factual information that might lead someone not to donate. Departures from neutrality of the sort the presumptive approach demands might be more morally defensible, and might indeed be more effective at encouraging assent, if they are subtle. Indeed, the subtle type of presumptive approach is the one that seems to have been attempted in practice. Counsellors might not be explicitly presented as advocates for those waiting on the transplant list, but rather simply as "members of the medical team". Instead of a counsellor offering to provide "information about organ donation", he or she might offer "the opportunity" to donate and make the donor a "hero". Instead of concluding by offering time to make a decision, the counsellor

might instead presumptively offer to "lead" the patient or next of kin "through the process" of providing consent.²⁵

The difficulty for this attempted defence of the presumptive approach is that in order for it to continue to be defined as presumptive, the way that counsellors approach donors and next of kin must be slanted towards encouraging their donations. This inevitably places some burden on those who would choose not to donate, and may threaten their ability to make their own autonomous choices altogether. Arguably, the lack of explicit presentation of advocacy that the subtle approach engenders is an even greater threat to autonomous choice than a less subtle approach would be; donors and families might justifiably feel "tricked" into donating by an apparently neutral party.²⁶ Moreover, the presumptive approach is premised on counsellors approaching donors or next of kin either at or around the time of death of the donor – inevitably a highly stressful context, and one in which the individuals concerned are particularly unlikely to be able to make appropriately reflective and rational decisions. It is easy to see how counsellors in these circumstances might unduly influence choices and violate individual autonomy. Even if the behaviour of counsellors were to be carefully and tightly regulated so as to avert this likely possibility, the risk of a slippery slope to violations of autonomy would remain ever-present, because the counsellor must be motivated to increase donation rates beyond what they would be on the neutral approach. The presumptive approach thus turns out to be subject to similar objections to the policies imagined under the Reversal Test that would make opting in more burdensome, and in some ways the objections are even more serious in the present case.²⁷

Our second policy alternative is the opt-out system. It would shift the slight burden of explicitly registering their choices from those who wish to donate to those who wish not to. It should be coupled with the provision of simple means of opting out, such as a toll free telephone number, a web site, and a freepost mail in system, in order to prevent imposing a significant burden on those who may wish to opt out. It might be objected that we can nevertheless predict that a number of people who would prefer not to donate their organs

after their deaths, will not express an official preference, and so will not opt out and will become donors by default. But given that the relative number of people who are against organ donation is small, this number is likely to be much smaller than the number of people whose preferences are similarly contravened under the present opt-in system. We could further reduce this number by heavily publicising the opt-out register. In contrast to the presumptive approach, a properly implemented opt-out system would tend to enhance rather than reduce our adherence to people's personal views and to clearly define and protect our respect for their autonomous choices.

Reflection prompted by the Reversal Test thus indicates that we hold an irrational status quo bias toward our opt-in organ donation system, and that the introduction of an opt-out system of organ donation would actually do better than the presumptive approach, and indeed better than the current system does, to protect the autonomous choices of donors and next of kin. Even if the introduction of an opt-out system were to generate opposition that produces a paradoxical short-term fall in donation rates, as has been feared, we can safely predict that in the long run its popularity would recover as it became accepted as the status quo.²⁸

NOTES

¹ Cf. M D D Bell, 'The UK Human Tissue Act and Consent: Surrendering a Fundamental Principle to Transplantation Needs?', *Journal of Medical Ethics* 32, 5 (2006): 283–6.

² L. Wright, 'Is Presumed Consent the Answer to Organ Shortages? No', *British Medical Journal* 334, 7603 (2007): 1089–1089.

³ Sheldon Zink and Stacey Wertlieb, 'A Study of the Presumptive Approach to Consent for Organ Donation: A New Solution to an Old Problem', *Critical Care Nurse* 26, 2 (2006): 129–36.

⁴ Alberto Abadie and Sebastien Gay, 'The Impact of Presumed Consent Legislation on Cadaveric Organ Donation: A Cross-Country Study', *Journal of Health Economics* 25, 4 (2006): 599–620.

⁵ In a 2009 UK survey, 35% of respondents said they thought they were on the NHS Organ Donor Register (the actual number on the register at the time was about 27%), but a further 45% said they intended to sign up and hadn't got round to it (the register has been open since 1994) NHS Blood and Transplant, 'NHSBT News Release: New Research Highlights Need to Bridge Gap Between Good Intentions and Action', 2009 <<http://www.nhsbt.nhs.uk/news/2009/newsrelease021109.html>>

[accessed 25 March 2012]; See also Organ Donation Taskforce, *The Potential Impact of an Opt Out System for Organ Donation in the UK: An Independent Report from the Organ Donation Taskforce*, 17 November 2008, p. 8
<http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_090312> [accessed 15 February 2010].

⁶ A UK study found that relatives gave ‘uncertainty about the patient’s wishes’ as a reason in 19% of cases of refusal. Other common reasons for refusal were: patient had said in the past that he or she did not want to be a donor (16%), relatives thought patient had suffered enough (16%), relatives did not want surgery to body (20%), and relatives divided over decision (16%). See Kerri Barber et al., ‘Potential for Organ Donation in the United Kingdom: Audit of Intensive Care Records’, *British Medical Journal* 332, 7550 (2006): 1124–7.

⁷ I can only mention a few examples in the following paragraphs. Readers interested in a more complete assessment of the evidence may refer to Daniel Kahneman and Amos Tversky (eds.), *Choices, values, and frames* (Cambridge: Cambridge University Press ; New York, 2000). After Tversky’s death, Kahneman received a Nobel Prize in Economics for their joint work on prospect theory, which is rooted in part in their demonstrations of loss aversion and status quo bias.

⁸ William Samuelson and Richard Zeckhauser, ‘Status Quo Bias in Decision Making’, *Journal of Risk and Uncertainty* 1, 1 (1988): 7–59.

⁹ This example is mentioned by Richard Thaler, ‘Toward a positive theory of consumer choice’, *Journal of Economic Behavior & Organization* 1, 1 (1980): 39–60, at p. 45.

¹⁰ Amos Tversky and Daniel Kahneman, ‘The Framing of Decisions and the Psychology of Choice’, *Science* 211, 4481 (1981): 453–8.

¹¹ See, e.g., B.J. McNeil et al., ‘On the elicitation of preferences for alternative therapies’, *New England Journal of Medicine* 306, 21 (1982): 1259–62 for a demonstration of loss aversion in doctors choosing between treatment options; Cited in Daniel Kahneman and Amos Tversky, ‘Choices, Values, and Frames’, *American Psychologist* 39, 4 (1984): 341–50.

¹² I would like to thank an anonymous reviewer for outlining the concerns addressed in this paragraph.

¹³ By analogy: consider your having a subscription to a weekly magazine with an expiration date six months in the future. In one respect, the status quo is that you receive the magazine each week. In another, the status quo is that you will stop receiving the magazine on a certain week. Even if the first status quo tends to influence you in favour of maintaining your subscription, the second will tend to influence you in favour of letting it expire. That is why publishers prefer to set up subscriptions with an automatic renewal built in.

¹⁴ Eric J. Johnson and Daniel Goldstein, ‘Do Defaults Save Lives?’, *Science* 302, 5649 (2003): 1338–9.

¹⁵ Dominic Wilkinson, discussing opt-out systems for organ donation and for medical testing, likewise points to status quo bias as both a partial explanation of their effectiveness and a source of resistance to them in his ‘Challenging the Status Quo’, *Journal of Bioethical Inquiry* 6, 2 (2009): 235–7.

¹⁶ Dominic Wilkinson op. cit.; Scott K. Aberegg, Edward F. Haponik and Peter B. Terry, ‘Omission Bias and Decision Making in Pulmonary and Critical Care Medicine’, *Chest* 128, 3 (2005): 1497–505.

¹⁷ Ironically, Aberegg et al. present their own study that uses just this sort of method, rather than asking their subjects to try to imagine what they would have done if presented with the alternative framing of the options, and measuring whether their decisions change.

¹⁸ Nancy Steblay et al., ‘The Impact on Juror Verdicts of Judicial Instruction to Disregard Inadmissible Evidence: A Meta-Analysis’, *Law and Human Behavior* 30, 4 (2006): 469–92.

¹⁹ Nick Bostrom and Toby Ord, ‘The Reversal Test: Eliminating Status Quo Bias in Applied Ethics’, *Ethics* 116, 4 (2006): 656–79, at pp. 664–672.

²⁰ An anonymous reviewer asked whether the reversal test can be applied to “personal contexts”, for example where you love a person or a pet just as they are, without thinking that there is any particular reason that they are (from an outsider’s point of view) “optimal” just as they are. My response is that such cases seem to involve your emotional attachment to certain things being just the way they are (just as you might have an emotional attachment to the layout of your own home, for example), and this in itself (or more precisely, the fact that you would be less happy if things were changed) can give you a perfectly good reason for keeping them that way. So there’s no *irrationality* in preferring the status quo – and therefore no status quo bias - in cases of this kind. Moreover, our relationships with other people or pets might themselves provide special reason for valuing and for trying to induce or maintain such emotional attachments to these others being just the way that they are. Since we are unlikely to have any underlying emotional attachments to the opt-in organ donation policy staying just the way that it is, these considerations do not cast doubt on the present employment of the reversal test.

²¹ These four assumptions are, of course, open to dispute, which I unfortunately do not have space to go into here. Interested readers will find an enlightening discussion of similar issues in: T. M Wilkinson, ‘Individual and Family Decisions About Organ Donation’, *Journal of Applied Philosophy* 24, 1 (2007): 26–40.

²² It might be objected that the system of opt-in organ donation system prevalent in English-speaking countries is best explained as having evolved as a natural extension of the informed consent model used elsewhere in medical practice (e.g. for providing surgical treatment), and that this explanation cannot equally account for the presence of opt-out systems in other countries. However, if right, this explanation does not suffice to justify the status quo, because there are good reasons for thinking that the cases of treatment and cadaveric organ donation are morally dissimilar, and that therefore the consent model for the one ought not to have been extended to the other. In particular, the dead cannot give informed consent, and interferences with one’s body that occur after one is dead are generally less practically significant than those that occur while one is living. It is true that some people find a great deal of symbolic significance in what happens to their corpses, and it is plausible that this gives us moral reason for care concerning such matters. But just as some think it important that their corpses remain “whole”, many others will find it equally important that their corpses serve a life-saving purpose. So there is no clear justification for extending the idea that medical intervention demands informed consent from the living to the dead in cases of cadaverous organ donation. Nor is the general medical consent model generally extended to the dead in practice: investigative post mortems are often imposed mandatorily, without any consent either from the deceased or their family members.

²³ See above, fn. 5

²⁴ Two alternative policy options – the inappropriately named system of “compulsory donation”, and the system of mandated choice – eliminate or reduce the impact of the default option; in the former case by removing options entirely, and in the latter case by requiring all (or nearly all) competent adults to state an explicit preference between two options, where neither is presented as a default (e.g. on an application for a driver’s licence). Mandated choice could also be combined with an opt-out policy in case people register no choice, and/or with a version of the presumptive approach to encourage donation (see P Chouhan and H Draper, ‘Modified Mandated Choice for Organ Procurement’, *Journal of Medical Ethics* 29, 3 (2003): 157–62.) I cannot, unfortunately, discuss these alternatives in adequate detail here. Briefly, I regard “compulsory donation” as ethically (and politically) unacceptable because of the way in which it would undermine autonomy. We need not, I think, set ourselves against mandated choice *per se*, but I believe that mandated choice without either presumed consent or a presumptive approach would be likely to be practically ineffective in increasing the supply of organs, because of status quo bias. My objections to the pure presumptive approach are

laid out below, and would still largely apply to a version of it combined with mandated choice. I therefore confidently recommend an opt-out policy, and leave open the question of whether this option ought to be combined with mandated choice.

²⁵ Cf. Zink and Wertlieb op. cit.; Robert D. Truog, 'Consent for Organ Donation – Balancing Conflicting Ethical Obligations', *New England Journal of Medicine* 358, 12 (2008): 1209–11.

²⁶ It has sometimes been said that introducing an opt-out system for cadaveric organ donation would set us on a slippery slope and undermine the practice of doctors getting informed consent in other areas of medicine. This seems unlikely, since the two consent models are so clearly different, and there's no obvious reason for using opt-out generally for treatment as well as for cadaveric organ donation. The slippery slope argument might be more effective if wielded against the presumptive approach though, since the presumptive approach can be quite subtle and hard to distinguish from an informed consent model in practice, and yet it may still present a very serious threat to individual autonomy.

²⁷ Some similar points in opposition to the presumptive approach are mounted in Truog op. cit.

²⁸ Thanks to Roger Crisp, Thomas Douglas, Toby Ord, Derek Parfit, Janet Radcliffe-Richards, Julian Savulescu, Dominic Wilkinson, members of the audience at a James Martin Seminar in Oxford and anonymous reviewers for *Journal of Applied Philosophy* for their helpful comments on earlier versions of this material.