A Promise Acceptance Model of Organ Donation

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Abstract: I aim to understand how the act of becoming an organ donor impacts whether it is permissible for a family veto to override an individual's wish to donate. I argue that a Consent Model does not capture the right understanding of donor autonomy. I then assess a Gift Model and a Promise Model, arguing that both fail to capture important data about the ability to revoke one's donor status. I then propose a Promise Acceptance Model, which construes becoming an organ donor as accepting a promise the state makes to you to use your organs. This model, which implies that family vetoes are impermissible, captures the data other models struggle to accommodate.

Keywords: consent; donor registry; family veto; organ donation; promise; promise acceptance

1. Introduction

Imagine that you are renewing your driver's license. The form asks whether you wish to be a posthumous organ donor; you check the "yes" box to add your name to your state's organ donor registry. The act you have just performed brings about legal changes. Once you are declared brain-dead, it will be legal for any of your usable organs to be transplanted to medically suitable recipients.[1] In many jurisdictions, had you not explicitly designated yourself an organ donor, transplanting your organs would be legal only with the permission of your family.[2] And had you explicitly refused to be an organ donor, transplanting your organs would not be legal under any circumstances.

[1]Individuals may sign up to donate all of their transplantable organs (heart, kidney, pancreas, lung, liver and intestine) or only certain organs, as well as their eyes and many kinds of tissues (including bone, skin, heart valves, and tendons.) For the purposes of present discussion, "organ" will refer broadly to any of the parts just stated.

[2]The 2006 Revised Unified Anatomical Gift Act in the U.S. (from the National Conference of Commissioners on Uniform State Laws) expands the list of people who are legally permitted to make the decision to donate to include not only immediate family members (spouse, parent, grandparent, sibling, child, or grandchild), but also close friends ("an adult who exhibited special care and concern for the decedent"), whoever is the decedent's legal guardian at time of death, and whoever has legal authority to dispose of the body.

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Becoming an organ donor brings about ethical changes, as well. Whether it is morally permissible for a doctor to recover a recently deceased person's organs for transplant presumably depends, at least in part, on whether that person while living decided to be an organ donor. To accurately track these ethical changes, we need a clearer understanding of the act that brings them about. Different types of act affect the ethical situation in different ways; for example, granting consent creates a permission to act, such that an act that would otherwise be wrong (such as removing someone's organs) becomes morally permissible once consent has been granted. Giving a gift transfers property, so that the right to possess an item (such as an organ) transfers from one person to another. And making a promise creates an obligation where there was none before; promising to perform some action (like donate your organs) creates a moral obligation to so act. What kind of act do you perform when you change the normative situation by becoming an organ donor? Do you grant consent, give a gift, make a promise, or do something else?

How we construe the act of donation will help determine whether doctors are merely *permitted* or are morally *required* to use a donor's salvageable organs. This is of great importance for cases in which the deceased has signed an organ donor card but her family objects to donation. If becoming an organ donor entails mere permission, it will be easier to morally justify siding with the family; if becoming an organ donor entails even a pro tanto moral obligation, justifying a family veto will be much harder. In most jurisdictions, the law is clear-cut about such conflicts. For example, the 2006 Revised Uniform Anatomical Gift Act (UAGA), which has currently been adopted by 47 U.S. states, explicitly states that the consent of family members is not needed when a deceased individual is an organ donor, and that objections from family members are not acceptable legal grounds for refusing to recover organs from a designated donor.[3]

In practice, however, such laws are frequently not followed. Most hospitals regularly seek family consent before proceeding with organ transplantation, even when the deceased is on a donor registry. And in cases of conflict, most medical professionals in the U.S. (as well as in the U.K. and continental Europe) side with the family.[4] While this is often

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[3]As of early 2014, the act has been adopted by every U.S. state or territory except New York, Florida, and Puerto Rico; it is currently under consideration in Pennsylvania.

[4]Martin (T.M.) and Stephen Wilkinson note that seeking family consent, and adhering to family veto if the family objects, is so common that laws governing organ donation should not be taken as a reliable guide to actual practice: "The Donation of Human Organs," *The Stanford Encyclopedia of Philosophy* ed. Edward N. Zalta (2011): http://plato.stanford.edu/archives /win2011/entries/organ-donation/. The NHS in Britain conducted a national potential organ donor audit from March 2012 to March 2013; their Activity Report on Organ Donation and Transplant shows that "the [family] consent/authorisation rate is 88%

motivated by a commendable desire to avoid causing distress to grieving relatives, it is also a means of avoiding negative publicity and costly litigation from unsatisfied family members. In this paper, I am concerned with nonlegal criteria for adjudicating disputes between individual donors and their families. Ethically, should a family veto ever be allowed to override an individual's decision to donate? Getting clearer about the nature of the act of organ donation will help us answer this question.

The most natural construal of what happens when someone becomes an organ donor is giving consent. I consider a Consent Model in section 2, and argue that while this fits closely with the language most frequently used to describe organ donation, it does not adequately capture the robustness of the state's duty to act on a donor's wishes, and is overly flexible about the conditions under which an individual's decision to donate can be overridden. In section 3, I assess two more models that are suggested by language sometimes used to describe organ donation: a Gift Model and a Promise Model. I argue that neither model is plausible, for both fail to capture important data about the ability to revoke one's organ-donor status. In section 4, I outline a new approach: a Promise Acceptance Model, under which becoming an organ donor is construed as accepting a promise that the state makes to you to use your medically suitable organs for transplant after you die. I argue that this model is consistent with our practice and fully captures the data about the conditions under which a decision to donate organs should be respected and when it may be revoked.

2. The Consent Model

In legal documents governing organ transplantation and in literature from organ procurement organizations, the word "consent" is frequently used to describe what happens when someone signs up to be an organ donor. For example, the website of the U.S. Department of Health and Human Services describes donation as beginning "when people perform the simple act of indicating their consent to be a donor by enrolling in their state's

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when a patient's wish is known at the time of potential donation, but 105 families overruled their loved one's known wish to be an organ donor": *Organ Donation and Transplantation: Activity Report 2012/2013*: http://www.organdonation.nhs.uk/statistics/transplant_activity_report, p. 111. For further information about the frequency of family veto in the U.K., see Sheila M. Bird and John Harris, "Time to Move to Presumed Consent for Organ Donation (Analysis)," *British Medical Journal* 340:c2188 (2010). For information from the American Medical Association about how common it is to ask for family consent in the U.S., see Douglas W. Hanto, Thomas G. Peters, Richard J. Howard, and Danielle Cornell, "Family Disagreement Over Organ Donation: Case Study and Commentary," *Virtual Mentor* 7, no. 9 (2005), http://virtualmentor.ama-assn.org/2005/09/ccas2-0509.html.

donor registry."[5] The online organ donor registration form for California states "by putting your name on the Donate Life California Organ and Tissue Donor Registry you consent to having your organs and tissue made available for transplantation upon death."[6] Language on organ registration forms varies, and not all forms use explicit consent language. But it is unsurprising that many do talk explicitly of consent; consent is a crucial concept in medicine, and patients are routinely required to give their informed consent before medical procedures and examinations. Such language suggests a *Consent Model,* according to which signing up to be an organ donor entails *consenting* to the use of your organs after your death.

Consenting to some act grants a permission that "ensures that the consentor is not wronged by some deed that would otherwise be far from innocuous."[7] For example, it is morally wrong to drill someone's tooth, enter her home, or kiss her without her permission. With her consent, though, these acts are morally permissible. The Consent Model presupposes that posthumously removing someone's organs without her permission is morally wrong.[8] Signing up to be an organ donor involves consenting to the posthumous use of one's organs, thus making permissible an otherwise impermissible act.

In general, merely granting consent to someone *allows* that person to behave in a certain way, but does not morally *require* her to so act. If I invite you into my home, thereby consenting to your entering my property, you do not necessarily wrong me if you fail to enter. There might be independent reasons for you to accept my invitation; perhaps you solicited the invitation in the first place, and I have gone so far out of my way to extend it to you that it would be rude for you to refuse. These independent reasons might be strong enough to make it the case that you would in fact wrong me by failing to enter my home. But this is a contin-

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[5]http://organdonor.gov/about/organdonationprocess.html.

[6]https://register.donatelifecalifornia.org/register/.

[7]David Owens, *Shaping the Normative Landscape* (Oxford: Oxford University Press, 2012), p. 164. See chap. 7 for an enlightening and detailed discussion of consent.

[8]The Consent Model will not make sense unless it makes this presupposition. If posthumously removing one's organs without permission were *not* morally wrong, consent would be superfluous; if it is permissible for me to whistle while going about my work, your consenting to my whistling does not make any sense. There are multiple reasons why we might think that posthumously removing someone's organs without permission is impermissible. For example, we have the right to bodily integrity while living, and might expect this right to extend to the integrity of our bodies after we die. Or perhaps agents may be posthumously harmed by violations of this integrity, which might be why many people care deeply about what happens to their bodies after death (e.g., about whether they are buried or cremated). In order to assess the plausibility of the Consent Model, I need not evaluate these reasons. It is enough simply to note that the Consent Model is committed to some such reasons, for which there are a variety of contenders.

gent and extrinsic wrong; my granting consent does not in and of itself make it wrong for you to fail to act on that consent.

If registering as an organ donor merely grants consent, then medical professionals are not obligated to act in accordance with that consent. So they do not violate an obligation if they defer to family objections and fail to transplant the usable organs of a registered donor, just as you do not violate an obligation if you choose to remain outside after I have consented to your entering my home. This brings us to a worry about the Consent Model. When I consent to your entering my house, it is consistent with my consent that you refuse for a good reason (e.g., because you are late for work and do not have time to visit me) or for a trivial reason (e.g., because I have poor taste in art and you don't want to look at the Thomas Kinkade paintings hanging on my wall). Similarly, if I consent to being an organ donor, it is consistent with my consent that a doctor refuse to use my organs for a compelling reason or for a trivial reason. This reason might be that my family objects. But the doctor might also refuse because of an objection from anyone who happened to be visiting me when I died—such as a co-worker, or even my rival. Or perhaps the doctor will refuse because the nurse on duty believes organ transplantation is against her religion,[9] or because the transplant surgeon is exhausted and does not want to perform the necessary surgery.

It is not obviously problematic to decline an invitation to enter my house because you do not wish to subject yourself to kitschy paintings. Is it morally problematic to decline someone's organs because her co-worker objects, or because it would offend a nurse's religious sensibilities? We cannot properly answer this question without considering the current immense organ shortage. In the U.S. alone, over 115,000 people languish on the waiting list for transplants, with another name added every ten minutes. On average, 18 people on the waiting list die every day whose deaths might have been prevented were there more organs available.[10] It is plausible that this shortage provides an independent moral obli-

[9]The majority of organized religions consider posthumous organ donation an act of charity that is best left to an individual's conscience, and many religions actively encourage donation. There is some debate among Jewish scholars as to whether Jewish law permits organ donation, but the general consensus is that it is permitted after cardiac death so long as the organs will be immediately used to save lives. Jehovah's Witnesses object to blood transfusion but do not object to organ transplantation in principle, so long as all blood is removed from the organ before it is transplanted (which is not always possible in practice). Only Roma Gypsy folk religion and Japanese Shinto religion have broad, categorical objections to organ donation, based on beliefs about the afterlife and the impurity of dead bodies, respectively. For more information, see http://www.unos.org/donation/index.php?topic= fact_sheet_9.

[10]Statistics are from www.donatelife.net/understanding-donation/statistics. T.M. Wilkinson cautions that statistics like these are often unreliable indicators of the true extent

gation for doctors to accept the consent given by potential donors whenever possible, just as the fact that I have gone far out of my way to invite you to my home independently obligates you to accept my invitation.

If we follow this line of reasoning, we will conclude that family objections should rarely override an individual's consent. Organ donors can save the lives of up to eight people. When we weigh the emotional distress of a donor's unwilling family against the interests of those whose lives may be saved by donation (and the interests of their families), it seems unlikely that the emotional distress of the family will win out. As David Shaw suggests, "a doctor's qualms about causing more distress for the family cause deaths by omission and greater consequent emotional distress to far-off families, whose relatives will die because there were not enough organs available."[11] In a similar vein, H.E. Emson notes that family objections fail "in the face of what I regard as the overwhelming and preemptive need of the potential recipient," and are "particularly unacceptable when the deceased has during life expressed consent for cadaver organ donation."[12] This entails that trivial or even good reasons to refrain from acting on a donor's consent will usually be morally insufficient.[13]

However, the Consent Model still faces serious worries in principle. First, claiming that there may be independent moral obligations to act on a donor's consent makes decision-making for doctors extremely compli-

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of the shortage: see *Ethics and the Acquisition of Organs* (Oxford: Oxford University Press, 2011), pp. 3-5. Such statistics are typically calculated by subtracting the number of transplants performed from the number of people on the waiting list. But the number of transplants is annual, while the number of people on the waiting list is cumulative over several years. Moreover, waiting lists likely underrepresent the true numbers of people who need transplants, as people who have very little chance of getting an organ are unlikely to even make it onto a waiting list at all. And even if these numbers are reliable, we should exercise caution when drawing conclusions about how many preventable deaths resulted from the shortage, since when a person on the organ waiting list dies it may be difficult to know whether the death was caused by organ failure or by some other malady, and whether the death could have been prevented by a transplant. However, none of these considerations entails that there is not a massive shortage, and that a significant number of lives would be saved were more transplantable organs available.

[11]David Shaw, "Personal View: We Should Not Let Families Stop Organ Donation From Their Dead Relatives," *British Medical Journal* 345:e5275 (2012).

[12]H.E. Emson, "It is Immoral to Require Consent for Cadaver Organ Donation," *Journal of Medical Ethics* 29 (2003): 125-27, p. 126.

[13]Of course, this claim is subject to empirical verification. Cases in which doctors recover organs in spite of family objections, especially if widely publicized in popular media, might have the unintended side effect of turning enough people away from agreeing to organ donation that the number of organs available for transplant actually decreases. For discussion of this possibility, see Wilkinson and Wilkinson ("The Donation of Human Organs"), as well as Jurgen De Wispelaere and Lindsay Stirton, "Advance Commitment: An Alternative Approach to the Family Veto Problem in Organ Procurement," *Journal of Medical Ethics* 36 (2010): 180-83.

cated, for assessment of whether such independent obligations exist will have to be done on a case-by-case basis. Doctors would need to determine how much weight to give a particular family objection, as not every family objection is of equal importance. Individual family members may disagree with each other, and families may object to donation for a variety of reasons, some good and some bad. What happens if the donor's spouse wants to honor the deceased's wishes to donate, but his parents or children refuse donation? Does it matter whether the family objects because they hold sincere moral objections to organ transplantation, or because they are misinformed about what brain death entails?[14] What if the family refuses out of a mean-spirited and deliberate wish to spite their dead relative? The problem with this complexity is that decisions about organ donation need to happen extremely quickly, as there is a very narrow timeframe during which organs are usable after death. Ideally, then, we want a quick, default framework for decision-making. Mere permission does not provide this, leaving the burden of weighing independent moral considerations and coming to a final decision with the doctor.[15]

Second, the Consent Model does not mesh with common understanding of what becoming an organ donor involves. Public service announcements touting organ donation speak as though your organ donor status *guarantees* that your organs will be used if they are medically suit-

[14]For an interesting survey of the reasons why people refuse organ donation, see Susan E. Morgan, Tyler R. Harrison, Walid A. Afifi, et al., "In Their Own Words: The Reasons Why People Will (Not) Sign an Organ Donor Card," *Health Communication* 23 (2008): 23-33. The most common reasons stem from false beliefs: that doctors will not work as hard to save organ donors as they would to save nondonors (or may actively seek to end donors' lives), that donors are not "really" dead when their organs are harvested, and that organs go first (or only) to the rich and famous while the poor languish at the bottom of the transplant list. Also frequently cited is the belief that it is unjust for hospitals to profit from organ transplantation while the family of the deceased receives no financial compensation.

[15]Medical professionals might take a rule-consequentialist approach, and adopt a default rule regarding family consent that they believe is likely to lead to acting in accordance with independent moral obligations in the greatest number of cases. However, default rules are only a contingent solution to a more basic conceptual problem. To illustrate this, consider a thought experiment abstracting away from the organ shortage. Suppose that it is possible to create human organs in a lab, and that these organs have the same rates of success and failure as do organs taken from cadavers, meaning that there is no organ shortage, and no one dies because she is unable to receive a transplant. But growing organs in a lab is expensive, making lab-grown organs not nearly as efficient a use of resources as recycling organs from donor bodies. On the assumption that more efficiently using resources is not always and automatically a strong enough independent moral obligation to override a family veto of an individual's wish to donate (in the way that saving lives might be), we are again faced with a problem of weighing family objections on a case-by-case basis. Ideally, we want a framework that gives doctors a default option regardless of the contingent circumstances they find themselves in.

able and there are appropriate recipients. "Save a life!" they proclaim, not "Allow someone else to make a decision about whether you will save a life, depending on a variety of independent circumstances, such as whether there is currently an organ shortage."

As an organ donor, when I first learned that doctors regularly defer to family vetoes in spite of explicit donor status, I felt angry, and even violated. This is a common reaction; the U.K. Organ Donation Taskforce conducted focus groups around Britain, discovering that "members of the public had expressed outrage at the idea that relatives could over-ride the wishes of individuals when they were not in a position to insist."[16] Elizabeth Buggins, chair of the taskforce, notes that many people consulted "were angry and horrified."[17] In an editorial in an online Australian newspaper, Tory Maguire claims that "surely the point of the Organ Donor Registry is to make sure those who wish to donate can make the decision for themselves while they're still here to make it," rather than allowing families to make the decision.[18]

These reactions seem to be based in the compelling assumption that signing up to be an organ donor involves *more* than a mere permission that may or may not be acted upon. Giving permission puts the final decision about whether to act on this permission in the hands of medical professionals, and makes this decision subject to the influence of family objections. Reasonable popular perception seems to be instead that the decision to proceed with organ donation should be in the hands of the donor, involving the donor's full agency and autonomy. Because this perception is so robust and widespread, we should be skeptical of any model that fails to accommodate it, especially if viable alternatives that can accommodate it are available.

3. The Gift Model and the Promise Model

3.1. The Gift Model

Language of giving is ubiquitous when discussing donation. Donated organs are referred to as "anatomical gifts" in legal documents governing

[16]Jeremy Laurance, "Number of organ donors increases by 50% but relatives should not have the last word, says head of Government taskforce." *The Independent*, 11 April 2013, http://www.independent.co.uk/life-style/health-and-families/health-news/number-of-organ-donors-increases-by-50-but-relatives-should-not-have-the-last-word-says-head-of-government-taskforce-8567896.html.

[17]Ibid.

[18]"Should we scrap the family veto on organ donation?" *The Punch* (22 January 2013), http://www.thepunch.com.au/articles/should-we-scrap-the-family-veto-on-organ-donation.

organ transplantation, and the official U.S. Government Information on Organ and Tissue Donation and Transplantation subtitles its webpage "Donate the Gift of Life."[19] Multiple nonprofit organ procurement organizations use "gift" in their titles, such as Gift of Hope (serving Indiana and parts of Illinois) and Life Gift (serving Texas). This suggests another model for the act of becoming an organ donor. According to the *Gift Model*, becoming a donor involves *giving* your organs to the relevant organ procurement organization(s) and/or medical institutions, hereafter referred to as "the state" for convenience. (We might also conceive of the recipient of the gift being the person or people who will receive the transplanted organs, in which case the state functions merely as an intermediary.)

If the Gift Model is to be coherent, it cannot be the case that signing up to become an organ donor *immediately* gives one's organs to the state. Becoming an organ donor does not immediately cede one's right to bodily integrity, for the state clearly does not own or control the heart and lungs of an organ donor while she is still alive and using them. Nor can it be the case that an agent who signs up to be an organ donor declares that she will give away her organs when the relevant time for transplantation arrives in the future, for organ donation of the sort we are discussing occurs only after the donor is dead and unable to act at all, let alone make a gift.[20]

Rather, the Gift Model must claim that a donor joining the registry makes a gift *now* that comes into effect only at an unspecified future time after the donor dies. That is, the donor changes the normative situation in the present by making it such that a property transfer will come into effect in the future. We can call this a "future gift." Such gifts might be unusual in ordinary life, but are not unheard of. For example, a mother might give her wedding veil to her teenage daughter with the understanding that this gift will not take effect until an unspecified future time when the daughter decides to get married. Although the property does not transfer until a later time, making a future gift changes the normative situation in the present. Signing the organ donor card makes it the case *now* that your organs belong to the state *after you die*, just as giving your daughter your wedding veil makes it the case *now* that it belongs to her *whenever she marries*.

Giving a gift involves transferring property from one party (the giver) to another (the recipient.)[21] Gifts must be *accepted* by the recipient in order for the property to successfully transfer. The recipient has the right

[19]See www.organdonor.gov.

[20]We cannot remedy this by stipulating that the relevant time of action be the last point at which an agent is capable of acting before she dies, since successful donations often come from the victims of unexpected accidents, head trauma, or stroke. Such causes of death are usually quite sudden, so there is no opportunity for the donor to act beforehand.

[21]"Party" should be understood flexibly: the recipient of a gift may be an entity or may consist of multiple persons.

to refuse the gift—say, if it is so costly that she feels uncomfortable accepting it, or if it is something she doesn't actually want. In principle, then, the state could refuse the future gift of a donor's organs. However, there are sometimes independent reasons to refrain from refusing a gift—say, if doing so would cause great offense to the giver. The shortage provides strong independent reasons for the state to accept gifts of organs.

After the recipient accepts a gift, she is free to use it in any way she likes.[22] One might worry that if becoming an organ donor involves giving one's organs to the state, the state as recipient may use those organs however it wishes. Hopefully, this would be using the organs for transplant to the most medically needy recipients. But it is consistent with treating the organs as a gift that the state sell the organs to a third-party, or even use them as props in a TV medical drama. Granted, there are likely to be independent moral obligations preventing the state from using the organs in such ways. But were there no such obligations in a particular case, the state could use the organs any way it chose. However, this worry is refuted by the fact that it is possible to give a gift with certain conditions in place as to how it is to be used. For example, one family member might give an heirloom to another family member only on the condition that it remain in the family. The recipient must accept this condition in order to receive the gift, and will therefore be bound by the condition. We could stipulate that donors give their organs to the state only on the condition that they be used for the most medically needy recipients, which entails that the state may not use the organs in any way it chooses after all.

But there is a final worry that the Gift Model cannot accommodate. The receiver of a gift is allowed to *return* that gift to the original giver. This is not to say that returning gifts is always morally permissible; extrinsic factors may make returning a gift so rude or unkind as to render it immoral on independent grounds. For example, it might be impermissible to return a gift if doing so would impose disposal costs on the giver, or if doing so would greatly offend the giver. But it is at least sometimes permissible; consider someone who returns a gift to her cheating ex-lover following a break-up. This is a unilateral change of normative situation; the jilted lover who returns a ring that her ex gave her successfully transfers ownership of the ring back to her ex.

The Gift Model predicts that the state as recipient is allowed to return the gift that the donor has made by refusing ownership of the organs. Granted, the state will not be able to transfer ownership of the organs

[22]More carefully: someone who receives a gift is morally free to use that gift in any way that it is morally permissible to use one's property; obviously, it is not morally permissible to use a serving platter as a weapon against an innocent person just because it was given to you.

back to the donor after the donor has died, since the dead cannot own anything. But it might transfer ownership of the organs back to the donor's next-of-kin, or whoever else has legal rights over the donor's body. Or the state might return the future gift before the donor's death. A teenager who rejects the symbolism associated with traditional weddings might refuse ownership of her mother's wedding veil after her mother has made her a future gift of it, but before the time at which she gets married and the veil will transfer to her. Similarly, the state might refuse ownership of the organs after the donor has made a future gift of them, but before the ownership of the organs actually transfers—say, while the potential donor is on life support and is near brain death. Family objections might motivate such a refusal. Or the refusal might be motivated by religious objections from a sensitive hospital employee.

In general, the organ shortage will provide independent reasons for the state not to return a gift of organs. But, as with the Consent Model, whether returning the gift is appropriate will need to be decided on a case-by-case basis, which leads to an overly complicated decision-making process. Moreover, the fact that the state may unilaterally return the gift of someone's organs is troubling in principle, because it does not give donors the control that they desire (and that we tend to assume they should have.)

Even more problematically, the Gift Model predicts that the donor as giver is not permitted to unilaterally revoke the gift and thereby regain ownership of her organs. Once you have given a gift to someone, you cannot simply take it back. You might ask for the gift to be returned, but if the receiver refuses, the gift remains in the possession of the receiver.[23] If you give your organs away by agreeing to be a donor, there is no way to change your mind and alter your donor status. But an organ donor does have the legal power to reverse her decision to donate for any reason and at any time up until the point of death; Section 6 of the Revised UAGA outlines the means by which anyone may revoke her organ donor status. And we assume that the donor has the moral prerogative to change her mind, as well. So the Gift Model is incompatible with both current law and common moral intuition.

It is understandable why organ procurement organizations appeal to the language of giving; talk of giving is powerful, and captures the charitable and generous spirit with which most donors approach organ dona-

[23]At first glance, it might seem that conditional gifts allow for revocation of a gift. For example, a woman might make her young daughter a future gift of her wedding veil on the condition that the daughter marry someone of whom the mother approves. If the daughter decides to marry someone her mother disapproves of, she will not get the veil, and so the gift appears to be revoked. But this is not actually a revocation. Rather, the gift is never made in the first place, because the necessary condition for making it is not met.

tion. But such language is best understood as metaphorical, and it is a mistake to interpret talk of giving too literally.

3.2. The Promise Model

Although less common than talk of consent or giving, talk of promising is sometimes used to describe organ donation. Janet Pardue-Wood, director of the National Kidney Research Fund in Wales, is quoted in a newspaper article as saying: "Signing the donor card is making a promise to help other people when they need it."[24] In the winning submission for a regional essay contest about organ donation, Shirley V. Hochhauser writes:

> When you say "yes" to having the words "organ donor" printed on the bottom of your new license, think of it as a promise ... becoming a designated organ donor is saying "I cannot promise I will be able to save your life, but I promise I will give you hope" ... I made a promise, and I hope you will, too.[25]

This is evidence that at least some ordinary people conceive of the act of becoming a donor as making a promise. This suggests a third possible model: the *Promise Model*, under which signing up to be an organ donor involves *making a promise* to the state to donate one's organs after death.

There is an immediate problem with this model that echoes a problem for a simple construal of the Gift Model. A promise to act at some future time obligates the promisor to act *at that time.* According to the Promise Model, the donor promises to donate her organs *after her death.* Obviously, agents who have died cannot act, so the donor cannot keep her promise. How can an agent sincerely promise to do something that she *knows* she will be unable to do? The Promise Model seems to be a nonstarter.

We could perhaps make conceptual sense of the Promise Model if it were possible for someone else to become morally obligated to carry out a promise on behalf of a deceased or incapacitated person. For example, suppose an old gambler promises his poker buddies that he will repay his debts to them. But the gambler dies before the debts are repaid. Might the heirs to his estate "inherit" the moral obligation to fulfill his promise and repay the poker buddies? If so, then maybe it is possible for the family of a deceased donor to become morally obligated to fulfill the donor's promise to give up her organs—which they might do by acting as advocates to ensure that donation occurs if medically possible, or at least granting their explicit consent. If this is the case, then we could un-

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[24]"Helena's Hope for more organ donors," *Wales Online*, 2 December 2003, http://www.walesonline.co.uk/news/wales-news/helenas-hope-more-organ-donors-2456309.

[25]Website of the Lehigh Valley Coalition on Organ and Tissue Donation, http://www.donors1.org/volunteer/groups/lehigh/.

derstand becoming an organ donor as making a promise that you will give up your organs for transplant after you die. Only you are not the one who discharges this promise; rather, your family is morally obligated to do so on your behalf, just as the heirs of the gambler are morally obligated to discharge his debts on his behalf.[26]

However, I doubt that the heirs to the gambler's estate are in fact obligated to carry out his unkept promises, and suspect that whatever plausibility the example has stems from the fact that it concerns a monetary debt, and there are legal mechanisms in place for creditors to collect from the estates of deceased debtors. If we construct an example using a promise of a different sort, we will likely have different intuitions. If the old gambler promised his neighbor that he would paint her fence but died before doing so, it does not seem that his heirs become obligated to paint the fence. It would be nice for the gambler's family to paint the fence, but they do not violate any moral obligations if they fail to do so.

Moreover, allowing promissory obligations to transfer from one person to another would put undue burdens on the person to whom the obligation transfers. Ideally, organ donors and their families will be on the same page about donation—the families will know and respect, if not agree with, the donor's wishes. But the family might have sincerely held and deeply principled objections to organ donation, in which case it would be extremely problematic to claim that the family must become morally responsible for fulfilling their loved one's promise to donate her organs. Claiming that promises to donate transfer to the family puts an undue burden on the family.

It is more plausible for the Promise Model to claim that a person who signs an organ donor card promises to immediately perform some normative situation-changing action at the moment in which she signs the card, analogous to making a future gift. This is the only way to ensure that the donor is both able to act and is the only one who carries the burden of acting. But this way of understanding the Promise Model makes the promise redundant, for it makes no sense to promise to, for example, consent *now* to the use of one's organs after death. All of the normative work in such a case is done by the granting of consent, and promise-making plays no additional role. The Promise Model so understood collapses into the Consent Model. The same sort of argument applies, mutatis mutandis, to promises to immediately perform any other normative situation-changing action, such as promises to make a future gift of one's organs—in which case the Promise Model would collapse into the Gift Model.

Even if the Promise Model were coherent and nonredundant, it would

[26]Thanks to James S. Taylor for bringing this possibility to my attention and suggesting this example.

face similar problems to those of the Gift Model, for it would be unable to accommodate the conditions under which people may revoke their donor status. Like gifts, promises must involve two parties: a promisor who makes the promise, and a promisee to whom the promise is made, and who must accept the promise.[27] An accepted promise creates a pro tanto obligation, such that all else being equal, the promisor is morally required to act as promised. All else is not equal if certain conditions occur, such as a more important conflicting moral obligation arising, or the parties to the promise realizing that a belief on which the promise was fundamentally grounded is false, and so on. But even without any such conditions in place, a promise ceases to bind if the promisee *releases* the promisor from the promise, just as a gift from A to B ceases to take effect if B returns the gift to A. In general, the promisee has the power to release the promisor at any time and for any reason, even though independent circumstances might make release rude or impermissible in a particular situation. The promisor does not share this power; while she may ask the promisor to release her, she cannot unilaterally release herself.

The Promise Model states that the organ donor is the promisor and the state is the promisee, which entails that the state holds exclusive power of release. Once the state accepts the promise by adding someone's name to the donor registry, it can choose to release the donor of her obligation to donate, at any time and for any reason—perhaps because the family objects, but also for less compelling reasons, such as the transplant surgeon's exhaustion. Granted, independent reasons might prevent the state from releasing the donor from the promise. But as with the Consent and Gift Models, this is problematic because it complicates the picture, and puts authority over whether to use the organs solely in the hands of the state. For reasons already discussed, this is a worrisome intrusion on the donor's autonomy and control over what happens to her body. Even more worrying, according to the Promise Model, the donor does *not* have a similar unilateral power of release. Ruling out such revocation is a fatal flaw for the Promise Model, as it is for the Gift Model.

The language of promising captures something important that is missed by the Consent and Gift Models. Conceptually speaking, neither consenting nor giving offers any sort of guarantee about what will happen; consenting provides mere permission, and giving transfers owner-

[27]I do not wish to rule out by stipulation the possibility of making promises to one's self. I argue in "Resolutions are Not Promises to the Self" (unpublished ms.) that talk of making a promise to oneself is metaphorical, and that apparent self-promises are better understood as resolutions. However, my commitment to the existence of both a promisor and a promisee is compatible with self-promises, so long as one person functions as both promisor and promisee.

ship but does not typically require that the gift be used in a particular way. Promising is a stronger concept: the person who promises to Φ is pro tanto *required* to do so. Common opinion rightly holds that signing an organ donor card provides the donor with some kind of *guarantee* that her organs will be used if medically possible. Perhaps we can capture this guarantee by construing organ donation as the *state* making a promise to the donor, rather than the other way around. In the next section, I outline this proposal, and argue that it captures data that the other three models have a hard time accommodating.

4. The Promise Acceptance Model

Literature about organ donation does not usually refer to any actions undertaken by the state when an individual signs up to be an organ donor. After all, there is only one obvious action involved, which is the action taken by the donor in signing up (e.g., checking a box on a driver's license application, joining an online registry, and so on). But there is a productive way of construing the state as acting: perhaps it is the case that in creating a donor registry in the first place, the state makes a general offer of a promise to use an individual's medically usable organs for posthumous transplant. When an individual signs up to for that registry, she *accepts* this promise, thereby consenting or agreeing to the use of her organs.[28] This acceptance does not merely entail consent. It also puts a moral obligation in place for the state, which entails that the state is pro tanto morally obligated to use the individual's organs for transplant after her death—*unless* the individual has released the state from the promise by revoking her organ donor status, which she as promisee retains the ability to do. Call this the *Promise Acceptance Model*, or the *PA Model*.

Granted, it is not likely that the state actively conceives of itself as making promissory offers to citizens when creating a donor registry. Nor would most people who sign donor registries describe themselves as accepting promises. However, I think the PA Model is the best way to con-

[28]My primary focus in this paper is on opt-in systems of organ donation like those in the U.S. and U.K, according to which citizens are presumed not to be donors unless they opt in by joining the registry. The Promise Acceptance model fits most naturally with an opt-in system, but it can also be applied to an opt-out system like that in many European countries, such as Spain and Austria, in which citizens are presumed to be donors unless they explicitly opt out. A Promise Acceptance account of such a system would propose that the state make a general promise to all of its citizens to use their organs after death, and that citizens' implicit acceptance of this promise is presumed unless they reject the promise by opting out. It is beyond the scope of this paper to determine whether this is a plausible construal of such a system, but at first glance I do not find the notion of implicit acceptance problematic, so long as opting out is a well-publicized and easy option for citizens.

strue the act of becoming an organ donor. This may entail a reconception of our current practices, but it is not a disruptive or drastically revisionary proposal. The model is consistent with current practice, and it would be easy to explicitly cash out our practice in terms of promise acceptance.

The PA Model is appealing because it squares nicely with data the other models struggled to capture. First, the PA Model puts control of what happens to the organs fully in the hands of the individual: although the state makes the initial promissory offer, an obligation to use the organs is in place only after the individual accepts the promise. Moreover, the individual retains the right to change her mind and release the state from the promise at any point and for any reason by officially revoking her organ donor status. The state as promisor does not share this right. Second, the PA Model accommodates the legal requirements of the Revised UAGA—and our compelling and common moral intuitions—about whether family vetoes should be allowed to override an individual's decision. The PA Model predicts that all else being equal, the state is morally *obligated* to use a donor's organs, rather than merely permitted to do so. Family veto cannot remove or undermine this obligation.

Unlike under the Consent Model, we do not have to assess why the family is objecting or how strong their objection is in order to determine whether the family should have veto power: the state's promise to use the organs functions as a default option, and family objections typically do not override that default. The qualifier "typically" is necessary, however, which brings us to a potential worry. As I noted earlier, promises are pro tanto obligations that may be overridden in particular circumstances, such as satisfying a more important conflicting moral obligation. This leaves it conceptually open that the state's promise to use a donor's organs might be overridden. Might the family's objections to donation function as an overriding conflicting moral obligation, at least in some cases? It might seem that we are once again saddled with the problem of complexity that plagued the other models: each potential donor will have to be assessed on a case-by-case basis, to see if there is a more important conflicting obligation that overrides the state's promise to use the organs.

This worry is misplaced, for consent does not provide agents with a default option; if Anne gives Laura permission to kiss her, kissing Anne is not a default option for Laura. Rather, Laura always has to go through some process of deliberation about whether to act on the consent that has been granted and kiss Anne. But promising does provide agents with a default, and a strong default at that; if Laura promises Anne that she will meet her at 8:00, Laura does not typically need to deliberate about whether to meet her. It is only in unusual situations—say, if some unexpected relevant new information arises, such as Laura's child suddenly

falling ill—that Laura will need to deliberate and determine whether the promise to Anne has been outweighed.

Likewise, the promise to use donated organs provides the agents of the state with a strong default option. Our discussion of the Consent Model showed us that the severe organ shortage makes it the case that family objections of any strength are rarely (if ever) sufficient to override the need for life-saving transplantable organs. And so family objections are not the sort of unusual circumstance that would trigger deliberation about whether the state's promise to use the organs is overridden.

It is an asset of the PA Model that it leaves it open that there might at least in theory be other moral obligations that would override the promise that the state has made to the individual. Such cases are presumably very few and far between in real life, but we want to at least accommodate the possibility. For example, imagine that a designated organ donor dies, and his eccentric billionaire mother objects to harvesting his organs. She tells the hospital that if it leaves her son's organs intact, she will donate her vast fortune to funding research into artificial replacement organs. Assume that this research program is capable of progressing quickly, but has been halted due to lack of funds. In the long run, the billionaire's fortune will save the lives of an enormous number of people who need transplants, many more than the seven or eight lives that might be saved with her son's organs.

In such a complicated case, it is at least possible that the state's obligation to fund research into artificial organs by acceding to the billionaire's demands outweighs its obligation to keep the promise it made to her son. The PA Model allows for this possibility. And if it turns out that the state does not have a more important conflicting moral obligation to accept the billionaire's money—perhaps because she is immoral to offer it only on the condition that a promise be broken—the PA Model will predict that the promise ought to be kept after all. I do not wish to settle the ethical question here, but merely to point out that a framework invoking promises is flexible enough to accommodate whatever the correct answer turns out to be.

One might worry that the PA Model is implausible because it invokes a moral obligation to keep promises to the dead. I suspect that commonsense morality assumes that we are generally obligated to keep promises to the dead, although philosophical views about the extent to which such promises bind vary.[29] But regardless of what we think about

[29]Joel Feinberg, Steven Lupor, and George Pitcher each independently argue that the antemortem individual may be harmed by events that occur after her death; it is easy to see why we would be obligated to keep promises to the dead if they can somehow be harmed by their breaking while still living. See: Joel Feinberg, *The Moral Limits of the*

keeping promises to the dead in general, there is an important precedent for the PA Model that is uncontroversial both in law and commonsense morality: namely, legal wills. The state and its representatives are obligated to carry out the terms of a will after an individual's death, and few think that family objections to how the deceased wished to distribute her material goods provide a legitimate veto. If it is unproblematic that the state is obligated to keep legal contracts made to the dead in the case of wills, it should not be especially problematic that it is obligated to keep promissory obligations to the dead in the case of organ donation.[30]

Moreover, the PA Model is consistent with commonplace laws about whether donor status can be reversed by anyone but the donor. For example, one of the terms and conditions that someone must sign to become a donor through any of the Donate Life America state registries states that "a document of gift, not revoked by the donor before death, is irreversible and does not require the consent of any other person."[31] The PA Model accommodates this condition, while the Gift Model and the Promise Model do not, as they entail that a document of gift can be reversed if the state returns the gift or releases the donor from her promise. The PA Model therefore captures what the state is typically legally committed to, which I have argued is what it *should* be committed to, as well. If we were to be explicit about this model—that is, if organ donations were unambiguously cashed out as accepted promises—our actual practice might more closely match these legal and moral norms. And this would be a desirable outcome, as it would likely lead to fewer doctors inappropriately deferring to family veto.[32]

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Criminal Law, Volume I: Harm to Others (Oxford: Oxford University Press, 1987), pp. 79-95; Steven Luper, "Moral Harm," *Philosophical Quarterly* 57 (2007): 239-51; and George Pitcher, "The Misfortunes of the Dead," *American Philosophical Quarterly* 21 (1984): 183-88. For skepticism about whether accounts of promissory obligation that conceive of promises as directed obligations can accommodate the obligation to keep promises to the dead, see Ashley Dressel, "Directed Obligations and the Trouble with Deathbed Promises," *Ethical Theory and Moral Practice* (2014), DOI: 10.1007/s10677-014-9520-1.

[30]In making this analogy, I do not wish to imply that bodies are property, or that we have the exact same legal and moral claims over our bodies as we do over our property; a treatment of this complicated issue is beyond the scope of this paper.

[31]See, e.g., the Florida consent form at http://www.donatelifeflorida.org/register.

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