THE RIGHTS AND RESPONSIBILITIES
OF POTENTIAL ORGAN DONORS:
A Communitarian Approach

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The Communitarian
NETWORK
Preface

This position paper does not deal with one of the profound social problems our society is grappling with; it does not suggest ways to eliminate the budget deficit or stop the violence on our streets. However, it points to a public policy that if properly implemented could save thousands of lives, improve the quality of life for many others, and significantly cut medical costs. Second, the policy suggested provides an exceptionally fine case in point to illustrate how communitarian thinking leads to new insights, conclusions and public policies that make the world more attentive to community needs without in any way infringing on individual rights.

The issue at hand is organ donorship, and the solution is a communitarian one, emphasizing the rights and responsibilities of this nation’s potential organ donors: the American public. Right now, thousands of Americans are loosing their lives while others endure needless physical hardship and excessive medical costs because they do not have ready access to organs. Tragically, current organ procurement policy, generally a matter of individual voluntarism, means that thousands of potential organs are wasted. The communitarian approach would solve this problem by making organ donation a social duty--that is, everyone would be expected to
donate their organs after dying. But we are not authoritarians. Individuals and their families would be given sufficient opportunities to register their conscientious objection to the policy and opt out. In this way, we can meet the compelling public interest in organs without sacrificing our respect for individual rights.

In these pages, Dr. James Nelson shows why a communitarian approach to organ donation should be chosen over other alternatives and how such an approach might be implemented.

Amitai Etzioni
Recommendation

This is a call for a major revision of the moral basis of public policy concerning the retrieval of transplantable human organs from the newly dead. At present, we see such organs as potential gifts, to be freely given or freely withheld; this is wasteful, both medically and morally. Instead, we ought to adopt a communitarian policy that sees organ donation in the light of a social duty, as an act on behalf of our fellows and the community, that is to be routinely expected of any of us who die in circumstances that make organ retrieval feasible.

The following pages present a rationale for this policy. Broad details of procedural implementation are also discussed; these can be modified as ongoing deliberation and experience may suggest. The basic approach is that people who dissent from this obligation will have opportunities to register their refusal that are easily accessible and widely advertised in ways attentive to the linguistic and cultural diversity of our country. Essentially, any person who refuses to donate may so indicate on her or his driver’s license or when checking into a hospital by filling out a simple form. Members of the immediate family will also be able to act on behalf of the person.
Discussion

The advent of reliable antirejection drugs has made organ transplantation a highly sought-after form of therapy. But the practice of removing viable organs from dead people, and using them to forestall the death and relieve the suffering of others, has left us with problems that have proved tougher to solve than overcoming the physical body’s tendency to attack what is foreign. As a community, we are not likely to "reject" organ transplantation; its success in saving or greatly improving identifiable lives is simply too vivid. But years into the era of organ transplantation, we still have no explicit justification for determining how much we owe to fellow human beings who need these organs to live, and to the community that bears the human and economic costs when organs are not available.

Current organ procurement policy, largely a matter of individual voluntarism, is resulting in far fewer organs than are needed. Currently, individuals (or their families) may decide whether or not they wish to donate their organs when they die. They may, if they choose, indicate their wishes on driver’s licenses or donor cards. People may also signal their desire to be an organ donor once in a hospital, or their families may authorize donation after their death.
The effectiveness of present policy is bolstered somewhat in most states by laws mandating that hospital personnel request permission to transplant from the families of all appropriate candidates. At the same time, however, it is undermined by the reluctance of many health care professionals to ask--adherence to the "required request" laws is fairly spotty (Arthur Caplan and Paul Welvang, "Are Required Request Laws Working?" Clinical Transplantation, Vol. 3, 1989). The current bottom line is that the supply of organs procured for transplant falls far short of the demand, and, if anything, the gap is widening.

Here, I justify a communitarian approach by which the retrieval of organs would be a routine expectation. Under this system, adults who satisfy current medical criteria for organ donor candidacy would have their organs retrieved as needed for the purpose of transplantation. Further, newly dead adults would also be expected to provide crucial transplantable tissues--for example, corneas--as needed. But this policy avoids the dangers of authoritarianism by providing an explicit escape clause: the newly dead would be exempt if they had registered what amounts to a kind of conscientious objection to such a policy, or if their families registered such an objection on their behalf after death.
The Communitarian Network

Organ Donation

The moral motivation for this proposal has two dimensions. One is utilitarian: the shortage in donated organs, and the likelihood that such a policy revision would lead to greater availability. The second is more fundamental: construing organ retrieval as a routine matter is a powerful way of expressing our commitment to the significance of each other’s lives and to the community we share.

The Shortfall in Organs

Last month, 26-year-old Susan Fowler died after a pig liver transplant failed to keep her alive. Her doctors attempted the pig transplant after their efforts to find a human liver in time were unsuccessful. Had she had earlier access to a human liver, Fowler might still be alive (Associated Press, "Pig Liver Transplant for Dying Patient is Defended," The New York Times, October 14, 1992).

Fowler’s experience is emblematic of a growing problem in America. Advances in medicine and surgical proficiency mean that more Americans saddled with defective organs can benefit from organ transplantation. But these advances have also meant that demand for new organs has outstripped the available supply, leaving
many Americans with little hope as they or their loved ones face interminable waits for available organs. A *New England Journal of Medicine* article by Aaron Spital provides a handy if disquieting digest of the gap between organ supply and human need: Spital’s assembled data show that waiting lists for transplantation steadily grow at a level of roughly 200 per month, and that nearly 24,000 people in the U.S. are now awaiting new organs ("The Shortage of Organs for Transplantation: Where Do We Go from Here?" *The New England Journal of Medicine*, Vol. 325, No. 17, October 24, 1991).

Of those waiting, 19,000 or so are candidates for renal transplant, and it is estimated that at least 30 percent of the more than 100,000 patients currently receiving dialysis could also benefit from a new kidney. It is sobering that while the number of Americans on dialysis grew by 25,000 between 1986 and 1989, the number of kidney transplants performed actually fell—from 8,976 to 8,899. While the availability of dialysis means that kidney transplantation does not count as a life-saving technology, it is generally seen as a procedure which substantially improves quality of life, and it is clearly cost-effective: renal transplantation over the long run saves up to $25,000 annually per person when compared with extended dialysis. Heart and liver transplantation unambiguously enjoy the status of life-saving
therapies; approximately 3,000 patients are now candidates for these procedures, and it is estimated that as many as 30 percent of those people will die waiting (Spital, "The Shortage of Organs for Transplantation: Where Do We Go from Here?" The New England Journal of Medicine, Vol. 325, No. 17, October 24, 1991; John Carey, "There Just Aren't 'Enough Hearts to Go Around'," Business Week, November 27, 1989).

It is far from likely that this situation will change if the basic direction of organ procurement policy does not. At the same time that advancing technology and the easing of restrictions of the selection of recipients act to add to the pool of candidates, life-saving measures such as seat-belt laws reduce the pool of available organs. To make matters still worse, the prevalence of HIV infection is estimated to have cut the number of potential donors by at least 10 percent (Roger W. Evans, Carlyn E. Orlans, Nancy L. Ascher, "The Potential Supply of Organ Donors," JAMA, Vol. 267, No. 2, January 8, 1992).

**Moral Weaknesses in the Present System**

Our current procurement system is so biased toward respecting individual willingness to volunteer that it compels us to waste an immensely precious resource
unless potential donors or their families give explicit consent. While this bias is a familiar one, it is extremely hard on reflection to make sense of it in this context. Unless the retention of decomposing organs can be seen to have some value to the dead (or to their former intimates) that countervails the value of the transplanted, viable version of those organs to those who would suffer or die without them, or that a policy of complete voluntarism has a value in itself which trumps the needs of the ill, it looks flatly irrational.

But the possible value of organs to those who are dead is, at best, obscure; it is far from clear that any serious, direct interest of the dead or their families could be violated by organ transplantation. Some individuals, on the basis of certain metaphysical or religious views, may believe that there is such an interest; the communitarian policy we suggest fully accommodates beliefs of this kind. Some other people may simply find the idea of the rupture of bodily integrity after death profoundly disquieting; given that those from whose bodies organs might be removed are newly dead, and likely to have died suddenly and traumatically, such responses on the part of family members are understandable and will be fully respected under the suggested policy. A community trying to strike a prudent and discerning balance between individual vulnerabilities and common need should
choose to respect the desires of those who, anticipating such an event, want to spare their loved ones' feelings, or of those families whose sentiments would be badly bruised were organs to be taken from their newly dead. However, the very routinization of organ removal might well erode this revulsion, where it exists. Such reactions are not necessarily etched in stone; both education and the expressive force of social practices like routine retrieval are likely to modify them.

Finally, it might be maintained that sensibilities traditionally associated with human bodies--reverence and respect--are valuable to us all, quite independently of the particular religious traditions in which such attitudes have evolved and been nurtured. But it should be possible to distinguish routinely retrieving human organs from desecrating human bodies; organ retrieval is not incompatible with the body's role in the rites we perform to mark the significance of a human being's death, and the goals of such retrieval are deeply significant and are such that human organs typically hold out our only chance of achieving them. However, this objection does call attention to the importance of continuing to see organ procurement as an awesome thing, however "routine" it may become.

Moving from individual beliefs and reactions to the level of social policy, some
may find that the altruism expressed by voluntaristic organ donation is valuable, that the moral value of being able to make a gift of a part of one's body to others—to strangers in particular—is great, and worth preserving, even if its preservation should cost lives and suffering. But it is difficult to accept that the ennobling character of voluntarism overrides the value of saving lives, a tremendously valuable act in itself.

Some objection to routine organ removal may be based not so much on values as on fears and misunderstandings about the nature of brain death, and about the motives of health care professionals. These misunderstandings are the more excusable as they are encouraged by careless locutions on the part of some of those professionals: doctors and nurses sometimes talk to families in ways that make brain death seem a distinct kind of death, rather than a different criterion for recognizing the presence of the same state that traditional cardio-pulmonary criteria also identify (See Tom Tomlinson, "Misunderstanding Death on a Respirator," Bioethics, Vol. 4, No. 3, July, 1990). Although deserving serious educational response, misunderstandings about brain death cannot themselves justify a social policy that expresses in direct if not eloquent terms the willingness to waste a highly significant human good. What present policy amounts to is the public denial that there is any such thing as a civic duty of beneficence which anyone should take at all seriously.
The shortfall in organs has lead to proposals to commodify organs, allowing individuals to sell them, or families to make them available for a consideration--free funeral expenses, for example. Thomas G. Peters, a transplant surgeon at the Jacksonville Transplant Center in Florida, is one of a number of doctors to call for financial incentives to be provided to potential donors or next of kin, raising the specter of a market in organs: "Frankly, I'm against financial incentives. But I'm for saving lives, and therefore I'm for whatever it takes to save lives." (Prerna Mona Khanna, "Scarcity of Organs for Transplant Sparks a Move to Legalize Financial Incentives," The Wall Street Journal, September 8, 1992); recently, several commentators have also written sympathetically about such policies (see, for example, Mark T. Nelson, "The Morality of a Free Market for Transplant Organs," Public Affairs Quarterly, Vol. 5, No. 1, January, 1991 and Lori B. Andrews, "My Body, My Property," Hastings Center Report, Vol. 16, No. 5, October, 1986).

But if a voluntaristic policy is overly indifferent to the good of the community, proposals to commodify organs are positively contemptuous of it. To sell organs as property would at best confirm the already prevalent emphasis on the desires of the individual rather than on the needs of others. At worst, it would exploit those desperate for money and would grant organs to the highest bidder, thus adding a
new and disturbing dimension to the economic differences that rive our society. And not our society only: an import market would surely follow, allowing wealthy Americans to benefit from the poverty of others around the world. It is not fanciful to imagine still other liabilities: for example, the possibility that organs might be procured with violence, and the diminution of the quality of available organs, a likely outcome in the face of our experience with vended blood (see Charles Dougherty, "Body Futures: The Case Against Marketing Human Organs," *Health Progress*, Vol. 67, No. 5, June, 1987). Even if such a policy were feasible, it is not one we should promote as being socially acceptable.

Another route, to be distinguished from the approach advocated here, would be to establish an authoritarian approach to organ donation. Although this course of action remains purely hypothetical, it is one which requires some discussion. An authoritarian approach, disregarding the principle of respect for individual autonomy, would see the community interest in organs as paramount. Under an authoritarian organ removal policy, organs could be retrieved on demand, without providing occasions for anyone to register religious or other objections to the policy. Such a policy would be abhorrent because it would violate the values and deeply held feelings of some individual members of the community and/or religious
minorities. The organ crisis does not warrant such an approach. After all, we allow conscientious objection even when the country is under direct attack in war. By contrast, the communitarian approach strikes the proper balance between community needs and values and consideration of individual values and feelings.

**Presumed Consent?**

Some justify routinely retrieving organs by invoking the notion of "presumed consent" (see, for example, Arthur L. Caplan, "Organ Transplants: The Cost of Success," Hastings Center Report, Vol. 13, No. 6, December, 1983). They assume that everyone who has not explicitly "opted out" has authorized an "anatomical gift." The communitarian approach invokes neither the empirical fiction underlying presumed consent, nor its value foundation. "Presumed consent," if understood as involving a prediction about what people would in fact do given the chance, seems shaky. Recent evidence indicates that as a matter of fact, in presuming consent for donation, one would often be mistaken. A 1990 Gallup poll and individual transplant group statistics suggest that such presumptions would be wrong about half the time (Robert Veatch, "Routine Inquiry About Organ Donation--An Alternative to Presumed Consent," New England Journal of Medicine, Vol. 325, No. 17, October 24, 1991). While
reliable means of determining who has "opted out" of presumed consent would presumably reduce this "false positive" rate, one would still be left with the real possibility of making a mistake concerning a person's intentions about donation prior to her or his death, and hence, with weighing such a violation of personal autonomy against whatever good might be gained by not allowing the organ simply to decompose.

This brings us back to the value foundations for presumed consent. As it is hard to figure out what substantial value decaying organs have to the dead or those who have loved them—that is to say, what contribution their retention could demonstrably make to anyone's interests—the reluctance to yield organs has to be understood on either the ground of what goes beyond demonstration (i.e., metaphysics) or what goes beyond interests (i.e., attitudes). Both our beliefs about the ultimate character of the world, or our sentiments, are by and large regarded as matters of personal choice in this country. Personal choice, then, becomes the value valorized by voluntaristic policy, whether based on presumed or express consent. But this spells trouble for presumed consent: a procurement policy ultimately built on an ethical foundation that extols choice above all else cannot justify the large number of violations of personal choice it necessarily entails given that up to half of the
American population prefers that their organs go untouched after death. On its own terms, then, presumed consent represents a potentially highly coercive policy. In contrast, a communitarian policy of organ retrieval, allowing conscientious objection, makes a clear statement acknowledging our reliance on each other, and legitimating at least a minimal expectation that members of the political community are willing to supply others with objects of great value, when it can be done at no cost to themselves.

**The Communitarian Rationale**

If the current voluntaristic procurement policy overstresses the value of individual autonomy, and if authoritarianism pays no attention to such a value, the communitarian policy recommended here represents an important conceptual alternative. It does not rest on respect for pure autonomy above all, but on a richer moral ground which takes beneficence seriously. Many of the moral traditions most significant in our culture, religious and secular, converge in supporting the idea that we have a duty to provide aid to others if they are at significant risk of loss or damage, if our contribution is needed to prevent this loss and would probably do so, if our action presents us with little risk, and if the benefits to the other outweigh the
harm we are likely to incur (for discussion of the principle of beneficence, see Tom L. Beauchamp and James F. Childress, *The Principles of Biomedical Ethics*, Oxford: Oxford University Press, 3rd edition, 1989, chapter 5).

The implications of such a communitarian duty for transplantation are straightforward. The brain dead have in their keeping something which is of no value to them (apart from considerations of metaphysics or sensibility) but of great significance to others and to the community. To deny that they have a duty to provide this good to others--or, if talk of the duties of the dead seems objectionable, to deny that any who retain an interest in the dead person have such a duty--is simply to deny that there is any such thing as a duty of beneficence to the community. A policy embodying such a denial stands on an image of human relationships which presupposes that we neither feel nor ought to feel bound to nonintimates except as self-interest--occasionally leavened by a charity that is purely above and beyond the call of duty--dictates.

While there are certainly thinkers who maintain such libertarian views, the underlying image of human beings as fundamentally self-interest maximizers is empirically highly suspect and normatively incompatible with a civil society (for
evidence and discussion, see Amitai Etzioni, *The Moral Dimension*, New York: Free

There may be a temptation to admit that there are indeed individual duties of
beneficence, and that allowing one's organs to be transplanted after death falls well
inside them, but conceding this does not entail that such a duty ought to be fostered
by the community. But consider that a communitarian organ procurement policy
does not represent simply ladening burdens (even if they be vanishingly small
burdens) on some so that others may benefit: it is a policy that offers a benefit to all
(at least, on the presupposition that justice demands access to transplantation as a
universal health benefit). Insofar as routine retrieval makes more organs available,
assuming equity in allocation, everyone benefits, at least to the extent of becoming
more secure against organ failure, if not actually undergoing a transplant personally,
or having an intimate receive one. Insofar as routine retrieval "merely" expresses that
members of the community can expect at least minimal support from each other,
everyone benefits in a different way. And finally, we gain in two important and
discernable ways from increased organ availability. First, on the human scale,
thousands are saved from premature loss of life and, for those benefitting from new
kidneys, many thousands more can look forward to a measurably higher quality of life. Second, the economic benefits of ceasing to rely on dialysis for end-stage renal disease sufferers is considerable. The point is that fostering a social expectation for organ donation is not a matter of forcing us to direct our charity as the state determines; rather, it is a matter of enhancing the character of our communal lives.

**The Status of Conscientious Objectors**

The policy advocated here would constitute a strong statement about the kind of community we take ourselves to be—that we are compassionate enough to provide substantial aid to each other, at least when it can be done at little cost to each individual. Clearly, however, such a level of compassion does not exhaust our moral self-understanding. We also should recognize, as a community that strives to be respectful of difference, particularly of conscientious dissent, that the community has an interest in giving substantive recognition to such dissent. In this way can we avoid the dangers of authoritarianism.

Accordingly, a reasonable communitarian organ procurement policy will provide ample opportunities for citizens to dissent from the policy. Note that such
a commitment does not necessarily signal that citizens of the community have an established "right" to withhold their organs. Rather, a policy that carefully accounts for the sincere differences that exist within the community over organ donation symbolizes the community’s commitment to a measure of pluralism.

A related question arises concerning the consequences of such dissent. Should those who place particular value on the retention by the dead of their organs be allowed equal opportunity to benefit from the organs of others? Considerations of justice would seem to suggest not. Stipulating that anyone who elects to conscientiously dissent ought to be at a lower priority for obtaining a transplanted organ, as is done in Singapore, given continued organ scarcity, does not seem unjust on its face. Yet the point deserves closer scrutiny. I have proposed here that objection to routine retrieval of organs be seen as a kind of conscientious objection to a broadly endorsed social value. Such conscientious objection ought not only to be tolerated, but not be punished. Conscientious objectors to military service in wartime are not stripped of the state’s protection. However, military protection is not a benefit which can be distributed on individual basis, as is the case with transplantable organs, so it is not on this analogy alone that caution about lower priority for dissenters rests. The more fundamental point is that we do not have a uniform moral history as a
community, and this fact needs to be taken into account in communitarian policy formation.

Suppose, for example, it were to turn out that African-Americans dissented disproportionately from routine retrieval, and that their disproportionate dissent were based on a lack of trust that the health care system would treat people of color equitably. There seems good reason for such a supposition (see, for example, Carl M. Kjellstrand, "Age, Sex and Race Inequality in Renal Transplantation," *Archives of Internal Medicine*, Vol. 148, June, 1988). Even if racially skewed patterns of organ distribution were ended, the residual mistrust would have serious claim to our moral respect, and hence, those individual African-Americans who dissent ought not suffer as a result.

The question about how to justly respond to dissent becomes quite complicated, therefore. Would a communitarian organ procurement policy that generally gave a lower priority to dissenters, but made exceptions for members of groups subject to discrimination in transplant medicine--racial minorities and women--be socially viable? Such a policy would certainly have to deal with many conceptual and practical issues, and would likely give the impression of being
invidiously discriminatory toward dissenters not in the excepted categories. It seems to me that the best policy would be to distribute available organs on the basis of need, at least initially, and only reopen debate on the relevance of dissent after the policy had time to smooth out previous inequities, and build up trust.

Another significant issue concerns who is entitled to register dissent—specifically, whether families should be empowered to register a conscientious objection on behalf of deceased loved ones who had not done so in their own person. ("Family" in this context means specifically a spouse, parents, or those standing in the place of spouses or parents, and/or children, not all kin.) The answer most consistent with the moral foundations of this policy might seem to be in the negative—we ordinarily think of conscientious objection as reflecting one’s own deepest convictions. However, to make this suggested revision in social policy as widely acceptable as possible, the threshold for objection should be pitched very low—low enough to be exercised by "bonded" surrogates of the sort we generally suppose families to be. It might be thought that allowing families to dissent will eviscerate whatever advantage this proposal may have in terms of securing more organs. But, as work by Charles Dougherty suggests, there is reason to believe that approaching next of kin to remind them of a policy for which their acquiescence is expected,
rather than for expression of an active preference for organ retrieval, makes the task psychologically easier for both the professionals and the family (Charles Dougherty, "A Proposal for Ethical Organ Donation," *Health Affairs*, Vol. 5, No. 3, pp. 105-110, Fall, 1986). It should not be thought necessary to inform family members if none are readily accessible in order for transplantation procedures to go ahead.

As in the case of policy concerning dissenters, policy about the role of families in organ procurement is revisable. These suggestions about both families and dissenters represent an attempt to strike the right balance between the goods of human life and community solidarity and the goods of respect for intimacy and for difference. Our experience with policy as it develops will help us to see more accurately just where that balance can be achieved.

**Precedents**

Some American states have already moved beyond explicit consent as a requirement for certain forms of tissue donation. In Georgia, for example, the 1978 passage of a statute allowing medical examiners to remove eyes or corneal tissue under specified circumstances had a major impact on corneal transplant: prior to the
effective date of the law, approximately 25 such operations occurred each year, but in 1984, more than 1000 people regained their sight through transplantation. (National Conference of Commissioners on Uniform State Laws, Uniform Anatomical Gift Act 1987).

Without passing judgement on its political system, I note that Singapore has recorded good results since moving to a system whereby organs are routinely retrieved. Its Human Organ Transplant Act, which became effective in 1987, presumes that all mentally competent citizens or permanent residents between the ages of 21 and 60 are kidney donors unless (a) they are Muslims (who are presumed to have religious objections, unless they specifically indicate otherwise), or (b) they have registered their dissent. The country has experienced a two-and-a-half fold increase in the number of kidneys available for transplant between 1986 and 1990 (Bernard Teo, "Organs for Transplant: The Singapore Experience," Hastings Center Report, Vol. 21, No. 6, November-December, 1991).

**Implementation**

On the federal level, we recommend the convening of a national conference
in which a communitarian policy of organ procurement would be discussed and
refined, and relevant amendments drafted for the Uniform Anatomical Gift Act.
Georgia’s law, as it concerns the retrieval of corneal tissue, might serve as a model
for federal legislation ranging over all transplantable tissue (see below). Georgia
provides that, upon a request from an authorized official of an approved eye bank
for corneas for transplantation or research, such tissue may be retrieved so long as
no objection by the decedent is known to the persons named as appropriate for
authorizing transplantation (coroners, medical examiners, hospitals), or that no
objection is made known to the retrieval by a ranked list of intimates starting with
the decedent’s spouse, and continuing through her adult children, parents, or next
of kin. The Georgia law reads as follows:

(a) (1) Upon the request of any approved eye bank in any case in which
a patient is in need of an eye for a transplant, a physician performing an
autopsy by consent, a coroner, a medical examiner, hospital, or funeral director
may provide the eye of a decedent whenever all of the following conditions are
met:

(A)(i) A decedent who may provide a suitable eye for the
transplant is under the jurisdiction of a coroner or medical examiner and an
autopsy is required in accordance with Article 2 of Chapter 16 of Title 45; or

(ii) The physician has been requested, as provided by law, to
perform an autopsy on a decedent who may provide a suitable eye for the
transplant;
(B) The express written consent to the removal of the eye is given by the next of kin of the decedent; and

(C) The removal of the eye will not interfere with the subsequent course of an investigation or autopsy.

(2) No physician, coroner, medical examiner, hospital, or funeral director authorizing removal of eye tissue nor any eye bank or its personnel requesting or participating in such removal shall be liable or responsible in any civil or criminal action for the removal or subsequent transplant of the tissue, provided that its removal was in accordance with the requirements of this subsection.

(b) (1) Upon a request from an authorized official of an approved eye bank for corneal tissue to be used for transplants or research, a coroner, a medical examiner, hospital, funeral director, or an authorized official acting for the coroner may permit the removal of the corneal tissue of a decedent by individuals designated by the eye bank for the delivery to the eye bank for such purposes if all of the following conditions are met:

(A) The decedent from whom the tissue is to be taken is under the jurisdiction of a coroner or medical examiner pursuant to Code Section 45-16-27;

(B) No objection by the decedent during his lifetime or, after his death, by the appropriate person listed in paragraph (2) of this subsection is known to the coroner, medical examiner, or authorized official acting for the coroner at the time the tissue is removed; and

(C) The person designated by the eye bank to remove the tissue is a person authorized to do so under Code Section 31-23-5.

(2) Objection to the removal of corneal tissue may be made known to the coroner, medical examiner, hospital, funeral director, or authorized official acting for the coroner by the decedent during his lifetime or by the following persons after the decedent’s death:

(A) The decedent’s spouse;
(B) If no spouse survives him, any of the decedent’s adult children;

(C) If no adult children or spouse survives him, either of the decedent’s parents;

(D) If no parents, adult children, or spouse survives him, any of the decedent’s brothers or sisters; or

(E) If none of the foregoing survives him, the decedent’s next of kin.

(3) No coroner, medical examiner, hospital, funeral director, or authorized official acting for the coroner authorizing the removal of corneal tissue nor any eye bank, its personnel, or other person requesting or participating in the removal of corneal tissue for the eye bank shall be liable in any civil or criminal action for removing corneal tissue from a decedent and using same for transplant or research purposes without obtaining prior consent from any individual listed in paragraph (2) of this subsection if such individual failed to object prior to such removal as authorized in this Code section and the removal was in accordance with this Code section.

("Removal of Eye or Corneal Tissue," Official Code of Georgia Annotated, Title 31, Chapter 23 at 6).

Important lacunae in Georgia’s approach would have to be filled in were it to be extended in the ways envisaged here. For example, the range of intimates allowed to conscientiously object on behalf of the decedent would have to be specified in ways that take into account important changes in the private lives of many Americans in the late 20th Century; for example, we should have to deal with the difficulties involved in assessing the claims of significant others not legally married, particularly in view of the fact that many couples are not legally allowed
to marry. More importantly, a computerized national registry for dissenters, as used in Belgium, should also be developed, in order to minimize the chances that organs might be removed from someone simply because their "organ non-donor" card (to be issued by a local motor vehicle department or public health service) was unavailable.

On the local level, mechanisms for educating citizens about the new policy need to be developed and implemented. Current opportunities for discussion between health care providers and recipients at local medical facilities should be pressed into service; for example, a conversation concerning organ retrieval policy should be included in the discussion on advance directives for health care decision making, which is now mandated by the Patient Self-Determination Act. The letter of this recently enacted law mandates that such discussions occur in hospitals and clinic settings, but its spirit strongly suggests that physicians ought to initiate wide discussions about health care matters with their patients in outpatient contexts: such conversations should include, as a matter of course, information about routine retrieval.

As suggested above, motor vehicle bureaus, public health service departments
and voter registration sites should also be pressed into service as sources of education on organ procurement, and provide opportunities for dissenting citizens to register their conscientious objection. Specifically, those seeking to opt out could be issued non-donor cards, or could receive a notation on their driver's licenses.

**Conclusion**

A communitarian policy of routine retrieval of human organs possesses the promise of reducing the wastage of a precious human resource. It also sends a clear message that we as a society take avoidable suffering and death with seriousness. Organ transplantation is a way of responding to suffering and death which involves little or nothing in the way of individual burden, but still possesses great symbolic power, as a concrete way of sharing selves. It provides a source of meaning, not simply with respect to the often tragic, often unexpected death of people who can provide organs to others, but to all of us: in terms of what we take ourselves to be, and as well as how we act, it makes of us a more admirable community.
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Dr. Nelson is the author of over forty publications in biomedical ethics and philosophy which have appeared in such leading journals as The New England Journal of Medicine, American Philosophical Quarterly, The Journal of Medical Ethics, The Hastings Center Report, Theoretical Medicine, Bioethics and Dialogue. He has received major grants from the National Institutes of Health and the National Science Foundation, and has served as a consultant to ethics committees in Veterans Administration Medical Centers in Minneapolis and St. Cloud. Currently, he is a consultant to the ethics committee of Stamford Hospital, Stamford, Connecticut.
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