OPTING IN TO AN OPT-OUT SYSTEM: PRESUMED CONSENT AS A VALID POLICY CHOICE FOR ONTARIO’S CADAVERIC ORGAN SHORTAGE

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ABSTRACT

Established within the context of a severe shortage of organs and tissues for transplantation, this thesis explores whether presumed consent for cadaveric organ donation is a legitimate policy choice for Ontario. The medical, legal and social reasons underlying organ scarcity and increased demand for transplantation are examined, and the shortcomings of Ontario’s current express consent system are analyzed. The various criticisms of presumed consent are also explored, including concerns with respect to its effectiveness, level of public support and implications for personal autonomy. Although the Citizens Panel on Increasing Organ Donations recommended against enacting presumed consent legislation, it is argued that the Panel was too dismissive of this concept given a perceived lack of public support. It is concluded that presumed consent can meet the concerns of critics, and that as part of a broader strategy could significantly increase the number of cadaveric organ and tissue donors in the province.
ACKNOWLEDGEMENTS

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I. INTRODUCTION

In February of 2006, Bill 61 was tabled in the Ontario Legislature. Bill 61 contemplated changes to the *Trillium Gift of Life Network Act*,\(^1\) such that upon the death of a person, tissue from that person’s body could be removed and made available for transplant without the consent of the person from whom the tissue was removed. A deceased person’s tissue and/or organs would be donated unless that person had specifically opted out of the donation program. Bill 61 died on the Order Paper in the last provincial election,\(^2\) but reinvigorated the debate over whether presumed consent for cadaveric organ donation presents a workable solution for Ontario’s organ and tissue shortage.

Indeed, the issue of presumed consent was subsequently considered by the Citizens Panel on Increasing Organ Donations (the “Citizens Panel”),\(^3\) which ultimately recommended against enacting such legislation.\(^4\) The Citizens Panel concluded that presumed consent was “too passive a method to be a clear statement of an individual’s intent,”\(^5\) and that it could not ensure Ontarians their first priority concerning organ donation, being that their wishes alone be respected.\(^6\) Furthermore, in recommending against enacting presumed consent legislation, the Citizens Panel concluded that there was no consensus as to its effectiveness and noted that the nature of the debate with respect to presumed consent had been corrosive.\(^7\)

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\(^1\) *Trillium Gift of Life Network Act*, R.S.O. 1990, c. H.20, as amended [*TGLN Act*].
\(^3\) Ontario Bar Association, Health Law Section, “Submission from the Health Law Section of the Ontario Bar Association on Bills 33, 61, 67 and 79 Pertaining to Organ Donation”, (N.p., 2007) at 3 [Bills 33].
\(^5\) *Ibid*.
\(^6\) *Ibid*.
\(^7\) *Ibid*. 

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Yet the gap between the number of Ontarians on waiting lists and the number of available organs continues to widen due to increasing demand.\(^8\) The main problem with Ontario’s current express consent system for cadaveric donation is that it has consistently failed to provide enough donor organs to keep pace with the ever-growing demand for transplantation.\(^9\) Unfortunately, the altruistic system as it has been implemented in Ontario has not worked. As such, despite the conclusions of the Citizens Panel, one can query whether it relied too heavily on the perceived lack of public support in rejecting a presumed consent regime. It may be that the Citizens Panel’s conclusion that presumed consent lacked public support led to a more cursory examination of the other issues surrounding presumed consent than was actually warranted. In any event, increasing the availability of organs and tissue in Ontario may be an important enough goal from a public health perspective such that the current attitudes of Ontarians should not be sufficient reason to outright reject a change in policy, with the level of public support representing only one factor to be considered in determining whether presumed consent could increase the availability of cadaveric organs and tissues. Organ scarcity in this province is a serious and unresolved public health issue, and given this, all possible methods of increasing the supply of organs and tissue in Ontario, including presumed consent, should be thoroughly considered. This thesis will focus specifically on the option of presumed consent, exploring whether this particular organ donation model offers a workable and ethical solution to Ontario’s organ and tissue shortage.

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II. THE SCARCITY AND DEMAND FOR ORGANS

a) Low Donation Rates

Canada consistently has one of the lowest organ donor rates in the developed world.\(^{10}\) According to the Canadian Organ Replacement Registry, Canada’s crude donation rate for deceased donors in 2005 was 12.8 per million population, well below Spain at 35.1 and even the United States at 21.5.\(^{11}\) The vast majority of cadaveric organ donations in Ontario involve donation after neurological determination of death, when a person has suffered a devastating brain injury such as may occur following an aneurysm, severe head injury or stroke.\(^{12}\) However, over time there has been a decrease in the number of patients who die from such causes,\(^{13}\) with the number of deaths in Ontario by way of cerebral vascular accident half of what is was thirty years ago and about the lowest in the industrialized world.\(^{14}\) In Ontario, helmet laws have decreased the death rate for riders of two-wheeled vehicles to the lowest in the world.\(^{15}\) In addition, seatbelts, airbags, drinking-and-driving laws and advances in highway design and construction have also reduced deaths from motor vehicle accidents significantly,\(^{16}\) such that the probability of an Ontarian being an eligible brain dead donor is now about 1 in 550.\(^{17}\) Some estimate that brain death occurs in only approximately 1-2% of all in-hospital deaths, severely limiting the donor pool.\(^{18}\) However,

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\(^{12}\) Trillium Gift of Life Network. Online: Trillium Gift of Life Network website <http://www.giftoflife.on.ca> [TGLN website].

\(^{13}\) See Ontario Ministry of Health and Long-Term Care, Citizens Panel, supra note 4 at 10.

\(^{14}\) Ibid.

\(^{15}\) Ibid.

\(^{16}\) Ibid.


\(^{18}\) See Zdeb, supra note 8 and Norbert R. Hoferichter, The Waiting Game: Crisis in the Organ Donor System (Toronto: Abbeyfield Publishers, 2001) at 139.
the Citizens Panel puts this estimate even lower, stating that less than 1% of those who die in hospital each year meet the strict criteria for donation after brain death.  

Given the absolute limit on the number of donors who suffer from brain death, the first, and likely most difficult step in the donation process is finding a donor. Such brain dead donors must die in hospital in an intensive care unit (“ICU”) where the necessary care can be given to maintain the organs immediately. Moreover, maintaining a brain dead beating heart donor is labour intensive, as the donor must be artificially maintained by ventilator to keep their organs suitable for transplant. In addition, although every year in Canada approximately 6,000 people die who could become donors, only approximately 400 do so. As such, the problem is not only a lack of suitable donors, with donations from the brain dead unable to meet the need, but also a failure to turn potential donors into actual donors. Each and every opportunity to procure organs is important, as brain dead donors can potentially donate their kidneys, lungs, heart, liver, pancreas, small bowel and other tissue components, with twenty-seven organs and tissues that can be harvested for transplantation. Indeed, no other source is capable of providing as many organs. A single brain dead donor can save the lives of four people by way of donating their heart, both lungs and their liver, improve the lives of five more people by donating both kidneys, corneas and

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19 *Supra* note 4 at 9.
24 See TGLN website, *supra* note 12.
29 See Hoferichter, *supra* note 18 at 145.
pancreas, and benefit the lives of many more by donating bone, skin, and tissue.\textsuperscript{31} Certainly, the Citizens Panel recognized the need to use every potential donor to the maximum benefit,\textsuperscript{32} and in fact Ontario reaches the best standards internationally by obtaining an average of 3.8 organs from each brain dead donor.\textsuperscript{33} As such, given that the number of brain dead patients is limited and once a patient becomes a donor, efficiency is high, an increase in donors can only occur if more of these patients become donors.\textsuperscript{34}

In contrast to donation after neurological death, an estimated 75\%-80\% of people who die in hospital are medically suitable for donating tissue.\textsuperscript{35} With tissue donation, there is no need for blood flow to be maintained by artificial ventilation after death.\textsuperscript{36} Corneas, skin, bone, cardiovascular tissue and connective tissue are the most common types of tissue transplanted,\textsuperscript{37} with one tissue donor capable of improving the lives of as many as seventy-five individuals.\textsuperscript{38} As such, in theory at least, the procurement of tissue should not present as many obstacles.

b) Increase in Demand

With the advent of more effective immunosuppressive drugs such as Cyclosporin and improvements in transplant immunology, surgical techniques,\textsuperscript{39} peri-operative care,\textsuperscript{40} and the use of artificial organs as a bridge to transplant,\textsuperscript{41} transplantation has become more

\begin{thebibliography}{9}
\bibitem{32} Supra note 4 at 11.
\bibitem{33} Ibid.
\bibitem{34} Ibid. at 12.
\bibitem{35} Ibid. at 12.
\bibitem{36} Ibid. at 12.
\bibitem{37} Ibid.
\bibitem{38} Ibid.
\bibitem{39} Laura A. Siminoff \textit{et al.}, “Factors Influencing Families’ Consent for Donation of Solid Organs for Transplantation” (2001) 286(1) JAMA 71 at 71.
\end{thebibliography}
successful, with transplant procedures in Canada now boasting a success rate of 85-95%.

Rejection rates have declined and the expected life of a transplanted organ in Ontario has lengthened, with survival of ten to twelve years being the norm. Certainly, the Trillium Gift of Life Network (“TGLN”) is correct in recognizing that “(o)rgan transplantation has evolved from an experimental treatment to the treatment of choice for thousands of Ontarians who await the gift of life.” Not only are physicians performing transplants that would not have been attempted ten years ago, but better patient management has allowed transplant for those who would previously have been excluded from consideration. Organ transplantation is now a well established treatment for renal, cardiac and liver failure, as well as for some respiratory diseases, and as organ transplant surgeries have become more successful, this has encouraged those people that might otherwise have opted not to undergo a transplant to proceed.

The increased success of organ transplantation however has led to the demand for organs dramatically rising and far outstripping the supply. As the number of organs available for transplantation in Ontario has remained relatively unchanged over the past decade, the gap between the number of patients on waiting lists and available organs has

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42 See Hoferichter, supra note 18 at 146.
44 See Ontario Ministry of Health and Long-Term Care, Citizens Panel, supra note 4 at 2.
45 See TGLN website, supra note 12.
46 See Ontario Ministry of Health and Long-Term Care, Citizens Panel, supra note 4 at 2.
47 See Matesanz, Miranda and Felipe, supra note 27 at 103.
48 See Krueger, supra note 21 at 324.
49 Leo Roels, “Donor Hospital Development in Non-University Hospitals” in G.M. Collins et al., eds., Procurement, Preservation and Allocation of Vascularized Organs (Boston: Kluwer Academic Publishers, 1997) at 255 [Donor Hospital] and see Gerson, supra note 41 at 1013.
51 See TGLN website, supra note 12.
continued to widen, with the transplant waiting list increasing by two thirds from 1995 to 2005. From 1994 to 2004, demand measured by waiting lists for organ transplants increased by 100%, while organ transplantation increased by only 17% during this same period. Although 2004/05 and 2005/06 saw increases in cadaveric donation of 14% and 19% respectively, even greater increases in donation rates are necessary to meet the demand. The aging of the Baby Boom generation has also increased the number of patients who require transplants. Some experts have predicted that over the next three decades, the shortfall in Ontario between organ supply and demand will increase by 291%. The increasing incidence of end stage organ disease is also problematic. As 250,000-300,000 Canadians are infected with viral Hepatitis C, a 500% increase in demand for liver transplants has been predicted over the next decade alone. At any time approximately 1,700 Ontarians are waiting for a transplant, with one Ontarian dying every three days while waiting for an organ. As such, the rationing that necessarily results from the demand exceeding the supply essentially condemns many patients to death.

52 See Zdeb, supra note 8.
53 Patrick Dare, “Ontario Organ Donation Registry on the Way” Canada.com (3 August 2007), online: Canada.com website <http://www.canada.com/topics/bodyandhealth/story.html?id=3b45b75f-074d-4ee4-b8fd-ff006080463d>.
54 See Ontario Ministry of Health and Long-Term Care, Citizens Panel, supra note 4 at 39.
55 Ibid.
56 Ibid.
57 Ibid. at 2.
59 See Ontario Ministry of Health and Long-Term Care, Citizens Panel, supra note 4 at 39.
60 See Hoferichter, supra note 18 at 126.
63 See TGLN website, supra note 12.
Waiting lists do not present the whole picture, as given the chronic shortage, some transplant clinics are very selective about who is put on the list. Certainly, more patients would be placed on the waiting list despite their failure to strictly meet the criteria if more organs were available.

The organ shortage is not specific to Ontario, and from 1993 to 2003, the number of Canadians waiting for a transplant increased by 84% while the number of cadaveric organs available remained virtually unchanged. There are not enough organs and tissues available in Canada to meet the need, with a new name added to the waiting list every twenty minutes. However, there is evidence that Ontarians wait longer than Canadians living in other provinces for transplantation, at least for kidneys. Tonelli et al. found significant differences in the likelihood of kidney transplantation from deceased donors and predicted waiting times between different geographic regions in Canada. Compared with patients living in Ontario, those in Atlantic Canada, Quebec, Saskatchewan and Alberta were significantly more likely to receive a kidney transplant. Furthermore, the median predicted waiting time for a non-diabetic patient less than forty years of age was 3.1 years in Alberta, 7.8 years in British Columbia and 8.0 years in Ontario.

c) Failure of the Current System to Keep Pace with Science

The fact that Ontarians may be faring worse than other Canadians when it comes to organ transplantation is particularly troublesome when one considers Ontario’s strong history

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65 Supra note 4 at 3.
67 See Ontario Ministry of Health and Long-Term Care, Citizens Panel, supra note 4 at 3.
68 Greg Knoll and John Mahoney, “Non-Heart-Beating Organ Donation in Canada: Time to Proceed?” (203) 169(4) CMAJ 302 at 302.
69 See Hoferichter, supra note 18 at 125.
70 Ibid.
72 Ibid. at 481.
73 Ibid.
in transplant related research. The world’s first heart valve transplant, successful lung transplant, successful double lung transplant, and successful liver-bowel transplant all took place here. In less than forty years, organ transplantation has advanced from the experimental stage to clinical reality, such that “miracles were set to become technical routine.”

However, the amazing potential of organ transplantation to save the lives of Ontarians has been severely constrained by the failure of public policy to keep pace with technological advances. The current cadaveric organ procurement system, which relies entirely upon altruism and express consent, appears to have been inherited from the earliest days of transplantation, when living related donors provided the only technologically feasible source of organs. This policy choice however has never been seriously questioned or evaluated. As such, an express consent, altruistic system was locked into place without any real inquiry as to its effectiveness in a technological environment that now relies primarily on unrelated cadaveric donors.

As Ontario’s laws with respect to organ procurement have not adapted over time to medical advances and have failed to respond effectively to the rapid growth in the demand for transplantable organs, the result has been a chronic and growing shortage of human organs that has in turn denied life-saving treatment to desperately ill patients who occupy ever-increasing waiting lists. Moreover, the shortfall in organs available for transplantation

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74 See TGLN website, supra note 12.
75 Ibid.
76 See Martin, supra note 40 at 287.
78 See Kaserman, supra note 43 at 46.
79 Ibid. at 49.
80 Ibid. at 50.
81 Ibid. at 51.
82 Ibid. at 51.
83 Ibid.
84 See TGLN website, supra note 12.
has inhibited the further utilization of therapeutically promising organ transplantation techniques.\textsuperscript{84} As such, the greatest challenge that the medical community faces in the organ donation and transplantation field continues to be organ scarcity,\textsuperscript{85} with the benefits and continued success of organ transplantation threatened by this shortage.\textsuperscript{86}

d) Presumed Consent as an Option

Medical science has provided a real chance of survival for patients with failing organs, but the scarcity of organs for transplant nullifies much of that promise.\textsuperscript{87} Obviously, the supply of organs is of paramount importance to the continued success of organ transplantation,\textsuperscript{88} but express consent regimes for cadaveric donation have consistently failed to provide enough donor organs to keep pace with the ever-growing demand.\textsuperscript{89} One can argue that the current express consent organ donation system in Ontario has failed to procure enough organs at least in part because it operates under the assumption that individuals are not organ donors.\textsuperscript{90} Indeed, some contend that an increase in organ supply sufficient to meet current needs is not feasible within an express consent regime.\textsuperscript{91} Unfortunately, organ donation systems that rely on public altruism have simply failed to meet the demand for

\textsuperscript{84} James Blumstein, “The Use of Financial Incentives in Medical Care: The Case of Commerce in Transplantable Organs” in Andrew Grubb and Maxwell Mehlman, eds., Justice and Health Care: Comparative Perspectives (Toronto: John Wiley & Sons Ltd., 1995) at 10.
\textsuperscript{87} Teri Randall, “Too Few Human Organs for Transplantation, Too Many in Need... and the Gap Widens” (1991) 265 JAMA 1223 at 1223.
\textsuperscript{88} See Higgins and Evans, supra note 86 at 11.
\textsuperscript{89} See Blair and Kaserman, supra note 9 at 405.
\textsuperscript{90} See Gloria J. Banks, “Legal and Ethical Safeguards: Protection of Society’s Most Vulnerable Participants in a Commercialized Organ Transplantation System” (1995) 21 Am. J.L. & Med. 45 at footnote 151 and at 64-65, where Banks argues that in the American context at least, the organ donation system of “encouraged voluntarism” is viewed by Arthur Caplan as no longer effective in meeting the demand for organs.
organs,\textsuperscript{92} with most organs still taken to the grave.\textsuperscript{93} Moreover, initiatives within the express consent regime have been unsuccessful in significantly increasing donor supply.\textsuperscript{94}

Although Ontario’s current regime with respect to cadaveric donation is premised on a form of express consent, this is just one of several possible policy choices.\textsuperscript{95} Arguably, pure voluntarism may be the moral ideal, but it has failed to generate the organs needed to save lives.\textsuperscript{96} As such, concern for those patients who require transplantable organs in order to survive and dissatisfaction with the current regime’s failure to meet their needs\textsuperscript{97} has led to calls for change in the present system\textsuperscript{98} and also increased public receptivity to new ideas for increasing the organ supply.\textsuperscript{99} Legislators and the public have been asked to consider novel approaches to organ donation, with one alternative being presumed consent.\textsuperscript{100} Arguably, the chronic shortage of organs for transplantation is one of the most pressing health policy issues in many developed countries,\textsuperscript{101} including Canada. Organ scarcity is a serious and unresolved public health problem\textsuperscript{102} requiring an equally serious response,\textsuperscript{103} and one can contend that presumed consent should be carefully considered as part of a possible solution to Ontario’s organ shortage.

\textsuperscript{94}See Martin, \textit{supra} note 40 at 288.  
\textsuperscript{96}See Higgins and Evans, \textit{supra} note 86 at 75.  
\textsuperscript{97}J. Michael Dennis \textit{et al.}, “An Evaluation of the Ethics of Presumed Consent and a Proposal Based on Required Response” (30 June, 1993), online: UNOS website \texttt{<http://www.unos.org/Resources/bioethics.asp?index=2>}.  
\textsuperscript{98}Steven M. Cooper, “Consent and Organ Donation” (1985) 11 Rutgers Computer & Tech. L.J. 559 at 570.  
\textsuperscript{100}See Martin, \textit{supra} note 40 at 287.  
\textsuperscript{102}See Higgins and Evans, \textit{supra} note 86 at 13.  
\textsuperscript{103}Elizabeth Wicks, \textit{Human Rights and Healthcare} (Portland: Hart Publishing, 2007) at 155.\end{flushleft}
III. OVERVIEW OF ONTARIO'S ORGAN DONATION LEGISLATION

a) *Uniform Human Tissue Donation Act*

Organ and tissue donation and transplantation, as part of health care, come under provincial jurisdiction. In each province, the provincial statute dealing with organ and tissue donation is based on a uniform statute that was created by the Uniform Law Conference of Canada, a joint federal-provincial body that was formed to harmonize the laws of the provinces and territories. The most recent version of this uniform statute is the *Uniform Human Tissue Donation Act* (the “*Uniform Act*”) of April 1990. Under the *Uniform Act*, which forms the basis of all organ and tissue donation legislation in Canada, post-mortem consent can either be by way of the donor while living or by way of a proxy for the deceased in the absence of donor consent.

b) Post-Mortem Consent Regime Under the *Uniform Act*

The *Uniform Act* is drafted such that organ and tissue donation legislation is to be a complete and self-contained consent regime. Under the *Uniform Act*, a donor must be at least sixteen years of age and must understand the nature and consequences of transplanting tissue from their body after death. As such, this is an informed consent regime. If the potential donor has not given consent, or has not reached the age of consent, the *Uniform Act* lists a hierarchy of proxies who may give consent on their behalf based on the proxy’s relationship with the potential donor before death. The proxy must be at least sixteen years of age, understand the nature and consequences of transplanting tissue from the deceased after death, and have no reason to believe that the deceased would have objected to

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105 Ibid.
106 Ibid.
107 Ibid.
108 Ibid. at 5; also see *Uniform Human Tissue Donation Act*, s. 2.
110 Ibid.
111 Ibid.
the consent. The proxy can give consent only after the death of the person, with the decision of the highest ranking proxy prevailing. In addition, the coroner may give consent if no proxy can be found after reasonable efforts.

c) Post-Mortem Consent Regime Under the Current Trillium Gift of Life Network Act

In Ontario, TGLN was created in December 2000 by the Ontario Government. TGLN is a not-for-profit agency responsible for coordinating and supporting organ donation in Ontario, with its mission being to save and enhance more lives through organ and tissue donation. TGLN has assumed the role of Ontario’s central organ and tissue donation agency, with the challenge of significantly increasing organ and tissue donation across the province and improving related processes and functions.

The relevant legislation in Ontario is the Trillium Gift of Life Network Act (“TGLN Act”), which provides that any person age sixteen or over may consent to post-mortem organ or tissue donation in writing at any time or orally during the person’s last illness in the presence of two witnesses. The TGLN Act provides that consent so given is "binding and full authority" for the use of the body or specified body parts of the deceased, except if there is reason to believe that consent has been withdrawn.

Although the post-mortem consent regime for organ donation under the TGLN Act is largely based on the Uniform Act, the informed consent regime expressly required under

\[112\] Ibid. at 4-5.
\[113\] Ibid. at 5.
\[114\] Ibid.
\[115\] Ibid.
\[116\] See TGLN website, supra note 12.
\[117\] See Ontario Ministry of Health and Long-Term Care, Citizens Panel, supra note 4 at 2.
\[118\] See TGLN website, supra note 12.
\[119\] Ibid.
\[120\] See TGLN Act, supra note 1.
\[121\] Ibid. at s. 4(1).
\[122\] Ibid. at s. 4(3).
\[123\] See Ontario Bar Association, Health Law Section, Bills 33, supra note 3 at 5.
the *Uniform Act* is not reflected in the *TGLN Act*,\(^\text{124}\) which contains no express requirement that the donor must understand the nature and consequences of their decision to donate tissue from their body after death\(^\text{125}\) or that the proxy give informed consent to the post-mortem donation.\(^\text{126}\) Moreover, in the absence of the donor’s consent or ability to consent, the hierarchy of proxies who may provide consent to post-mortem organ donation is slightly different,\(^\text{127}\) and there is no age requirement for the proxy.\(^\text{128}\) Furthermore, although the *Uniform Act* indicates that, in the absence of a proxy being reasonably located, the coroner may consent to donation, most jurisdictions have not adopted this rule.\(^\text{129}\) Generally, the person with legal possession of the body is the proxy of last resort, which at common law is the executor of the deceased’s estate as appointed in their will or the administrator of the estate appointed by the court if there is no will.\(^\text{130}\)

d) Recent Considerations of Presumed Consent in Ontario

Although presumed consent laws are most popular in continental Europe, this regime has been contemplated in Ontario, most recently by way of a private member’s bill and the Citizens Panel on Increasing Organ Donations.\(^\text{131}\) In February of 2006, Bill 61, *An Act to Amend the Trillium Gift of Life Network Act*\(^\text{132}\) was tabled in the Ontario legislature, the purpose of which was to change the consent regime in Ontario for post-mortem organ donation to a presumed consent regime, with the ability to register an objection.\(^\text{133}\) Bill 61 provided that upon the death of a person, tissue from that person’s body could be removed and made available for transplant, medical education, or scientific research, unless that


\(^{125}\) *Ibid.* at 5.

\(^{126}\) *Ibid.*

\(^{127}\) *Ibid.*


\(^{129}\) *Ibid.*

\(^{130}\) *Ibid.*

\(^{131}\) *Ibid.* at 3.

\(^{132}\) Bill 61, *An Act to Amend the Trillium Gift of Life Network Act*, 2\(^{nd}\) Sess., 38\(^{th}\) Leg., Ontario, 2006 [Bill 61].

\(^{133}\) See Ontario Bar Association, Health Law Section, Bills 33, *supra* note 3 at 11.
person or their substitute had objected to tissue being removed after their death. The proposed hierarchy of proxies was the same as under the current legislation, with the proxy prohibited from making an objection if they had reason to believe that the deceased would not have objected to the removal of their tissue or organs. The Bill proposed that believers or members of certain prescribed religions, cults, associations or groups could be exempted by regulation from the post mortem use of organs or tissue without consent.

Certainly, Bill 61 was not without its faults, and ultimately it died on the Order Paper in the last provincial election. One problem related to the exemption of certain groups from the presumed consent regime, as it was unclear how it would be known that a potential donor was a believer of a particular religion or whether they were in fact a member of an exempted group. Moreover, the exemption of certain religions, cults, associations or groups would have been problematic, as there was no ability within the Bill for a member of a prescribed exempted group to opt back in and consent to organ donation. As such, the Bill could have unnecessarily eliminated some people who wished to donate organs. Moreover, the Bill did not put a positive obligation on TGLN or donor coordinators to attempt to determine whether an objection had been made before proceeding with organ or tissue removal. In a negative option scenario, in which one would be required to opt out so as to avoid the possibility of posthumous organ donation, a positive duty to attempt to determine whether an objection had been made would be essential.

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134 Supra note 132 at s. 4.
135 See Ontario Bar Association, Health Law Section, Bills 33, supra note 3 at 12.
136 See Bill 61, supra note 132 at s. 5(6).
137 Ibid. at s. 4 (2)(a).
138 See Legislative Assembly of Ontario website, supra note 2.
139 See Ontario Bar Association, Health Law Section, Bills 33, supra note 3 at 12.
140 Ibid.
141 Ibid.
142 Ibid.
143 Ibid.
Subsequently, in November 2006, the Minister of Health and Long-Term Care announced the creation of the Citizens Panel on Increasing Organ Donations. Following a series of public meetings and surveys, the Citizens Panel prepared a report setting out its advice and recommendations for increasing organ donations in Ontario. With respect to presumed consent for cadaveric organ donation, the Citizens Panel concluded that presumed consent could not ensure Ontarians their first priority concerning organ donation, being that their wishes alone be respected. Furthermore, given the corrosive nature of the debate with respect to presumed consent and the fact that there was no consensus as to its effectiveness, the Citizens Panel recommended against enacting presumed consent legislation. Premier Dalton McGuinty agreed, stating that presumed consent would not reflect the views of most Ontarians.

e) Ontario’s Current Model of Express Consent

The current cadaveric organ donation model used in Canada, including Ontario, is that of express consent, otherwise known as the opt-in system, whereby a person or their family must make the decision to donate their organs after they have died or no donation will occur. No procurement of organs for transplant can take place without explicit consent. In express consent regimes, the default position, in the absence of express consent, is non-donation, in other words, a presumption of non-consent.

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144 Ibid. at 3.
145 See Boadway, supra note 50.
146 Ibid.
147 Supra note 4 at 75.
148 Ibid.
149 Antonella Artuso, “Preem’s Organ Donor Call Disputed” The Toronto Sun (28 September 2005) 40 [Lexis Nexis].
150 See Ontario Ministry of Health and Long-Term Care, Citizens Panel, supra note 4 at 73.
151 See Arnold, supra note 95 at para 14.
153 Maxwell J. Mehlman, “Presumed Consent to Organ Donation: A Reevaluation” (1991) 1 Health Matrix 31 at 31 [Reevaluation].
Adults in Ontario are free to indicate their willingness to donate organs after death, typically in writing on a card that is issued with their driver's license, or they may make no decision at all. If a deceased fails to record a preference before their death, it falls to transplant professionals to obtain the permission of their family, according to a scheme that ranks family members in a descending order of closeness. Officially at least, the consent of the family cannot be used to override the express wishes of the deceased, and the existence of a recorded consent makes it unnecessary to consult with the deceased's family. Practically however, medical staff have no way of verifying whether a deceased who has recorded a willingness to donate has subsequently changed their mind, since such a wish is revocable at any time and may be made orally rather than in writing. Moreover, although there is statutory liability for a transplant professional who proceeds with procurement when they have reason to believe that consent has been withdrawn, there is no penalty for families who lie about a change in the deceased's recorded intentions.

Express consent regimes can be criticized for frequently allowing organs not to be used where the deceased's wishes were that they should have been. Opportunities for organ recovery can also be lost due to inadequate searches for declarations and lack of communication of positive findings. Moreover, in express consent regimes, organ

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154 See *TGLN Act*, *supra* note 1 at s. 4(1).
156 See *TGLN Act*, *supra* note 1 at s. 5(2).
158 See Arnold, *supra* note 95 at para 14.
159 See *TGLN Act*, *supra* note 1 at s. 4(3).
162 See Arnold, *supra* note 95 at para 14.
donation levels are well below the level of willingness to donate organs after death that have been demonstrated in polls.\textsuperscript{165}

\section*{IV. PRESUMED CONSENT}

\subsection*{a) What is Presumed Consent?}

Presumed consent is “(t)he system by which consent to donate is presumed unless a person has expressly indicated otherwise during his/her lifetime; also known as the opting-out system.”\textsuperscript{166} With presumed consent, the default position in the absence of express objection is donation.\textsuperscript{167} There is much misunderstanding over the meaning of presumed consent, with many people mistakenly confusing it with policies authorizing organ procurement without any consent at all.\textsuperscript{168} Some of this confusion may stem from the fact that there are several different types of presumed consent laws, differing in how the presumption is made,\textsuperscript{169} with the content and enforcement of these laws varying greatly across countries\textsuperscript{170} and sometimes even within a country.\textsuperscript{171}

An opt-out system can be “hard” or “soft.” In a “hard” system, the lack of an objection from the deceased is sufficient authority for organ removal to proceed\textsuperscript{172} regardless of the family’s wishes,\textsuperscript{173} which are neither considered nor requested.\textsuperscript{174} In such regimes,

\textsuperscript{165}See Price, \textit{supra} note 163 at 110.
\textsuperscript{166}See Ontario Ministry of Health and Long-Term Care, Citizens Panel, \textit{supra} note 4 at 34.
\textsuperscript{167}See Childress and Liverman, \textit{supra} note 152 at 10.
\textsuperscript{170}See Abadie and Gay, \textit{supra} note 101 at 602.
\textsuperscript{172}See Price, \textit{supra} note 163 at 85.
\textsuperscript{173}Denise Mackey and Maria Kjerulf, "The Ethics of Organ Donation: Examining Consent Policies and Donor Criteria" (2000) 78:1 University of Toronto Medical Journal 51 at 52.
\textsuperscript{174}Melissa N. Kurnit, “Organ Donation in the United States: Can We Learn From Successes Abroad” (1994) 17 B.C. Int’l & Comp. L. Rev. 405 at 419.
families cannot refuse and their views are not taken into account.\textsuperscript{175} Few countries however strictly follow this “hard” system,\textsuperscript{176} with most presumed consent nations using the “soft” model, whereby physicians still consult with family members, such that they have the opportunity to explain the law to relatives and ask them if they know whether the patient had an unregistered objection to organ donation.\textsuperscript{177} In “soft” regimes, although technically no discussion with the family is required, in most countries the family is still consulted\textsuperscript{178} and has the last word on whether organs will be donated,\textsuperscript{179} even if no objection by the deceased has been declared.\textsuperscript{180}

As the gap between the need and the supply of organs has increasingly widened, many scholars have urged the adoption of presumed consent to organ donation.\textsuperscript{181} However, proponents of presumed consent have always faced an uphill battle,\textsuperscript{182} with this regime being viewed as controversial “because it departs from the ethical, societal, and legal norms and practices of express consent.”\textsuperscript{183}

**b) Existing Presumed Consent Laws**

Although most jurisdictions in North America operate under express consent regimes for cadaveric organ procurement, most nations in continental Europe adopted presumed consent legislation\textsuperscript{184} following the recommendation of the Council of Europe\textsuperscript{185} in 1978.\textsuperscript{186}


\textsuperscript{176} See Krueger, supra note 21 at 331.

\textsuperscript{177} See Ontario Ministry of Health and Long-Term Care, Citizens Panel, supra note 4 at 73.

\textsuperscript{178} See Krueger, supra note 21 at 331.

\textsuperscript{179} See Abadie and Gay, supra note 101 at 600.

\textsuperscript{180} See Mackey and Kjerulf, supra note 173 at 52.

\textsuperscript{181} See Orentlicher, supra note 99 at 1.

\textsuperscript{182} Ibid.

\textsuperscript{183} See Childress and Liverman, supra note 152 at 212.

\textsuperscript{184} See Price, supra note 163 at 86.

\textsuperscript{185} Council of Europe, Committee of Ministers, Resolution (78)29 (1978).

\textsuperscript{186} Ibid. at art. 10.
The successful implementation of presumed consent in several other countries warrants an inquiry as to whether that success could be emulated in Ontario.

i) North America

Surprisingly, presumed consent already exists in a limited form in both Canada and the United States. Both Manitoba and Newfoundland allow for the removal of the pituitary gland without consent by anyone lawfully performing a post mortem examination, provided that there is no known objection from the donor or their family.\(^{187}\) In the United States, all states have adopted the model of the *Uniform Anatomical Gift Act* (“UAGA”),\(^{188}\) with the version of the *UAGA* that was approved in 1987\(^{189}\) allowing presumed consent for organ harvesting in the event that no objection from the prospective donor or the donor's family is known after a reasonable search for the family.\(^{190}\) Although not all states adopted the 1987 version of the *UAGA*,\(^{191}\) several have enacted limited forms of presumed consent legislation, allowing for the removal of corneas and/or pituitary glands\(^{192}\) when the body is in the custody of the coroner, with no search and no requirement for family consent, so long as there is no known objection.\(^{193}\) Some states have gone further, with Minnesota for example permitting hospitals to remove the brains of deceased individuals who suffered from Alzheimer's disease.\(^{194}\) Indeed, at one time or another, more than two-thirds of the states


\(^{190}\) See *UAGA (1987)*, *supra* note 188 at §4(a).

\(^{191}\) See Keller, *supra* note 189 at 886.


have adopted presumed consent statutes.\textsuperscript{195} However, there has been little or no effort to educate the public with respect to these laws, and there is no evidence of widespread understanding that these laws exist.\textsuperscript{196} In addition, most recently the 2006 \textit{Revised Uniform Anatomical Gift Act}\textsuperscript{197} eliminated the presumed consent provisions of the 1987 \textit{Uniform Anatomical Gift Act} and now recommends retrieval of corneas, other tissues, and organs only when there has been express consent by the deceased prior to death or by a family member of the deceased.\textsuperscript{198}

\textit{ii) Europe}

Presumed consent has enjoyed much success in Europe, with Spain’s organ transplant system being widely acknowledged as the most successful on the continent.\textsuperscript{199} Spain operates under a “soft” system of presumed consent, where in practice organs are not removed without explicit family approval.\textsuperscript{200} Belgium also operates under a “soft” system, with physicians encouraged to approach all families and inform them of their option to refuse donation\textsuperscript{201} if there is no known objection by the deceased.\textsuperscript{202} In addition, Belgium gives physicians the choice not to harvest organs if they determine that such action would prove too distressful for the family.\textsuperscript{203} However, although physicians typically inform the family of their option to refuse donation, they may remove organs without family consent\textsuperscript{204} as there is

\textsuperscript{195} See Orentlicher, \textit{supra} note 99 at 4.
\textsuperscript{196} See Childress and Liverman, \textit{supra} note 152 at 207.
\textsuperscript{197} \textit{Revised Uniform Anatomical Gift Act} (2006).
\textsuperscript{198} See Orentlicher, \textit{supra} note 99 at 5.
\textsuperscript{199} Kathleen Robson, “Systems of Presumed Consent for Organ Donation - Experiences Internationally” 9 (Scottish Parliament Info Center (SPICe), Briefing No. 05/82, (16 December, 2005), online: Scottish Parliament website <http://www.scottish.parliament.uk/business/research/briefings-05/SB05-82.pdf> at 11.
\textsuperscript{200} See Abadie and Gay, \textit{supra} note 101 at 602, Matesanz, Miranda and Felipe, \textit{supra} note 27 at 104 and Childress and Liverman, \textit{supra} note 152 at 28.
\textsuperscript{201} See Robson, \textit{supra} note 199 at 9.
\textsuperscript{202} \textit{Ibid.}
\textsuperscript{203} \textit{Ibid.}
\textsuperscript{204} See Kurnit, \textit{supra} note 174 at 423.
no legal obligation to inform the family of the intended removal of organs.\textsuperscript{205} Many other European nations, including France, Poland, Switzerland, Finland, Greece, Italy, Norway and Sweden all presume that their citizens consent to the donation of their organs at death unless the individual has expressly opted out during their lifetime,\textsuperscript{206} although the deceased’s family can prevent organ removal by exercising their right to object to it after their relative’s death.\textsuperscript{207}

In contrast to the “soft” systems utilized in much of Europe, Austria operates a “hard” version of presumed consent.\textsuperscript{208} In Austria, a citizen's rejection of organ donation is only legally enforceable if it is in writing.\textsuperscript{209} Relatives of the deceased may not object to the donation of the deceased's organs.\textsuperscript{210} Physicians in Austria have no affirmative duty to search for documents indicating non-consent, and if there is doubt as to whether the patient has objected, removal is permitted.\textsuperscript{211} In fact, medical personnel do not even have to inform family members that the organs are being removed.\textsuperscript{212} Moreover, an Austrian citizen who has registered an objection and later needs a transplant is placed at the bottom of the waiting list.\textsuperscript{213} According to Martin, the acceptability of this “hard” version of presumed consent in Austria stems from its long history of autopsy without consent.\textsuperscript{214}

c) The Impact of Presumed Consent on Cadaveric Donor Rates

Whether or not presumed consent can be ethically and legally defended as a viable option for Ontario, one can argue that the first issue that should be considered is whether

\textsuperscript{205} Paul Michielsen, “Presumed Consent to Organ Donation: 10 Years’ Experience in Belgium” (1996) 89 J.R. Soc. Med. 663 at 663.
\textsuperscript{207} See Calandrillo, supra note 93 at 125.
\textsuperscript{208} See Ontario Ministry of Health and Long-Term Care, Citizens Panel, supra note 4 at 73.
\textsuperscript{209} See Kurnit, supra note 4 at 73.
\textsuperscript{210} Ibid.
\textsuperscript{211} Ibid.
\textsuperscript{212} See Robson, supra note 199 at 11.
\textsuperscript{213} Ibid.
\textsuperscript{214} Supra note 40 at 290.
presumed consent would translate into an increased availability of donor organs and tissue in the province. Certainly, presumed consent would need to have a reasonable chance of significantly increasing procurement rates in Ontario in order for any legislative change to be seriously considered.

There is ongoing debate as to whether presumed or express consent is the preferred legal response to organ procurement, with many positing that presumed consent would result in an increased number of organs for transplant. However, the conclusions of analysts have varied as to whether this is actually the case. Supporters of presumed consent contend that as everyone would be considered a potential donor subject to opt-out, presumed consent laws would result in an increased supply of organs for transplant. Certainly, Spital and Mustarah argue that switching to a presumed consent law would increase the organ donation rate, the basic idea behind this being that the presumed consent system benefits from the organs of donors who have not declared any preference for donation while living. Many other scholars have agreed that presumed consent produces a significantly larger supply of cadaveric donors than the express

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215 See Price, supra note 163 at 15.
216 Ibid. at 87.
consent system. For example, Roels et al. contend that in Europe at least, presumed consent legislation could eliminate the chronic organ shortage.

Opponents of presumed consent however argue that there is no obvious correlation between high post mortem rates of donation and the existence of presumed consent laws, and contend that presumed consent has not provided an adequate supply of organs. Moreover, it is argued that as in many jurisdictions, the donation regime is not operated consistent with its legal framework, all conclusions as to whether presumed consent increases the availability of organs must be tentative.

In addition, the Citizens Panel determined that statistics were not conclusive as to the effectiveness of presumed consent, noting that while some presumed consent countries had donation rates that were higher than where informed consent was the norm, others were well below.

One reason frequently cited for the failure of presumed consent to greatly increase organ donation rates on its own is that transplant professionals in many countries ignore the law of presumed consent and refuse to procure organs without seeking the permission of the deceased’s family. In other cases, it is caused by the failure of medical personnel to report potential donors. However, as Arnold notes, “neither of these constitutes a failure of

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220 See Kaserman, supra note 43 at 64.
221 L. Roels et al., “Three Years of Experience with a “Presumed Consent” Legislation in Belgium: Its Impact on Multi-Organ Donation in Comparison with Other European Countries” (1991) 23(1) Transplant. Proc. 903 at 904 [Three Years]. See also The Presumed Consent Foundation, Inc. Online: The Presumed Consent Foundation, Inc. website <http://www.presumedconsent.org/solutions.htm> [Foundation website]. The Presumed Consent Foundation, Inc. believes that presumed consent could have a dramatic impact on the number of organs available for transplant, significantly reducing the waiting list and the number of deaths on the waiting list.
224 See Price, supra note 163 at 87.
225 Ibid.
226 Supra note 4 at 73.
227 Ibid.
228 See Price, supra note 163 at 91-92.
presumed consent *per se*; they are, rather, failures of implementation … Such failures are not truly arguments against presumed consent, but are rather arguments in favour of educating both the medical community and the public at large so that there are no ambiguities or surprises when doctors and families meet.”^230

Despite the criticisms noted above, it has been demonstrated that many nations following the presumed consent model have higher levels of donation,^231 with data indicating that presumed consent is effective in increasing the rate of organ procurement.^232 Indeed, the five best organ procurement rates in developed countries are from those countries with presumed consent.^233 For example, Spain’s donation rate in 2007 was a very impressive 34.4 per million population.^234 In addition, the passage of a presumed consent law in Singapore in 1987 led to a sharp rise in donation rates.^235 In Poland, presumed consent was introduced in 1995,^236 with the number of cadaveric donors increasing from five to twelve per million population over six years.^237 By contrast, Denmark had one of the highest cadaveric organ procurement rates in Europe under presumed consent, which rates were cut in half with the introduction of an express consent law in 1986.^238

Belgium presents an excellent example of the potential success of a presumed consent regime, with well documented evidence that a change in the law from contracting in to

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^230 Supra note 95 at para 31.
^231 See Robson, *supra* note 199 at 14.
^233 See Nowenstein, *supra* note 77 at para 15.
^235 See Price, *supra* note 163 at 90.
^238 See Price, *supra* note 163 at 91.
contracting out led to an increase in organ supply.\textsuperscript{239} Belgian data after the 1986 enactment of presumed consent legislation shows much variation in organ donation rates between different areas of the country, with those areas that continued to seek relatives’ permission despite the new law remaining static while those that adopted presumed consent experienced a sharp increase.\textsuperscript{240} Interestingly, when the presumed consent legislation was passed, a transplant centre in Antwerp opposed the new system and retained the old opt-in system\textsuperscript{241} while another transplant centre in Leuven adopted the new legislation.\textsuperscript{242} Over a three year period, rates of donation in Antwerp remained constant, while rates in Leuven increased from fifteen to forty donors per year.\textsuperscript{243} Moreover, in the whole country organ donation rose by 55\% within five years despite a concurrent decrease in the number of organs available from traffic accidents.\textsuperscript{244} In addition, the implementation of presumed consent in Belgium had an immediate beneficial effect on the number of organs harvested and transplants performed, with kidney procurements alone increasing by 86\% by the year 1987-1988.\textsuperscript{245} By 1989, the number of cadaveric kidneys available for transplant in Belgium had increased by 119\% in comparison with the pre-presumed consent period.\textsuperscript{246} During this same time period, other countries without presumed consent laws in the same geographical region, such as the Netherlands and Germany, did not have similar increases.\textsuperscript{247} A decade after the implementation of presumed consent in Belgium, organ donation levels had risen to among

\textsuperscript{240} See Price, supra note 163 at 90.
\textsuperscript{241} See Robson, supra note 199 at 9.
\textsuperscript{242} \textit{Ibid}.
\textsuperscript{243} \textit{Ibid}.
\textsuperscript{244} See Kennedy \textit{et al.}, supra note 239 at 1651.
\textsuperscript{245} See Roels \textit{et al.}, Organ Retrieval in Belgium, supra note 232 at 2078.
\textsuperscript{246} See Roels \textit{et al.}, Three Years, supra note 221 at 903.
\textsuperscript{247} See Price, supra note 163 at 89.
the highest in the world,\(^{248}\) with supporters pointing out that only 2% of the Belgian people had opted out.\(^{249}\) Some however argue that Belgium's data is not an accurate depiction of presumed consent's success, because Belgium's new laws came into effect when Europe's organ donation rate was increasing independently.\(^{250}\)

The Austrian experience also provides some support for the notion that presumed consent increases the supply of donor organs over other donation approaches.\(^{251}\) In Austria, the number of donors per million rose from an average of 4.6 per million population before presumed consent legislation to an average of 27.2 per million population between 1986 and 1990.\(^{252}\) However, some argue that an increase in the number of motor vehicle accidents, rather than the “hard” presumed consent model, accounted for this increase in donation.\(^{253}\) Others argue that Austrians are more accepting of the concept of presumed consent because Austria has a long history of autopsies performed without consent, with this practice ingrained in physicians\(^ {254}\) who are therefore more likely to be willing to remove organs without express consent.\(^ {255}\)

Given the mixed bag of evidence with respect to the effectiveness of presumed consent in increasing cadaveric organ donation rates, one can agree with Coleman that “(a)lthough the evidence is not overwhelming, presumed consent seems to increase organ


\(^{249}\) Sarah Boseley, “Taking it with You: It is Fatuous to Offer Sentimental Respect to Corpses When Their Organs Could Be Used to Save Lives” The Guardian (9 July 1999) at 9.

\(^{250}\) See Robson, supra note 199 at 9.

\(^{251}\) See Mehlman, supra note 153 at 42.

\(^{252}\) See Robson, supra note 199 at 11.

\(^{253}\) Ibid.

\(^{254}\) See Mehlman, supra note 153 at 42.

\(^{255}\) Ibid.
supply.”  

Presumed consent appears to have been effective, along with other measures, to increase the number of available organs for transplant.  

i) The Problem with Comparisons  

Nevertheless, despite the demonstrated success of presumed consent in some countries, one can question the transferability of statistical findings from one country to another. Comparisons between countries are difficult to interpret because there are a myriad of other factors which are highly variable from country to country that are necessary to ensure a successful transplant program, such as the predominant cause of death, the availability of trained staff and transplant surgeons, and the number and characteristics of patients on the waiting lists. Given that there are many other factors that influence organ donation rates, there is debate over whether direct comparisons can be attributed to presumed consent legislation alone. For example, following the passage of a presumed consent law in Belgium in 1986, the number of donor kidneys increased 114% between 1986 and 1989. However, given the unlimited admission to the waiting list by non-residents, and the very high rate of dialysis in Belgium, the number of persons on the waiting list remained stable, demonstrating that comparing procurement regimes with the effects on waiting list lengths in isolation from other factors is too simplistic to provide answers. Furthermore, as Belgium is a small country with a population of approximately ten million, its figures for organ procurement cannot be strictly compared with larger countries.

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257 See Childress and Liverman, supra note 152 at 223.  
258 See Kaserman, supra note 43 at 65.  
259 See Robson, supra note 199 at 14.  
260 Ibid.  
261 See Price, supra note 163 at 89.  
262 Ibid.  
263 Ibid. at 89 note 29.  
264 See Matesanz, Miranda and Felipe, supra note 27 at 115.
In addition, Kaserman argues that there are complex social/political reasons that specific countries have adopted the policies they have in place which are not fully accounted for in any statistical model. It may be difficult “to draw accurate or meaningful international comparisons, even for those countries closely aligned geographically, politically, and socioeconomically,” as a combination of factors influences the effectiveness of a given country’s response to organ donation, including its history, political philosophy, social, legal and cultural factors, economics, and medical practices.

Moreover, the methods used to calculate the rates of donation are subject to debate. It is questionable whether the rate of donation per million is an adequate measure for international comparison, as different jurisdictions use different definitions of "donor" in calculating their rates which may include consented donors and actual donors. As such, there is no international harmonized definition of “the number of donors per million population.” For example, in the United States a donor is counted if organs are recovered, even if they are unsuitable for transplantation, whereas in Canada, a donor is only counted if at least one organ is actually transplanted. Rates also differ by organ type and by live versus deceased donation. Given these inconsistencies, the methods used to calculate donation rates can alter the comparisons between countries, with numbers from other

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265 Supra note 43 at 65.
266 See Childress and Liverman, supra note 152 at 27-28.
267 Ibid.
268 Ibid. at 27.
269 Ibid. at 212.
270 David Baxter, The Urban Futures Institute Report 51, Beyond Comparison: Canada's Organ Donation Rates in an International Context (Vancouver: Urban Futures Institute, 2001) at 4-16 and Childress and Liverman, supra note 152 at 27.
271 See Childress and Liverman, supra note 152 at 27.
272 Ibid.
273 Valerie Hauch, “It Shouldn’t Take a Miracle; Thousands of Canadians Need Organ Transplants and Five Die Every Week While Waiting” The Record (25 Sept, 2004).
274 See Childress and Liverman, supra note 152 at 27.
275 Ibid.
jurisdictions not necessarily being what they seem. Until one knows the definition of donor in a particular jurisdiction and its cerebral vascular death rate, one cannot make sense of the numbers. In addition, the reliability and validity of data should be considered. Nevertheless, even when different measures are used to calculate donation rates, several countries including Spain, Belgium and Austria consistently have higher rates.

ii) Confounding Factors

Despite demonstrated success in increasing cadaveric organ procurement rates in many presumed consent countries, some argue that the success experienced in countries with opt-out laws is not as a result of presumed consent at all but actually due to other factors. These other factors may also be responsible for the failure of presumed consent in countries like Sweden, which switched to presumed consent in 1996 but continues to have one of the lowest rates of organ donation in Europe. Indeed, Arnold argues that the success of presumed consent is difficult to measure, as in most countries where it appears to succeed it is accompanied by other proactive measures, while in countries where it fails it is plagued by other systemic problems.

Several factors other than legislative defaults have been hypothesized to affect cadaveric donation rates, including the level of wealth, religious and cultural responses to death and to the body after death, social norms, education, and the social security system. Moreover, a study conducted in 2003 indicated that increased prevalence of

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276 Dr. Ted Boadway, The Medico-Legal Society of Toronto Conference, “Organ donation: Do you know where your organs are tonight?” (personal notes taken at “Organ donation: Do you know where your organs are tonight?”, Toronto, (21 February 2007) [unpublished].
277 Ibid.
278 See Childress and Liverman, supra note 152 at 27.
279 Ibid.
280 See Organ Donation Taskforce, supra note 234 at 22.
281 Supra note 95 at para 31.
282 See Kennedy et al., supra note 239 at 1650.
283 See Abadie and Gay, supra note 101 at 601.
284 See Michielsen, supra note 205 at 665.
transplant centres per million people, the percentage of the population enrolled in higher education, and the percentage of the population that is Roman Catholic led to higher rates of organ donation. Practical issues are also important, such as the medical infrastructure in a particular region, the density of the population and its age stratification, the number of traffic accidents, the density of transplant co-ordinators, the number of ICUs and the corresponding number of ICU beds available. Indeed, the British Medical Association (“BMA”) contends that donation rates cannot be improved without better infrastructure and resources.

Certainly, some argue that organ donation rates can be significantly increased in the absence of presumed consent. Kennedy et al. argue that “(s)upply can be increased by energetic educational campaigns, by having more transplant coordinators, by the provision of specialist teams to take over the care of potential donors, and by provision of financial incentives to encourage doctors and institutions to refer patients,” all of which are independent of the law. Furthermore, Price states that “a highly organized and well-resourced system, employing large numbers of transplant co-ordinators in a decentralised system, can itself have a major impact on donor rates.”

iii) The Example of Spain

Certainly, it is not easy to evaluate the proposition that presumed consent leads to an increased availability of donor organs, given the infinite number of variables that can impact

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286 See Abadie and Gay, supra note 101 at 601.
287 See Persijn and Cohen, supra note 171 at 251.
288 See Michielsen, supra note 205 at 665.
289 See Kennedy et al., supra note 239 at 1650.
291 Supra note 239 at 1650.
292 Ibid.
293 Supra note 163 at 92.
on donor rates. However, one may turn to the country that is most successful in procuring organs under presumed consent to search for answers.

Undoubtedly, Spain has been exceedingly successful in increasing its cadaveric donor rate under a system of presumed consent, with higher donation rates than any other country. However, although Spain adopted presumed consent in 1979, the legislative change had no impact on donation rates until a national transplant organization, the Organización Nacional de Transplantes (“ONT”) was founded in 1989, after which donor rates began to rise. The ONT is a network of transplant coordinators located in ICUs across Spain who are responsible for promoting, facilitating, and coordinating organ donation and transplantation. ONT is widely considered to be the most effective organ procurement organization in the world, focusing on improving three areas in the organ donation process, being the detection of potential organ donors, the management of donors and interaction with the donors' families. The “Spanish model” is based on a system of independent transplant coordination teams who request consent from families of potential donors, a hospital reimbursement policy that compensates hospitals for organ procurement costs, and a multi-layered network at the national, regional, and hospital level which coordinates and manages organ procurement activities. After being founded in 1989, ONT instituted an active donor detection program with well-trained transplant co-ordinators, an extensive transplant network, hospital level co-ordinators, increased economic

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294 Ibid. at 87.
295 See Abadie and Gay, supra note 101 at 606.
296 See Robson, supra note 199 at 11.
297 See Organ Donation Taskforce, supra note 234 at 22.
298 See Robson, supra note 199 at 11.
300 See Abadie and Gay, supra note 101 at 606-607 at footnote 22.
302 See Abadie and Gay, supra note 101 at 606-607 at footnote 22.
reimbursement for hospitals, professional and public education efforts, death audits conducted in hospitals, and a focus on expanded criteria donors and on donation after circulatory determination of death.\textsuperscript{303} As such, it is clear that presumed consent legislation in Spain did not result in increased donation rates on its own.\textsuperscript{304} In fact, Dr. Rafael Matesanz, president of the Spanish National Transplant Organization, gave evidence to the Organ Donation Taskforce in the UK that presumed consent was not the reason for the success of the Spanish system, pointing instead to other changes in the infrastructure that had been made.\textsuperscript{305} Others argue that “Spanish organ procurement rates are mainly the result of efforts to overcome obstacles such as untrained requesting staff, unidentified donors and a reluctance to approach grieving families,”\textsuperscript{306} with the success in Spain resulting from “efforts to overcome the obstacles met in every step of the process, in every region of the country, and in every hospital.”\textsuperscript{307}

Certainly, it appears that the decision to appoint donor transplant coordinators to every ICU in the country,\textsuperscript{308} not only those hospitals with a transplant unit,\textsuperscript{309} contributed largely to Spain’s success by increasing the likelihood that opportunities would not be missed to recover organs from potential organ donors who died in smaller hospitals.\textsuperscript{310} Indeed, the past and present directors of ONT credit Spain’s spectacular success to the hospital transplant coordinators, whose main objective is to detect and facilitate organ procurement.\textsuperscript{311} Another important aspect of the Spanish Model is that hospital coordinators are responsible for the

\begin{thebibliography}{99}
\bibitem{303} See Childress and Liverman, \textit{supra} note 152 at 27.
\bibitem{304} See Kennedy \textit{et al.}, \textit{supra} note 239 at 1651.
\bibitem{305} See Organ Donation Taskforce, \textit{supra} note 234 at 22.
\bibitem{306} See Matesanz, Miranda and Felipe, \textit{supra} note 27 at 115.
\bibitem{307} See Matesanz and Miranda, \textit{supra} note 301 at 27.
\bibitem{308} Jeremy Laurance, “Should Organ Donation be Automatic or a Matter of Personal Choice? The Big Question” \textit{The Independent (London)} (18 July 2007) [Lexis Nexis].
\bibitem{309} See Matesanz and Miranda, \textit{supra} note 301 at 26.
\bibitem{311} See Organización Nacional de Transplantes, \textit{supra} note 299.
\end{thebibliography}
entire organ donation process, reporting directly to their hospital director without having to answer to any middle management. Thus the hospital coordinator is empowered to effectively enforce and develop the policies of ONT. Moreover, those involved in the organ transplant system in Spain are specially trained and highly motivated, which has proven crucial for organ procurement.

iv) The Abadie and Gay Study

In light of the argument that factors other than presumed consent have led to the increase in cadaveric donation rates in presumed consent countries, likely the most convincing evidence that presumed consent can lead to higher procurement rates is found in a study by Abadie and Gay, who constructed a dataset on organ donation rates and potential factors affecting organ donation and used a panel of twenty-two countries over the ten year period of 1993 to 2002 to analyze the impact of presumed consent laws on donation rates. Abadie and Gay recognized other factors that appeared to have had an impact on donation rates, such as the predominant cause of death, the availability of beds and staff in ICUs, the number and efficiency of transplant coordinators, the number of transplantation surgeons, the number of specialized units in the region, and the number and characteristics of patients on waiting lists, including which organs they required, as well as religious and cultural views of and attitudes towards death and the body. However, using regression analysis they found that although these factors accounted for some of the variation in the donor rates, presumed consent laws had “a positive and sizeable effect on organ donation rates,” and

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312 Ibid.
313 See Gallagher, supra note 310 at 410.
315 See Matesanz, Miranda and Felipe, supra note 27 at 114.
316 See Abadie and Gay, supra note 101 at 599 and 600.
317 See Childress and Liverman, supra note 239.
318 See Kennedy et al., supra note 239.
319 See Abadie and Gay, supra note 101 at 607.
320 Ibid. at 599.
when other determinants of donation rates were accounted for, presumed consent countries had on average roughly 25–30% higher donation rates than informed consent countries, with this result robust to changes in the regression specification.\textsuperscript{321}

Abadie and Gay recognized that their results could be biased if unobserved determinants of cadaveric organ donation rates were correlated with presumed consent legislation.\textsuperscript{322} For example, they noted that those countries where public support for organ donation was high might be more likely to enact presumed consent laws.\textsuperscript{323} Given the possibility that unobserved determinants of cadaveric organ donation rates might be correlated with presumed consent laws, Abadie and Gay used the panel structure of their dataset to test and ultimately reject the hypothesis that unmeasured (additive) determinants of organ donation rates confounded their empirical results.\textsuperscript{324} Using a specification test they were able to demonstrate that there was no compelling evidence of confounding country effects.\textsuperscript{325}

\textit{v) Absolute Limits on Ontario’s Possible Success}

Despite the immense achievements in Spain, one must be realistic and acknowledge that Ontario is unlikely to reach the levels of success enjoyed in some of the countries it has sought to emulate, as its age demographics and mortality patterns are less conducive to high rates of potential cadaveric donors.\textsuperscript{326} For example, relative to Spain, Canada has a lower proportion of its population in the age range that provides the most potential donors.\textsuperscript{327} Canada also has proportionately fewer deaths as a result of motor vehicle accidents,

\begin{footnotes}
\textsuperscript{321} Ibid. at 610.
\textsuperscript{322} Ibid.
\textsuperscript{323} Ibid.
\textsuperscript{324} Ibid. at 600.
\textsuperscript{325} Ibid. at 611.
\textsuperscript{326} See Arnold, supra note 95 at para 13.
\textsuperscript{327} Ibid. at footnote 33.
\end{footnotes}
motorcycle accidents, gunshot wounds and intra-cranial events than some other jurisdictions with higher donation rates, which are the types of death that produce the most potential donors. Other countries have younger demographics with more men working in heavy industry, which translates into more brain-dead patients. Certainly, the Citizens Panel recognized that it was unlikely that Ontario would ever reach the donation rates of some other jurisdictions, given its actual numbers of brain-dead patients. As such, it may be that even if presumed consent could be successfully implemented in Ontario, it would be incapable of fully resolving the organ shortage. Moreover, Abadie and Gay note that an increase in the supply of cadaveric organs would likely be followed by an increase in the number of referrals to the waiting lists and a reduction in the supply of organs from living donors. However, even if Ontario may be incapable of achieving the same donation rates as Spain, measures of a system’s success in converting potential donors into actual donors can provide insights into the potential for additional organ donations. Certainly, as the number of cadaveric donors in Ontario is finite, the challenge is to convert more potential donors into actual donors within this small group.

vi) Presumed Consent as Part of a Broader Strategy

Despite these issues with respect to confounding factors and the difficulties of comparison, the BMA believes that as part of a broader strategy, a shift to presumed consent would likely have a positive effect on donation rates in the UK. The same can be argued

328 See Ontario Ministry of Health and Long-Term Care, Citizens Panel, supra note 4 at 13.
329 See Arnold, supra note 95 at footnote 33.
330 See Ontario Ministry of Health and Long-Term Care, Citizens Panel, supra note 4 at 13.
331 Ibid.
332 See Kaserman, supra note 43 at 430.
333 Supra note 101 at 613 at footnote 32.
334 Ibid. at 612.
335 See Childress and Liverman, supra note 152 at 27.
for Ontario – although presumed consent alone may not be the answer, it may be one factor that is either necessary or desirable as part of Ontario’s organ procurement system in order to significantly increase cadaveric donation rates.

Certainly, it is intuitive that the legislative scheme alone will not dictate the success or failure of an organ procurement system. However, scholars note that on balance, there is "a general tendency for countries with presumed consent to have higher donation rates,”\textsuperscript{337} with substantial \textit{prima facie} evidence that presumed consent laws are a major factor in increasing the rate of organ donation,\textsuperscript{338} even though other factors may be important, or even more important.\textsuperscript{339} Admittedly, the increased organ procurement rates in Spain, Austria and Belgium were not accomplished by a change in legislation alone.\textsuperscript{340} As such, presumed consent may be one mechanism for increasing organ supply, but it is unlikely on its own to be a sufficient condition for success,\textsuperscript{341} and would obviously be much more effective in the context of a "highly organized and well-resourced system, employing large numbers of transplant co-ordinators."\textsuperscript{342}

Arguably, although it may be “difficult, if not impossible, to identify the single most important causal factor”\textsuperscript{343} for increased donation rates, perhaps searching for a single factor is the wrong approach. Undoubtedly there is debate with respect to the relative contribution and correlation between presumed consent policies and other policies, social practices and conditions that may also help to increase organ donation rates.\textsuperscript{344} The question however should not be whether presumed consent offers a solution in and of itself, but whether it can

\textsuperscript{338} See Price, supra note 163 at 91.
\textsuperscript{339} Ibid.
\textsuperscript{340} See Kennedy \textit{et al.}, supra note 239 at 1650-1652.
\textsuperscript{341} See Price, supra note 163 at 92.
\textsuperscript{342} Ibid. at 91-92.
\textsuperscript{343} See Childress and Liverman, supra note 152 at 213.
\textsuperscript{344} Ibid.
form a part of the solution to the organ donor crisis. Presumed consent may provide an adequate legal foundation and framework for success, such that an opt-out policy in tandem with other improvements to the organ procurement system could be effective in increasing cadaveric organ donation rates.

Critics however argue that presumed consent “would be so inhumane, manipulative and unpopular that it must be rejected for those reasons alone,”\(^{345}\) with the ends not justifying the means.\(^{346}\) So, the question then becomes, “assuming that presumed consent would significantly increase the supply of donor organs, must it be rejected for other reasons?”\(^{347}\) In answer to this question, the shortcomings of the current system of express consent will be discussed below, followed by an analysis of how the various criticisms of presumed consent can be overcome in Ontario.

V. EXPRESS CONSENT BARRIERS TO ORGAN DONATION

Those opposed to presumed consent raise ethical, religious, legal and practical objections.\(^{348}\) However, express consent itself presents several barriers to organ donation, including the need to obtain family consent and reluctance on the part of physicians to request organ donation from grieving families.\(^{349}\)

a) Family Consent

i) High Refusal Rates from Families

Siminoff \textit{et al.} argue that “(t)he major factor limiting the number of organ donors is the low percentage of families who consent to donation.”\(^{350}\) The impact of permitting the family to refuse should not be underestimated,\(^{351}\) for in Canada, families give consent in only

\(^{345}\) See Mehlman, \textit{supra} note 153 at 45.
\(^{346}\) \textit{Ibid.}
\(^{347}\) \textit{Ibid.}
\(^{348}\) \textit{Ibid.} at 44-45.
\(^{349}\) See Gerson, \textit{supra} note 41 at 1020.
\(^{350}\) \textit{Supra} note 39 at 71.
\(^{351}\) See Pattinson, \textit{supra} note 66 at 435.
half of cases where the deceased previously gave permission for posthumous organ procurement. Hoferichter cites an even worse statistic, stating that out of 500 deaths of people who had signed their organ donor cards, only 160 Canadian families gave permission for organ donation.

In express consent jurisdictions, relatives are typically asked for their consent for the removal of organs from the deceased even where the deceased previously provided an explicit consent to donate. Despite donor consent and a signed donor card, physicians in Ontario will not under any circumstances remove organs without the consent of family members. As such, donor cards have not been effective in facilitating organ donations, with the deceased’s family playing a more determinative role in organ donation and procurement than the deceased. Moreover, if the family refuses to provide medical information with respect to the deceased, the deceased may become medically ineligible to donate in any event. Staff depend upon the family to provide information that is essential for ensuring the quality and safety of donated organs, and details obtained from relatives about the patient’s medical and behavioural history can play an important part in the success of a transplant.

353 See Hoferichter, supra note 18 at 127.
354 See Price, supra note 163 at 151.
355 Kevin Connor, “Too Many People are Dying: Presumed Consent Legislation ‘Stuck in a Holding Pattern at Queen’s Park’” The Toronto Sun (8 Jan 2007) at 8.
358 Ibid.
361 See Organ Donation Taskforce, supra note 234 at 12.
Certainly, the procedure for procuring cadaveric organs in Ontario is not in keeping with the understanding of Ontarians, who the Citizens Panel found believed that their wish to donate as expressed on their organ donor card would carry weight and that their wishes would be carried out on their death.\textsuperscript{362} When the Citizens Panel told Ontarians that “the cards are almost never requested, or even seen in the hospital, their reactions ranged from dismay to anger to bitterness.”\textsuperscript{363} When the Citizens Panel went on to explain that instead of checking the card, the hospital would consult the family and that the family’s decision would prevail, even if this conflicted with the deceased’s wishes, “the reactions ranged from incredulity to rage.”\textsuperscript{364}

\textit{ii) Reasons for Family Refusal}

In a survey of 2,141 respondents, the Citizens Panel found that the main reasons for family refusal in Ontario are a lack of awareness of the family member’s wishes\textsuperscript{365} and not wanting to take responsibility for such a major personal decision.\textsuperscript{366} Often the family of the deceased is either not aware, or unwilling to acknowledge, the wishes of their deceased relative.\textsuperscript{367} Family consent however is highly dependent on whether the family is aware of the deceased’s wishes.\textsuperscript{368} A 2001 survey conducted for Health Canada found that 83\% of families were very likely to consent to the donation of a family member's organs if the family member had registered to donate and discussed donation with their family, and another 13\% were somewhat likely to consent.\textsuperscript{369} However, if the family member had registered but not discussed the matter with their family, the numbers decreased to 65\% who were very likely

\textsuperscript{362} \textit{Supra} note 4 at 3.
\textsuperscript{363} \textit{Ibid.}
\textsuperscript{364} \textit{Ibid.}
\textsuperscript{365} \textit{Ibid.} at 49.
\textsuperscript{366} \textit{Ibid.} at 50.
\textsuperscript{368} See Chandler, \textit{supra} note 356 at para 16.
\textsuperscript{369} Environics Research Group Ltd., “Organ and Tissue Donation: Canadian Public Awareness, Knowledge and Attitudes,” prepared for Health Canada (N.p, 2001) at 37.
to consent and 26% who were somewhat likely to consent.\textsuperscript{370} Siminoff \textit{et al.} also found that prior knowledge of the deceased’s wishes was significantly associated with willingness to donate,\textsuperscript{371} with families who discussed more topics and had more conversations about organ donation being more likely to consent to donation.\textsuperscript{372} Knowing that the deceased family member had signed a donor card, having had an explicit discussion about donation with them, and a belief that the deceased relative would have wanted to donate, even exclusive of an explicit discussion, were strongly associated with family consent to organ donation.\textsuperscript{373}

Certainly, Ontarians understand the importance of speaking to their family about organ donation. An attitudinal research survey of 603 Ontarians conducted in March of 2004\textsuperscript{374} by Navigator Ltd.\textsuperscript{375} found that 96% of those surveyed believed that it was important to tell their families whether or not they would want their organs to be donated after death.\textsuperscript{376} Fifty-five percent of respondents reported that they had told their family of their wish to donate their organs,\textsuperscript{377} while 44% advised that they had participated in a family discussion about organ donation.\textsuperscript{378} However, cadaveric donation rates remain low in part because many who support donation have not discussed their decision with their family.\textsuperscript{379} In fact, a 1996 survey found that 54% of Canadians did not know their family’s wishes regarding organ donation.\textsuperscript{380} Most people do not know that their donor card is likely not to be relied upon, and as such do not understand the importance of telling their family their wishes.\textsuperscript{381}

\begin{itemize}
\item \textsuperscript{370} \textit{Ibid.}
\item \textsuperscript{371} \textit{Supra} note 39 at 71.
\item \textsuperscript{372} \textit{Ibid.}
\item \textsuperscript{373} \textit{Ibid.} at 73.
\item \textsuperscript{374} See TGLN website, \textit{supra} note 12.
\item \textsuperscript{375} \textit{Ibid.}
\item \textsuperscript{376} \textit{Ibid.}
\item \textsuperscript{377} \textit{Ibid.}
\item \textsuperscript{378} \textit{Ibid.}
\item \textsuperscript{379} \textit{Ibid.}
\item \textsuperscript{380} See Hoferichter, \textit{supra} note 18 at 142.
\item \textsuperscript{381} See DeJong \textit{et al.}, \textit{supra} note 92 at 473.
\end{itemize}
All that may be needed is a “single, memorable conversation.”

Without a family conversation, family members may resort to playing it safe and declining donation.

Siminoff et al. also found that family and patient sociodemographics (ethnicity, patient’s age and cause of death) were significantly associated with willingness to donate. In addition, attitudes and beliefs were significantly associated with the decision to donate organs. Families who were surprised to be asked about organ donation or felt harassed or pressured were less likely to donate. Some families in the Siminoff study were confused as to when the moment of death occurred. Other factors found to be correlated with consent included the costs of donation, its impact on funeral arrangements, concerns with respect to disfigurement of the body, and assurance that the family had choice as to which organs to donate. As such, Siminoff found that the beliefs that individuals held with respect to organ donation played a significant role in the consent decision.

iii) Preoccupation with Family Feelings

Admittedly, physicians who work in ICUs in Ontario told the Citizens Panel that they felt it was important not to add further stress to families by forcing them to comply with their deceased relative’s donation wishes. One can argue however that this preoccupation with the consent and feelings of the surviving family is not appropriate. Herring makes the
strong point that if the deceased’s wishes as to their will cannot be overridden to avoid the
distress of relatives, surely the wishes of the deceased in relation to their body, an
indisputably more intimate aspect of the person, should also not be overridden. Nonetheless, it can be argued that requiring consent from the family is “misplaced in view of the urgent
need for more transplantable tissue,” and that it is morally right to shift the locus of
decision making away from the family so that “the policy of saving human life is given
priority” over family feelings. Arguably, the societal need for organs is “so great that it
should prevail over the interest of the family in keeping the cadaver inviolate.”

In any event, it can be argued that the feelings of the next of kin would be better spared not by allowing them to make the decision with respect to their relative’s organs, but by having the donation decision completely removed from them. Kennedy et al. state that families should not be put in the position of having to make the decision themselves, but that their primary role as relatives should be to corroborate that the deceased did not actually register an objection. By not registering an objection to donation, the deceased person under a presumed consent system could implicitly accept the possibility of becoming a donor, which would free the family of responsibility and thus make it easier for the family not to refuse donation. A presumption of consent might be easier on families as it would permit physicians to remove organs upon the deceased’s death without having to force the deceased’s family through the experience of a request for organ donation while

394 See Cooper, supra note 98 at 588.
396 See Cooper, supra note 98 at 576.
397 Ibid. at 573.
398 Supra note 239 at 1651.
399 See Michielsen, supra note 205 at 663 and Mesich-Brant and Grossback, supra note 359 at 695.
simultaneously being informed of their relative’s death.\textsuperscript{400} Indeed, Kennedy \textit{et al.} posit that relatives may find it easier to agree to donation if they are simply asked to confirm the intention of the deceased.\textsuperscript{401} If this is so, presumed consent has the moral benefit of relieving relatives of the burden of deciding about donation at a time of great psychological stress.\textsuperscript{402} A change in the law might therefore achieve the dual effect of increasing the supply of organs and lessening the distress of relatives.\textsuperscript{403}

Arguably, in Ontario “(w)e ask the wrong persons, at the worst possible times, what they never should have been asked at all.”\textsuperscript{404} Certainly, the grief and stress involved at the time of death of a relative should be an important consideration in determining what organ consent regime is most appropriate. Indeed, it can be argued that the express consent system requires staff to intrude on the family’s grief to ask for consent at a very difficult time.\textsuperscript{405} As the best donors are generally young, healthy people who have died suddenly through massive trauma,\textsuperscript{406} families are often overwhelmed and in shock.\textsuperscript{407} Unfortunately, the family often suffers the news of the death at the same time that the hospital personnel make a request for organ donation.\textsuperscript{408} Moreover, to be effective an organ must be removed as soon after death as possible,\textsuperscript{409} at a time when the emotional burden for the family is large.\textsuperscript{410} However, it may be very difficult for relatives to accept that their loved one’s body, maintained by artificial respiration, is in fact dead and will obviously be so when the respirator is turned off.


\textsuperscript{401} \textit{Ibid.}

\textsuperscript{402} \textit{Ibid.}


\textsuperscript{405} See Gerson, \textit{supra} note 41 at 1028.

\textsuperscript{406} See Cooper, \textit{supra} note 98 at 573.

\textsuperscript{407} See Spital, Mandated Choice, \textit{supra} note 403 at 148.

\textsuperscript{408} See McNeil Jr., \textit{supra} note 400 at 359.


\textsuperscript{410} See Krueger, \textit{supra} note 21 at 335.
Family members who are unwilling to accept the news of death will not be conducive to making a rational decision regarding organ donation.\(^{412}\)

Furthermore, the current practice of requesting consent from the family of the deceased may lead to refusals based on emotional reactions at the time of death.\(^{413}\) Often, refusal will be a grieving response, and family members will have a different opinion at a time too late for transplantation.\(^{414}\) Organ procurement teams consistently state that many families "express regret weeks, months, and even years later at not having considered the option of organ donation, not having acted on the stated wishes of their deceased loved one to donate, or having refused a request for a donation."\(^{415}\)

Moreover, most families who have donated their family member’s organs say that this helped them find comfort in a tragic situation.\(^{416}\)

b) Common Misperceptions

It can be argued that opt-in organ donation is not entirely effective because many people forget to sign their donor cards, are too afraid to sign, or fear that they will not receive the same level of medical care if they are registered as an organ donor.\(^{417}\) Some people fear that if they sign up to become a donor, physicians will not try as diligently to save their life,\(^{418}\) and that over-zealous organ procurers might pronounce them dead prematurely or even hasten their deaths to obtain their organs.\(^{419}\) Moreover, a 2001 Health Canada survey found that there were ethnically-based differences in whether or not respondents were

\(^{411}\) See Emson, \textit{supra} note 409 at para 10.
\(^{412}\) See McNeil Jr., \textit{supra} note 400 at 349.
\(^{413}\) See Ontario Ministry of Health and Long-Term Care, Citizens Panel, \textit{supra} note 4 at iii.
\(^{414}\) See McNeil Jr., \textit{supra} note 400 at 359.
\(^{416}\) See Hoferichter, \textit{supra} note 18 at 147.
\(^{417}\) Derek Tsang, “A Comprehensive Approach to Organ Donation in Ontario” (28 February 2008), online: Queen’s University website <http://qlink.queensu.ca/~7dsc/t/misc/organ_donation_webpub.pdf>.
\(^{418}\) See Calandrillo, \textit{supra} note 93 at 129.
concerned that physicians would be more likely to declare them dead prematurely if they were known to be donors.\textsuperscript{420} These fears however relate to organ donation programs in general,\textsuperscript{421} and are not specific to either express or presumed consent regimes. In the event that some people believe these misperceptions, then it is likely that express consent reduces the number of people opting in. However, most respondents in a 2001 Health Canada poll rejected the notion that physicians might prematurely declare someone dead in order to harvest organs.\textsuperscript{422} As such, these misperceptions should not present a barrier to presumed consent.

However, in addition to fears that organs may be retrieved before death, the Citizens Panel found from their discussion groups that there was “widespread lack of awareness and a great deal of misinformation and wrong perceptions”\textsuperscript{423} about organ donation, with these beliefs forming a barrier to those considering donation.\textsuperscript{424} Surveys reveal that most Canadians lack general knowledge about organ donation, mostly because they do not want to discuss this morbid topic.\textsuperscript{425} Among some of the main myths mentioned by the Citizens Panel were the thoughts that a black market trade for organs exists in Ontario, that enduring consent already exists, and that by signing an organ donor card, you are automatically a donor.\textsuperscript{426} Moreover, most Ontarians in the Citizens Panel’s discussion groups believed that a central registry already existed.\textsuperscript{427} The Panel concluded that a public guarantee that one’s wishes would be known and respected and a demonstration that this promise was real would go a long way towards alleviating concerns so that people could

\textsuperscript{420} See Chandler, \textit{supra} note 356 at para 30.
\textsuperscript{421} See Mehlman, \textit{supra} note 153 at 64.
\textsuperscript{422} See Environics Research Group Ltd., \textit{supra} note 369 at 32.
\textsuperscript{423} \textit{Supra} note 4 at 43.
\textsuperscript{424} \textit{Ibid.} at 6.
\textsuperscript{425} See Zdeb, \textit{supra} note 8.
\textsuperscript{426} \textit{Supra} note 4 at 45.
\textsuperscript{427} \textit{Ibid.}
seriously consider the matter itself.\textsuperscript{428} Again, these concerns relate to organ donation in general as opposed to the type of consent under which the system operates.

c) Psychological Factors

A central defect of Ontario’s express consent policy is the major disconnect between potential donors’ understanding and intention with respect to donation on the one hand, and their willingness to act accordingly on the other.\textsuperscript{429} Opinion polls have consistently shown that upward of 85\% of Ontarians are in favour of organ donation and transplantation,\textsuperscript{430} with a November 2006 poll putting that figure at an astoundingly high 93\%.\textsuperscript{431} The Citizens Panel also found that Ontarians “recognized the importance of organ donation and overwhelmingly supported it as being part of our health-care system.”\textsuperscript{432} However, although Ontarians say they are willing to donate, far fewer actually discuss it with their families or register their commitment,\textsuperscript{433} with the majority of Ontarians failing to take the steps necessary to ensure that their intentions are acted upon in the event of their deaths.\textsuperscript{434} For instance, an Environics poll in 2001 found that 94\% of Canadians supported organ donation, but fewer than 40\% had signed organ donor cards.\textsuperscript{435} Moreover, a survey of 603 Ontarians in March of 2004 by Navigator Ltd.\textsuperscript{436} found that 53\% of respondents reported having signed an organ donor card,\textsuperscript{437} while 45\% of those who had not signed claimed they would be willing to do so.\textsuperscript{438} In addition, TGLN found that Ontarians were virtually unanimous in their belief that it was

\textsuperscript{428} Ibid. at 6.
\textsuperscript{429} See Arnold, supra note 95 at para 15.
\textsuperscript{430} See Ontario Ministry of Health and Long-Term Care, Citizens Panel, supra note 4 at 73.
\textsuperscript{431} Ibid.
\textsuperscript{432} Ibid. at 26.
\textsuperscript{433} See Chandler, supra note 356 at para 18.
\textsuperscript{434} See Arnold, supra note 95 at para 16.
\textsuperscript{436} See TGLN website, supra note 12.
\textsuperscript{437} Ibid.
\textsuperscript{438} Ibid.
important to tell their families whether or not they would want their organs to be donated after death, however, only 44% reported actually having had a family discussion.

What accounts for this disparity between intention and action? Despite the fact that checking a box to opt in may seem easy, psychological barriers may prevent individuals or their families from consenting to donation at the time of their death. The lack of participation in the organ procurement system is at least partially due to the public’s uneasiness with the concept of organ harvesting and their own mortality, as considering the subject means conceding that death is inevitable. Many people who otherwise support organ donation in the abstract have difficulty envisioning their own deaths and find it hard to contemplate donating their organs, which in turn may render them unable to articulate their true wishes. Moreover, lack of awareness, laziness, concerns about donation in practice and indifference may account for the low numbers who opt in.

Unfortunately, decades of public education have not changed the fundamental failing of express consent, which is that people are unwilling to expend the small effort required to translate good intentions into actions. Indeed, the Citizens Panel recognized that even though 84% of the respondents to their survey knew that there were not enough organs available to meet the need in Ontario, and although Ontarians had “no theoretical objection to the solution, getting them to follow through to the next logical step and take action

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440 Ibid.
441 Orly Hazony, “Increasing the Supply of Cadaver Organs for Transplantation: Recognizing that the Real Problem is Psychological Not Legal” (1993) 3 Health Matrix 219 at 240-241.
443 See Coleman, supra note 256 at 6.
444 See Moustarah, supra note 64 at 232.
445 See Silver, supra note 395 at 697.
446 See Organ Donation Taskforce, supra note 234 at 24.
447 See Calandrillo, supra note 93 at 113.
448 See Ontario, Trillium Gift of Life Network, supra note 439.
449 Supra note 4 at 73.
The disparity between the number of people who claim to favour donation and those who actually do donate their organs continues to present a perplexing and difficult problem. Some have suggested that publicity campaigns on organ donation would increase rates, but there is little evidence that such efforts can influence the public absent a huge publicity budget. For example, a British television campaign by the Department of Health was successful in reducing organ donation refusal rates from 30% to 22% during a period of intense publicity, but as soon as that period was over, organ donation rates fell to pre-campaign levels.

Presumed consent laws on the other hand are based upon the belief that while most people wish to donate their organs, they are simply reluctant to address the issues of death and organ transplantation while still healthy. As such, “(b)y eliminating the need to confront donation actively in order to donate, presumed consent might overcome these psychological impediments and allow individuals to give effect to their true beliefs.” As presumed consent avoids asking the question, organ retrieval can occur in a less psychologically harmful way for donors. Presumed consent then can be viewed as one way to overcome the inertia, bridging the gap between what Ontarians say they want to do and what they actually do. Moreover, Silver argues that although it is commonly believed

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450 Ibid.
453 Ibid.
454 Ibid.
456 See Mehlman, supra note 153 at 44.
458 See Ontario Ministry of Health and Long-Term Care, Citizens Panel, supra note 4 at 73.

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that the public is opposed to presumed consent, it may be that most people are in fact in favour of it or indifferent and simply cannot admit it or act upon it.  

**d) Reluctance to Request Donation**

Cadaveric organ donation in the express consent system is also hampered by professional attitudes, as some health care staff are unwilling or unable to approach the family to discuss organ donation and obtain consent. Health care professionals however are crucial in the process of organ procurement, not only to obtain consent but also because they are responsible for the initial identification of potential donors and the diagnosis of brain death. Medical personnel are understandably hesitant to broach the topic of organ donation, even in places where legislation requires inquiry. However, a failure to make the inquiry can lead to a loss of organs, as some people claim that they are not registered as donors simply because they were never asked. The time required to perform the administrative tasks accompanying donation may also act as a deterrent for organ donation discussions. This problem could be solved in Ontario by ensuring that physicians can appropriately bill for all matters associated with the organ donation process, and by employing specialized transplant co-ordinators who could shoulder most of the additional workload.

Presumed consent could make the organ donation process easier for health care professionals by eradicating the need to request consent from families and changing the tone of any conversation with families with respect to possible organ donation. Studies have suggested that if organ donation discussions are part of the routine, the apprehension that

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460 Supra note 395 at 697.
461 See Krueger, supra note 21 at 335.
462 See Matesanz, Miranda and Felipe, supra note 27 at 114.
463 See Coleman, supra note 256 at 7.
464 Ibid. at 8.
465 See Krueger, supra note 21 at 335.
accompanies such conversations can be lessened. Although a “hard” version of presumed consent would likely be difficult to apply in Ontario given anticipated reluctance on the part of the medical community, a “soft” version such as that used in Spain could be more successful. Certainly, a study conducted in Spain found that of 200 families that initially rejected organ donation, 78% changed their minds after the process was adequately explained to them.

VI. ADDRESSING THE CRITICISMS OF PRESUMED CONSENT

a) Whether Presumed Consent is in Fact Consent

i) No Basis for the Presumption of Consent

Some argue that “presumed consent” is a misnomer and that presumed consent is no consent at all. Indeed, Erin and Harris argue that without the actual consent of the individual, there is no consent. Richardson agrees, contending that “(p)resumed consent is public-relations-speak for the denial of a need even to seek consent.” Under presumed consent, the argument goes, the language of presumed consent is adopted even when there is no basis for this presumption, and despite the fact that it is not possible to presume that everyone who has not executed an opt-out in fact would want to have their organs used. As such, consent is fictionalized in the absence of any positive indication that removal has actually been agreed to.

466 See Gerson, supra note 41 at 1020.
467 See Matesanz, Miranda and Felipe, supra note 27 at 103.
468 See Robson, supra note 199 at 11.
470 See Pattinson, supra note 66 at 429.
472 Supra note 469 at 78.
474 See Robert Arnold et al., supra note 168 at 202.
475 See Pattinson, supra note 66 at 429.
Presumed consent is also criticized for relying on an individual’s silence, with some arguing that silence may not be “universally indicative of a deliberate undertaking.” What lies behind the silence may not be clear, and it is always possible that silence or failure to act could be based on a misunderstanding of the issues at stake, the procedures to express dissent, or could be indicative of ignorance of the fact that opting out was necessary. As such, critics of presumed consent argue that it may be unrealistic to consider tacit consent to be deliberate intention. The Citizens Panel has also expressed concern, stating that an opt-out system is “too passive a method to be a clear statement of an individual’s intent.” Admittedly, the fact that someone has not opted out does not mean that they have agreed to be a donor and it may simply be that they have failed to think about organ donation. Critics therefore argue that presumed consent allows the state to act upon a silent consensus and remove organs without explicit permission, which some have described as "coercion by inertia."

The ethical basis of presumed consent has also been questioned. Veatch views presumed consent as “the most outrageously unethical of all possible policies for organ procurement.” Veatch and Pitt contend that “those who support a societal right to procure organs without consent find it embarrassing to speak bluntly about taking organs without

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476 See Jacob, Another Look, supra note 457 at 296.
477 See Jacob, On Silencing, supra note 169 at 266.
478 Ibid. at 267.
479 See Jacob, Another Look, supra note 457 at 295.
480 See Jacob, On Silencing, supra note 169 at 269.
481 Supra note 4 at 75.
482 See Fevrier and Gay, supra note 218 at 2.
483 See Chandler, supra note 356 at para 85.
486 See Veatch, Transplantation Ethics, supra note 473 at 160.
and as such attempt to “preserve the appearance of the preferred gift-mode and the guise of respect for individual choice.” Veatch however views presumed consent as routine salvaging in disguise. Jacob also sees ethical problems, pointing out that most people are disinclined towards active protest, and arguing that the “ease of smoothly targeting inactive or uninformed citizens as potential donors has disturbing qualities.” However, supporters of presumed consent state that under all regimes, the deceased and possibly their relatives may object to organ removal, such that presumed consent still represents a consensual removal and not a taking.

Clearly, the above criticisms must be fully considered to determine whether presumed consent in Ontario is capable of accurately reflecting Ontarian’s wishes. Certainly, those who argue in favour of presumed consent “contend that it is just as much a form of ‘consent’ as any other.” In the United States, the Committee on Increasing Rates of Organ Donation has stated that presumed consent need not be a fiction. In fact the Committee found that it could be valid and effective consent, depending on the nature and structure of social practices, as well as the competence and understanding of those whose silence was presumed to be consent, and the voluntariness of their choices. Beauchamp and Childress argue along the same lines, contending that presumed consent can rightly be viewed as a form of tacit consent, assuming that the deceased in question was during life aware of the regime and the implications of action or inaction, had a reasonable time within which to object, and that

488 Ibid.
489 See Veatch, Transplantation Ethics, supra note 473 at 175.
490 See Jacob, Another Look, supra note 457 at 295.
491 See Jacob, On Silencing, supra note 169 at 243.
492 See Price, supra note 163 at 85.
493 Ibid. at 106.
494 See Childress and Liverman, note 152 at 209.
495 Ibid.
the potential effects of refusing were not extremely detrimental.\textsuperscript{496} Moreover, although critics of presumed consent assume that consent is only real if the person consenting does so with an affirmative act as opposed to by default through silence,\textsuperscript{497} Arnold argues that as the “essence of giving, or of consent, is the decision to give or consent; the mechanism by which the decision is communicated is unimportant. So long as the decision is an informed one and the person has a reasonable opportunity to make it, a presumed gift or consent is as ethically valid as an express one.”\textsuperscript{498} One can argue then that presumed consent could be implemented in Ontario in such a way as to effectively take each of the above criticisms into account.

\textit{ii) Presumed Consent Not Justified Unless All Would Agree}

In addition to concerns with respect to the basic meaning of consent, some opposed to opt-out policies argue that the term “presumed consent” cannot be justified unless there is evidence that essentially all people would consent to such an arrangement if asked.\textsuperscript{499} Veatch and Pitt argue that the presumption that people would agree to the posthumous donation of their organs must be corroborated with empirical evidence,\textsuperscript{500} stating that “until there is empirical evidence that the presumption of consent is warranted, those who favor the state’s procurement without some explicit permission should affirm their communitarianism and acknowledge that their policy commits them to the view that the state has the right to take organs without permission.”\textsuperscript{501} Interestingly, one can argue that such empirical evidence has been demonstrated. A 2001 Environics poll found that 94\% of Canadians supported organ donation. Surveys have consistently shown that the majority of people would want to

\textsuperscript{497} See Arnold, \textit{supra} note 95 at para 27.
\textsuperscript{498} \textit{Ibid}.
\textsuperscript{500} See Veatch and Pitt, \textit{supra} note 487 at 1889.
\textsuperscript{501} \textit{Ibid}., at 1891.
donate their organs upon their death but that only a small minority have signed an organ
donor card.\textsuperscript{502} As such, although support for presumed consent in Ontario is not unanimous,
it is reasonable to presume that any given person would want to donate their organs after
their death.\textsuperscript{503} Thus, in the vast majority of cases, presumed consent could legitimately
presume that most Ontarians were in favour of cadaveric organ donation.

\textit{iii) The Problem of Errors}

Inevitably, errors would occur under an opt-out system, as “population statistics do
not apply at the level of the individual.”\textsuperscript{504} In a presumed consent regime, of the small
percentage of people that were not in favour of cadaveric organ donation, a certain
proportion would have failed to opt out, leaving a smaller percentage of persons for whom
organs would be removed after death without their consent. As such, the presumption of
consent would be wrong for that percentage of the population who did not support donation
and who had not opted out.\textsuperscript{505}

However, Cooper rightly points out that \textit{any} model which values consent by the
deceased must make provisions to interpret silence,\textsuperscript{506} with such silence taken as constructive
consent, constructive objection, or a non-decision calling for decision by the deceased’s
family.\textsuperscript{507} Indeed, Price states that “(b)ecause errors are endemic across the board, arguments
that presumed consent will result in errors as regards the deceased’s true wishes are
inconclusive in themselves.”\textsuperscript{508} Certainly, errors also occur under the express consent
system, where express statements of consent for posthumous organ donation are available in
a much smaller percentage than reflect the true size of the potential donor pool as

\textsuperscript{502} See Herring, \textit{supra} note 469 at 380.
\textsuperscript{503} \textit{Ibid.}
\textsuperscript{504} See Ontario Ministry of Health and Long-Term Care, Citizens Panel, \textit{supra} note 4 at 74-75.
\textsuperscript{505} See Childress and Liverman, \textit{supra} note 152 at 210.
\textsuperscript{506} \textit{Supra} note 98 at 565.
\textsuperscript{507} \textit{Ibid.}
\textsuperscript{508} \textit{Supra} note 163 at 111.
demonstrated by public opinion surveys.\textsuperscript{509} Indeed, in express consent regimes, the assumption that people have reached a decision \textit{not} to donate if they have not signed a donor card may very well be mistaken,\textsuperscript{510} and errors may occur when it is assumed that the absence of expressed consent implies a refusal to donate.\textsuperscript{511} As only about half of individuals in Ontario give explicit consent ahead of time,\textsuperscript{512} a presumption has to be made at death for the other half one way or the other.\textsuperscript{513}

Furthermore, in express consent regimes the decision whether to allow organ removal can be made by the family of the deceased\textsuperscript{514} whether or not the deceased’s wishes are known.\textsuperscript{515} There is generally no formal mechanism for recording objections in express consent systems,\textsuperscript{516} and although one might logically assume that under express consent, silence should constitute a presumed objection,\textsuperscript{517} this is not the case, with silence in an express consent system viewed as a neutral feature.\textsuperscript{518} As such, in an opt-in system, even in the absence of consent by the deceased, a relative can provide consent for organ removal,\textsuperscript{519} or the family can overrule the deceased’s explicit express consent.\textsuperscript{520} As such, it remains highly questionable whether the family’s decision in an opt-in system is actually in keeping with the deceased’s wishes or whether it presents an error.

Given that errors are inevitable no matter what system of cadaveric organ donation is employed, one can question which error is more morally acceptable. Herring posits that

\begin{itemize}
  \item \textsuperscript{509} Ibid. at 91.
  \item \textsuperscript{510} Eric J. Johnson and Daniel G. Goldstein, “Defaults and Donation Decisions” (2004) 78(12) Transplantation 1713 at 1713 [Donation Decisions].
  \item \textsuperscript{511} See Moustarah, \textit{supra} note 64 at 232.
  \item \textsuperscript{512} See TGLN website, \textit{supra} note 12.
  \item \textsuperscript{513} Robert Higgins \textit{et al.}, eds., \textit{The Multi-Organ Donor: Selection and Management}, (Malden, MA: Blackwell Science, 1997) at 75.
  \item \textsuperscript{514} See Price, \textit{supra} note 163 at 15.
  \item \textsuperscript{515} \textit{Ibid.} at 113.
  \item \textsuperscript{516} \textit{Ibid.} at 98.
  \item \textsuperscript{517} \textit{Ibid.} at 112.
  \item \textsuperscript{518} \textit{Ibid.}
  \item \textsuperscript{519} See Wicks, \textit{supra} note 103 at 156.
  \item \textsuperscript{520} See Koch, \textit{supra} note 352 at 28.
\end{itemize}
“(o)ne way of resolving the debate is to ask: which is worse, not to have your organs removed when you would have wanted them to be (...) or to have your organs removed post-mortem when you would not have wanted them to be.”\textsuperscript{521} Although some argue that it is correct to err on the side of avoiding organ donation in cases of doubt, one can make a strong argument that errors resulting in organ donation are preferable given the pressing need for organs.\textsuperscript{522} As Cohen states, “while the lifesaving use of organs that ought not to have been used cannot be right; it is at least a wrong more tolerable than the wrong of not using organs that should have been used.”\textsuperscript{523}

One can easily agree with Dennis \textit{et al.} that the origin of divergence between supporters and opponents of presumed consent lies in the ethical assessment of tolerable risk.\textsuperscript{524} Advocates of an opt-out system “look at the issue through the lens of need and argue along lines of utility.”\textsuperscript{525} Supporters accept cases of false positives, arguing that those not in favour of donation ultimately have the responsibility to register their objection and that false positives must be weighed against the greater good of increasing the supply of organs.\textsuperscript{526} In addition, supporters argue that in the absence of an indication either way as to whether the deceased consented or objected to donation “we do a disservice to humanity by presuming a lack of altruism.”\textsuperscript{527} However, Orentlicher contends that “the harm from an erroneous donation under presumed consent may be greater than the harm from an erroneous non-donation under actual consent”\textsuperscript{528} arguing that when balancing risks of error, one should compare not only the number of people that might be wronged but also the magnitude of the

\textsuperscript{521} \textit{Supra} note 469 at 381.
\textsuperscript{523} \textit{Supra} note 404 at 2171.
\textsuperscript{524} \textit{Supra} note 97.
\textsuperscript{525} See Ontario Ministry of Health and Long-Term Care, Citizens Panel, \textit{supra} note 4 at 73.
\textsuperscript{526} See Dennis \textit{et al.}, \textit{supra} note 97.
\textsuperscript{527} See Wicks, \textit{supra} note 103 at 156.
\textsuperscript{528} \textit{Supra} note 99 at 20.
risk of the errors.\textsuperscript{529} He goes on to argue that the distress to the living from the possibility that their organs might be taken after death is more substantial than the distress from the possibility that organs might not be taken.\textsuperscript{530} This however, is debatable, and would be highly dependent on how strongly the person in question held their beliefs with respect to organ donation.

**b) Personal Autonomy**

Canadians are very divided about presumed consent, and it may be perceived as too much of an encroachment on individual autonomy.\textsuperscript{531} Indeed, the Citizens Panel found that the “topic of presumed consent stirred up some of the liveliest debates at the Panel’s public consultation meetings and in the discussion groups.”\textsuperscript{532}

**i) Deference to Individual Decisions**

Certainly, one can argue that an individual is best suited to make an informed decision as to the disposition of their own body after death\textsuperscript{533} and that their choice should be given complete deference.\textsuperscript{534} Moreover, if personal autonomy is to be respected, the decision of the deceased during life with respect to organ donation must outweigh their family’s concerns.\textsuperscript{535} “By definition, cadaveric donors are not capable of seeing their wishes carried out,”\textsuperscript{536} and any law requiring that a request be made to the deceased’s family comes too late for the individual to make their own decision as to organ donation.\textsuperscript{537} Indeed, surveys have shown that most people believe that the individual is best suited to decide about organ donation.

\textsuperscript{529} Ibid.
\textsuperscript{530} Ibid. at 22.
\textsuperscript{531} See Environics Research Group Ltd., supra note 369 at 45.
\textsuperscript{532} Supra note 4 at 73.
\textsuperscript{533} See Spital, Mandated Choice, supra note 403 at 151.
\textsuperscript{534} See McNeil Jr., supra note 400 at 349.
\textsuperscript{535} See Blumstein, supra note 84 at 35 and Wilcox, supra note 31 at 950.
\textsuperscript{536} See Mesich-Brant and Grossback, supra note 359 at 691.
\textsuperscript{537} See Veatch, Transplantation Ethics, supra note 473 at 161.
donation and that families should not be able to override the wishes of their loved ones.\textsuperscript{538} Accordingly, this is the case in Ontario, where the Citizens Panel found that "(b)oth in discussions and in survey results, the position of Ontarians was unanimous – they want their wishes respected and overridden by no one."\textsuperscript{539} The Citizens Panel found that 88\% of 2,141 respondents to an on-line and mail-back survey\textsuperscript{540} felt that it was up to the individual to have the final say.\textsuperscript{541} Respondents also supported the idea that upholding the wishes of those who agreed to donate their organs upon their death was the preferred donation method.\textsuperscript{542}

However, Ontario’s current system of express consent does not succeed in ensuring that the wishes of the deceased are honoured.\textsuperscript{543} In practice, the opt-in regime results in explicit consents being overridden by the deceased’s family\textsuperscript{544} and also allows the family to consent to donation when the deceased may not have wished to donate.\textsuperscript{545} Although this practice of permitting the deceased’s family to thwart the deceased’s wishes is widespread,\textsuperscript{546} allowing the family’s wishes to take precedence over the deceased’s choice violates the principles of respect for autonomy and self-determination.\textsuperscript{547} Understandably, the responses of families are often their own personal value judgments\textsuperscript{548} and do not reliably reflect the autonomous wishes of the deceased.\textsuperscript{549} The Citizens Panel found that Ontarians were angered and dismayed that the reality of organ donation did not live up to their\textsuperscript{548}

\textsuperscript{538} A. Spital, “Mandated Choice. A Plan to Increase Public Commitment to Organ Donation” (1995) 273 JAMA at 504-506.
\textsuperscript{539} Supra note 4 at 3.
\textsuperscript{540} Ibid. at 48.
\textsuperscript{541} Ibid. at 50.
\textsuperscript{542} Ibid.
\textsuperscript{543} See Arnold, supra note 95 at para 28.
\textsuperscript{544} Ibid.
\textsuperscript{545} See Wilcox, supra note 31 at 951.
\textsuperscript{547} Ibid.
\textsuperscript{548} See Veatch, Transplantation Ethics, supra note 473 at 176.
\textsuperscript{549} See Cohen, supra note 404 at 2169.
expectations. Ontarians believed that their donor cards would guarantee that their donation wishes would be respected at the time of their death, and were shocked to learn that donor cards are almost never asked for and that the family’s decision prevails even if it contradicts the deceased’s wishes. One can argue then that express consent as it currently operates is not respectful of autonomous choices because family members can refuse or consent to donation against the deceased’s wishes. The express consent regime also presents some practical problems that could interfere with personal autonomy, as an opt-in system:

“Wrongfully presumes that another may speak for the decedent unless the latter both disallows such a gift and has effectively communicated his refusal to some of his next of kin and that one of these is at home and available to respond to a single phone-call at the time of death, and that he actually remembers the decedent’s refusal and makes it known in appropriately formal language despite the overpowering emotional nature of the situation.”

Admittedly, if express consent were properly applied, such that an express wish to donate one’s organs posthumously was respected irrespective of family wishes, then an express consent system could respect the autonomy of those who had opted in. This could be accomplished simply by obeying current law. However, as psychological factors and other barriers often prevent individuals from opting in despite their true intentions, it can be argued that presumed consent would still more accurately reflect the majority’s true wishes. As such, if indeed it is a goal in Ontario to respect what the majority of Ontarians want, which is that their own wishes take precedence, the current system must change.

550 Supra note 4 at 1.
551 Ibid. at i.
552 See Higgins et al., supra note 513 at 75.
554 See Coleman, supra note 256 at 34.
One can make a strong argument that presumed consent is morally defensible because it ensures that an individual's wishes are actually carried out, rather than circumvented by their family's choices, and in doing so affirms individual autonomy and enhances the self-determination of the deceased more effectively than express consent as it currently operates. Within a presumed consent regime, the dispositional authority rests with the individual and only secondarily, if at all, with the family. By assigning dispositional authority over organs to the individual while they are alive, "(p)resumed consent may increase the likelihood that decisions about donation are voluntary and informed." Those who wished to decline could, and those who did not wish to decline could say nothing, with that choice being respected regardless of the family's opinion. As the decision whether to object to donation would be made voluntarily by people outside of a time of grief when they were not confronting their own death, it might also be more deliberative and dispassionate.

Notwithstanding, critics of presumed consent worry about infringing the autonomy of those who would fail to opt out but who indeed would not wish to donate. Presumed consent however could decrease the likelihood of organs being removed when the deceased would not have wanted to donate. Somerville notes that under an opt-in system, a person can do little before their death to ensure that their organs will not be donated by their family after death, but under an opt-out system, that person is better able to control the situation.

555 See Moustarah, supra note 64 at 231-232.
557 See Childress and Liverman, supra note 152 at 211-212.
558 Ibid. at 226.
559 See Mehlman, supra note 153 at 43.
560 See Arnold, supra note 95 at para 28.
561 See The Toronto Star, Donation Emergency, supra note 17.
562 See Mehlman, supra note 153 at 43.
564 See Childress and Liverman, supra note 152 at 219.
565 See Price, supra note 163 at 110.
because there would be a formal mechanism to record their objection that would have to be respected.\(^{566}\) This would of course allow those who had opted out to block their families from donating their organs after death,\(^{567}\) but one can argue that this is the correct approach in order to best protect individual autonomy.

Thus, it may be that if presumed consent were well implemented, individual freedom would be less likely to be violated\(^{568}\) than under the current system of express consent. As explained by Gerson, “(a) policy of presumed consent, rather than quashing individual rights, would make the donor the primary, and perhaps exclusive, decision maker in organ donation.”\(^{569}\) Certainly, The Presumed Consent Foundation, Inc. believes that presumed consent enhances the right of an individual to decide what will happen after they die.\(^{570}\) Cohen also argues that presumed consent can provide for the autonomous disposition of organs,\(^{571}\) contending that an opt-out system is more fair, more protective, and more likely to realize autonomy than presuming that consent would not have been given.\(^{572}\)

\textit{ii) Consistency with Majority Opinion}

Certainly, the argument that presumed consent is more respectful of donor autonomy is dependent on the assumption that the majority of people do wish to donate.\(^{573}\) In fact, most opinion polls suggest that this is the case.\(^{574}\) As such, one can argue that presumptions should be adopted that are consistent with what we know people want.\(^{575}\) Currently, the opt-in system presumes that the public are unwilling to become organ donors.\(^{576}\) However, as

\(^{567}\) See Childress and Liverman, supra note 152 at 226.
\(^{568}\) See Statz, supra note 367 at 1698.
\(^{569}\) Supra note 41 at 1020.
\(^{570}\) See Foundation website, supra note 221.
\(^{571}\) Supra note 404 at 2169.
\(^{572}\) Ibid. at 2172.
\(^{573}\) See Price, supra note 163 at 110.
\(^{574}\) Ibid.
\(^{575}\) See Cohen, supra note 404 at 2172.
\(^{576}\) See Keller, supra note 189 at 860.
Ontarians generally support organ donation,\(^{577}\) presumed consent would enable the majority to do what they say they want to do.\(^{578}\) As the number of people in Ontario that are willing in principle to donate far exceeds the proportion of those who actually communicate an intention to do so, presumed consent could give effect to the wishes of most people better than the current express consent system,\(^{579}\) with a presumption in favour of donation more likely to realize the autonomy of the deceased than a presumption against.\(^{580}\) Presumed consent would “enable the majority to realize its general will more effectively, with less effort, and hence would increase the number of transplantable organs”\(^{581}\) by reinforcing the existing desire of most people to share their organs after death.\(^{582}\) Presumed consent would also enable the majority to follow through more easily on its expressed willingness to donate organs.\(^{583}\) As such, although the Citizens Panel did not accept the argument that presumed consent would give Ontarians what they want,\(^{584}\) one can agree with Cohen that presumed consent is the best realization of autonomy in a population that strongly favours cadaveric organ donation.\(^{585}\) Moreover, by capitalizing on the public consensus in favour of donation that often goes unacted upon,\(^{586}\) donor rates could likely be increased.

In reality however, neither opt-in nor opt-out policies can absolutely guarantee that a deceased’s wishes will be respected\(^{587}\) and neither can completely ensure the individual’s right of self-determination.\(^{588}\) Orentlicher states that if autonomy might be violated with either actual consent or presumed consent, one can question how to go about balancing the

\(^{577}\) See Ontario Ministry of Health and Long-Term Care, Citizens Panel, *supra* note 4 at 73.

\(^{578}\) See Childress and Liverman, *supra* note 152 at 218.


\(^{580}\) See English and Sommerville, *supra* note 337 at 150.

\(^{581}\) See Childress and Liverman, *supra* note 152 at 218.

\(^{582}\) See Keller, *supra* note 189 at 861.

\(^{583}\) See Childress and Liverman, *supra* note 152 at 223.

\(^{584}\) *Supra* note 4 at 74.

\(^{585}\) *Supra* note 404 at 2169.

\(^{586}\) See Calandrillo, *supra* note 93 at 133.

\(^{587}\) David Lamb, *Organ Transplants and Ethics* (Brookfield: Avebury, 1996) at 151.

\(^{588}\) See Roels, Donor Hospital, *supra* note 49 at 260.
two risks of error. Should we be more worried about the loss of autonomy under presumed consent or the loss of autonomy under express consent? Orentlicher posits that public views can help us decide whether presumed or express consent better serve the interests of personal autonomy. As public opinion surveys consistently find that a majority of people say they want to donate their organs after death, it makes sense to base the law’s default rule according to the majority’s preference. As most Ontarians are in favour of donation, it can be argued that presumed consent would result in fewer errors than express consent.

iii) The Ability to Opt Out

Although some critics of presumed consent claim that a presumption of organ donation takes away an individual’s freedom and violates their personal autonomy, one can argue that presumed consent does not negate the right of individuals with respect to their bodies, as a means of refusal is always provided and individuals are given ample opportunity to object if they wish during their lifetime. With presumed consent, “the ultimate goal is to give effect to the individual’s wishes,” and the opportunity for objectors to “empower their anti-donation preference” is in keeping with that goal. Veatch however argues that even with an opt-out, the requirement to actively register an objection raises serious questions. Dennis et al. agree, arguing that individuals do not have a social duty to express an objection, and that asking people to publicly express their objection does not

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589 Supra note 99 at 16.
590 Ibid.
591 Ibid.
592 Ibid. at 17.
593 Ibid. at 18.
594 See Williams, supra note 556 at 361.
595 See Veatch, Transplantation Ethics, supra note 473 at 146.
596 See Gerson, supra note 41 at 1026.
597 See Roels et al., Three Years, supra note 221 at 904.
598 See Price, supra note 163 at 109.
599 See Dennis et al., supra note 97.
600 See Veatch, Transplantation Ethics, supra note 473 at 160.
respect their right not to choose.\textsuperscript{601} \textit{Dennis et al.} go on to argue that individuals should have the right to delegate the organ donation decision to family members, and that presumed consent authorizes the collection of the organs of non-objectors who trust their family to make the decision.\textsuperscript{602} However, any system of presumed consent adopted in Ontario would undoubtedly by the “soft” version, such that the family could claim an unregistered objection after their relative’s death.

Admittedly, presumed consent “does communicate moral responsibility more so than express consent,”\textsuperscript{603} but one can make a strong argument that this burden on society is a small price to pay given the overwhelming need for organs. Indeed, Arnold argues that in the case of those who simply do not make the effort to opt out, “the social value of defending the autonomy of persons over a choice they are so utterly uninterested in making is simply lesser than the social value of saving more lives.”\textsuperscript{604} Moreover, Dickens recognizes that although presumed consent requires those who object to identify themselves to health or other public authorities and place their convictions on record, the ability to object itself preserves personal autonomy.\textsuperscript{605} As such, one can argue that presumed consent respects personal autonomy while at the same time trying to meet the increasing demand for organs.\textsuperscript{606}

\textit{iv) The Role of the State}

Critics of presumed consent also argue that an opt-out system suggests that the state is entitled to take their organs.\textsuperscript{607} This argument however either confuses (or perhaps deliberately conflates) presumed consent with routine removal regimes.\textsuperscript{608} Although both

\begin{itemize}
\item \textsuperscript{601} \textit{Supra} note 97.
\item \textsuperscript{602} \textit{Ibid.}
\item \textsuperscript{603} See Futterman, \textit{supra} note 91 at 166-167.
\item \textsuperscript{604} \textit{Supra} note 95 at para 28.
\item \textsuperscript{605} See Dickens, Legal Aspects, \textit{supra} note 164 at 346.
\item \textsuperscript{606} See Moustarah, \textit{supra} note 64 at 234.
\item \textsuperscript{607} See Ontario Ministry of Health and Long-Term Care, Citizens Panel, \textit{supra} note 4 at 74.
\item \textsuperscript{608} See Childress and Liverman, \textit{supra} note 152 at 205.
\end{itemize}
systems involve opting out, the fundamental distinction between these regimes “rests on their different interpretations of the relation of the individual and his or her dead body to the state or society,” with routine removal being communitarian while presumed consent remains primarily individualistic.

v) Concern for the Autonomy of Vulnerable People

Critics of presumed consent also argue that the presumption in favour of donation is a burden on the poor and uneducated, who would have less opportunity to exercise their autonomy. Indeed, the Citizens Panel stated that with respect to presumed consent, “the major concern focused on doubts that the government would properly inform everyone, especially new Canadians, those whose mother tongue is neither English nor French, and those with mental disabilities.” However, both presumed consent and express consent are default rules, with both systems excluding marginalized groups from consent schemes. As any default rule can potentially harm the most vulnerable members of society, one can rightly question as Jacob does why the default rule of donation is guiltier of social exclusion than the default rule of non-donation.

To the extent that one accepts the argument that marginal persons, such as the homeless, the disenfranchised, the illiterate, or the dissenting member within a tight and homogeneous community may lack access to a forum to express their wishes with respect to organ donation, one can argue that presumed consent would work to the benefit of those

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609 Ibid. at 205-206.
610 Ibid. at 206.
612 See Childress and Liverman, supra note 152 at 206.
613 See Lamb, supra note 587 at 142.
614 Supra note 4 at 46.
615 See Jacob, Another Look, supra note 457 at 293.
616 See Jacob, On Silencing, supra note 169 at 272.
617 See Jacob, Another Look, supra note 457 at 297.
618 See Jacob, On Silencing, supra note 169 at 272.
who wished to donate their organs after death.\textsuperscript{619} Although critics of presumed consent use the example of vulnerable persons as an argument against an opt-out system, one can equally criticize the express consent system for the same problem, as the express consent system may also discriminate against marginalized people who want to donate their organs after they die.\textsuperscript{620} As such, the argument that presumed consent unduly burdens the vulnerable is weak, as a default rule of presumed refusal can be just as exclusionary as that of presumed consent.\textsuperscript{621}

\textit{vi) Cultural and Religious Issues}

It can be argued that presumed consent legislation would not respect Ontario’s diverse population. Certainly, “(q)uestions concerning the boundary between life and death have cultural roots in many societies,”\textsuperscript{622} and Bowman and Richard note that “the space between life and death is socially, culturally and politically constructed, and is fluid and open to dispute.”\textsuperscript{623} Many Canadian Aboriginal people in particular are very uncomfortable with the concept of organ donation,\textsuperscript{624} while other Ontarians may also be hesitant about organ donation as they do not know whether their religion prohibits it. The Citizens Panel found that religion strongly influences many Ontarians’ decisions whether or not to donate,\textsuperscript{625} with even those who do not consider themselves to be very religious turning to their faith to make an ethical and moral judgment with respect to donation.\textsuperscript{626} The Citizens Panel reviewed the official attitudes of religious groups in Ontario and found that while officially, all major

\textsuperscript{619} \textit{Ibid.}
\textsuperscript{620} \textit{Ibid.}
\textsuperscript{621} See Jacob, Another Look, \textit{supra} note 457 at 299.
\textsuperscript{622} See Ontario Bar Association, Health Law Section, Bills 33, \textit{supra} note 3 at 8.
\textsuperscript{624} M. Emory, “Native America Calling” (January 2001), online: Native America Calling website <http://www.nativeamericacalling.com>.
\textsuperscript{625} \textit{Supra} note 4 at ii.
\textsuperscript{626} \textit{Ibid.} at 8.
world religions permitted organ donation, many Ontarians stated that their faith leader had spoken against it. However, in their survey the Citizens Panel found that of those respondents who were unfamiliar with organ donation, only 3\% stated that it might be against their religious beliefs, indicating that religion is not a significant barrier to organ donation in Ontario. As such, given the fact that all major religions either affirmatively encourage or passively approve of organ donation, and the low percentage of Ontarians who feel that their religion presents a barrier to donation, religious concerns need not preclude the adoption of presumed consent.

Nevertheless, pursuant to the Canadian Charter of Rights and Freedoms, Canada has a commitment and obligation to respect diversity and individual rights and as such, any attempt to increase the cadaveric organ donation rate must be careful to respect diverse opinions. Indeed, it has been shown that ethnic and religious minorities are less likely to consent to organ donation. A 2001 Health Canada poll reported that those whose religion was non-Christian, those whose ethnic background was either non-European or European other than French or British, and those born outside Canada were more likely to be undecided with respect to organ donation. Non-Christians older than sixty-five were most likely to have decided not to donate. One can argue however that exempting specific groups from presumed consent legislation would not be the answer, as this would presume that all people of a particular group adhered to all tenets of their faith or culture. In any event, presumed

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627 Ibid.
628 Ibid. at ii.
629 Ibid. at 49.
631 See Mehlman, supra note 153 at 53.
633 See Ontario Bar Association, Health Law Section, Bills 33, supra note 3 at 8.
635 See Environics Research Group Ltd., supra note 369 at 12.
636 Ibid.
consent as a default rule might assist some people to realize their wish to donate despite external social or religious pressures to do otherwise. Moreover, it would be difficult if not impossible to determine whether a deceased belonged to a particular exempted group at the time of their death. As such, the diversity of Ontario’s population could be respected by ensuring that all people understood the concept of presumed consent, were aware of the choice to opt out, and that the means for doing so took into account the province’s diverse population.

c) Whether the Legislative Default Matters

There is clearly a heated debate with respect to legislative defaults for cadaveric organ donation. Some argue that presumed consent is not the cause of organ procurement success in opt-out countries, because in most countries that technically operate under a presumed consent model, presumed consent is not enforced. However, Abadie and Gay argue that “legislative defaults on organ donation may affect the consent decisions of the families, even if they are not enforced.” Increasing donation consent rates from families is still viewed as the most promising route to raising donation rates by UNOS, and there is evidence that adopting opt-out legislation, even if the family’s consent is required in practice, does generally increase willingness to consent.

Certainly, it is true that countries with “soft” opt-out laws and those with opt-in laws tend to have similar practices of consultations with the deceased’s family. Nevertheless,

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637 See Jacob, Another Look, supra note 457 at 295.
638 See Abadie and Gay, supra note 101 at 600.
639 See Gallagher, supra note 310 at 408.
640 Supra note 101 at 613.
642 See Kennedy et al., supra note 239 at 1651.
643 See Childress and Liverman, supra note 152 at 217.
family decisions are influenced by the legislative default.\textsuperscript{644} When the family are asked to supply consent, they refuse permission in a sizeable number of cases.\textsuperscript{645} In contrast, when family are accorded simply a power to veto donation, their objections are at a more modest level.\textsuperscript{646} For example, although in Belgium first degree relatives may object where a potential donor has not objected to donation during their lifetime, the knowledge that the deceased had not registered an objection has been found to largely facilitate further contacts with these relatives.\textsuperscript{647} As such, it has been demonstrated that families will likely agree more readily to organ donation if approached from the standpoint of presumed consent.\textsuperscript{648} Indeed, in those countries with opt-out policies, the turn down rate is much lower, being about 20\% in Spain.\textsuperscript{649}

The crucial difference with a system of presumed consent would appear to be in the approach to relatives.\textsuperscript{650} With a “soft” opt-out, in which the family can still refuse consent, presumed consent is more about the procedures for approaching relatives after death.\textsuperscript{651} The family can be approached very differently when the deceased’s silence is presumed to indicate consent to donate rather than when it is assumed to indicate a refusal.\textsuperscript{652} Presumed consent allows staff to approach the family as the family of a “donor” rather than a “non-donor.”\textsuperscript{653} Certainly, the law can give shape to the dialogue with respect to organ donation.\textsuperscript{654} Instead of being asked to consent to donation, families are advised that their

\begin{footnotesize}
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\item \textsuperscript{644} See Fevrier and Gay, \textit{supra} note 218 at 4.
\item \textsuperscript{645} See Price, \textit{supra} note 163 at 91.
\item \textsuperscript{646} \textit{Ibid.}
\item \textsuperscript{647} See Roels, Deschoolmeester, and Vanrenterghem, \textit{supra} note 248 at 1473.
\item \textsuperscript{648} See Childress and Liverman, \textit{supra} note 152 at 223.
\item \textsuperscript{649} See Abadie and Gay, \textit{supra} note 101 at 600.
\item \textsuperscript{650} See British Medical Association, Organ Donation, \textit{supra} note 290.
\item \textsuperscript{651} Philip Johnston, “Should We Be Forced to Donate Our Organs?” \textit{The Daily Telegraph (London)} (14 January 2008) [Lexis Nexis].
\item \textsuperscript{652} See Childress and Liverman, \textit{supra} note 152 at 217.
\item \textsuperscript{653} \textit{Ibid.}
\item \textsuperscript{654} See Nowenstein, \textit{supra} note 77 at para 56.
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relative did not opt out of donation. By asking “Do you happen to know whether the deceased ever expressed opposition to giving their organs for transplantation?” which is usually met with a ‘no’, the health professional then has an opportunity to emphasize that the deceased never expressed opposition to donating. As such, the questions asked to the family can be shaped by the presumption of donation. Thus the benefit of presumed consent is that families can be asked not if they consent to donation but only to verify that they do not object. This shift may at first sight appear subtle, but it nonetheless has been shown to make a substantial difference, making it easier for families to accept organ donation. Given this, presumed consent can provide the basis for a helpful ritual in tragic circumstances.

Irrespective of how the legislative default affects the family of the deceased, there is also evidence that the legislative default may affect a person’s decision whether to opt out of a presumed consent regime in the first place. Johnson and Goldstein examined the role of defaults using an online experiment, asking 161 respondents whether they would agree to donate organs in response to one of three questions with varying defaults. With an opt-in default policy, respondents were asked to assume that they had just moved to another state where the default was to not be an organ donor and they were given a choice to confirm or change that status. The opt-out condition was identical, except the default was to be a donor. The third condition required them to choose with no prior default.

See British Medical Association, Organ Donation, supra note 290.

See Nowenstein, supra note 77 at para 58.

Ibid. at para 59.

See British Medical Association, Organ Donation, supra note 290.

See Roels, Donor Hospital, supra note 49 at 260.

See Childress and Liverman, supra note 152 at 217.


See Johnson and Goldstein, Donation Decisions, supra note 510 at 1714.

Ibid.

Ibid.

Ibid.
explanations were largely eliminated as respondents could change their choice with a mouse click.\textsuperscript{666} What Johnson and Goldstein found was that the default had a dramatic impact, with donation rates being about twice as high when opting-out as when opting-in.\textsuperscript{667} As such, it appears that the way in which a request to become a donor is framed will influence the outcome,\textsuperscript{668} with the choice of default option having a significant effect on donation rates.\textsuperscript{669} Indeed, it may be that increases in the donation rate could be achieved cost effectively simply through a change in the way the organ donation question is asked.\textsuperscript{670}

In fact, Johnson and Goldstein posit that defaults can influence individual choices in three ways.\textsuperscript{671} First, decision makers may believe that defaults are suggestions by the policy maker, implying a recommended action.\textsuperscript{672} Second, as many people would rather avoid making an active decision about donation, since it can be unpleasant and stressful,\textsuperscript{673} people may be more likely to accept the default as it is effortless.\textsuperscript{674} Finally, defaults often represent the status quo, with change usually involving a tradeoff.\textsuperscript{675} As Johnson and Goldstein explain, respondents to their research often state that becoming a donor yields satisfaction, which they think of as a gain.\textsuperscript{676} However, they also often mention a loss, contemplating that their body after death will no longer be intact.\textsuperscript{677} As losses loom larger than equivalent gains, a phenomenon known as loss aversion, Johnson and Goldstein explain that changes in the default may result in a change of choice.\textsuperscript{678} For current non-donors, becoming a donor

\textsuperscript{666} Ibid.\textsuperscript{667} Ibid.\textsuperscript{668} Ibid. at 1713.\textsuperscript{669} Ibid.\textsuperscript{670} Ibid.\textsuperscript{671} Ibid. at 1714.\textsuperscript{672} Ibid.\textsuperscript{673} Ibid.\textsuperscript{674} Ibid.\textsuperscript{675} Ibid.\textsuperscript{676} Ibid.\textsuperscript{677} Ibid.\textsuperscript{678} Ibid.
involves the tradeoff between a gain and a loss. However, Johnson and Goldstein note that “(f)or donors, changing status alters the tradeoff—losing the satisfaction, while gaining freedom from negative imagery. In each case, loss aversion suggests an increased weighting of what is foregone, making the default seem more attractive.” Most humans are “disinclined toward active protest of that which is customary and routine,” and there is no reason to believe that Ontarians would act any differently.

d) Altruism

Critics also argue that presumed consent lacks the altruistic element that is present in the express consent system. Certainly, the current organ donation regime in Ontario is built on altruistic principles and volunteerism. In the altruistic model, potential donors have to opt in to the system in order to donate organs. The Law Reform Commission of Canada has stated that “altruistic transfers nurture community bonds and generosity” and "become the material and symbolic gifts of life that bond strangers to our communities.” Essentially however, the express consent system lessens the likelihood of donation by requiring two acts of altruism: the first from the deceased who opts in during life, and the second from their family, who must also make an altruistic act by consenting to donation at the time of their loved one’s death.

With presumed consent however it is assumed that organs will be donated unless the deceased has previously opted out of the system. As such, some argue that the spirit of

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679 Ibid.
680 Ibid.
681 See Silver, supra note 395 at 706.
682 See Jacob, Another Look, supra note 457 at 294.
683 See Statz, supra note 367 at 1683.
684 Ibid. at 1682.
686 Ibid.
687 See Mesich-Brant and Grossback, supra note 359 at 707.
688 See Statz, supra note 367 at 1682.
volunteerism and the virtue of generosity are undermined by presumed consent. However, in so far as one accepts this argument, one can contend that societal generosity should take priority over individual or family generosity when lives are at stake.

It has also been argued that as presumed consent relies on passivity, it may be unlikely to encourage active altruism. However, an altruistic contribution can be “reflected by the absence of objection rather than the presence of consent.” As such, presumed consent would not prevent individual acts of generosity, as non-objection itself could still reflect generosity and altruism. Moreover, one can question whether altruism must be active in order to be beneficial - “(w)hile altruistic action ideally might be preferred to altruistic inaction, altruistic behaviour, even of an inactive sort, is better than nonaltruistic behavior.” In fact, presumed consent may represent generosity with a Canadian spin. Indeed, one woman at a discussion group held by the Citizens Panel expressed that as Canadians care enough to fund a universal health care system, presumed consent would simply represent a further reflection of this generosity. In addition, it can be argued that presumed consent could facilitate rather than reduce altruistic behaviour, as it would allow people to fulfill their altruistic impulses by refraining from objecting, which is psychologically easier than having to give their express consent.

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690 See Higgins et al., supra note 513 at 75.
691 See Childress and Liverman, supra note 152 at 221.
692 See Jacob, Another Look, supra note 457 at 294.
693 See Futterman, supra note 91 at 166.
694 See Childress and Liverman, supra note 152 at 221.
695 See Mehlman, supra note 153 at 46.
696 See Ontario Ministry of Health and Long-Term Care, Citizens Panel, supra note 4 at 74.
697 See Higgins et al., supra note 153 at 46.
698 Ibid.
Certainly, some view presumed consent as allowing organ donation to be seen as a quasi-civic responsibility, 699 “grounded on notions of social solidarity in society.” 700 However, the view of cadaveric organs as public assets under presumed consent 701 is not without controversy. Although in an opt-out system, cooperative behaviour is taken as the starting point 702 and it is viewed as normal to donate, 703 Childress contends that presumed consent “does not presuppose that bodily parts belong to the state. The individual and/or family still controls the disposition of those bodily parts; the only difference is the shift in presumption about the individual’s wishes.” 704 As such, presumed consent can retain the spirit of altruism.

e) Constitutionality

In Ontario, a presumed consent regime could be subject to a Charter 705 challenge based on a breach of security of the person 706 or freedom of religion. 707 However, as presumed consent legislation would allow for opting out, there is no obvious reason that it would run afoul of Charter rights, 708 as “an opting-out system that reasonably reduced the risk of an unintended donation would be likely to satisfy the requirements of due process.” 709

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700 See Machado, supra note 699 at 193.
706 See Ontario Bar Association, Health Law Section, Bills 33, supra note 3 at 13; Also see Section 7 of the Charter which states that “7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.”
707 See Constitution Act, 1982, supra note 632 at s. 2(a).
709 See Mehlman, supra note 153 at 58.
Certainly, the limited presumed consent laws in the United States with respect to the removal of corneas and pituitary glands have largely survived constitutional challenge.\textsuperscript{710}

i) No Property Right in the Cadaver

In the United States, the constitutionality of presumed consent statutes have been challenged on the basis that property rights have been infringed.\textsuperscript{711} While no property right exists in the body in a traditional sense, the courts have recognized a right of possession for purposes of burial.\textsuperscript{712} However, in \textit{Georgia Lions Eye Bank v. Lavant}\textsuperscript{713} the court made it clear that a person's common law quasi-property right in a cadaver for burial purposes is not a constitutionally protected property right as cadavers are not constitutionally protected property.\textsuperscript{714} Again in \textit{State of Florida v. Powell},\textsuperscript{715} the court upheld the constitutionality of a presumed consent statute and determined that the appellants had no protectable liberty or property interest in the remains of their relative,\textsuperscript{716} with the rights of the deceased’s family limited to those of burial and sepulture.\textsuperscript{717} Moreover, the court held that the deceased’s own constitutional rights had terminated at death.\textsuperscript{718} However, in \textit{Brotherton v. Cleveland},\textsuperscript{719} the Sixth Circuit Court found that removal of the deceased’s corneas constituted a deprivation of the constitutionally protected due process rights of the spouse under the U.S. Constitution and that the wife’s right was sufficiently proprietary for constitutional purposes.\textsuperscript{720} However, “(i)t has long been a maxim of the common law that there is no property in a dead body or its

\textsuperscript{710} See Calandrillo, \textit{supra} note 93 at 126.
\textsuperscript{711} See Price, \textit{supra} note 163 at 127.
\textsuperscript{713} \textit{Georgia Lions Eye Bank v. Lavant}, 255 Ga. 60, 335 S.E.2d 127 (Ga. 1985) [Georgia Lions].
\textsuperscript{714} \textit{Ibid.} at 128.
\textsuperscript{715} \textit{State of Florida v. Powell}, 497 So. 2d 1188 (Fla. Sup. Ct. 1986) [Powell].
\textsuperscript{716} See Price, \textit{supra} note 163 at 128.
\textsuperscript{717} \textit{See Powell, supra} note 715 at 1191.
\textsuperscript{718} \textit{Ibid.} at 1190.
\textsuperscript{719} \textit{Brotherton v. Cleveland}, 923 F.2d 477 (6th Cir. 1990).
\textsuperscript{720} \textit{Brotherton v. Cleveland}, 923 F 2d 477 (6th Cir. 1991) at 483.
parts,”721 and the lack of a Canadian constitutionally protected property right would likely preclude a claim based on family property in the deceased.722

ii) A Section 1 Analysis

A challenge launched under the Charter of Rights and Freedoms723 based on freedom of religion724 or on the right to life, liberty and security of the person725 would of course be subject to a section 1 analysis, and it would have to be demonstrated that presumed consent was not a "reasonable limit" on such a right as could be "demonstrably justified in a free and democratic society."726 Certainly, one can argue that a “reasonable limit” would be that such rights “could not be exercised at the cost of the lives of potential recipients waiting for organs.”727

In order to determine whether any violation of a right as a result of presumed consent could be saved by section 1, one must turn to the Oakes test.728 Given the severe organ shortage in Ontario,729 it would be very difficult to demonstrate that the government’s objective in limiting the Charter right was not a pressing and substantial objective.

Moreover, it would also be a challenge to demonstrate that changing the legislative default with respect to organ donation was not rationally connected to the objective, as studies have shown that presumed consent leads to increased donor rates.730

With respect to the need for minimal impairment, a plaintiff would have to demonstrate that the requirement of opting out more than minimally impaired their right to

721 See Pattinson, supra note 66 at 469.
722 See Arnold, supra note 95 at para 50.
724 Ibid. at s. 2(a).
725 Ibid. at s. 7.
727 See Arnold, supra note 95 at para 52.
728 See Oakes, supra note 726.
729 See Ontario Ministry of Health and Long-Term Care, Citizens Panel, supra note 4 at 10.
determine what became of them at death. However, under a presumed consent regime objections could be easily registered such that it would be very difficult to show that the process of opting out was an onerous limitation on a right. Some however might argue that other aspects of the organ donation system could be improved that could help increase donation rates without violating Charter rights or by impairing such rights in a more minimal fashion. One can argue however that the legislative default provides the foundation upon which the rest of the organ procurement system is based. Piecemeal improvements likely could not on their own significantly raise procurement rates, with a noticeable increase in rates requiring comprehensive improvements to all aspects of the organ donation system.

With respect to the requirement that the measures utilized be proportional to the objective, Arnold argues that any right that the family may claim with respect to the body of the deceased would be subject to the dictates of public policy. The challenge of saving and enhancing more lives through organ and tissue donation by significantly increasing donation across the province has been handed to TGLN by the provincial government, and most certainly represents an important public policy goal. Moreover, the leading Canadian case of Edmonds v. Armstrong Funeral Home Ltd. suggests that while the fiction of a quasi-property right of custody and possession vested in the deceased’s family has been maintained for the purpose of arranging burial, "these rights are subordinate to the demands of justice or public good." Indeed, in State v. Powell the court applied a rational basis review and determined that Florida's corneal release statute was constitutional

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731 See Arnold, supra note 95 at para 56.
732 Ibid.
733 Ibid. at para 50.
734 See TGLN website, supra note 12.
735 Ibid.
737 Ibid. at para 10.
738 Ibid. at para 18.
739 See Powell, supra note 715.
as it rationally promoted the permissible state objective of restoring sight to the blind.\textsuperscript{740} Moreover, in \textit{Georgia Lions Eye Bank v. Lavanti}\textsuperscript{741} the court held that the removal of the deceased’s corneas without family approval served the greater good of society,\textsuperscript{742} reasoning that maintaining public health was one of the fundamental duties of the state.\textsuperscript{743} As such, a robust argument can be made that the benefits of presumed consent legislation, being the saving and improvement of more lives, would outweigh the seriousness of any infringement.

\textit{iii) The Prior Acceptance of Opt-Out Schemes}

Although there is no case law on point with respect to the constitutionality of schemes in which an individual must opt out of a legislative scheme to give effect to their right, it appears that the courts have accepted such arrangements.\textsuperscript{744} For example, in \textit{Taylor v. Rossu,}\textsuperscript{745} which involved a challenge to the constitutionality of the support provisions of the \textit{Alberta Domestic Relations Act,}\textsuperscript{746} the Alberta Court of Appeal recommended an opt-out option which would permit couples to opt out of the legislative scheme with respect to spousal support\textsuperscript{747} as a less intrusive alternative to a measure it had struck down as violating section 15 and not saved under section 1 of the \textit{Charter.}\textsuperscript{748} As such, “the notion that a person might have to take positive action to exercise a fundamental freedom does not appear to have been considered enough in itself to invalidate the law.”\textsuperscript{749} In addition, the Supreme Court of Canada has upheld schemes that refused opt-outs where they would have weakened the

\begin{footnotesize}
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\item \textsuperscript{740} \textit{Ibid.} at 1193-94.
\item \textsuperscript{741} See \textit{Georgia Lions, supra} note 713.
\item \textsuperscript{742} \textit{Ibid.} at 129.
\item \textsuperscript{743} \textit{Ibid.} at para. 11.
\item \textsuperscript{744} See Arnold, \textit{supra} note 95 at para 57.
\item \textsuperscript{746} \textit{Alberta Domestic Relations Act,} R.S.A. 1980, c. D.37.
\item \textsuperscript{747} See \textit{Taylor, supra} note 745 at para 152.
\item \textsuperscript{748} \textit{Ibid.}
\end{itemize}
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purpose of the legislation, even where the purpose was arguably less compelling than saving lives.\(^{750}\)

f) Conflicting Interests

In the case of organ procurement from a deceased without their express consent, there are admittedly a number of conflicting interests at hand.\(^{751}\) There is the interest of the deceased in only having their organs donated following their prior wishes, the interest of society in overcoming the organ shortage, the interest of the recipient in being saved, and the interest of the family of the deceased in having their emotional stability preserved at a time of loss.\(^{752}\) Whether consent for organ donation should be express or presumed depends in large part on how one weighs the interests of those awaiting organ transplants against the importance of self-determination.\(^{753}\) As Dunstan states, “(u)tility alone cannot determine the ethics of choice between them, even though it must be weighed in the political process of legislation.”\(^{754}\)

Undeniably, organs from the dead are a potential source of life for others.\(^{755}\) As such, maximizing the supply of organs can be viewed as a morally good social policy\(^{756}\) of sufficient importance that other values and rights may be compromised.\(^{757}\) Certainly, from a utilitarian perspective, organ scarcity represents the routine disposal of a highly valuable commodity with the potential to save lives.\(^{758}\) Emson takes an extreme view, and sees the

\(^{750}\) See Lavigne v. Ontario Public Service Employees Union, [1991] 2 S.C.R. 211, in which the appellant, a community college teacher who was required to pay dues to the respondent Union under a mandatory clause in a collective agreement, objected to certain expenditures made by the Union and applied for declaratory relief. The Supreme Court of Canada held that an opt-out could seriously undermine the Union’s financial base and the spirit of solidarity required for unionism.

\(^{751}\) See Sperling, supra note 188 at 1.

\(^{752}\) Ibid. at 1-2.

\(^{753}\) See Price, supra note 163 at 37.


\(^{755}\) See Emson, supra note 409 at para 12.


\(^{757}\) See Dennis et al., supra note 97.

\(^{758}\) See Abadie and Gay, supra note 101 at 600.
proportionate benefit of donation to be too great to be subordinate to anything else,\textsuperscript{759} arguing that to “grant the right and power of consent to an individual who may be affected emotionally, is to elevate the possible emotional affect of one person, as more important than the physical life of another.”\textsuperscript{760} In a similar vein, Rowinski \textit{et al.} posit that it may be that organs are so valuable that society cannot afford to have people’s choices impede supply.\textsuperscript{761} Moreover, Harris totally rejects the appropriateness of consent as a gatekeeper for cadaveric donation,\textsuperscript{762} arguing that the moral justification for mandatory organ donation for the purpose of saving a life is at least as compelling as the justification for compulsory autopsies.\textsuperscript{763}

Presumed consent, however, does not present such a radical view, and recognizes that human dignity and self-determination must lead to the rejection of the notion that human bodies after death can be treated as a source of spare parts.\textsuperscript{764} However, given the societal importance of organ donation, an opt-out policy burdens those who object to organ donation with the task of registering their objection.\textsuperscript{765} Supporters of presumed consent claim that this regime does not radically deviate from traditional humanistic values because "by making the basic presumption one which favors life, and thus putting the burden of objecting upon persons who would deny life to another, the policy of saving human life is given priority.”\textsuperscript{766} Moreover, an opt-out policy allows for the subordination of the public interest in obtaining cadaveric organs for the sake of the living only by the wish of the deceased themselves, expressed before death,\textsuperscript{767} not by the deceased’s family.\textsuperscript{768} Certainly, given the scarcity of

\textsuperscript{759} \textit{Supra} note 409 at para 13.
\textsuperscript{760} \textit{Ibid.} at para 15.
\textsuperscript{761} \textit{Supra} note 236 at 477.
\textsuperscript{762} See Pattinson, \textit{supra} note 66 at 431.
\textsuperscript{763} \textit{Ibid.}
\textsuperscript{764} D. Giesen, \textit{International Medical Malpractice Law} (Dordrecht: Martinus Nijhoff, 1988) at 621.
\textsuperscript{765} See Dennis \textit{et al.}, \textit{supra} note 97.
\textsuperscript{766} See Silver, \textit{supra} note 395 at 705.
\textsuperscript{767} See Hyde, \textit{supra} note 712 at 209.
\textsuperscript{768} See Blumstein, \textit{supra} note 84 at 35.
organs in Ontario,\textsuperscript{769} a strong argument can be made that only the wishes of the deceased prior to death should trump the societal right to use the organs of the dead. Indeed, corneal removal statutes have been upheld in the United States on the basis of the power of the state to act in the interest of public welfare and by a balancing act between societal needs and individual concerns.\textsuperscript{770} One can argue that any greater consideration of individual or familial rights cannot justify another’s death that an organ transplant could have forestalled.\textsuperscript{771}

\textbf{g) Implementation Issues}

\textit{i) Practical Requirements}

Some argue that a system of presumed consent would be impossible to implement in practice.\textsuperscript{772} Certainly, one can agree with Mehlman that policymakers would need to address a number of practical difficulties before a successful system of presumed consent could be achieved.\textsuperscript{773} To work properly, a refusal to donate would have to be easy to file, processed immediately (to avoid the possibility of a lag between the time it was made and the time it might be needed, should the person die in the interim), and available for immediate access by transplant professionals faced with the imminent death of a potential donor.\textsuperscript{774} “(C)lear, easy, nononerous, and reliable ways for individuals to register their objections to being organ donors” would need to be developed.\textsuperscript{775} An effective mechanism would be required for recording and reviewing opt-outs,\textsuperscript{776} and individuals would need to be able to modify their decision at any time.\textsuperscript{777} In addition, checking the register would have to be mandatory before

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    \item \textsuperscript{769} See TGLN website, \textit{supra} note 12.
    \item \textsuperscript{770} See Spielman, \textit{supra} note 546 at 24.
    \item \textsuperscript{771} See Dickens, Legal Aspects, \textit{supra} note 164 at 352.
    \item \textsuperscript{772} See Arnold, \textit{supra} note 95 at para 29.
    \item \textsuperscript{773} See Mehlman, Reevaluation, \textit{supra} note 153 at 65.
    \item \textsuperscript{774} See Arnold, \textit{supra} note 95 at para 29.
    \item \textsuperscript{775} See Childress and Liverman, \textit{supra} note 152 at 216.
    \item \textsuperscript{776} See Liddy, \textit{supra} note 484 at 820.
    \item \textsuperscript{777} See Michielsen, \textit{supra} note 205 at 663.
\end{itemize}
organ removal could proceed.\textsuperscript{778} A presumed consent system would also need to account for the removal of organs from minors, from patients who had never been competent, and from patients who died without family members being available.\textsuperscript{779}

One can argue that given advances in technology, the burden of registering a refusal to donate need not be unduly heavy to impose on individuals\textsuperscript{780} and that simple mechanisms for registering an objection could easily be made available\textsuperscript{781} so as to provide ample opportunity for objection to organ donation.\textsuperscript{782} Indeed, Arnold states that in Ontario, individuals could register their intention with the same ease with which they access health information on the government's websites or replace driver's licences at computer kiosks.\textsuperscript{783} Furthermore, Fentiman has proposed an electronic registry and a system in which people could register their objections when they obtain or renew a driver’s license, when they file a tax return, when they apply for welfare, disability or other government benefits, and when they visit a hospital or doctor’s office.\textsuperscript{784} Similar to Belgium, Ontario could use a computerized central registry to record objections\textsuperscript{785} so as to simplify the process of ascertaining whether an objection had been made.\textsuperscript{786}

Certainly, in order “(t)o be ethically acceptable, a policy of presumed consent would require widespread and vigorous public education to ensure understanding.”\textsuperscript{787} There is concern that presumed consent might disproportionately impact on the illiterate, uneducated, or non-English/French speaking Ontarians, who might fail to make an objection because they

\textsuperscript{778} See Organ Donation Taskforce, supra note 234 at 19.
\textsuperscript{779} See Mehlman, supra note 153 at 49.
\textsuperscript{780} See Hyde, supra note 712 at 209.
\textsuperscript{781} See Kennedy \textit{et al.}, supra note 239 at 1651.
\textsuperscript{782} See Orentlicher, supra note 99 at 20.
\textsuperscript{783} \textit{Supra} note 95 at para 29.
\textsuperscript{785} See Roels \textit{et al.}, Organ Retrieval in Belgium, supra note 232 at 2078.
\textsuperscript{786} See Kennedy \textit{et al.}, supra note 239 at 1651.
\textsuperscript{787} See Childress and Liverman, supra note 152 at 210.
or their proxies did not understand the legislation.\textsuperscript{788} Consideration would need to be given to these sections of society as well as hard-to-reach groups such as the homeless.\textsuperscript{789} Certainly, there would need to be a significant and sustained communications program using many different forms of media\textsuperscript{790} to ensure that all members of society knew about the new system and what it would mean for them.\textsuperscript{791} Moreover, it would be necessary for public education to precede reform,\textsuperscript{792} with a sufficient period of time prior to enforcement of presumed consent legislation to ensure that people had enough time to register their objection.\textsuperscript{793} Legislative change would have to be accompanied by continued publicity, including information with respect to how people could opt out.\textsuperscript{794}

In the event that presumed consent were introduced, a rise in donation rates would have to be anticipated in advance so that hospitals were prepared to handle additional operations and post-operative care for transplant patients.\textsuperscript{795} At present, ICUs are under significant stress, with ICU beds in Ontario always full.\textsuperscript{796} ICU resources would need to be increased\textsuperscript{797} and physicians would need to be appropriately compensated for tasks associated with organ donation and transplantation.\textsuperscript{798}

\textsuperscript{788} See Ontario Bar Association, Health Law Section, Bills 33, \textit{supra} note 3 at 14 and Jacob, Another Look, \textit{supra} note 457 at 296.
\textsuperscript{789} See Organ Donation Taskforce, \textit{supra} note 234 at 31 and Jacob, Another Look, \textit{supra} note 457 at 296.
\textsuperscript{790} See Organ Donation Taskforce, \textit{supra} note 234 at 31.
\textsuperscript{791} \textit{Ibid.} at 4.
\textsuperscript{792} See Cohen, \textit{supra} note 404 at 2170.
\textsuperscript{793} See Organ Donation Taskforce, \textit{supra} note 234 at 14.
\textsuperscript{794} See British Medical Association, Organ Donation, \textit{supra} note 290.
\textsuperscript{795} See Hoferichter, \textit{supra} note 18 at 130.
\textsuperscript{796} See Boadway, \textit{supra} note 276.
\textsuperscript{797} Dr. Carl Cardella, The Medico-Legal Society of Toronto Conference, “Organ donation: Do you know where your organs are tonight?” (personal notes taken at “Organ donation: Do you know where your organs are tonight?”, Toronto, (21 February 2007) [unpublished].
\textsuperscript{798} Dr. Carl Cardella and Dr. Ted Boadway, The Medico-Legal Society of Toronto Conference, “Organ donation: Do you know where your organs are tonight?” (personal notes taken at “Organ donation: Do you know where your organs are tonight?”, Toronto, (21 February 2007) [unpublished].
ii) Cost Effectiveness

Some argue that presumed consent would be less cost-effective than enhancing educational efforts for express donation. With respect to the possibility of implementing presumed consent in the UK, the Organ Donation Taskforce in its recent report stated that implementing a presumed consent system would require “very considerable costs for a suitable infrastructure.” Included in this cost would be the need for an initial public awareness program as well as ongoing education. In addition, capital expenditures would be required for the development and establishment of a secure database, running costs, the cost of inputting the initial data, and the ongoing training of healthcare professionals. Moreover, others have argued that a tension could exist between making presumed consent more cost-effective than other organ donation regimes and satisfying the conditions necessary to make such consent valid.

However, The Presumed Consent Foundation, Inc. believes that presumed consent could be implemented quickly, easily, and relatively inexpensively. One can certainly argue that if the majority can be presumed to support organ donation, it is more efficient to develop means by which the minority who do not support organ donation can opt out. Tracking the much smaller percentage of those who do not wish to be donors would be easier and less costly than tracking the majority who do. Indeed, the Belgian example of a centralized non-donor registry has demonstrated that the system need not be expensive or

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799 See Childress and Liverman, supra note 152 at 216.
800 Supra note 234 at 20.
801 Ibid.
802 Ibid.
803 See Childress and Liverman, supra note 152 at 216.
804 See Foundation website, supra note 221.
805 See Roels, Deschoolmeester, and Vanrenterghem, supra note 248 at 1473.
806 See Foundation website, supra note 221 and Herring, supra note 469 at 381.
complex. As such, the problems inherent in designing an acceptable opt-out system may not be insurmountable.

Moreover, there are certainly cost benefits for the province to realize if organ transplantation rates can be increased as a result of presumed consent. For example, dialysis costs approximately three times as much as successful transplantation. The Citizens Panel advised that it costs the health care system $30,000 to $50,000 a year less to maintain a kidney transplant patient than it does to maintain the same person on dialysis. As of March 2007, Ontario had approximately 5,000 patients with functioning transplants, saving the system about $200 million each year. As there were approximately 9,000 patients on dialysis at that time, there were hundreds of millions of dollars more to be saved with additional donors. Furthermore, the human benefit of dramatically improving an organ transplantee’s health and quality of life should also be considered.

iii) Changes to Societal Attitudes Required

One of the main worries with presumed consent is that it might undermine the public trust in the health care system and actually reduce organ donation rates. Indeed, some surveys of the public have suggested that presumed consent may have a negative impact on organ procurement. Veatch warns that some who are not opposed to donation could be sufficiently offended by presumed consent that they would record their objections to the whole process by opting out. Moreover, if physicians and administrators routinely failed

807 See Roels, Deschoolmeester, and Vanreenterghem, supra note 248 at 1474.
808 See Mehlman, supra note 153 at 50.
810 Supra note 4 at 17.
811 Ibid.
812 Ibid.
813 See Kaserman, supra note 43 at 54.
815 See Martin, supra note 40 at 290 and 291.
816 See Veatch, Transplantation Ethics, supra note 473 at 177.
to act upon presumed consent, any benefits of the system would likely be lost.\textsuperscript{817} Certainly, Abadie and Gay contend that although some recent studies have shown successful transitions to presumed consent, it may be that in some countries changing the legislative default without first building sufficient social support could generate an adverse response.\textsuperscript{818} Clearly then, a properly functioning and effective presumed consent system would have to be based upon popular support\textsuperscript{819} and an acknowledgement and acceptance of the need for change by the public.\textsuperscript{820} This is certainly the position of the BMA, which believes that an increase in public awareness and debate will change public opinion in favour of presumed consent in the UK.\textsuperscript{821}

Unfortunately, the Citizens Panel found a fairly negative response of Ontarians to presumed consent. In its report, the Citizens Panel noted that when presumed consent was explained as “the hospital would assume you wish to donate organs and want them used for transplant unless you have registered your refusal to donate,”\textsuperscript{822} 51% of those unfamiliar with organ donation rejected this approach and 40% strongly rejected this approach.\textsuperscript{823} Moreover, 41% of those who said they were familiar with organ donation rejected this approach and 28% strongly rejected this approach.\textsuperscript{824} Ultimately, the Citizens Panel concluded that those Ontarians not familiar with organ donation (arguably the majority) rejected presumed consent as they believed that it took away their right to choose.\textsuperscript{825} Furthermore, participants felt that it would not be much of a leap for presumed consent to be perceived as organ

\begin{flushleft}
\textsuperscript{817} See Liddy, \textit{supra} note 484 at 820. \\
\textsuperscript{818} \textit{Supra} note 101 at 613. \\
\textsuperscript{819} See Liddy, \textit{supra} note 484 at 819 and Hyde, \textit{supra} note 712 at 209. \\
\textsuperscript{820} See Futterman, \textit{supra} note 91 at 168. \\
\textsuperscript{821} British Medical Association Medical Ethics Committee, \textit{Organ Donation in the 21st Century: Time for a Consolidated Approach} (London: British Medical Association, June 2000) at 17. \\
\textsuperscript{822} \textit{Supra} note 4 at 50. \\
\textsuperscript{823} \textit{Ibid.} \\
\textsuperscript{824} \textit{Ibid.} \\
\textsuperscript{825} \textit{Ibid.}
\end{flushleft}
harvesting. This however misunderstands the concept of presumed consent, in which everyone could register an objection, and emphasizes the need for public education with respect to this concept. One can certainly agree with Arnold who argues that given that Ontarians support donation of their own organs and those of family members when they know the family members' wishes, there “is no particular reason to assume Ontarians would reject presumed consent as the mechanism for making those wishes known and actionable, so long as the concept was explained fully and tactfully.”

Moreover, one can question the Citizens Panel’s reliance on its discussion groups as the best indicator of Ontarians’ opinions. The Citizens Panel stated that of the three research modalities utilized, it believed that its discussion groups were the truest reflection of what Ontarians in general want, and that it was in these discussion groups that opposition to presumed consent was the strongest. However, the Citizens Panel held several public meetings across the province where nobody attended, and was ultimately forced to pay focus groups $50 per person. One can only speculate as to whether the inclusion of those who were only willing to participate if paid affected responses.

Indeed, although Dr. Ted Boadway of the Citizens Panel stated that Ontarians “don’t want negative option billing, and they don’t want negative option for their body,” a Toronto Star Angus-Reid poll conducted in August 2008 found much more widespread support for presumed consent than was found by the Citizens Panel. The Angus-Reid poll found that 64% of Ontarians supported provincial legislation that would make everyone an

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826 Ibid. at 74.
827 See Ontario, Trillium Gift of Life Network, supra note 439.
828 Supra note 95 at para 32.
829 Supra note 4 at 74.
830 Ibid.
832 Ibid.
automatic donor unless they opted out,\textsuperscript{834} while 32\% opposed the idea.\textsuperscript{835} As such, the basis upon which to build public support in Ontario may already exist. Social support could be increased by intensifying public education with respect to donation, increasing trust in the health care system, and encouraging a shift in societal understanding of the value of donation.\textsuperscript{836} The transition could be gradual,\textsuperscript{837} with an interim step within the current opt-in policy being a move towards an approach of expected donation from families so as to solidify the societal norm of organ donation as a social responsibility and as standard practice.\textsuperscript{838} Policy makers could develop phase-in policies,\textsuperscript{839} attempting over time to create the social conditions that would be required for the adoption of effective presumed consent.\textsuperscript{840}

Moreover, public opinion is not static.\textsuperscript{841} Unpopular laws, such as the mandatory wearing of seatbelts, are often imposed by government where "the initial public irritation [is] seen as of lesser importance than the overall societal benefit."\textsuperscript{842} Presumed consent may send the message that organ donation is a societal good, and change attitudes over time by shifting expectations\textsuperscript{843} such that donation becomes the pervasive norm.\textsuperscript{844} Public opinion is also shaped by generational effects.\textsuperscript{845} For instance, a study in Belgium ten years after presumed consent was introduced found higher levels of awareness and support among young people than older people, demonstrating that even a moderate-to-high level of resistance to the

\textsuperscript{835} \textit{Ibid.}
\textsuperscript{836} See Childress and Liverman, \textit{supra} note 152 at 10.
\textsuperscript{838} See Childress and Liverman, \textit{supra} note 152 at 10.
\textsuperscript{839} \textit{Ibid.} at 224.
\textsuperscript{840} \textit{Ibid.} at 227.
\textsuperscript{841} See Arnold, \textit{supra} note 95 at para 33.
\textsuperscript{842} See English and Sommerville, \textit{supra} note 337 at 148.
\textsuperscript{843} See Ontario Bar Association, Health Law Section, Bills 33, \textit{supra} note 3 at 13.
\textsuperscript{844} See Childress and Liverman, \textit{supra} note 152 at 224.
\textsuperscript{845} See Arnold, \textit{supra} note 95 at para 33.
policy at the time of introduction can lessen over time and give way to majority support.\textsuperscript{846} Moreover, the Citizens Panel found that there was a greater degree of opposition to presumed consent among adults aged thirty years and older, especially among those over fifty,\textsuperscript{847} with young adults aged eighteen to thirty more in favour of presumed consent as a way to deal with public apathy.\textsuperscript{848} As suggested by Abadie and Gay, further research would be useful to better understand how societies perceive and respond to legislative changes of this nature.\textsuperscript{849} Perhaps on a go forward basis however one should be nurturing the positive attitudes of young people towards presumed consent in the hope that their opinions will remain consistent and strengthen as they age.

VII. ALTERNATIVES TO PRESUMED CONSENT

There may be other, less drastic ways to increase the pool of organ and tissue donations in Ontario.\textsuperscript{850} This includes methods proposed in other Bills, including public awareness and education, and reminding Ontarians to make a decision when obtaining health cards or driver’s licences.\textsuperscript{851} Providing financial incentives to donors, xenotransplantation, organ exchange mechanisms for living donors with incompatible recipients, and preferential assignment of organs to registered donors have all been suggested as proposals to help alleviate the organ shortage.\textsuperscript{852}

\textsuperscript{847} \textit{Supra} note 4 at 47.
\textsuperscript{848} \textit{Ibid.}
\textsuperscript{849} \textit{Supra} note 101 at 613.
\textsuperscript{850} See Ontario Bar Association, Health Law Section, Bills 33, \textit{supra} note 3 at 13.
\textsuperscript{851} \textit{Ibid.}
\textsuperscript{852} See Abadie and Gay, \textit{supra} note 101 at 601.
a) Required Request

One option that has been implemented in most states is that of routine request, which requires hospitals to discuss the option of organ donation with adult patients and inform family members of their authority to consent to organ donation for a deceased relative. In addition, federal law mandates required requests for institutions receiving Medicare or Medicaid funds. One problem with routine inquiry however is that organs need to be harvested quickly from a donor's body, leaving little time for the family to grieve before they are asked about donation. In support of required request, one can argue that it preserves the gift mode, and that not asking families deprives them of the right to have the option. However, one study found that only 30% of families were asked about consenting to donation despite the legal obligation of physicians to do so, likely due to physicians’ reluctance to request donation and because enforcement of the required request rule is non-existent. Unfortunately, in those states with required request laws, the overall rate of family consent has remained relatively unchanged, even where compliance has been high.

Ontario has in fact already implemented a limited form of required request. In January of 2006 the provincial government enacted a section of the TGLN Act calling for routine notification and request (“RNR”) requiring thirteen hospitals to report every death to

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854 See UAGA (1987), supra note 188 at §5.
855 See Coleman, supra note 256 at 18.
856 See Statz, supra note 367 at 1685.
857 See Veatch and Pitt, supra note 499 at 180.
858 See Hyde, supra note 712 at 210.
860 Monique C. Gorsline and Rachelle L.K. Johnson, “The United States System of Organ Donation, the International Solution, and the Cadaveric Organ Donor Act: "And the Winner is ... " (1994) 20 J. Corp. L. 32 at 33-34.
861 See Higgins et al., supra note 513 at 51.
862 See Price, supra note 163 at 103-104.
TGLN.\textsuperscript{863} It is also required that every patient and/or family with the potential to make a gift of life decision be approached.\textsuperscript{864} A year later TGLN worked with eight more hospitals to add RNR to their facilities.\textsuperscript{865} Since RNR began, referrals have more than quadrupled.\textsuperscript{866}

The first year of RNR resulted in a 153\% increase in the number of referrals made to TGLN from participating hospitals, leading to a 93\% increase in the number of tissue donors and a 16\% increase in the number of organ donors.\textsuperscript{867}

\textbf{b) Mandated Choice}

Another option that has been proposed in the hopes of increasing organ donor rates is mandated choice, which requires all persons to indicate, on a form such as a driver's license application or income tax return, their wishes for or against donation.\textsuperscript{868} However, mandated choice is not without controversy. Arnold argues that “(m)andated choice invites reactionary negative responses in that it forces people into a decision which they may not have had time to consider properly and to which they may thus react to with a conservative refusal to donate.”\textsuperscript{869} With mandated choice, those wishing to delay the decision may default to a refusal, a decision that their families would likely honour at the time of their death.\textsuperscript{870} Critics also argue that mandated choice is coercive\textsuperscript{871} and violates an individual’s right not to make a decision\textsuperscript{872} or to leave the decision to family members. Veatch however argues that so long

\begin{itemize}
  \item \textsuperscript{863}See TGLN website, \textit{supra} note 12.
  \item \textsuperscript{864}See Ontario Ministry of Health and Long-Term Care, Citizens Panel, \textit{supra} note 4 at 67.
  \item \textsuperscript{865}See TGLN website, \textit{supra} note 12.
  \item \textsuperscript{866}\textit{Ibid.}
  \item \textsuperscript{867}\textit{Ibid.}
  \item \textsuperscript{868}Carol J. Roberts, "Presumed Consent for Organ Procurement Does It Have a Future in the U.S.?” (2003) 35:2 Journal of Neuroscience Nursing 107 at 108.
  \item \textsuperscript{869}\textit{Supra} note 95 at para 20.
  \item \textsuperscript{870}Joyce Frieden, “Increasing organ donations is a tough challenge; need for organs could be eased by increasing donor consent rates and harvesting more organs per donor” \textit{Internal Medicine News} (1 September 2004).
  \item \textsuperscript{871}See Spital, Mandated Choice, \textit{supra} note 403 at 150.
  \item \textsuperscript{872}Jim Ritter, “Don’t want to give organs? You might have to say so; AMA backs studying ‘presumed consent’ to increase transplants” \textit{Chicago Sun-Times} (21 June 2005) [LexisNexis].
\end{itemize}
as negative answers and opportunities for expressing uncertainty were provided for, required
responses could still affirm the primacy of the individual.\textsuperscript{873}

In Ontario, Conservative MPP Frank Klees proposed a Bill that would have forced
Ontarians renewing their driver’s licences or health cards to declare whether or not they
wished to donate their organs once they died.\textsuperscript{874} Ontario however is clearly not going the
route of mandated response. The Ministry of Health and Long-Term Care has advised that
when an Ontarian registers or renews their health card only a “yes” to organ and tissue
donation will now be collected and stored in the OHIP database.\textsuperscript{875} Only 12.5% of Ontarians
have thus far registered “yes.”\textsuperscript{876} Previously recorded “no” and “undecided” responses will
not be shared with TGLN past July 1, 2009.\textsuperscript{877}

c) Donation After Cardiac Death

Another option for which there has been renewed interest\textsuperscript{878} is donation after
cardiac death (‘‘DCD’’),\textsuperscript{879} offering families the option of donation in cases where
neurological criteria for death have not been met but the decision to withdraw life-sustaining
treatment has been made.\textsuperscript{880} A DCD patient has no hope of survival or meaningful functional
status\textsuperscript{881} and has experienced cardiac arrest, with diagnosis of death being based on cardiac
rather than neurologic criteria.\textsuperscript{882}

One problematic feature of donation after cardiac death is that organs from non
heart beating cadaver donors must be harvested from the deceased almost immediately after

\begin{footnotesize}
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\item \textsuperscript{873} See Veatch, Transplantation Ethics, \textit{supra} note 473 at 180.
\item \textsuperscript{874} See Williamson, \textit{supra} note 435.
\item \textsuperscript{875} Ontario Ministry of Health and Long-Term Care, “Public Information, Fair Notice: An important change to
how organ and tissue donation decisions are registered in Ontario” online: Ontario Ministry of Health and
\item \textsuperscript{876} \textit{Ibid.}
\item \textsuperscript{877} \textit{Ibid.}
\item \textsuperscript{878} See TGLN website, \textit{supra} note 12.
\item \textsuperscript{879} \textit{Ibid.}
\item \textsuperscript{880} \textit{Ibid.}
\item \textsuperscript{881} \textit{Ibid.}
\item \textsuperscript{882} American College of Critical Care Medicine, Ethics Committee, “Recommendations for nonheartbeating
\end{itemize}
\end{footnotesize}
they die, as the organs die within the body quickly after the donor's heart stops and blood circulation ceases. Although some organs live longer than others in the body after death, the maximum warm ischemic time that most organs can endure without being damaged is about forty-five minutes. Improved medications and surgical techniques have however resulted in better outcomes for recipients of these donated organs. In contrast, the organs of brain dead donors can be maintained artificially for hours or even days before being harvested and transplanted.

In Europe and the United States, donation after cardiac death has been an option for families for over thirty years. In Ontario, this option is now being piloted in select hospitals, with ten cases of donation after cardiac death in Ontario in the fiscal year 2006/2007. Given the organ shortage in Ontario, the Citizens Panel recommended that every Ontario hospital that provides donors should institute donation after cardiac death policies consistent with the National Recommendations, estimating that donation after cardiac death could increase the number of donations by up to 25%.

VIII. CONCLUSION

In its 2000 Throne Speech, the Ontario government "accepted as a millennium challenge the goal of doubling the organ donation rate by 2005." This goal however was
ultimately abandoned by TGLN, and despite the medical and scientific progress that has been made in organ donation and transplantation, many still die waiting for an organ given a severe and persistent shortage. While an astounding 85% of Ontarians would accept an organ if they had a life-threatening disease that could only be treated with a transplant, in 2008 there were only 175 cadaveric donors in Ontario. Obviously, the numbers simply do not add up. If death and suffering are to be prevented, the organs must come from somewhere, and living organ donors cannot meet the need.

Extraordinary advances in the donation and transplantation of human organs and tissues have brought about previously unimaginable societal benefits, but have in turn created “profound implications involving autonomy and belonging, opposing moral considerations, and legal concerns.” However, presumed consent may be capable of meeting these concerns while at the same time significantly increasing the organ donor rate. Admittedly, the link between a presumed consent regime and increased organ donation rates is not straightforward, with many other factors also affecting the number of organs available for transplant. Presumed consent, if workable, would likely only be a part of what would be required to significantly increase organ donation in Ontario. Undoubtedly, a revised legal regime alone would not be enough, with no one “magic bullet” to improve organ donation rates.

That other legitimate policy choices may be capable of increasing Ontario’s cadaveric organ donation rate is freely admitted. What is argued however is that the Citizens Panel

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893 Ibid. at para 11.
894 See Kaserman, supra note 43 at 45.
895 See TGLN website, note 12.
897 See Vawter, supra note 886 at 66.
898 See Futterman, supra note 91 at 161.
899 See Herring, supra note 469 at 382.
900 Ibid.
901 See Siminoff et al., supra note 39 at 76.
dismissed solid evidence with respect to the ability of presumed consent to increase donation rates and placed too great of an emphasis on the current attitudes of Ontarians in its rejection of presumed consent as a possible legislative choice. Presumed consent may be a viable option, but not the only option, that as part of a comprehensive strategy could help raise the rate of organ donation and transplantation in Ontario. Although presumed consent in Ontario would be a radical shift from the current system,\(^{902}\) “When systems fail, alternatives must be sought.”\(^{903}\) We must be cognizant of the ramifications of our public policy choices,\(^{904}\) with the current express consent system failing to bridge the gap between hope and despair\(^{905}\) and passing a death sentence on many Ontarians.\(^{906}\) Given the expected benefit of an increased availability of cadaveric organs, and in view of the shortcomings of the current express consent system, it is worthwhile to conduct further research with respect to the possible effectiveness of a presumed consent regime\(^{907}\) in Ontario. Certainly, it can be argued that the Citizens Panel was too dismissive of this concept.

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\(^{904}\) See Calandrillo, supra note 93 at 69.

\(^{905}\) See Keller, supra note 189 at 894.

\(^{906}\) See Moustarah, supra note 64 at 232.

\(^{907}\) See Mehlman, Reevaluation, supra note 153 at 66.
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