



Winning Hearts and Minds: Using Psychology to Promote Voluntary Organ Donation

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Abstract. Recent psychological research concerning determinants of and barriers to organ donation is reviewed with the intention of ascertaining acceptable and potentially effective ways of improving organ retrieval. On the basis of this review, five recommendations are made. (1) Individuals' donation wishes, where explicit, should be decisive. (2) Next of kin should witness donor decisions. (3) Mandated choice should replace voluntary 'opting-in'. (4) Initial donation choices should be repeatedly re-evaluated. (5) Those involved in organ procurement should distance themselves from model of bodies as machines or gardens and embrace models where bodies are viewed as sacred extensions of self. In combination, these recommendations are argued to be preferable in several ways to opt-out/presumed consent procurement options.

Key words: psychology, organ donation, organ procurement, presumed consent

[I]t is morally incumbent on health care professionals . . . to make every effort to alter the conditions that create scarcity; therefore, those who pursue strategies aimed at securing more organs are doing what is morally required. Those who are made uneasy by efforts to ameliorate scarcity and wonder about what motives lie behind them are often put in the position of appearing to defend abstract sentiments instead of saving lives (Caplan, 1995: 210).

The shortage of cadaver donor organs: Can psychology help? (Perkins, 1987)

Introduction

Organ transplantation saves the lives of many and improves the medical status and quality of life of many more. Organ transplantation also saves health services considerable amounts of money, as the cost of operations and follow-up care is often a fraction of the cost of continued care without transplantation (Perkins, 1987). However, there are currently more than 65,000 people waiting for organ donations in the United States alone, with suitable transplant organs being retrieved from fewer than 10,000 donors in

America during 1998.¹ Similarly, in the UK 6,502 people currently require an organ transplant and in 1998 organs were recovered from only 758 donors.² Whatever country one chooses, the number of people on waiting lists for organ transplants far exceeds the number of organs donated for that purpose. Exceptional circumstances aside, this mismatch in numbers between those in need of transplant organs and those willing to give them becomes more pronounced every year. Approximately 1 in 3 people accepted for organ transplantation die whilst waiting for a suitable donor (DeChesser, 1986; Randall, 1991).

A great many suggestions have been made for increasing the number of organs available for transplant (Dennis et al., 1998; Dukeminier, 1970; Kokkedee, 1992; Obermann, 1997; Thukral and Cummins, 1990). The most dramatic of these is termed 'routine retrieval.' When such a scheme is legally in place, cadavers and their contents are essentially the property of the state (Hessing, 1990). Citizens have no property rights over their own or relatives' dead bodies.³ Health professionals are permitted to remove any and all organs from cadavers for whatever purposes the state deems fit, without need of further permission or satisfaction of any conditions. Despite possible analogies with state conscription of bodies and their parts during wars or the conduct autopsies (Veatch, 1995), most find the notion and implications of routine retrieval of cadaver organs unacceptable. Routine retrieval removes all possibility of individual altruism, autonomy, and volunteerism: organs are supplied rather than donated (Obermann, 1997). No true liberal democracy could countenance such a practice and opinion polls in various countries demonstrate strong public opposition as well (Kokkedee, 1992).

Much more popular with policy advisors are 'opt-out' schemes. Here, cadaver organs may be removed unless appropriate people have availed themselves of whatever 'opt-out' possibilities are in place. Schemes vary according to who can opt-out, what they may opt-out of, and how they may do so. Most proposals allow for the possibility of individuals declaring objections to posthumous removal of their own organs, while some also permit relatives of the deceased to object. Similarly, most schemes respect registered objections, while some also countenance verbal and hearsay opposition. Where objections have not been made, routine retrieval becomes the default position. Most advocates of opt-out schemes claim that consent may be presumed where opting-out has not occurred. The United Network for Organ Sharing (UNOS), who co-ordinate organ donation across the United States, considered proposing such a scheme recently, but did not (Dennis et al., 1998). Similarly, an opt-out scheme was debated and rejected by the British Parliament in 1984 (Lewis and Snell, 1986). This year, the British Medical

Association (BMA) has overwhelmingly voted to lobby the government to reconsider adoption of an opting-out/presumed consent scheme.⁴

The main arguments in favour of opt-out schemes are utilitarian: organ retrieval seems more successful in opt-out countries than opt-in ones (where individuals and/or their proxies have to explicitly consent to organ donation), and switching from an opt-in to an opt-out scheme seems to increase the number of organs procured (Kokkedee, 1992; Spital, 1991).⁵ The option of opting-out is also held to protect if not enhance altruism, autonomy, individualism, and voluntarism (Spital, 1991). Opt-out is further considered to more fairly place the burden of decision-registration (i.e., opting-out) with the minority who personally oppose retrieval instead of with the majority who support it, as is suggested is the case with opt-in schemes (i.e., opting-in; Obermann, 1997). Finally, it has been suggested that organ removal being a 'standard procedure' in opt-out schemes makes things easier for both relatives and health professionals (Spital, 1991; cf. Sque and Payne, 1996).

In this paper it is argued that there are compelling reasons to oppose calls for opt-out/presumed consent. Analysis of psychological determinants of donation decisions suggests that such schemes are potentially both counter-productive and unnecessary. The same analysis is used to promote an alternative means of attempting to procure more organs for donation. This is followed by some informed speculation about the assumptions and motives of health professionals who call for adoption of opt-out organ procurement schemes. The paper ends with a caution about the level of confidence with which it is possible to predict the effects of *any* change to organ procurement practices.

Psychology and Organ Procurement

This paper is not a literature review of psychological determinants of organ donation decisions. A recent comprehensive review of such factors is provided by Radecki and Jaccard (1997); see also Brkljacic and Balija, 1999. Rather, this paper examines the implications of empirical investigations within psychology for optimising organ retrieval efforts. There is undoubtedly room for improvement. Despite the vast majority of people approving of organ donation (Gallup, 1993; Shanteau and Harris, 1990), only about 1 in 7000 of the 3/4 million people who died in the UK in 1995 became organ donors (Sque and Payne, 1996). This equates to approximately 10–20% of the potential organ donor pool who actually become donors (Ford and Smith, 1991; Spital, 1991; Younger, 1992).

Respecting Autonomy

Relatives of the deceased are a major barrier to effective organ procurement. Despite loose or absent legal requirements to do so in most opt-in countries, next-of-kin are almost always asked for their permission to remove organs from a deceased relative, even if the latter is known to have formally consented to donation (Harris et al., 1991; Wright, 1998). Refusal rates upon request vary, standing at 20% in Germany (Kokkedee, 1992), 30% in the Netherlands (Kokkedee, 1992), and in the U.S. between 40% or 50% (Protas, 1997; Robbins et al., 1999d; Siminoff et al., 1999) and “many more families say[ing] ‘no’ than ‘yes’ to requests” made in the United States (Caplan, 1995: 213). A very robust finding is that the prime determinant of next-of-kin decisions is attempted execution of the known or inferred wishes of the deceased (Gallup, 1993). Thus, when the deceased’s wishes are known or accurately inferred, next of kin decisions are properly thought of as proxy decisions. The majority of people think that this is exactly how it should be. That is, most people believe that donation decisions should properly be made by the deceased, with kin and others having very little right to override such wishes (Harris et al., 1990, 1991; McIntyre et al., 1987; Manninen and Evans, 1985. Cf. Burroughs et al., 1998; McNamara et al., 1999. But see Wright, 1998, Table 15). Unfortunately, the deceased’s wishes are all too frequently neither known nor confidently guessed at. Most people do not inform their kin of their desires should donation become possible (Gallup, 1993; Guadagnoli et al., 1999; Spital, 1992) and many would-be donors do not carry donor cards. In such circumstances, a whole host of factors bear upon kin’s decisions, many of which militate against donation (see Cerney, 1993; Harris et al., 1991; Protas and Batten, 1991; Radecki and Jaccard, 1997; Sque and Payne, 1996; Tymstra et al., 1992).

It seems then that a majority of people approve of donation but many who personally want to donate do not take adequate measures to inform those who currently have decision-making powers, i.e., their kin. In line with majority perceptions of the right thing to do, kin tend to adhere to the deceased’s wishes wherever possible. Where this is not possible kin decisions are affected by a multitude of factors, many of which press towards non-donation. In sum, these considerations lead to the first recommendation:

Recommendation 1: Individuals’ donation wishes, where explicit, should be decisive.

It is possible that this measure alone would increase available organs. At present, health professionals often do not look for donor cards that may be decisive in affecting kin consent (Lewis and Snell, 1986; Osborne and Gruneberg, 1979; Overcast et al., 1984; Protas, 1997; Spital, 1991). Also,

as shall be explored in some depth towards the end of this paper, health professionals may frequently 'forfeit' available organs by failing to approach relatives for consent or approaching them in such a way as to make consent unlikely. Thirdly, family distress and other 'contaminants' currently 'over-rule' some would-be donors' wishes (cf. Richardson and Hurwitz, 1995; Smith et al., 1986). If health professionals were able to honour donors' known wishes without needing to obtain additional consent from relatives, this would presumably negate all three of these factors that must currently depress the number of organs retrieved for donation.

Other benefits would also flow from adoption of this first recommendation. Individual autonomy would be greater and consent would be clearer than under both opt-out and many present opt-in systems. This is valuable in itself, but may also further increase availability of organs. Knowing that one's wishes would be decisive might encourage more people to make such wishes known. It is possible that some people do not currently sign donor cards because they know that their stated wishes may be ignored by health professionals and/or their family.⁶ This point will be returned to below. For now, it may simply be noted that there are many potential benefits to people having an increased sense that they control the posthumous destiny of their own bodies. At the very least, such a practice would seem consistent with laws that allow people to dispose of their property more or less as they wish when they die (Lopes, 1990).

Respecting the Family

Most family members are likely to be happy about the possibility of Recommendation 1 being adopted. As has already been noted, the prime determinant of kin donation decisions is ideally the known wishes of the deceased. Honouring such wishes is therefore unlikely to be problematic for most people. Additionally, kin will more often avoid the pain of having to make decisions 'on the deceased's behalf' in considerably trying circumstances, e.g., at a time of shock and when a number of interested parties may be demanding or suggesting incompatible courses of action (see Spital, 1991; cf. Sque and Payne, 1996).

Although there are advantages to 'protecting' families from stressful decision-making, families' wishes should nevertheless inform the decision made by donors. Health professionals' jobs would be less stressful were they to know that next of kin were aware of their relatives' donation decisions. It also seems that people feel special attachment to particular organs of their loved ones, notably hearts and eyes (Sanner, 1994; Sque and Payne, 1996. Cf. Shanteau and Skowronski, 1990; Skowronski, 1997). Donors may wish to honour such feelings by bequeathing 'ownership' of and responsibility for

such organs to their loved ones when they die themselves. Each of the above is possible only if individuals have discussed their intended donation decisions with those who will be most directly affected by them. Recommendation 2 is therefore that:

Recommendation 2: Next of kin should witness donor decisions.

Kin should have an option to express disapproval of, but not negate, the donation decisions of their relatives.

There are several reasons to expect such a condition to *increase* organ availability. If adopted, next of kin are likely to be relatively prepared for both the fact and process of donation, thus preventing any need for family or health professionals to ignore (non-)donors' wishes in order to prevent additional family distress. Second, families' wishes to block donation of specific organs may be less likely to lead to actions by them that effectively veto all donations. Third, family discussions may encourage other family members to consider making donation decisions for themselves and any dependants. Fourth, and crucially, family discussions are unlikely to affect donation decisions that people have already made or indeed donation attitudes that people have already formulated (Birkimer et al., 1994; cf. Richardson and Hurwitz, 1995). Finally, compulsory signing by kin makes discussion of issues more or less obligatory and ensures that donation decisions are explicit and public. All of these factors are likely to increase commitment to the donation decision (Schneider, 1990).

Respecting Priorities

The recommendations made so far may well make improvements on most current 'opt-in' system of organ procurement, but their effects are likely to be modest if merely enacted as minor modifications to such systems. Indeed, in at least one respect they may be counterproductive. This is because each is likely to add to the complexity of processes that must be undertaken to register donation intent. Such complexity is potentially a strong barrier to organ procurement (Horton and Horton, 1990; Prottas and Batten, 1991; cf. Shanteau and Harris, 1990). This is one of several reasons for the third recommendation:

Recommendation 3: Mandated choice should replace voluntary 'opting-in'.

Organ procurement systems in most opt-in countries practically take the form of 'presumed dissent'. That is, unless citizens make a specific effort to register desires to become donors, it is assumed that their wish is to be non-donors. Similarly, kin are presumed to object to organ retrieval unless they

have given explicit information to the contrary. The assumptions underlying such systems are as faulty as those underlying 'presumed consent' schemes. The fact is, while registration (either way) is voluntary, most people do not register despite desires of any persuasion. People opposed to becoming donors do not register such objections and people willing to be donors do not register this either (Skowronski, 1997; Veatch, 1991, 1995). In Belgium, citizens have the option of explicitly registering as a donor or as a non-donor. Less than 2% of the Belgian population have registered either way (Kokkedee, 1992).

The reasons why people do not register their wishes when it is possible to do so are not well known. Likely factors include procrastination, beliefs that registering is ineffective or unnecessary, and distraction. One clear factor is simply failing to consider the issue(s) at all (Exley et al., 1996; Lewis and Snell, 1986; Robbins et al., 1999a). While registration (of whatever form) is voluntary, it is incumbent on relevant authorities to make every effort to inform people of the choices to be made (and the arguments for each); to inform people of the possible consequences of each choice-alternative; and to make every effort to encourage people to make and register their choices. Some have considered the enormity of such a task as a reason to oppose 'presumed consent' opt-out schemes, but the same logic could be applied to oppose 'presumed dissent' opt-in schemes. A much simpler and more effective alternative to both schemes would be to make donation choices compulsory (cf. Spital, 1991).

Making anything compulsory removes some form of autonomy, in this case the decision not to make a choice about donation (Obermann, 1997). Here, though, the restricted autonomy involved in forcing a donation decision may be considered as more than countered by the increased autonomy of one's wishes being honoured if donation becomes a possibility (especially if Recommendation 1 accompanies Recommendation 3, as is suggested here). Also, the 'pain' of being forced to make donation decisions might be eased by an option allowing delegation of authority to some other party (e.g., health professionals, the state, or, most practical and likely, kin), subject to the designated authority registering acceptance of that role (Herz, 1999; Obermann, 1997). Any marginal loss of autonomy involved in mandated choice must also be weighed against the intended increase in the number of freely given organs available for transplantation. Even if increasing the number of possible organ transplants is the goal, it may be defensible to oppose routine retrieval in the name of individual autonomy. It seems far less defensible to oppose mandated choice on the same grounds.

As has already been mentioned, most people tend to have thought little if at all about organ donation, particularly members of ethnic minorities who are under-represented in terms of being organ donors (Robbins et al., 1999a).

Evidence suggests that merely encouraging people to think about organ donation can have beneficial effects on attitudes and behaviour (Exley et al., 1996; Lewis and Snell, 1986; Sanner, 1994; Skumanich and Kintsfather, 1996. Cf. Carducci and Deuser, 1984; Carducci et al., 1989). In Birkimer et al. (1994, study 2) for example, merely getting people to contemplate donation issues for two minutes lead to 23% of them signing an available donor card. No members of a control group (who heard a persuasive message about diet) did so. Mandated choice will of course oblige people to at least address donation issues. Mandated choice can also be set up so that people have a deadline by which a decision must be reached. Birkimer et al. (1994) suggest that the positive effects on donation decisions stemming from enforced contemplation of issues may be enhanced if a decision must be made within a certain time. In their study 3, for example, a one-week deadline for declaration of decisions increased signing of the available donor card from 26% (for those encouraged to contemplate arguments about possible positive and negative aspects of donation) to 40%.

Signing a card (and/or registering donation wishes in some other way) is itself an action that shows commitment to the stance taken (Schneider, 1990). Discussing issues with families and obtaining notification from them that this has been done will firm that commitment, as will carrying the card. Being regularly informed about one's decision will also strengthen commitment to that decision, especially if (a) the reminder validates the decision one has made, and (b) if one has to acknowledge or confirm each reminder (Lipsitz et al., 1989; Sarason et al., 1993). People internalise decisions that they show commitment to over time, even if they initially made those decisions for somewhat spurious (but unforced) reasons (Piliavin, 1990). Such effects may be enhanced by 'altercasting,' i.e., praising the altruism of those indicating donation – whatever reasons they actually had for consenting (Piliavin, 1990).⁷ Such altercasting will of course be made easier by the genuine repetition and reversibility of the decision made. Repeated request (or similar) therefore makes the likelihood of 'reactance' (i.e. acting in opposition to how one feels pressured into acting – even if the latter was originally one's own preference) less than it would be in single-choice or opt-out systems (Obermann, 1997; Veatch, 1991; Wicklund, 1997. See also Fogarty, 1997). Also, allowing people the opportunity to review their decisions will of course increase their autonomy and the clarity of any consent (or dissent) they indicate. Recommendation 4 is therefore that:

Recommendation 4: Initial donation choices should be repeatedly re-evaluated.

In all then, four recommendations have been made in this section. In combination they recommend that 'opt-in/presumed dissent' systems (in place in

the US and several European countries) be replaced by a system in which all adult citizens have to make a donation decision: yes, no, or deferral to a proxy (cf. Herz, 1999). This decision must be explicitly acknowledged by kin and/or any selected proxy. Each citizen should be regularly reminded of their decision and acknowledge this reminder each time or avail themselves of an opportunity to change it (i.e., repeated re-evaluation). Declared decisions must be respected and not over-ruled by any other potentially interested party (e.g., the state, health professionals, family). These recommendations have been arrived at as a result of reviewing pertinent psychological research with the explicit intention of discovering potential ways of increasing organ procurement with minimum violation (if not enhancement) of other societal goods (e.g., autonomy, volunteerism, etc.).

Potential Moderators of Organ Donation

Moderators are factors that influence how stimuli are responded to. The stimuli of principal concern here are appeals to donate organs. Moderators of responses to such appeals will be briefly reviewed with the specific aim of recommending acceptable ways of making appeals to maximise organ procurement.

One moderator has already been mentioned. In general, the more complex a system for registering a willingness to become a donor, the fewer people will so register. The relative complexity of the recommendations above (e.g., obtaining family acknowledgement of one's decisions) was one reason for recommending mandated choice. Nevertheless, processes of making and registering choices should be made as simple as possible. One way of increasing the ease of decision-making is by making one option appear more attractive than others, whilst still (honestly) presenting the decision as a choice.

It has been noted more than once above that people are in general very favourably disposed towards organ donation. This seems to be corroborated by research findings suggesting people's donation decisions are affected more by perceived negative characteristics than by perceived positive ones (Cacioppo and Gardner, 1993; Horton and Horton, 1990; Parisi and Katz, 1986; Skowronski, 1997). Persuasion messages that address concerns about negative aspects of organ donation do appear to be more effective than ones that focus only on the positive aspects of donation, although perhaps only for people unfamiliar with such arguments (Birkimer et al., 1994; Ford and Smith, 1991; Winkel and Huismans, 1986). The implication is obvious: donation appeals should include attempts to address concerns potential donors

have. Such concerns must of course be identified in advance of the appeal being implemented.

It is a mistake to treat potential organ donors as a homogeneous group. There is a range of possible reasons for wanting to donate and perhaps a broader range of reasons to be ambivalent about doing so. Such motives and barriers need to be carefully identified and appeals tailored to specific groups typically sharing such concerns (cf. Clary et al., 1998; Flora et al., 1997; Fox, 1990). Differences among ethnic groups have to date received the most attention (e.g., McNamara et al., 1999; Robbins et al., 1999a; Schweitzer et al., 1997), although it must be noted that such research goes beyond the mere noting of sociodemographic differences among people with differing donation-orientations. Such identification may only be truly useful if the reasons for the differences found can be discovered and the knowledge used to alter the beliefs and behaviour of members of the relatively recalcitrant groups. Other distinctions of importance include those between new and committed would-be donors (Cacioppo and Gardner, 1993; Piliavin et al., 1990; Sarason et al., 1993); ready and reluctant would-be donors (Nolan and McGrath, 1990); people with low or high interest in donation issues (Skumanich and Kintsfather, 1996); and people at various 'stages' in the processes of making and maintaining donation decisions (Guadagnoli, 1999; Robbins et al., 1999d; Rohr and Robbins, 1998; Shanteau and Harris, 1990). Without adequate 'social marketing,' donation appeals may be missed or even rejected by key groups of potential donors (Exley et al., 1996; Robbins et al., 1999a). On the other hand, careful social marketing can potentially pitch and place particular organ donation appeals with great effectiveness, e.g., to people already thinking about end-of-life issues (cf. Christenson and Fells, 1998).

The primary impetus towards organ donation seems to involve altruistic or quasi-altruistic (i.e., other-concerned) motivation. Some donate to be consistent with or strive towards an altruistic self-concept (and some relatives consent to donation to be consistent with or strive towards an image of the deceased as altruistic) (Batten and Prottas, 1987; Belk, 1990; Radecki and Jaccard, 1997). Others seem to care more about benefiting specific others connected with the self in some way, such as relatives, in-groups, communities, or people empathised with (Batten and Prottas, 1987; Belk, 1990; Exley et al., 1996; Sanner, 1994; Shanteau and Skowronski, 1990; Stevens, 1998; Walker et al., 1990). To the extent that donor motivation is generally altruistic, appeals might profitably acknowledge donors' benevolence (i.e., 'altercast', see Piliavin, 1990) and stress the extent to which organ donors allow others to be helped. More problematic is how best to utilise the knowledge that some donors wish to benefit *specific* others, partic-

ularly when allowing 'directed-donation' may raise the risk of appearing to allow, condone, or even promote racism and other forms of prejudice (but see Veatch, 1998). It might nevertheless be worth authorities stressing the fact that members of particular social categories are over-represented on organ waiting lists and yet under-represented among organ donors, and also the fact that most donations tend to occur among people very closely matched on characteristics typically associated with same-group membership (e.g., within ethnic categories).⁸

The main moderators between altruistic motivation and organ donation form a cluster that is difficult to disentangle. The cluster itself concerns various forms of anxiety, primarily anxiety about how people might be treated by health professionals as a result of being potential donors. An important aspect of this anxiety stems from worries that health professionals may not be sufficiently robust in attempts to keep potential donors alive and/or fears about being prematurely or inappropriately declared dead (Caplan, 1995; Exley et al., 1996; Lewis and Snell, 1986; McNamara et al., 1999; Sanner, 1994; Stevens, 1998; Walker et al., 1990). Some commentators appear rather impatient of peoples' concerns about declarations of death and subsequent procedures (e.g., Sanner, 1994). Death is death, after all. Such an attitude seems unsympathetic. Declarations and criteria of death have varied regionally and across time, with vigorous debate continuing among very intelligent, knowledgeable, and experienced experts (Arnold et al., 1995, especially chapters by DeVita et al. and Arnold and Younger). A significant minority of centres in the US and across Europe consider a person dead if their heart stops, without too much concern for the state of the person's brain, while the majority of centres determine death by cessation of brain activity whilst making sure that the heart is (artificially) kept beating (Arnold et al., 1995, especially chapter by Kootstra and Daemen). Practically, then, brain and heart criteria are being used as individually sufficient but individually unnecessary indicators of the same state: death. As individually unnecessary, neither can be synonymous with death, despite the clear beliefs of some.⁹ Health professionals and documentary makers are unclear about appropriate criteria for defining death, so it should hardly be surprising that the public are (Horton and Horton, 1990; Panorama, 1980; Sanner, 1994; Shanteau and Linin, 1990; Sque and Payne, 1996; UNOS, 1997; Younger et al., 1989).

If people believe there may be discrepancies between declarations of death and occurrences of death, anxieties about donation processes are only to be expected. Who in their right mind would be unconcerned about the possibility of having organs removed whilst potentially conscious? However, it is not merely fear of negative experiences that makes people anxious. People are also concerned about what happens to their bodies after death. Many people,

especially those from low-donor groups (e.g., ethnic minorities) are deterred from donating their organs because they are anxious about their bodies being cut up and/or disfigured (Exley et al., 1996; Ford and Smith, 1991; McIntyre, 1990; McNamara et al., 1999; Prottas and Batten, 1991; Radecki and Jaccard, 1997; Skowronski, 1997; Stevens, 1998). In part this represents an extension of the altruism that inclines them towards donation in the first place, in that they are concerned to avoid distress to their relatives. More than this, though, people seem to have a genuine *personal* concern about the fate of their own bodies after death.

Belk (1990) considers various metaphors for the human body. He argues that health professionals and organ procurers tend to view the body either as a machine with interchangeable body parts or as a garden where organs grow to be plucked when convenient (but see Younger et al., 1989). Belk prefers two non-exclusive analogies that he believes members of the general public tend to share (but see Richardson and Hurwitz, 1995). First, the body is appropriately seen as a part of or an extension to 'the self.' Secondly, the body is appropriately seen as intrinsically valuable (i.e., "sacred"), so that it may be kept or freely given but which is made profane if treated (especially by others) as a commodity (cf. Wilkinson, this issue). The notion of such a mismatch between the analogies used for bodies by health professionals (and organ procurers) and those used by 'the public' is consistent with many of the findings above. Anxiety about what is done to and with the body after death makes sense if people feel that their corpses are a part of who they are. Altruism (and/or the need to be seen as altruistic), the primary motive for organ donation, only makes sense as a concept if a person feels that she is doing something for and/or giving something of her own to other people. Treating the body with disrespect, including treating it as a commodity or wasting organs taken from it, is tantamount to treating the *person* whose body it is (or was) with disrespect (Prottas, 1997; Sanner, 1994; Skowronski, 1997; Younger et al., 1989). Treating the body as its erstwhile owner wanted it treated, on the other hand, is precisely treating that person and their life with appropriate respect (cf. Dworkin, 1993). And, when in ignorance of the deceased's wishes, passing decisions on to those with fewer but significant 'shares' in the body, i.e., the relatives, also correlates with such a conception of the body (Belk, 1990; Sanner, 1994; Sque and Payne, 1996). The consistency of research findings with Belk's (1990) analysis grounds the final recommendation of this paper, namely that:

Recommendation 5: Those involved in organ procurement should distance themselves from model of bodies as machines or gardens and embrace models where bodies are viewed as sacred extensions of self.

If bodies are conceived as parts of selves, organ procurement messages that should be successful are those that *increase* the perceived autonomy of potential volunteers, i.e., ones that emphasise “an enhancement, rather than a diminution, of the self” (Barnett et al., 1987: 336; see also Belk, 1990 and Recommendation 1 above). Again, messages that stress benefits to the *self* (or rather, the extended self, to include relatives) should be more successful than ones simply pointing out benefits to anonymous others (Barnett et al., 1987; Fellner and Marshall, 1981; Finlay and Dallimore, 1991; Prottas and Batten, 1991; Skowronski, 1997; Sque and Payne, 1996). By extension, messages stressing probable benefit to people psychologically close to the self are more likely to be successful than ones suggesting possible benefit to people one feels no connection with or even feel antipathy toward (Caplan, 1995; Exley et al., 1996; Skowronski, 1997, cf. Radecki and Jaccard, 1997; Shanteau and Skowronski, 1990). It may also be noted in this context that many *recipients* of transplanted organs will prefer that the organs they receive have been freely volunteered for altruistic reasons (Sehgal et al., 1997). Finally, there is also ample psychological evidence (within the organ donation literature and beyond) to ground Belk’s (1990) further suggestions of attempting to increase perceived connections between potential donors and potential recipients (e.g., via senses of empathy, community, common fate, etc), stressing services to humanity and science, and emphasising that donation helps preserve and enhance the life of “sacred” others (cf. the role of morality and religion).

An Alternative Focus

The arguments and evidence above suggest that a multitude of things might potentially be done to quite dramatically improve organ procurement, short of moving to an opt-out system. This was certainly the British government’s line following the BMA’s recent call for such a move.¹⁰ Why then do some health professionals tend to so enthusiastically advocate opt-out systems? One possibility is that opt-out is selected as the most obvious candidate for removing the requirements or conventions of seeking consent from next of kin. Families typically find this distressing and many refuse consent and it is unsurprising that health professionals do not like approaching them with donation requests (Blok et al., 1999; Lewis and Snell, 1986). Indeed, there is growing evidence that health professionals often decide *not* to seek consent (even in the US where there are “required request” laws), particularly where next of kin are members of “low donation” social categories (Finlay and Dallimore, 1991; Ford and Smith, 1991; Guadagnoli et al., 1999; Obermann, 1997; Schweitzer et al., 1997). When approaches are made, they are often made in a far from optimum manner (Belk, 1990; Cerney, 1993; Harris et

al., 1990; Jasper et al., 1991; Sque and Payne, 1996). Reviewing a number of similar studies to those cited here, Sque et al. (in press) conclude by agreeing with Banning's (1987) assertion that such failings represent "the weakest link in the organ donation process" (cf. Lewis and Snell, 1986: 1078). Whether or not absent or inappropriate requests are the *biggest* determinant of lost organs (e.g. see Wright et al., 2000), such factors are without doubt very significant contributors to sub-optimal organ procurement (Siminoff et al., 1995). Training of health professionals involved in procurement is one often suggested response to this problem (Guadagnoli et al., 1999; Siminoff et al., 1995). Opt-out/presumed consent is the most obvious way of making such training (and the task it is intended to improve) unnecessary.

Many people already mistrust health services, particularly those from groups typically under-represented as organ donors. Moving to an opt-out system seems unlikely to improve matters in this respect (cf. Veatch, 1991). Moving to the system recommended above would seem far more likely to build trust whilst simultaneously increasing donation *and* relieving health professionals of an undoubtedly and unenviable stressful and taxing duty.

A Caveat

The recommendations offered in this paper are based on the best relevant psychological (and related) research known to the author. Nevertheless, it must be stated that much of this research is severely limited in important ways. An unfortunate number of the studies cited employ small and restricted samples, rely on hypotheticals for their experimental manipulations, fail to control for or otherwise counter variables that potentially confound experimental effects, have inadequate or absent control and comparison groups, assume deliberate and rational decision-making when perhaps they ought not, and/or employ poorly conceived and operationalised measures (Barnett et al., 1987; Shanteau and Harris, 1990; Simmons et al., 1987; Radecki and Jaccard, 1987). Each of these things limit, but do not invalidate, the studies and the conclusions that may be legitimately drawn from their findings. In particular, such studies cannot provide very confident predictions of the likely effects of *any* changes to organ procurement schemes. Small, local, and controlled studies, even perfect ones, will tell us little about what would happen if large changes should occur in uncontrolled contexts (where, for example, those antithetical to organ donation and attendant processes may mount high publicity campaigns opposing the 'intended' effects of whatever changes are made). Nevertheless, induction from existing evidence is perhaps the only method available to make grounded predictions of any kind. And the evidence gathered and drawn upon in this paper suggests that a number of

organ procurement measures should be considered in preference to “opt-out” systems. In particular, unless and until further research suggests otherwise, it is recommended that 5 suggestions be implemented:

1. Individuals’ donation wishes, where explicit, should be decisive.
2. Next of kin should witness donor decisions.
3. Mandated choice should replace voluntary ‘opting-in’.
4. Initial donation choices should be repeatedly re-evaluated.
5. Those involved in organ procurement should distance themselves from model of bodies as machines or gardens and embrace models where bodies are viewed as sacred extensions of self.

Notes

¹ E.g., see <http://www.livingbank.org/data.htm>.

² E.g., see <http://www.argonet.co.uk/body/DoH.html>.

³ A reviewer states that this is not the case in the UK, citing the following texts.

Matthews, P. (1995). *The Man of Property*. Medical Law Review.

Nuffield Report on Human Tissue.

Skegg, P.D.K. (1988). *Law and Medicine*. Oxford University Press.

⁴ See <http://www.bma.org.uk>.

⁵ Despite many forceful claims along such lines (e.g., Dennis et al., 1998), there is some reason to query the specific nature of these ‘successes.’ Kokkedee (1992) suggests (almost despite himself) that the ‘flagship’ successes of Austria and Belgium may be due to schemes that are in fact akin to routine retrieval, with no effective opt-out procedures and thus little basis for presuming consent (cf. Veatch, 1991, 1995). Spain, another much-touted ‘success,’ employs a number of rare initiatives in addition to opt-out and thus it is difficult to know the unique effects of the opt-out scheme itself (e.g., Katz, 1998; Matesanz, 1993, cited in Oberman, 1997). Finally, switching from opt-in to opt-out has not always resulted in improved organ retrieval (Obermann, 1997: 307).

⁶ Wright (1998, Table 7) shows that 83% of US organ procurement organisations (OPOs) will approach a family for consent even when the deceased has been found to have a signed donor card expressly saying “no” to the procedure family consent is being sought for.

⁷ Attempts may also be made to persuade change in those not indicating consent (e.g., see discussion of refutational messages below, and see Cialdini, 1993).

⁸ One important reason *why* members of the certain social categories tend to be over-represented on organ waiting lists stems directly from the fact that members of those social categories tend to be under-represented among organ donors, coupled with the fact that organ-matching best occurs within social-categories (Irwin, 1999).

⁹ E.g., Horton and Horton (1990) approvingly cite Mathieu (1988: 36): “Many people still do not understand the relationship of ‘brain death’ to death: They do not understand, that is, that brain death is simply death’ ” (p. 797).

¹⁰ See http://news.bbc.co.uk/1/hi/english/health/newsid_396000/396430.stm.

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