

A Critical Appraisal of Carl Cohen “Presumed Consent” in Organ Donation”

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Abstract: *This paper identifies the Achilles heels in Carl Cohen’s notion of organ donation. It posits that presumed consent cannot sufficiently solve the problem of organ shortage. Presumed consent though might improve the number of organs available; it does not resolve all moral challenges faced by presumed refusal as assumed by Cohen. In achieving this, we critically analyze concepts and processes involved in Carl Cohen’s presumed consent. We further identified ethical problems Cohen’s presumed consent failed to solve. This paper recommends a possible solution to the problem of organ shortage. This paper concludes that Cohen’s presumed consent cannot sufficiently solve the problem of organ shortage. The paper further shows that regenerative medicine, cloning, and other advanced medical research if well explored will solve to a large extent the problem of organ shortage.*

Keywords: *Presumed Consent; Presumed Refusal; Regeneration Medicine; Organ Donation; Organ Shortage*

INTRODUCTION

The development of science and technology in the last century cuts across all strata of existence. Technology is being inculcated in almost all areas of life; medicine is not an exception. Medical care has not only improved in its area of ordinary medical solutions, but it also succeeded in creating an extraordinary medical solution to the multiple health challenges faced by humans. Advancements in medical care, therapeutic interventions, and human capacity enhancement technologies are unprecedented. The development in medicine is changing human understanding of some medical terms; legal and societal positions on medical issues, re-understanding of our cadavers’ usefulness, moral analysis of our period of death among others, opening humans to vistas of open-ended possibilities hitherto thought as mysteries in yesteryears. Owing to today’s biotechnologies, human orientation, understanding, and meaning of death and life is now being redefined.

In pre-modern times, collapse in parts of the body tissues is a death certificate as hopes were usually lost when certain injuries or failures of a certain organ in the human body surfaced. The advancements in medical research dove-tailed in improved medical care and consequently, there are increasing hopes for life on the severely incapacitated and sick patients. One area, in which medical feats have raised hopes, though not without some fundamental moral problems, is organ donation. Organ donation according to Rainer Gruessner (2016) (1) is the act of giving one or more organs (or part thereof), without compensation, for transplantation into someone else. Before the 1950s, failure of a certain organ of the body such as kidney, bone marrow, liver, the heart is synonymous with a death sentence. The rate of increase in organ failure and continue demand for organs for transplantation as well as the personnel and equipment to carry out such transplantation calls for more involvement of the government in the creation and monitoring of this extraordinary medical attention.

While citizens of the western world have continued to benefit immensely from the new medical possibility of donating organ to save life, it is appalling to note that a larger chunk of the citizens of the third-world countries in need of such medical service lacks access to undergo the surgical process, except for a few who

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have the luxury of medical tourism. The world, no doubt, is increasingly becoming a global village; and as such, the possibility that new medical discoveries in the first-world states will soon become widespread in the third-world countries cannot be ruled out. In anticipation of this, the critical question is: are the moral problems involved in organ donation to be imported to the developing third-world nations, or are new and unique moral dilemmas to be expected?

The need to understand the predominant ethical challenges faced in organ donation in the western world and whether or not such moral problems will necessarily arise in the developing world especially in Sub-Saharan African cannot be glossed over. This is because the more there is hope for the survival of the sick, the greater the likelihood of fear of living with a moral burden.

Daniel Springer (2) observes that the need for organ donors is growing at a tremendous rate which is brought about by the increasing rate of organ failure in the world today. The development of sophisticated technology has resulted in our ability to save more lives than ever before through organ transplantation; however, if organs are not available for donation, it makes little difference if the technology needed to transplant them exists or not. The mass difference between the demand and supply rate of an organ has opened various dimensions to the procurement of organ which is laced with ethical issues.

Today, our ethical concern has widened, with the various technological innovations, our ethical fields further expand to examine issues relating to any newly developed ideas for the use of human.

The various ethical issues that arise in organ transplantation begin with the process of donating the organ. Ethical issues arise when the number of people willing to donate falls and the government results in the use of opt-out options rather than opt-in. The fall in the received organs which coincides with the rise in organs needed to solve the increasing list of people in the waiting list resulted in a new method and program by the government to ensure an increase in the organ generated either through living or dead donors.

James McIntosh defines opt-in as “the process where people have to actively sign up to a register to donate their organs after death, while in the opt-out system, organ donation will occur automatically unless a specific request is made before death for organ not to be taken.” (3) Opt-out as an option is a presumed consent where everyone by default is assumed to agree on donating his or her organ, which came up when the demand for organs is on the rise and available organs cannot serve those on the list. The issue of the medical definition of death also arises; while some doctors believe that brain death is sufficient for death, others believe that the heartbeats stoppage is what makes a person dead. Since the definition of death is not monolithic, the question of harvesting living organ for transplant raises an ethical concern

THE CASE FOR PRESUMED CONSENT

The discussions on cadaver organ donation usually raise the ethical question of consent. Organ generated from the dead has the potential to reduce the number of people in the waiting list, even though we have people dying daily we still have more useful organ being buried with death. Why do we waste useful life-saving resources?

The debate on organ donation can be considered in two forms, the donation by the living and donation by death. In this study, we are considering organ donation from the dead. The major question that arises is the question of autonomy. Does the dead body have the autonomy to decide over his or her body? How do we respect the autonomy of the dead? Can autonomy be transferred? Whose decision is valid: the dead or his/her family? How do we acquire the consent of removing an organ from death? All these questions require fundamental answers.

Carl Cohen in his paper ‘The case for presumed consent’ (4), makes an argument in support of “presumed consent” against the popular presumed refusal policy that is in place for deceased organ donation. He examines

the principle of presumed consent; why it is “the need and good” of our society; how to protect the right of those who object and the need to respect the family within the early stage of presumed consent.

PRESUMED CONSENT: WHAT ABOUT IT?

Presumed consent as a phrase in organ donation can be interpreted in different ways. The term came into limelight in 1968 when Dukenminier and Sanders presented the idea. The idea of presumed consent does not originate from Cohen. Presumed consent in some quarters is referred to as an opt-out option in organ donation. Danielle Cameron also campaigned for presumed consent to be the model of organ donation in the United State, which he proposed with his paper “Ethical and Philosophical Barrier to Organ Donation”. (5)

Presumed consent according to an online medical dictionary is “the assumption that a particular action would have been approved by a person or party if permission had been sought”. The main argument behind presumed consent is the autonomy of the self over its remnant.

Presumed consent is also called opt-out, it is considered that when everyone is presumed to have opted in to donate their organ by default, there is the option of opting out. Springer put this clearly:

Presumed consent is also referred to as the “opt-out” system because individuals would have the option of opting out of the system and not donating their organs. (6)

The argument for presumed consent from the position of Cohen is based on the premises of autonomy. Autonomy in this sense is about self-having autonomy over the body. Cohen didn't stop at such autonomy with a living human, he posits that we should respect the decision of the person over his or her carcass even after the death of such individual. He wrote:

Each of us is the possessor, master, of our own body, and therefore (it is almost universally agreed) we have the wide moral authority to give or withhold permission for the use of our body after death. (7)

We may want to ask that what is the difference between honoring one's autonomy and respecting autonomy. Cohen believes that the person's position on his or her body should be respected even after the ghost has been released, such autonomy should not be transferred as we usually witness in the present situation. He avers:

After death, authority over the body is commonly thought to rest with the decedent's family, who are likely to represent best the true will of the descendant. But even they cannot exercise the decedent's autonomy since no one can do that. (8)

Carl Cohen further argues that:

Organ procurement therefore now relies utterly upon consent expressly given (by the decedent before death, or by his or her family after death) that rebuts this presumption. I argue that this system of rules, formal or informal, ought to be wholly reformed; the underlying assumption that ought to be made is the very opposite of the one now made. (9)

Carl Cohen believes that the presumed refusal been implemented currently on organ procurement is ghastly inadequate. He concludes that the system we ought to be practicing should be the opposite of what we are currently doing.

Presume refusal will lead to mistaken non-removal which will reduce the number of organs generated for transplantation and in the end prevent patience on the waiting list from surviving. This position is aptly presented by Micheal Gill when he said:

...even if it does lead to fewer mistakes overall, it will also inevitably lead to more mistaken removals. And the moral harm of increasing the number of mistaken removals is greater than – or trumps – the moral benefit of decreasing the number of mistakes overall. (10)

For Cohen we should not rely on the family decision after the death of the deceased or the formal or informal expression of the death to use such cadaver to save a life, it should be assumed that such cadaver is permissible except the refusal to have been made by the dead before death calls.

In support of Carl Cohen, Micheal Gill presented his position on presume consent when he said:

The view I've presented, in short, takes presumed consent to be more akin to legislation that attempts to ensure that deceased persons' estates are disposed of in exactly the way that they would have wanted. (11)

THE NEED FOR PRESUMED CONSENT

Our discussion so far has been based on the change of the present condition of organ donation from opt-in to opt-out. There are several reasons why society needs to change from the present policy we are using. First is the fact that we are in dire need of more organs to save the life of many people dying regularly due to a lack of organs to be used for their transplant process.

The other reason is that the present position is in line with the minority. Only a few people are not willing to donate their organs, putting the majority into action for a situation where the minority can easily take simple action for the good of the country will be better off than the present position. We need to change our present policy from presumed refusal to presumed consent.

Another point is that the majority of us don't consider death at an early age, in fact even the old are not planning for death. From our failure to plan effectively for our death, we postpone mostly the time to file in our acceptance for organ donation during the present condition. With this, the majority of people willing to donate organs will find themselves dying without having filled the form for such usage. On this Cohen have this to say:

the failure of young person's to express their judgment while healthy, the psychological stress upon families at the time of dying of a loved one, the reluctance or awkwardness of physicians and administrators in making donation requests as patients are dying, or others – long experience teaches that circumstances commonly conspire to block the needed express consent for the donation of the organs for a decedent. (12)

From the foregoing, it is reasonable for us to accept the new policy of presumed consent based on the several advantages that it provided. It will surely assist us in solving a major extent the problem of organ shortage which has been making the world lost so many of our potentials. The benefit of organ transplantation which was discovered in 1978 has not been used to its maximum, this is as a result off the inadequacy of the present policy we use to harvest organs from our cadavers.

Cohen claimed that:

The disadvantages of presuming consent are minimal, nearly nil. On balance, therefore, an organ procurement system founded upon presumed consent is almost certainly good. (13)

Cohen is not the only one with the position that presumed consent will give large benefit to the society, Veatch also joined him in this position. He said:

Presumed consent, which permits the removal of organs unless the person has formally opposed it while living. This model emphasizes the greatest net benefit for society. (14)

Part of the other good in presumed consent has highlighted by Cohen is “Many people who, when rational and calm, would donate their organs without qualm, want not to think about the matter when not obliged to do so, and when forced to make that decision for others at moments of despair and stress, are agonized. At the very moment when the removal of a loved one’s vital organs is most dreadful to contemplate when feelings of guilt or helplessness are most likely to distort calm judgment, grieving families need not confront the matter.

PRESUMED CONSENT AND THOSE ON THE FENCE

There are several questions that some light critics will want to bring out. How do we protect the decision of individuals who wish not to donate their organs? Will it be stress-free to refuse to donate an organ? How are we going to ensure all organ donation refusal decision is maintained?

Some people for religious or other reasons will not want their organs used after their death. These people still live with us and if we attempt to create a new policy, we need to consider how to protect them.

For this set of people, Cohen is very quick to express his opinion about how to cater to them. To protect the interest of those who are not interested in donating an organ, Carl Cohen quickly adds that:

Some persons do not wish to have their organs removed for any purpose, even to save lives after their deaths. To them, it must be said, without hesitation or rancor, “as you wish.” Giving to every person the opportunity, while alive, freely to opt-out of the system of general donation is a social obligation entailed by respect for individual autonomy, and an obligation readily fulfilled. (15)

Another very important point to be noted which considering a change in policy, especially a policy that will affect almost everyone living, is the transition period. This is the period when we will change from the formal policy and move to the new one. This period is very delicate as it can make or mar the entire process. The process can be stalled or even halt if we didn’t handle the transition process very well. Handling the transition process well include educating the masses on the new rule, ensuring that people get the information and understand the message. The government can stage rally, various talks, use various mass media, seminar and a host of others to ensure that the masses are well educated about the change in policy.

The transition period also matters as campaigns need to be carried out to inform the masses of the change in the process of organ donation after death. Cohen avers:

of no one may it later be said that objections would have been registered if only the rules had been known. Wide public education must, therefore, precede the reversing reform, and the revised presumption must be openly and expressed in ways that all may fully grasp. (16)

From the foregoing, we conclude that it is the government's responsibility to ensure that the period of transition does not bring about rancor, that things were well documented and people just don't wake up and realize that the medical doctors now use their cadavers to save others life.

PRESUME CONSENT AND THE ETHICS OF ORGAN DONATION

Organ donation presupposes organ transplantation; this is because we don't need the donated organ for other things rather than to transplant it into another being for continued existence. It is not everyone that has organ failure qualified for transplantation, other consideration makes someone qualify for an organ transplant, and this includes the medical eligibility for transplant among others. This process is succinctly espoused by center for bioethics:

When a person falls ill because one of his or her organs is failing, or because the organ has been damaged in an accident or by disease, the doctor first assesses whether the person is medically eligible for a transplant. If so, the doctor then refers the individual to a local transplant center. The transplant center evaluates the patient's health and mental status as well as the level of social support to see if the person is a viable candidate for an organ transplant. If the patient is a transplant candidate, he or she will be placed on the waiting list.

The first and major sources of an organ donated are from the cadaveric donor. The cadaveric organ is the organ taken from a deceased body. The cadaveric donation can occur through three major means, the first is presumed consent otherwise known as opt-out, followed by presumed refusal which is also called opt-in, while the mandated choice made it compulsory to choose one's donation position.

Presume refusal suggests that removal of the organ from a dead person is illegal except such an individual has agreed before death that his or her organ should be donated after the termination of life. This suggests that there is a presumed refusal of all individuals in the state except those that opt-in for donating an organ.

This is explained in the words of James Taylor that organ "will not be removed from her postmortem body unless she has explicitly consented to this being done." (17) This method suggests that citizens must opt-in to become donors by registering to donate their organs after death. Usually, this method fails to produce a large number of organs that can serve the increasing rate of organ failure today. This method required people willing to donate an organ to act before death, it surely might exclude those willing to donate organs but are yet to take such step before their death from giving the gift of life.

The second instance is the opt-out option or presume-consent. This presupposes that all humans are willing to donate their organs except those that declined. In this view, every dead person will be considered a potential donor, only those that have penned down or register not to give out their organ after death will only be exempted.

This view made it possible to have a high level of donors in society. James Taylor opined that, for presumed consent, "will not be removed from her postmortem body unless she has explicitly consented to this being done." (18)

It is suggested that these two positions will still have some people cheated, the argument against presumed consent also goes for presumed refusal, they both have the potential of going against the will of at least a dead person.

Another challenge that might be faced with presume consent is the probability that the introduction of presume consent might affect the clinical caring for the end of life. Patience families will begin to have trust issues when the patient is declared dead; they began to think such a position was arrived at so that such a person's organ can be harvested. A survey in 2008 observes that:

There is a belief among some members of the medical profession that the introduction of presumed consent might damage the relationship of trust between clinicians caring for patients at the end of life and their families. (19)

The costs of introducing presume consent into the system are costly. This is because there is a need to communicate every living person of the change in the procurement process. There is also a need for a robust technology that will support such change and enable them to capture information and relate it in real-time. Simon (2011) posits that:

The introduction of a system of presumed consent would be highly complex and costly if it were to command the trust of the involved professions and the general public. Every member of the UK public at the time of introduction and moving forward would need to be contacted and offered the choice of opting out. This would require a significant and sustained communication program and any 'opt-out' register would need a robust IT system to support the process. (20)

The maintenance of presumed consent requires adequate publicity and effective technology that will enable the people to be aware of the change in policy.

SAME CRITIQUE FOR PRESUME CONSENT AND PRESUME REFUSAL

The major argument for the establishment of presumed consent can as well be used by supporters of presumed refusal. One of the major criticisms against presumed consent is that they believe that mistake in using a few person organs who might not want to donate their organ is better off than not using the organ of those that will be willing to donate their organ.

This argument is also what supporters of presumed refusal use in pushing home their points that, a mistake not to use some people's organ who might want to donate is better than using the organ of people who do not want to donate. The moral claim is based on the fact that we will be infringing on the right of the individual if he/she doesn't want to donate his/her organ and has not documented his/her wish against it before his/her death.

This argument which is one of the pillars of the "Presumed Consent" position can also be used against them as an argument by "Presumed Refusal". This position is based on the assumption that the person involved is willing to donate his or her organ, this assumption is further generalized. In a country, the argument for presumed consent rest on the foundation that the majority of people will be willing to donate, so we should assume everyone wishes to donate their organ, while those willing to opt-out should register their position.

The problem with this view is that some people who are not willing to donate their organs and have not gotten the right time to register their opinion will be short-changed with this kind of legislation. This position is further explained by Micheal Gill when he said:

It's striking that the argument for presumed consent and the argument against it both start from the same datum: that about 70% of Americans want to donate their organs after death; or, if you like, that about 30% of Americans do not want to donate their organs after death. (21)

The position that some people will be affected if the opposition position is used can both work for presume consent and presume refusal. The proponent of presume consent cannot successfully criticize a theory of something their position is also guilty of. Presume consent is guilty of mistaken removal as well as presume refusal is guilty of mistaken non-removal. Micheal Gill further posits that:

no matter how well presumed consent is instituted, there will still be some cases in which people who would have preferred to be buried with all their organs intact will have some of their organs removed; call these mistaken removals. (There will probably also be some mistaken non-removals under presumed consent and some mistaken removals under the current system, but these kinds of mistakes are likely to be considerably rarer.) (22)

This position maintained by both presume consent proponent and presume refusal proponent is sample research-based. Sample research itself cannot be used as conclusive support for an argument. This is because the research might be based on the wrong societal sample, or based on wrong current orientation by the society during the sampling. It has been identified that the argument that 70% of people in America wish to donate their organ and 30% do not want to donate arise from the Gallup survey in 1993.

It comes from a 1993 Gallup Poll, to which most recent commentators on both sides of the issue have referred. (23)

This survey is not sufficient evidence to prove that truly if presume consent is introduced a larger percentage of people in the country will be favored. We cannot use the current social situation to determine the moral rightness or wrongness of an action.

PRESUME CONSENT AND ORGAN SHORTAGE

Presumed consent came as a remedy to the long waiting period for organ donation. The proponent of presumed consent presents their argument on the position that if accepted the many people on the waiting list will be reduced as we will have more organs for the usage for organ donation.

An outward appearance of presumed consent suggests that it can solve the problem of insufficient organ donation, as it will make more organs available for transplant. However, reality has proved otherwise as it brings a lack of trust in physicians by the masses and makes more people skeptical about the preservation of their life in the hands of doctors. Recent researches on several donors per million persons have this to say:

A review of the accompanying chart indicates the wide disparity within European Presumed Consent countries donation rates, from a high of Spain's 33.5 to a low of Greece's 5.7, with a simple average of 12.5 nDPM (normalize donor per million person), which is insignificantly different from the Explicit Consent average of 12.1 nDPM (normalize donor per million person). (24)

From the above, it is crystal clear that countries where presumed consent were introduced were not far better off than others. The policy of presumed consent does not give a better percentage increase as expected with the initial presentation; this is due to several factors. Presumed consent alone cannot solve the problem of insufficient organs as a shortage of organs does not lie in the policy of opt-out run by most countries.

Religious and cultural beliefs also contribute to a countries response to organ donation. The cultural understanding of many influences their thoughts and their action; this does not exclude their medical beliefs as well as the use of their bodies. Dr. Rod McLeod observes that:

In many societies, people define themselves by their religious and cultural grouping, even when their faith or immersion in religion or culture is limited. There are wide variations between people of differing faiths, ethnic backgrounds and national origins and their approach to the end of life. (25)

Every nation is blessed with culture, this is our long-time believe and mostly it has become part of our belief system. The culture of a country affects the general thinking of people in that environment. As a country, cultural understanding will contribute more to their response to organ donation better than the donation policy applied in the state. On the part of religion, a research study has shown that:

of the European countries with more than 70% Roman Catholic populations nDPM averages 16.3 while the countries with populations that are less than 70% Roman Catholic donation rates were only 9.1 nDPM; with a mix of PC and EC in each group of countries. Thus, it is very likely that religion plays a far more dominant and successful role in increasing organ donation in Europe than Presumed Consent. (26)

The religion of an individual goes a long way in affecting the acceptance or rejection of organ donation. The higher the level of religious tolerance to organ transplantation in a country, the higher the number of per million persons that will donate an organ in that country. A pro-organ release religion will produce more people to donate organs than otherwise.

With the above point, it is clear that more needs to be done in the area of cultural re-orientation and religious position in organ donation. This will go a long way in improving the rate of organ donation rather than changing the policy from opt-in to opt-out.

PRESUME CONSENT AS A TOOTHLESS POLICY

One of the major challenges of donating organs at the end of life is the position of the deceased relative. It is usually a difficult period before the doctor announces to the relative the dying state of their person at the same time introducing the “gift of life” to them and waiting for their decision. The period of discussion coupled with the fast deterioration of organs makes many organs to be lost.

The introduction of presumed consent is a way of removing the authority of relative in deciding on organ donation. The relative will no longer need to be contacted once the patient is brain dead and his or her organ is useful for others on the waiting list. Alas, this is not the case as presumed consent is toothless in most countries it has been introduced. Even Carl Cohen agreed in his paper that we should allow the relative to still decide the death of the deceased on donating part of the remains of their person.

European countries that developed and maintain presumed Consent in their laws do not rely on it to recover organs. A 2012 survey of practices reports that donation professionals in all of these countries to require family consent before the recovery of organs. The fact that all countries that have presumed consent laws do not rely on the right of the state to take organs speaks to the public trust and autonomy issues that arise when countries seek to claim any type of property and makes it clear that the variance in donation rates is a function of cultural and operational aspects rather than legal characteristics of their donation programs.

Presumed consent as a policy has almost failed humanity in the quest for acquiring a large number of organs for patients on the waiting list. The policy is just an attractive policy with an unattractive result. Furthermore, the majority of people get to know better about organ donation at the point of death. The public information is usually misleading as most people are either uninformed or misinformed. Policies of this nature when introduced to the society usually release panic and the majority of people act out of ignorance to take a decision which mostly leads to negative action.

The majority of people when applying for either driver license or national document that requires them to document their donation position are either uninformed as at that time or misinformed, this will bring about the low positive response. A research conducted in Californians concludes that:

The significant variance between the 31% of Californians who register to be donors while applying for driver licenses and the 72% who donate at the time of death suggests a concern: when people are applying for a driver license a significant majority either feel under-informed, are misinformed, oppose donation, or simply do not choose to register at that time. Yet, when confronting the unavoidable end of life and the need to make final decisions, individuals and families seek and are receptive to information that prompts them to choose to donate. (27)

Third world countries are still battling with a basic medical need. Organ transplantation is an advanced medical that major western countries have laws and operational policies, unlike sub-Saharan Africa, where majorities of the countries have non functional or no policy for organ transplantation. Most third world countries don't have organ bank and transplantation is usually synonymous with medical tourism. Presume consent or refusal as policies in third world countries are mostly not operational because the technology is relatively new in third world countries' medical facilities. Also, some African culture considers donating organ as taboo.

REGENERATIVE MEDICINE AS A BETTER ALTERNATIVE

Regenerative medicine is a new approach in the medical field to resolve the advance medical situation such as organ transplantation. The research in regenerative medicine will assist in solving the issue of a lack of organs for transplant. Regenerative medicine as a concept is the process of reusing the organ generated from a person's body.

With this approach in medicine, the organ will no longer need to go through the process of rejection since it is the organ from the same body that is been re-introduced to the body. The organ will be taken from the patient's body and will be processed to form the organ needed for transplant. This approach is new and research is ongoing in regenerative medicine, we believe that if the research in regenerative medicine is improved upon, it will have a great impact in solving the problem of organ need since the organ will be generated from the patient's body. Medical practitioners are expected to explore the area of regenerative medicine effectively in solving the problem of organ shortage.

Practitioners in the field of organ transplantation and regenerative medicine need to work together to develop a lasting solution to the shortage of organs. Joseph P.V (et al) posits that

The success of transplantation has led to the need for regenerative medicine. The number of patients waiting for an organ for transplantation has surpassed 117,000. Many of these candidates may not receive an organ due to the limited supply of cadaveric grafts or those donated by altruistic living donors. It is the shared hope that regenerative medicine may one day augment organ transplantation by developing a new source of organs or potentially rehabilitating those that are not transplantable. (28)

The appearance of regenerative medicine fifteen years ago appears as a potential solution to organ transplantation. However, there are some challenges posed by regenerative medicine that needs to be examined. Up till date, "all the successful implanted bio-engineered organs are hollow organs, whereas the bio-engineering of modular organs such as cardiac, renal, hepatic, and pancreatic is still far from the realm of possibility." (29)

The above shows that regenerative medicine remains in the realm of potential solutions to cadaver organ donation, and as it is with potential solutions, various challenges come alongside them which might not be visible at the moment.

CONCLUSION

From the foregoing, we are able to examine presume consent as presented by Carl Cohen. We identified some of the Achilles hills inherent in the policy of presume consent. This paper presents an alternative from recent development in advance medicine. We conclude that if regenerative medicine, cloning, and other advanced medical research is intensified, we will be able to generate adequate organ without repeating the pitfall of presume consent and other policy available in generation organ for transplantation.

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