Counterplan text: A just society ought to recognize personal property rights in organs by legalizing cadaveric organ sales.

The counterplan is mutually exclusive. Presumed consent denies legal rights to organs.

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The meaning of 'presumed consent' The understanding of presumption of consent to organ donation may be considered, by some practitioners of law or science, to be an inaccurate and misleading term. This stems from the general understanding of 'presumption' in law and science: as an inference that is made on available fact or evidence with the understanding that vital information that can render the inference invalid may be missing. In law a presumption holds – that of innocence, for example – until a substantial body of evidence is produced to the contrary. Just like a scientific theory or hypothesis, a legal presumption is maintained for as long as no evidence is provided to disprove it or no valid objection is raised against it. A presumption, in law and science, is therefore a 'provisional estimate of facts' [3] based on some accepted fundamental state or pattern of behaviour. Unlike the presumptions in law or the hypotheses of science, presumption of consent for the use of body organs cannot afford any possibility of abandoning the presumption, reversing the decision or of retracting any action based on the decision (clearly, the deceased donor cannot raise objections). The presumption of consent for organ donation cannot therefore be taken as a presumption of donor willingness, with the specific understanding that there will be a provision for changing the course of action should further evidence emerge, but rather as a presumption of state rights to post-mortem body organs, unless an objection by the 'occupant' of the body is raised whilst the 'occupant' is still in 'residence'. Opponents of presumed consent argue that the absence of donor willingness is morally unacceptable because it can be seen as a violation of their wishes [4]. (It has even been suggested that the term presumed consent be replaced by 'specified refusal' to put the emphasis on the action taken rather than on assumption [5]). It is clear that presumed consent is advocated as a means of meeting organ donor shortages and not because the state wishes to assume ownership of body parts per se. Nevertheless, it places the greater emphasis on functionality of body organs and how they can be best utilised to sustain life rather than on the importance of requiring permission of the individual to donate his or her organs. It also takes away the power to 'gift' that donorship confers [6]. If functionality of body organs becomes of prevailing importance, it could be argued that the body is predominantly a vessel equipped with all the necessary instrumentation for maintaining life and that is occupied and used by the person to whom the body belongs. Consequently, if presumed consent is advocated, it could be reasoned that since after death the 'occupant' no longer needs the 'vessel', if any of the instrumentation is still functional it should be used to better or save the life of another. The acceptance of this premise and hence of the liberty of the state to assume the rights to decide about further usage (pending no objections) raises further issues about the right of ownership and hence who should benefit from body organs, and how presumed consent will extend to competent minors and mentally incompetent adults.

Prefer my evidence – it's from an expert in biomedical law, so she's most qualified to interpret the legal ramifications of "presumed consent."

The counterplan is sufficient to fully solve organ shortages – economic models prove.

Beard et al., 2008:

(T. Randolph Beard, Professor of Economics At Auburn University, John D. Jackson, Professor Emeritus Of Physics At The University of California, and David L. Kaserman, Research Fellow At The Independent Institute. The Failure Of U.S. Organ Policy. Health & Medicine, Winter 2008.)

To an economist, the solution to this problem is both obvious and simple: repeal the National Organ Transplant Act and its progeny and allow the price of cadaveric organs to rise to equilibrium, market-clearing levels. While we cannot be certain exactly what the equilibrium prices would be, at least two economic considerations suggest that they are likely to be relatively low. First, there appears to be a large pool of excess capacity at current collection rates. Estimates suggest that we are presently harvesting only about half of the potential number of cadaveric donors. And second, the opportunity cost of cadaveric organ donation is quite low for most potential donors. Therefore, the price elasticity of supply of organs is likely to be quite large and the market clearing price is correspondingly low. A related issue pertaining to the supply of cadaveric organs involves the overall adequacy of this source of transplantable organs. Specifically, is there a sufficient number of deaths each year in the United States that occur under circumstances that would allow organ donation so as to resolve the shortage fully? The answer appears to be yes, given a correct understanding of the economic definition of the term "shortage." In particular, a shortage is the difference between the quantity demanded and the quantity supplied at a given price, both of which are defined as f lows (i.e., a number of units per time period). Consequently, the organ shortage is also a flow that presents itself as an increase in the transplant waiting list (a stock) each period — say, a year. Importantly, the shortage is not given by the actual list itself. Thus, properly defined, **there does appear to be a sufficiently large supply of** potential **cadaveric donors to resolve the shortage fully** — that is, to stop adding to the waiting lists. Unfortunately, however, it will take years of surpluses to drain the backlog of excess demands that have accumulated from over 30 years of shortages — i.e., to eliminate the waiting lists. But the sooner we start doing so, the more lives will be saved. To continue to postpone **the only effective solution** in the unrealistic hope of resolving the shortage at a zero price is to condemn **thousands more patients to death** as they wait for organs that never arrive. WAITING LISTS YET TO COME The consequences of our failure to adapt our cadaveric organ procurement policy to the changed technological realities of the transplant industry have been unconscionable. Figure 2, above, suggests that more than 80,000 lives have now been sacrificed on the altar of our so-called "altruistic" system. In addition, the unnecessary pain and suffering of those who have been forced to wait while undergoing dialysis, unemployment, and declining health must also be reckoned along with the growing despair of family members who must witness all of this. Nonetheless, the pain, suffering, and death imposed on the innocents thus far pales in comparison to what lies ahead if more fundamental change is not forthcoming. In order to illustrate the severe consequences of a continuation of the altruistic sys- tem, we use the data presented in Figures 1 and 2 above to generate forecasts of future waiting lists and deaths. The forecasts represent our best guess of what the future holds if fundamental change continues to be postponed. The results should serve as a wake-up call for those who argue that we should continue **tinkering with the** existing **procurement system** while further postponing the implementation of financial incentives. The costs of such a "wait and see" approach are rapidly becoming intolerable.

The aff creates a ruse of solvency – policies that rely on altruism delay more effective reforms

Beard et al. 8:

(T. Randolph Beard, Professor of Economics At Auburn University, John D. Jackson, Professor Emeritus Of Physics At The University of California, and David L. Kaserman, Research Fellow At The Independent Institute. The Failure Of U.S. Organ Policy. Health & Medicine, Winter 2008.)

Aware of the increasingly dire consequences of continued reliance on the existing approach to cadaveric organ procurement and alarmed at the figures shown above, the transplant industry has examined and adopted a series of policy options ostensibly designed to improve the system's performance. All of these, however, **continue** to maintain **the** basic **zero-**

price property of the **altruistic system**. As a result, the likelihood that any of them, even in combination, will resolve the organ shortage is remote. At least seven such actions have been implemented over the last two decades or so: ▪ INCREASED EDUCATIONAL EXPENDITURES In the absence of financial incentives, moral suasion becomes the principal avenue through which additional supply may be motivated. Consequently, the organ procure- ment organizations (opo s) created under the 1984 Act have launched substantial promotional campaigns. The campaigns have been designed to both educate the gen- eral public about the desperate need for donated organs and educate physicians and critical care hospital staff regarding the identification of potential deceased donors. Over the years, a substantial sum has been spent on these types of educational activities. Recent empirical evidence, however, suggests that further spending on these programs is unlikely to increase sup- ply by a significant amount. ▪ ORGAN DONOR CARDS A related activity has been the process of incorporating organ donor cards on states' driver licenses. The cards can be easily completed and witnessed at the time the licenses are issued or renewed. They serve as a pre-mortem statement of the bearer's wish to have his or her organs removed for transplantation purposes at the time of death. Their principal use, in practice, is to facilitate the opo s' efforts to convince surviving family members to con- sent to such removal by revealing the decedant's wishes. The 1968 Uniform Anatomical Gift Act gave all states the authority to issue donor cards and incorpo- rate them in drivers' licenses. Moreover, a few states have recently begun to rely entirely on donor cards to infer consent without requiring the surviving family's permission when such cards are present. Survey evi- dence indicates that less than 40 percent of U.S. citizens have signed their donor cards. ▪ REQUIRED REQUEST Some survey evidence pub- lished in the late 1980s and early 1990s found that in a number of cases families of potential deceased donors were not being asked to donate the organs. As a result, donation was apparently failing to occur in some of those instances simply because the request was not being presented. In response to this evidence, federal legislation was passed in 1987 requiring all hospitals receiving any fed- eral funding (which, of course, is virtually all hospitals) to request organ donation in all deaths that occur under circumstances that would allow the deceased's organs to be used in transplantation. It appears that this legal obligation is now being met in most, if not all, cases. Yet, the organ shortage has persisted and the waiting list has continued to grow. ▪ REQUIRED REFERRAL While required-request legisla- tion can compel hospitals to approach the families of recently deceased potential organ donors with an appeal for donation, it cannot ensure that the request will be made in a sincere, compassionate manner likely to elicit an agreement. Following implementation of the required-request law, there were a number of anec- dotes in which the compulsory organ donation requests were presented in an insincere or even offensive manner that was clearly intended to elicit a negative response. The letter of the law was being met but not the spirit. As a result, additional legislation was passed that requires hospitals to refer potential organ donors to the HEALTH & MEDICINE regional opo so that trained procurement personnel can approach the surviving family with the donation request. This policy response has resulted in no percep- tible progress in resolving the shortage. ▪ COLLABORATION A fairly recent response to the organ shortage has been the so-called "Organ Donation Breakthrough Collaborative," which was championed by then-secretary of health and human services Tommy Thompson. The program was initiated shortly after Thompson took office in 2001 and is currently contin- uing. The program's basic motivation is provided by the observation of a considerable degree of variation in per- formance across the existing opo s. Specifically, the number of deceased organ donors per thousand hospi- tal deaths has been found to vary by a factor of almost five across the organizations. The presumption, then, is that the relatively successful opo s employ superior pro- curement techniques and/or knowledge that, if shared with the relatively unsuccessful organizations, would significantly improve their performance. Thus, diffu- sion of "best practice" techniques is seen as a promising method through which cadaveric donation rates may be greatly improved. A thorough and objective evaluation of the Thompson initiative has not, to our knowledge, been conducted. Figure 1, in conjunction with a recent econometric study of observed variations in opo effi- ciency, suggests that such an evaluation would yield both good news and bad news. The good news is that the program appears to have had a positive (and poten- tially significant) impact on the number of donations. In particular, it appears that, after 2002, the growth rate of the waiting list has slowed somewhat. Whether this effect will permanently lower the growth rate of the waiting list or simply cause a temporary intercept shift remains to be seen. The bad news, however, is unequivo- cal — the initiative is not going to resolve the organ shortage. Even if, contrary to reasonable expectations, all opo relative inefficiencies were miraculously elimi- nated (i.e., if all organizations' performance were brought up to the most efficient unit), the increase in donor collection rates would still be insufficient to eliminate the shortage. ▪ KIDNEY EXCHANGES Another approach that has received some attention recently involves the exchange of kidneys between families who have willing but incompatible living donors. Suppose, for example, a person in one family needs a kidney transplant and a sibling has offered to donate the needed organ. Further suppose that the two siblings are not compatible — per- haps their blood types differ. If this family can locate a second, similarly situated family, then it may be possi- ble that the donor in the first family will match the recipient in the second, and vice versa. A relatively small number of such exchanges have recently occurred and a unos -based computerized system of matching such interfamily donors has been proposed to facilitate a larger number of these living donor transactions. Two observations regarding kidney exchanges are worth noting. First, such exchanges obviously consti- tute a crude type of market in living donor kidneys that is based upon barter rather than currency. Like all such barter markets, this exchange will be considerably less efficient than currency-based trade. Puzzlingly, some of the staunchest critics of using financial incentives for cadaveric donors have openly supported expanded use of living donor exchanges. Apparently, it is not market exchange per se that offends them but, rather, the use of money to facilitate efficient market exchange. This combination of posi- tions merely highlights the critics' lack of knowledge regarding the operation of market processes. It is quite apparent that living donor kidney exchanges are not going to resolve the organ shortage. Opportunities for such barter-based exchanges are simply too limited. Finally, in another effort to encourage an increase in the number of living (primarily kidney) donors, several states have passed legislation authorizing reimbursement of any direct (explicit) costs incurred by such donors (e.g., trav- el expenses, lost wages, and so on). Economically, this policy action raises the price paid to living kidney donors from a negative amount to zero. As such, it should be expected to increase the quantity of organs supplied from this source. Because the explicit, out-of-pocket expenses associat- ed with live kidney donation are unlikely to be large rela- tive to the longer-term implicit costs of potential health risks, however, such reimbursement should not be expected to bring forth a f lood of new donors. Moreover, recent empirical evidence suggests that an increase in the number of living donors may have a negative impact on the number of deceased donors because of some degree of supply-side substitutability. Again, this policy is not a solution to the organ shortage. We must conclude that none of the above-listed policies should be expected to resolve the transplant organ shortage. We say this not because we oppose any of these policies; indeed, each appears sensible in its own right and some have unquestionably succeeded in raising the number of organ donors by some (perhaps nontrivial) amount. Rather, our concern is that every time another one of these marginalist policies is devised, it delays the only real reform that is capable of fully resolving the organ shortage. A cynical observer might easily conclude that the above string of largely ineffectual actions represents an intentional strategy of what might be termed "**illusory responsiveness**." That is, the policies were never really intended or expected to resolve or even substantially ameliorate the organ shortage. Rather, they have been undertaken strategically to create the illusion that serious efforts were being made to address the issue while postponing more effective reforms.

Presumed consent is paternalistic—this oppresses minorities

Jacob 3 writes[1]

Leaving aside the arguable issue of psychological barriers to organ donation, there are external elements that could prevent donation. Would-be donors may face social or religious pressure preventing donations. In this situation, paternalism may be useful. Presumed consent, as a default rule, might assist these individuals in the realization of their wishes despite external pressure. 2 i Nevertheless, there is a general sense of unease towards paternalism in current bioethical literature, especially in the feminist bioethical theory.27 **History teaches that both paternalism and beneficence**, or paternalism alone, **have been selectively applied towards** historically oppressed groups like women, disabled people, ethnic **minorities** and the poor. **Medical** and political **establishments** often **perceived these groups as inherently vulnerable and in need of special protection** or even admonishment in order **to** properly **look out for themselves**. The relationship between presumed consent for donating organs and paternalism has a particular character. **Presumed consent is portrayed as a practice** based on beneficence, **which avoids the harm of asking people to make hard choices**. Yet **this point is fraught with the belief that individuals**, especially in grieving families, **are too fragile to deal with important**, controversial and delicate **matters**. Perhaps a young and poor Aboriginal man can be spared the tough issues? And this unemployed, intoxicated hysterical white woman: why harass her with this dilemma when she is already so stressed? These images capture the paternalism of presumed consent theory. **Presumed consent rationalizes and justifies paternalism** on the basis of beneficence

[1] Marie-Andree Jacob. "On Silencing and Slicing: Presumed Consent to Post-Mortem Organ Donation in Diversified Societies." Tulsa Journal of Comparative and International Law. September 1st, 2003. http://digitalcommons.law.utulsa.edu/cgi/viewcontent.cgi?article=1200&context=tjcil

towards those who should give organs. Applying the beneficence argument to those who fear death requires presumptions that are similarly fraught with paternalistic and contemptuous problems.

Analysis

1) The CP text is fairly obvious. It's labeled and comes at the very beginning to give the judge and opponent a heads-up as if to say "Hey this is a counterplan!" Adam's CP text is **"A just society ought to recognize personal property rights in organs by legalizing cadaveric organ sales."** If he were debating a more specific aff such as one that defends the United States as an actor, Adam might change his CP text to say "The United States ought to…" Otherwise, this CP text is specific enough that it gives an idea of what the CP is about but not so specific that it gets bogged down in details or waste speech time.
2) This CP competes on both **mutual exclusivity and net benefits**. First, the mutual exclusivity argument states that the aff is incompatible with organ sales because it denies a right to one's own organs after death. This claim is backed up by the Pierscionek evidence, but it is not always necessary to read evidence for mutual exclusivity. Second, the net benefits. Adam has two clear net benefits for this counterplan we'll discuss below in 4).
3) The clue for finding solvency here lies in Adam's rhetoric: **"The counterplan is sufficient to fully solve organ shortages."** If not explicitly labeled as solvency, the CP can prompt the opponent and judge to recognize solvency by using rhetoric like "The CP solves" or "The CP increases X" where X is the good impact the aff wants to solve too. It's extremely important to have strong evidence in this section. Adam's Beard card seems to use empirical data and makes a comparative argument about organ sales vs. current procurement policies, which is exactly what you want in a good solvency card.
4) The CP has two clear net benefits: a) the **"ruse of solvency"** argument backed by the Beard card and b) the **paternalism and minority oppressio**n argument in the Jacob card. How do we know these are net benefits? Neither says "this is a net benefit," but the function is clear — Adam will use these pieces of evidence to show that there is a disadvantage or problem with doing the aff, i.e. presumed consent. From there, he can argue that the CP alone is better than the aff or a combination of the aff and the CP. If he wins 3) that the CP solves for organ shortage and that it also avoids the a) and b) problems with the aff, then he has a compelling 2NR ballot story.

https://www.premierdebate.com/articles/counterplans-in-ld-1/