Priority for organ donors in the allocation of organs: Priority rules from the perspective of equality of opportunity

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Article Published in Journal of Medicine and Philosophy Please refer to published version.

Albertsen, A. (2023). Priority for organ donors in the allocation of organs: Priority rules from the perspective of equality of opportunity. *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine*, *48*(4), 359–372. https://doi.org/10.1093/jmp/jhad023

Abstract
Should priority in the allocation of organs be given to those who have previously donated or declared their willingness to do so? This article examines the Israeli priority rule in light of two prominent critiques of priority rules, pertaining to failure to reciprocate and unfairness. The scope and content of these critiques are interpreted from the perspective of equality of opportunity. As the Israeli priority rule may reasonably be criticized for unfairness and failing to reward certain behaviors, the article develops an adjusted priority rule, which removes and adjust the elements in the Israeli priority rule deemed problematic. However, such a priority rule is complex to the extent that it may fail to increase donation rates and furthermore introduce new concerns of fairness, as the better off may be better able to navigate the complex adjusted priority rule.

Introduction

The shortage of organs for transplants and the suffering associated with that shortage have prompted numerous policies and proposals to alleviate the situation. One such proposal is to provide priority in the allocation of organs to those who have made a living donation or signed up for the donor registry. Such policies are termed priority rules (Jarvis 1995; Kolber 2002; Steinberg 2004). In April 2008, the Israeli Parliament introduced new legislation for the procurement and allocation of transplantable organs, which gives priority in the allocation of organs to organ donors, people who have signed up to be organ donors, and their relatives (Lavee et al. 2010, 1132; Ashkenazi, Lavee, and Mor 2015, 265).

Priority rules have a certain pedigree in Singapore (Iyer 1987, 135; Schmidt and Lim 2004, 2175; Teo 1991, 11) and Chile (Zúñiga-Fajuri 2015, 199), as well as in the United States. In Chile and Singapore, those who are registered as organ donors receive priority. In the US allocation system, those who have been living kidney donors are given priority should they need a kidney transplantation at a later point. The US does not, however, give priority for registering as a donor. While this article takes the Israeli legislation as a starting point and discusses it in some detail, the conclusions drawn about equality of opportunity-based priority rules are relevant for the broader set of priority rules.

The Israeli rule adds a new dimension to the existing academic debate over priority rules. A recent review of the literature identifies two distinct reasons for supporting a priority rule. These pertain to 1) increasing donation rates and 2) reciprocity, understood as the rewarding of those willing to contribute (J. Chandler, Burkell, and Shemie 2015, 190–91). This article provides a different take on priority rules, assessing them from the perspective of equality of opportunity. It utilizes John Roemer's conception of equality of opportunity, which stresses that people's opportunities to attain some good or avoid some

bad should reflect their genuine effort as opposed to circumstances beyond their control (Roemer 1993; 1998; 2003; 2012).[1]

This article First describes the Israeli priority rule. Then current experiences with priority rules are laid out. The third section presents the Romerian ideal of equality of opportunity and employs it to examine the content and scope of prominent critiques of priority rules from the general debate over priority rules in organ donation. The section presents critiques pertaining specifically to fairness and reciprocity. The next section discusses to what extent the Israeli priority rule may be vulnerable to these critiques. After this, an equality of opportunity-adjusted version of the Israeli priority rule is presented. A final section examines whether this priority rule gives rise to new concerns related to fairness.

The priority rule in Israel

Since April 2010, Israel has had a priority rule in organ donation. The law gives priority in the allocation of organs to living donors, people who have signed up to be organ donors, and their relatives, as well as the relatives of deceased donors (Lavee et al. 2010, 1132; Ashkenazi, Lavee, and Mor 2015, 265).[2] These acts make people eligible for priority points. Thus, by donating or declaring a willingness to give, people can bestow a benefit upon themselves and their families, should the need for an organ transplantation arise later. The organ procurement system in Israel is of the opt-in variety,[3] but with a significant role given to the family. If people consent to donate their organs by registering as an organ donor, their family still needs to sanction this before the organs can be removed. If people have not expressed their preferences regarding organ donation, the family is asked to make the decision.[4]

While similar in structure, the priority system varies between organs. The Israeli priority rule provides priority points to three specific groups (Berzon 2018, 2–3; Lavee et al. 2010, 1132; Lavee 2013; Levy 2018, 418).

- Group 1: Those who have performed a living donation (both directed and non-directed), and the first-degree relatives of deceased donors.[5]

[1] For other important contributions to the literature on equality of opportunity, see (Arneson 2008; Fishkin 2014; Segall 2013; Richards 1998).
[2] 'Receiving priority' denotes situations where one person receives priority over another who could also have benefitted from it.
[3] For a general description of opt-in systems, see (M. Wilkinson and Wilkinson 2016). The difference between opt-in and opt-out is often blurred by the various roles given to families (Price 2000, 92–94). In many opt-in systems the consent of the family will suffice for the removal of organs.
[4] The role of the family in organ donation is a controversial topic (Albertsen 2020; D. M. Shaw 2016; D. Shaw et al. 2017; Zambrano 2017).
[5] At first, this category included only those who had performed a non-direct donation of a kidney or a liver lobe (Quigley, Wright, and Ravitsky 2012, 971). It was later amended to cover both direct and indirect donations, and expanded with lung lobes (Levush 2012, 1614; Lavee 2013). The non-

- Group 2: Those who have been registered as donors for three years or more.
- Group 3: The first degree-relatives of registered donors.

Most priority is conferred on members of the first group, less on the second and even less on the third. If people belong to more than one group, they receive the priority of the highest category for which they qualify (Levy 2018, 418; Quigley, Wright, and Ravitsky 2012, 971).

For all organs, there is a very urgent category (Lavee et al. 2010, 1132). Those whose need for a liver, lung, or heart is deemed very urgent are treated first. This is also the case even if they are not eligible for priority points. If, among those in the urgent category, some are equally in need, those who also qualify for 1-3 above will receive priority. Priority points are thus most important for those below this level of urgency. The discussion below briefly illustrates how, at this level of urgency, priority points work in tandem with the medical need of potential transplant recipients.

The number of priority points each group receives differs between organs.[6] For lungs, livers and kidneys, the priority points received are added to a clinical score which utilizes commonly employed clinical measures. Those with the highest combined score receive an organ transplantation (Lavee et al. 2010, 1132). For livers, the Model for End-Stage Liver Disease (MELD) score is used as the clinical score. This ranges from 6 to 40 (Lavee et al. 2010, 1132).[7] For kidneys, a score ranging from 0 to 18 is assigned, based on age, waiting time, panel-reactive antibody concentration, and the HLA match with the donor (Lavee et al. 2010, 1132). For both kidneys and livers, the Israeli priority rule provides 3.5 priority points to Group 1, 2 points to Group 2, and 1 point to Group 3 (Lavee et al. 2010, 1132). For lungs, the lung allocation score (LAS) is utilized as the clinical score. It ranges from 0 to 100 and takes into account patient variables that affect survival in the next year without a transplant, as well as the projected length of post-transplant survival

inclusion of direct donors was among the things criticized as the law was initially presented (Quigley, Wright, and Ravitsky 2012; Wright and Silva 2010). While Lavee's description includes in Group 1 the relatives of living donors (Lavee et al. 2010, 1132), this is absent from later descriptions of the law (Levy 2018, 418).

[6] The use of points draws on Lavee's presentation of the law from 2010 (Lavee et al. 2010). Most presentations of the law mention the points, but do not include or discuss their numerical values (August 2012, 412; Berzon 2018; Levy 2018, 418; Quigley, Wright, and Ravitsky 2012; Zaltzman 2018). They are presented here for the sake of completeness and because the number of points awarded raise a concern. There is another difference in how the law is described. Sometimes the system is described as one where the various categories provide priority in cases of equal medical need (Quigley, Wright, and Ravitsky 2012, 971). According to Lavee this is only strictly true for the urgent category. If, however, we read equal medical need as deciding between people of similar medical need (i.e. not completely equal MELD scores, for example), these descriptions are roughly equivalent. Very few of the arguments presented in this article hinges of which of these descriptions are correct

[7] The success of MELD as a predictor of patient survival without receiving a transplantation is described in (Kamath and Kim 2007).

(Lavee et al. 2010, 1132).[8] For lungs, the priority rule provides 15 priority points to Group 1, 10 points to Group 2, and 5 points to Group 3 (Lavee et al. 2010, 1132). The allocation for hearts is somewhat different. For hearts, people are listed on the transplant waiting list as either Status 1 or 2. Those with Status 1 are considered very urgent (Lavee et al. 2010, 1132), and the role of priority points is here, as described above, relegated to that of tie-breaker. The rest are classified as Status 2. Priority is given, in descending order, to those eligible for Group 1, Group 2, and then Group 3 (Lavee et al. 2010, 1132). Those not eligible for priority points are placed at the bottom of the Status 2 list. Thus, among Status 2 potential heart transplant recipients, those who are relatives of deceased donors take priority over registered donors, who take priority over the family of registered donors, who take priority over those who do not fall into any of the categories (Lavee et al. 2010, 1132). Thus, for all organs, the priority rule works alongside measures reflecting other important criteria, typically some combination of the urgency of need and capacity to benefit (Lavee et al. 2010, 1132). While the priority points awarded do matter, it is important to keep in mind that need as defined by the clinical scores remains very important for the allocation of organs.

In addition to this, it is important to note that the Israeli priority rule is subject to relevant exemptions. Those below the age of 18 and those with limited cognitive abilities are exempted from the system (Lavee et al. 2010, 1132; Levy 2018, 418). These are treated on par with those who registered as donors and are eligible for priority.[9] However, not being willing to donate for religious reasons does not grant this kind of status (Lavee et al. 2010, 1132). Having laid out the content of the Israeli law, let us consider the expected and actual consequences of the priority rule in Israel and elsewhere.

The effect of priority rules on donation rates

As mentioned above, one motivation for introducing the priority rule is that such a rule increases the organ procurement rate. Assessing the available evidence is important because some have expressed doubts that priority rules will, in fact, positively affect donation rates. Wilkinson, for example, states that 'we do not have a good reason to think it would increase the supply of organs' (T. M. Wilkinson 2011, 167).

A number of experiments have been conducted to test how priority rules affect donation rates. Kessler and Roth found that introducing a priority rule yields a significant increase in people's willingness to register as donors (Kessler and Roth 2012; 2014a). Other

[8] In their description of how the LAS score was developed, Egan et. al. highlight how capacity to benefit and urgency are both included in the LAS score (unlike in the MELD score) because basing lung transplantation only on severity of disease was deemed to cause futile transplantations (Egan et al. 2006, 1220).

[9] Presumably, they will also get priority if their family members were deceased donors. This is unclear in the various descriptions of the law.

experiments identify similar effects (Li, Hawley, and Schnier 2013). These experiments are games set up to mimic the workings of a priority rule. While these games are carefully designed, it is always a concern that real-world policies will work differently. Therefore, we should also consider experiences from actual introductions of priority rules.

Singapore introduced a priority rule in 1987. The rule was introduced alongside an opt-out procurement system and gave priority in the allocation of organs to those who had not registered an objection to donation (Iyer 1987, 135). While the priority rule was introduced as one of several adjustments to the procurement legislation (Price 2000, 90; Schmidt and Lim 2004, 2175), the combined introduction of these changes did increase the donation rate in Singapore (Teo 1991, 10). The Chilean experience with a priority rule is quite different. In Chile, the priority rule was introduced because a newly implemented opt-out procurement system sparked a very high rate of people opting out (Domínguez and Rojas 2013, 1317). The introduction of the priority rule successfully brought an end to this negative trend (Zúñiga-Fajuri 2015, 200). While not a positive tale, the Chilean experience is about much more than the priority rule. Perhaps it is best understood as a cautionary tale for the implementation of opt-out procurement policies.

Israel introduced the priority rule in 2010. The first studies of its effects document a significant increase in the donation rate (Lavee et al. 2013, 781–82; A. Stoler et al. 2016, 2642–43; Avraham Stoler et al. 2016, 505–6). A study evaluating the donor rates in Israel from 1992 to 2013 concluded that the new law resulted in increased registration both when the legislation was passed and up to April 2012, when it came into effect (Avraham Stoler et al. 2016, 505). The latter date is important, as those registering before it would immediately be eligible for priority points, while those registering after the cut-off date would not be eligible for the first three years.[10] The results furthermore indicate that public awareness campaigns and efforts to make it easier to register also had a positive effect on donation rates (Avraham Stoler et al. 2016, 506).

There is little systematic knowledge about the incentivizing effects of the American priority rule, which has been in place since 1996. In 2016, however, a paper revealed that many who were eligible for priority experienced a significant delay in receiving it (Wainright et al. 2016), so steps have since been taken to improve the process (UNOS 2018). Unfortunately, the extent to which the US priority rule has improved kidney donation rates has not been assessed.

As a positive effect on the procurement rate is often cited as one important motivation for introducing priority rules, this section has reviewed some of the important

[10] For the argument that it is a good idea to have such a waiting period before granting priority, see (Dai, Zheng, and Sycara 2019).

available evidence, which corroborates the assumption that priority rules will increase the number of organs available. But even if we grant that such expectations are justified, concerns not pertaining to the likely increase of available organs have also been raised.

Equality of opportunity

This section presents Roemer conception of equality of opportunity. On this account, people have equal opportunity to achieve some good or avoid some bad if and only if the degree to which they obtain it reflects their autonomous effort as opposed to their circumstances, which they do not control (Roemer 1993, 147). This ideal is applicable across a wide range of goods and can be used to establish what is required for equality of opportunity to obtain regarding each good (Roemer 1998). While one can imagine several plausible uses of the ideal of equality of opportunity in this context, it will here be used in the sense, of equality of opportunity to receive priority points.[11]

The three most important concepts in Roemer's theory are *types, effort*, and *circumstance*. The latter refers to elements for which we are not deemed responsible and which affect our behaviour in the pursuit of some good (Roemer 1998, 5). To determine people's degrees of responsibility, Roemer envisions a process where society decides what counts as a circumstance in a specific context (Roemer 1998, 14). Using these parameters, people are then divided into types, which are groups of people facing relevantly similar circumstances (Roemer 1993, 150; 1998, 7; 2001, 449; 2003, 261). In assessing people's exercises of responsibility, their effort is compared to people within the same type (Roemer 1993, 149; 1998, 11). When comparing people across different types, people positioned equally compared to the median within their type are deemed to have exercised a similar degree of responsibility (Roemer 1993, 151–52; 2001, 450; 2012, 169). Equality of opportunity obtains when people's access to a good reflects only their effort and not their circumstance/type (Roemer 1993, 152). The Roemerian ideal provides a baseline for comparing people's opportunities and their actions within these, which is sensitive to how our efforts are affected by our circumstances.

This ideal of equality of opportunity is helpful for understanding the range and content of two prominent critiques often raised against priority rules. The two critiques

[11] This focus could be a supplement to (or a part of) other equality of opportunity concerns, such as equality of opportunity for health. This broader discussion is set aside to allow a more focused discussion of priority rules. It would include much discussed topics, such as the need to minimize the influence of social determinants on health, as well as the question of responsibility for health needs (Albertsen 2016; 2019; Albertsen and Knight 2015; Caplan 1994; Glannon 1998; Moss and Siegler 1991; Segall 2010; Zambrano 2016; Albertsen 2015; Nielsen 2013; Andersen and Nielsen 2016; Nielsen and Axelsen 2012; 2021; Bærøe and Cappelen 2015; Feiring 2008; Ahola-Launonen 2016; 2015; Davies 2021; Friesen 2016; Segall 2012; Preda 2018).

examined here pertain to fairness and reciprocity.[12] The scope and content of these critiques have received little attention. There are good reasons to think that Roemer's ideal of equality of opportunity may inform our understanding of these critiques of priority rules.

The first critique pertains to *fairness*. Proponents of it submit that a priority rule may unfairly disadvantage someone. The critique raised with reference to ineligible donors, who cannot donate because of genetic deficiencies or co-existing diseases, those who do not possess adequate knowledge about the procurement system (Gruenbaum and Jotkowitz 2010, 4476; T. M. Wilkinson 2011, 165; Childress and Liverman 2006, 256) and vulnerable minorities (Goering and Dula 2004, 37; List 2004, 40). While proponents of such fairness critiques are rarely specific regarding on what grounds something is unfair, one plausible interpretation is that the wrongness pertains to unequal opportunities. The theory of equality of opportunity already described can provide the substance and the content to the unfairness critique of priority rules.

The second critique is about *reciprocity*. Proponents of this critique agree that contributions should be reciprocally rewarded but argue that priority rules tend to fall short of achieving this. Priority rules often fail to reward important actions which potentially contribute to mitigating the shortage of organs (Nelson 2004, 28; Saunders 2012, 379–80).[13] Examples offered across the literature include large monetary donations to research, donating one's body to research, volunteering for campaigns aimed at increasing the donation rate, and other such activities. This will be termed the *failing to reciprocate critique*. While proponents of this critique do not always specify the content of the critique, the equality of opportunity approach offers helpful guidance. Whereas the reciprocity critique, broadly understood, can be taken to suggest that any contribution should be rewarded, the equality of opportunity approach may, sensibly, temper this notion. It underscores the importance of having equal opportunity for contributing and gives credence to the thought that it makes sense for people to be able to contribute in various ways.

From the above, we can distil a number of Roemerian sentiments, which, even without going into the details of designing types, can be used to assess priority rules. Priority received should reflect effort rather than circumstance. It is important that people have

[12] Another prominent critique raises the objection that priority rules do not allocate on the basis of medical factors, such as need and urgency (Committee on Increasing Rates of Organ Donation, Childress, and Liverman 2006, 257; Biller-Andorno 2004, 20; Gillon 1995, 196; den Hartogh 2010, 150). This is true for any priority rule. Therefore the critique is not discussed here. For a reply to this critique, see (T. M. Wilkinson 2011, 164). See also (J. A. Chandler 2005, 131; Nadel and Nadel 2005, 321–22).

[13] The critique cannot be that there are some morally good deeds which the priority rule fails to reward in allocating organs. Even if morality requires that all good acts are rewarded rewarding them in the allocation of organs is unfortunate. This is the case because only a fraction will need a transplant.

equal opportunity to perform acts, which will give them priority and people should not receive lower priority for reasons reflecting their social or natural circumstance. Furthermore, valuable contributions which (potentially) mitigate the organ shortage should make one eligible for priority to the extent that people are responsible for these. Those who have shown a comparable degree of responsibility in their respective types should get equal points. Consider next how the Israeli priority rule fares when evaluated from this perspective.

Israeli priority rule from the perspective of equality of opportunity

Roemer's conception of equality of opportunity underlines that it is problematic when the opportunities for doing something are unequally distributed due to various circumstances outside one's control. This is central to the assessment of fairness and reciprocity. The discussion proceeds by assessing each group separately, before highlighting broader issues which are relevant across the groups.

Group 1

How should the priority given to Group 1, those who have performed a living donation (directed or non-directed) and the first-degree relatives of deceased donors, be evaluated from the equality of opportunity perspective? Consider first awarding of priority points to those who have made a direct or indirect living donation from the perspective of equality of opportunity. The first thing to note is that natural circumstances affect people's opportunities for becoming living donors. Some are, medically speaking, not suited to donate their kidney or a liver lobe. This could be the case because of diseases in the organs or other diseases (such as various forms of cancers and HIV) which make them ineligible to donate, or because they are incompetent and unable to consent to donation.[14] People thus, due to natural circumstances, face unequal opportunities for making a living donation. These inequalities also have a social aspect. The risk of having bad organs is stratified along a social gradient (Nicholas, Kalantar-Zadeh, and Norris 2015; White et al. 2008), as are many diseases (Blane 2006; M. G Marmot and Wilkinson 2006; Michael G. Marmot 2015). From the perspective of equality of opportunity, it is problematic to disadvantage those who are without the opportunity to donate.

There is another social inequality that is related to information. If knowledge and information about the donation system are unequally distributed, it contradicts equality of opportunity. If some groups in society, such as socially disadvantaged or otherwise vulnerable groups, have little or no knowledge about the priority rule, they would not know how to gain priority. Rewarding living donation is thus, at least to some extent, problematic from the perspective of equal opportunity. Such inequalities are increased in cases where

[14] As mentioned the latter group is treated on par with those who have registered as donors.

some social or ethnic groups have a lower level of trust in the medical professionals and, therefore, would be less willing to undergo the procedure of becoming living donors.

There are, however, two considerations, each of which speaks against completely removing the priority given to living donors. The first consideration highlights that not providing any priority for living donations would be treating those who could donate and did on par with those who could donate and chose not to. That also seems to go against the ideal of equality of opportunity by treating differential effort equally.

A second consideration submits that we should not treat everyone unable to donate in the same manner. If it is the case that some of those who are not able to become living donors are themselves responsible for their bad health, then treating their inability to donate on par with those who are unable to donate because of congenital diseases would also conflict with equality of opportunity. How to best strike this balance is addressed in the next part of this paper.

Consider next the other qualification for Group 1 priority: sanctioning the donation of a relative's organs.[15] Family members in Israel effectively possess a veto over the procurement of organs from their relatives. Rewarding those who sanction a donation raises fairness concerns from the perspective of equality of opportunity. The opportunity to consent to the removal of a relative's organs is unequally distributed. While the Israeli priority rule ensures that this kind of priority can only be acquired once by each person, there is a distinct advantage for those who have large families. This is the case because the likelihood is larger that they will be given the opportunity to consent to the removal of their relative's organs. There is also another problem. Even without taking into account that people have families of different sizes, it remains the fact that only a tiny fraction of those who die will be eligible donors. Therefore, many are not given a chance to sanction the donation. This is unfair, as it amounts to the priority system rewarding circumstance.

Group 2

Consider the second group which receives priority under Israeli law: those who have been registered as donors for three years or more. Are there any problems of inequality of opportunity associated with this? It is important to note that some of the concerns related to living donation are not present here. Those not eligible to consent because of a lack of competence will receive priority similar to those who have signed up as donors. Those who are medically unsuited to donate a kidney or part of a liver as living donors can still register as donors. Signing up does not require a health check, and it may very well be that some

[15] This section discuss sanctioning. But one anonymous reviewer points out that it could be the case that some first degree relatives was not able to be present, when the decision was made. In one sense they have not sanctioned donation even if the rest of the family does this. However, for such cases, the arguments in this section seem even more applicable.

organs are suitable for transplantation (their skin or cornea may also benefit others). Thus, everybody can register as a donor, and doing is not dishonest on the part of those who are ineligible to make living donations.

However, a potential problem of information remains.[16] This might be a greater worry for deceased donation than for living. The latter is a very significant decision, which is often considered when a family member falls ill and always in deliberation with medical professionals. The priority rule should be part of the conversation. However, the decision to register as a donor is not necessarily preceded by such a conversation. Unequal information might, therefore, play a larger role in those decisions. And it is not purely about information. It is also about how opportunities to donate are shaped by the broader contours of our circumstances. If some groups in society, such as socially disadvantaged or otherwise vulnerable groups, have little or no knowledge about the priority rule, they are, in fact, disadvantaged by their circumstance. The empirical literature suggests that race, culture, and social status affect the propensity to donate (Ladin et al. 2015; Morgan, Miller, and Arasaratnam 2003, 708; Mossialos, Costa-Font, and Rudisill 2008). We might, in effect, be rewarding those for whom donation is the norm and setting back those who come from different backgrounds. This is contradictory to the ideal of rewarding effort.

Group 3 and cross-group concerns

Consider the third group, where the relatives of registered donors are given priority. [17] This is the category that most clearly contradicts the idea of equality of opportunity. It shares many of the problems already identified in the preceding groups but is more detached from the effort. It rewards people for the acts of their relatives. This is a clear example of rewarding circumstances. As for rewarding the first-degree relatives of deceased donors, there is a large element of luck here. The likelihood of receiving priority depends on the size of one's family. But the more fundamental problem is that whether a person receives priority depends on the choices of their relatives. This is unfair. Two people can themselves make the same choices, but only one of them will receive priority – because only one of them has relatives who are registered donors. The third category constitutes the clearest breach with the ideal of equality of opportunity.

There is also a fairness problem across groups. It is puzzling why different organs are rewarded differently under Israeli law. Consider Group 2 for livers and kidneys. A registered donor gets 2 priority points if he needs a kidney or a liver. But the scales to which these points are added are markedly different. For livers, it ranges from 6 to 40, while

[16] It can only be called a potential problem. We know that the Israeli law was introduced alongside large information campaigns. We also know that such campaigns rarely, if ever, reach all strata of society.

[17] One could consider it problematic that the family has this veto. For a critique of loopholes, see (Kessler and Roth 2014b).

for kidneys, it is from 0 to 18. Thus, the relative benefit of being a registered donor is greater for those who need a kidney than for those who need a liver. From the perspective of equality of opportunity, this is unfair and should be adjusted.

Finally, we should also consider whether there is another sense in which there is an unfairness associated with rewarding every donation equally. Some blood types are rarer, and some organs are of better quality. Should we reward this with more points? Clearly, this could be done for living donors. For people registering as deceased donors, there is more uncertainty about the eventual quality of their organs if they are at the end medically suited donors (i.e., die under the right circumstances). But at least for living donors, one could argue that among the group who donates, some provide a more valuable or a better kidney than others.[18] Should they, from the perspective of equality of opportunity, be rewarded for this? There is arguably a case for not doing so. Many of the features which make a kidney in high demand are beyond people's control. A person of a rare blood type, such as O, may indeed be contributing an even more scarce good than others. But there is no reason to think that the extra value is an effort on that person's part.

Interpretation of the unfairness critique as one of equality of opportunity shows that there are several elements of unfairness in the Israeli law, where current legislation rewards circumstance. The failing to reciprocate critique enables us to see another problem, namely, that there may be other important ways to contribute, which are not captured by the current legislation. It is to that concern that we now turn.

Failure to reciprocate

This section considers the Israeli priority rule in light of the *failure to reciprocate critique*. The critique's basic claim is that while it may be reasonable to reward people who potentially contribute to mitigating the organ shortage, there are deeds that are not properly rewarded but which should be. The most obvious way to accommodate this concern is to increase the number of ways in which advantage can be acquired. These need not be equally weighty, but it would be a sound method of rewarding other kinds of potential contributions. Does the Israeli legislation fail to reward such acts? A number of candidates were mentioned earlier, these will be evaluated later in the paper. Donating one's body to research and volunteering for an organization working to increase the donation rate should be taken into consideration to achieve reciprocity. Large financial donations to research is another. Such donations could arguably do much good in terms of mitigating the organ shortage in the future. Thus, several acts would potentially decrease the organ shortage but are not reciprocated by the

[18] An anonymous reviewer correctly points out that some deceased donors could be seen as (potentially) more valuable than others e (i.e. those of the young or those of type 0 blood type). The reply given in the context of the living donors, that this extra potential value is mostly unrelated to effort, would also provide a reason for not differentiating among deceased donors.

Israeli priority rule. The next section presents an equality of opportunity priority rule, amended to secure both fairness and reciprocity.

An equality of opportunity-adjusted priority rule

The above sections demonstrate that interpreting critiques regarding fairness and failure to reciprocate in light of the equality of opportunity concern is helpful in identifying elements of the Israeli priority rule worthy of reconsideration. This section addresses these concerns in an attempt to adjust the rule to provide equal opportunity for receiving priority.

An equality of opportunity priority rule must be introduced along with public campaigns to inform about the changes to the organ procurement system. Furthermore, there should be easily available opportunities for registering as a donor, and information about donation and the consequences of not registering should be distributed in ways that mitigate differences across types. These information campaigns should make a special effort to ensure that those who are turning 18 and thus losing their previously held exemption, know how they will fare if they do not sign up.[19] It would, however, be too careless to assume that an even more intense information campaign would completely remove the identified equality of opportunity problems. Therefore this section proceeds to discuss adjustments suitable for a situation where inequality in the propensity to donate across types remains. Note that these adjustments are consistent with keeping the urgent category already mentioned.

The discussion of the failure to reciprocate critique illustrates the need to reciprocate other kinds of behaviour. One plausible way of doing so would be to introduce another category for other contributions – one which provides some priority, but less than the other groups. But which actions should make one eligible for this kind of priority? The ideal of equality of opportunity can identify the extent to which such actions should be reciprocated. Donating one's body to research, volunteering for an organization working to increase the donation rate, and making large monetary donations to research have been mentioned. Should they all be given priority under an equality of opportunity priority rule? From the perspective of equality of opportunity, there might be good reasons to exclude large financial donations. The extent to which we would want to allow large cash donations to confer priority depends on the extent to which we believe inequalities in society adequately reflect equal opportunities. If considerable background injustices persist, the donation system should be ring-fenced to prevent such contributions resulting in priority. As the presence of such background injustices featured in the previous discussions of information and donation decisions, we should also acknowledge them in this context. Would there also be potential equality of opportunity problems with the other categories? This seems, to a

[19]This should also be the case for personal communication with anyone who's cognitive abilities improve to the extent where they lose their exemption.

lesser extent, to be the case. In the case of volunteering, it would be reasonable to suggest that people have quite different opportunities for doing so. This is the case because it is something that requires resources to do. Donation of one's body to research is not problematic from the perspective of equality of opportunity (or if so, only to a very small extent). Everyone can do it, even those who are ill. This, along with the plausible suggestion that donating one's body to research is a larger contribution than volunteering, might suggest the need to treat these acts differently.

Which adjustments of Group 1, 2, and 3 are required? We should exclude (or diminish the influence from) categories identified as unfair from the perspective of equality of opportunity. Some adjustments are clear. Group 1 provides priority to those who have made a living donation (both directed and non-directed), and the first-degree relatives of deceased donors. There is a distinct unfairness in at least the latter part of the group. Rewarding relatives for the behaviour of their donating family member is problematic. The opportunity to do so is unequally distributed in the population. Thus, we have equality of opportunity reasons to remove this. For similar reasons, Group 3, where first degree-relatives of registered donors are given priority, should be removed completely. This ends the adjustments to remove things, which are almost entirely a matter of circumstance. This would leave us with the following preliminary rendition of the priority rule:

- Group 1: Those who have performed a living donation (both directed and non-directed).
- Group 2: Those who have been registered as donors for three years or more.
- Group 3: Those who have donated their body to science
- Group 4: Those who have volunteered in information campaigns about the organ shortage.

There are, however, elements in some of the groups which provide a more mixed picture in terms of whether they should be considered circumstance or effort. This is the case for those currently in Group 1 who conduct a living donation and the registered donors in Group 2. Consider first living donation. The above section substantiates the thought that the opportunity to conduct a living donation is unequally distributed and affected by circumstance, which can, for some, mean that they are completely unable to donate. Removing the priority for living donation altogether due to the unequal opportunities it engenders, it fails to appreciate the effort made by those who make the donation. Such a policy would, crucially, fail to distinguish between donors and non-donors among the group of eligible donors. A final discussion relates to those unable to make a living donation. They could be provided with an exception, but this is further complicated if, among those who are unable to donate, some are in a relevant sense responsible for this while others are not.

One solution, based more on practical than principled grounds, is to not differentiate among those unable to make a living donation. The effort which would go into determining whether people are responsible for the conditions that make them unable to donate would be vast. For this reason, it seems more plausible to simply treat those unable to donate similarly. In doing so, we should not provide everyone unable to donate with an exemption. Providing top priority to all, who cannot make a living donation, assumes that they would have done so if they could. That seems a very generous assumption on their part.

In Group 2 a similar problem appears. Group 2 ensures priority to those who have been registered as donors for three years or more. Unequal propensity to donate across different parts of the population is unlikely to be solved by information alone. To the extent that the analysis of different types reveals social differences in propensity to donate, the equality of opportunity rule must seek to reflect this. And this should be done in a way which allows, to a certain extent, rewarding effort without rewarding circumstance.

Which adjustments to Group 1 and 2 could be made to cater for these difficulties? We could imagine a priority rule which bestows different advantages according to the socioeconomic group of the person in question, trying to equalize opportunities in that respect. Such a scheme could be put in place for both living and deceased donors. Roughly put, if people from Type A are in general more likely to donate than people in Type B, then donations from A should be awarded fewer points than donations from B, because donating among Type A is closer to median behaviour, and thus by assumption requires less effort than a donation from Type B. This, however, seems very impractical, and furthermore introduces an unfortunate ceiling effect, effectively setting a limit for how much priority certain groups can get which is a lower level than that of others. Another possible solution is to radically expand the system of exemptions to include exemption categories for each group. But we have already seen why this is not a good idea.

These difficulties arise because each category is separate in the Israeli system. This means that for each category, we much make a dichotomous choice. We must choose whether a person is eligible for that level of priority. We should create a more viable measure of effort, which allows us to grant exemptions where needed. While the current Israeli system only allows for people to receive the highest level of priority they are eligible for, an alternative proposal would provide them with priority based not on their highest group membership but rather *on the sum of the groups they belong to*.

The advantage of such an approach is that it constructs effort as a property ranging over these various acts, each of which potentially contributes to mitigating the organ shortage. Eligibility for priority points is no longer a dichotomous notion, but rather a matter of degree. This provides for a more helpful measure of effort and an easier way of integrating exceptions.

Under the current Israeli system, one would achieve maximum priority by conducting a living donation or sanctioning the donation of a relative's organ. Under the proposed system, whether one receives maximum priority would depend on one's actions across the four categories. Each category provides a fraction of the priority, which is today provided by conducting a living donation.[20] These fractions need not be equally large, as it is plausible to keep some of the relative importance of a living donation in place under the current legislation. As priority becomes a matter of degree across these different classes of behaviours the dynamics of the system changes. If a person has conducted both a living donation and donated his body to science, he would receive higher priority than one who had done only one of these. But the latter would still receive higher priority than a person not in any of the groups.

How should the size of the fractions relate to each other? Two considerations are important in that regard. One is whether being eligible for group 2 and 3 priority should outweigh being eligible for group 1 priority? The other is which role exceptions should have.

Consider the following scheme. Each of the four categories provide 1 point, so maximum priority is received with four points. Call this scheme [1,1,1,1]. This would allow someone who had registered as a donor and donated her body to science to outweigh someone who had conducted a living donation. It would also mean that we could not differentiate between an actually conducted living donation and a registered wish to donate. If we wish to keep some proportionality in how much acts are rewarded, this is not a good solution. It seems to really be putting too little weight on a living donation.

A readily available alternative would be a [2,1,1,1] scheme. But this would still treat equally signing up to donate and the other good acts, such as volunteering. So far, we have at least discussed as if the latter should result in less priority than the former. It would also allow a potentially problematic outweighing of those, who had conducted a living donation. Based on this a [5,3,2,1], the scheme seems preferable on these desiderata. Living donation would remain very important in assigning fractions of priority and important differentiations between the other groups would remain in place.

How could there be exemptions on such a scheme? Changing donation effort from a dichotomous variable to a range across four groups provides a better role for exemptions. Everyone in need of an organ transplant will go through an assessment to clarify which priority points they are eligible for and whether they should receive exemptions in any of the relevant categories. For people without exemptions full priority requires that you are eligible for each of the four groups. People would be able to receive exemptions in more than one category. Some exemptions are granted automatically, even before people need an

[20] Thus, a slight decrease in the weight given to donation behaviour might be the effect.

organ, thus suffering for deceases making one unable to conduct a living donation should automatically grant group 1 exemption, and people with cognitive disabilities should automatically receive a whole range of exemption. The exemption received in group 1 should not make one eligible for the full group 1 fraction, but only for some of it (such as 2 points). This is introduced because it is not likely that everyone eligible for an exemption would have donated.

But the equality of opportunity rule does not only provide exemptions for those disadvantaged by natural circumstances. It also offers us reasons to indemnify people against social disadvantages. Exemptions should be granted to the socially marginalized (such as the homeless) as they are very unequally situated to do the acts required to receive priority in groups 1-4. The system is more sensitive to the effect of social inequalities on donation behaviour and could be made even more fine-grained.

This system allows people unwilling to contribute in some ways to do so in other ways. This, alongside the possibility of exemptions, helps those who are without the opportunity to conduct a living donation. Secondly, it provides a more flexible way of granting exemptions to the socially marginalised. And thirdly, it removes the unequal rewarding of circumstance present in the current system.

The adjusted equality of opportunity priority rule and the new fairness problem

We are left with a priority rule which aims at ensuring that opportunities for treatment and donation are equal, and which strives to reward a broad range of contributions insofar as people are responsible for making these contributions. This priority is, of course, not perfect, even from the perspective of equality of opportunity, but remains an improvement over the existing Israeli legislation from the perspective of equality of opportunity. This final section assesses the extent to which the adjusted priority rule introduces further deficiencies.

The above adjustments are very likely to complicate the priority rule. Consider first adjustments made to include a wide range of exemptions, some of which are also based on social positions. This is likely to make the system much more complicated and harder to understand. The same goes for allowing other contributions to count. If we allow a wide range of actions to result in priority, this also complicates the system. People would need to understand when they have volunteered enough.

A complicated priority rule faces two difficulties. The first difficulty pertains to fairness, in the sense that we may fear that people would be unequally situated to understand and respond to the priority rule. New unfair inequalities may arise as a result of our attempts to mitigate unequal opportunities. The other concern pertains to efficiency. A simple priority rule is easier to respond to, and thus, all else being equal, we may fear that a very complex priority rule will be less efficient in convincing people to become donors because they cannot

figure out the extent to which doing so will actually benefit them. In the end, we may face a very difficult dilemma in designing priority rules, as attempts to cater to important critiques may give rise to new crucial concerns. Attempts to adjust the priority rule to increase equality of opportunity should take these considerations seriously.

The adjusted priority rule presented here did not go into assessments of whether people are responsible for their inability to become living donors. We can imagine schemes doing so, which are compatible with equality of opportunity (and perhaps recommended by it). It should be noted that going further down this path would make the rule even more complicated in the above sense.

Conclusion

The Israeli priority rule is vulnerable to prominent concerns pertaining specifically to failure to reciprocate and unfairness. A priority rule designed to ensure equality of opportunity for priority points, may in principle, do a good job avoiding concerns of fairness and reciprocity. However, such adjustments complicate the rule to the extent that it may fail to increase donation rates and furthermore introduce new concerns of fairness, as the better off may be better able to navigate the complex adjusted priority rule.

Bibliography

Ahola-Launonen, Johanna. 2015. "The Evolving Idea of Social Responsibility in Bioethics." *Cambridge Quarterly of Healthcare Ethics* 24 (02): 204–13. https://doi.org/10.1017/S0963180114000516.

———. 2016. "Social Responsibility and Healthcare in Finland." *Cambridge Quarterly of Healthcare Ethics* 25 (03): 448–65. https://doi.org/10.1017/S0963180116000098.

Albertsen, Andreas. 2015. "Luck Egalitarianism, Social Determinants and Public Health Initiatives." *Public Health Ethics* 8 (1): 42–49. https://doi.org/10.1093/phe/phu022.

———. 2016. "Drinking in the Last Chance Saloon: Luck Egalitarianism, Alcohol Consumption, and the Organ Transplant Waiting List." *Medicine, Health Care and Philosophy* 19 (2): 325–38. https://doi.org/10.1007/s11019-016-9684-7.

———. 2019. "Personal Responsibility in Health and Health Care: Luck Egalitarianism as a Plausible and Flexible Approach to Health." *Political Research Quarterly*, May, 106591291984507. https://doi.org/10.1177/1065912919845077.

———. 2020. "Against the Family Veto in Organ Procurement: Why the Wishes of the Dead Should Prevail When the Living and the Deceased Disagree on Organ Donation." *Bioethics* 34 (3): 272–80. https://doi.org/10.1111/bioe.12661.

Albertsen, Andreas, and Carl Knight. 2015. "A Framework for Luck Egalitarianism in Health and Healthcare." *Journal of Medical Ethics* 41 (2): 165–69. https://doi.org/10.1136/medethics-2013-101666.

Andersen, Martin Marchman, and Morten Ebbe Juul Nielsen. 2016. "Personal Responsibility and Lifestyle Diseases." *Journal of Medicine and Philosophy* 41 (5): 480–99. https://doi.org/10.1093/jmp/jhw015.

Arneson, Richard J. 2008. "Equality of Opportunity." In *The Stanford Encyclopedia of Philosophy*, edited by Edward N. Zalta.

Ashkenazi, Tamar, Jacob Lavee, and Eytan Mor. 2015. "Organ Donation in Israel—Achievements and Challenges:" *Transplantation* 99 (2): 265–66. https://doi.org/10.1097/TP.0000000000000591.

August, Jonathan G. 2012. “Modern Models of Organ Donation: Challenging Increases of Federal Power to Save Lives.” *Hastings Const. LQ* 40: 393.

Bærøe, Kristine, and Cornelius Cappelen. 2015. “Phase-Dependent Justification: The Role of Personal Responsibility in Fair Healthcare.” *Journal of Medical Ethics* 41 (10): 836–40. https://doi.org/10.1136/medethics-2014-102645.

Berzon, Corinne. 2018. “Israel’s 2008 Organ Transplant Law: Continued Ethical Challenges to the Priority Points Model.” *Israel Journal of Health Policy Research* 7 (1). https://doi.org/10.1186/s13584-018-0203-6.

Biller-Andorno, Nikola. 2004. “Between Solidarity and Self-Interest: How Fair Is the ‘Club Model’ for Organ Donation?” *The American Journal of Bioethics* 4 (4): 19–20. https://doi.org/10.1080/15265160490911640.

Blane, David. 2006. “The Life Course, the Social Gradiant and Health.” In *Social Determinants of Health*, edited by M. G Marmot and Richard G Wilkinson. Oxford; New York: Oxford University Press.

Caplan, A L. 1994. “Ethics of Casting the First Stone: Personal Responsibility, Rationing, and Transplants.” *Alcoholism, Clinical and Experimental Research* 18 (2): 219–21.

Chandler, Jennifer A. 2005. “Priority Systems in the Allocation of Organs for Transplant: Should We Reward Those Who Have Previously Agreed to Donate.” *Health LJ* 13: 99.

Chandler, Jennifer, Jacquelyn Burkell, and Sam Shemie. 2015. “Priority in Organ Allocation to Previously Registered Donors.” *Replacement Parts: The Ethics of Procuring and Replacing Organs in Humans*, 190.

Childress, James F., and Catharyn T. Liverman, eds. 2006. *Organ Donation: Opportunities for Action*. Washington, D.C: National Academies Press.

Committee on Increasing Rates of Organ Donation, James F. Childress, and Catharyn T. Liverman, eds. 2006. *Organ Donation: Opportunities for Action*. Washington, D.C: National Academies Press.

Dai, Tinglong, Ronghuo Zheng, and Katia Sycara. 2019. “Jumping the Line, Charitably: Analysis and Remedy of Donor-Priority Rule.” *Management Science*.

Davies, Ben. 2021. “Responsibility and the Recursion Problem.” *Ratio*.

Domínguez, J., and J.L. Rojas. 2013. “Presumed Consent Legislation Failed to Improve Organ Donation in Chile.” *Transplantation Proceedings* 45 (4): 1316–17. https://doi.org/10.1016/j.transproceed.2013.01.008.

Egan, T. M., S. Murray, R. T. Bustami, T. H. Shearon, K. P. McCullough, L. B. Edwards, M. A. Coke, et al. 2006. “Development of the New Lung Allocation System in the United States: **The New Lung Allocation System**.” *American Journal of Transplantation* 6 (5p2): 1212–27. https://doi.org/10.1111/j.1600-6143.2006.01276.x.

Feiring, E. 2008. “Lifestyle, Responsibility and Justice.” *Journal of Medical Ethics* 34 (1): 33–36. https://doi.org/10.1136/jme.2006.019067.

Fishkin, Joseph. 2014. *Bottlenecks: A New Theory of Equal Opportunity*. Oxford ; New York, NY: Oxford University Press.

Friesen, Phoebe. 2016. “Personal Responsibility within Health Policy: Unethical and Ineffective.” *Journal of Medical Ethics*, September, medethics-2016-103478. https://doi.org/10.1136/medethics-2016-103478.

Gillon, R. 1995. “On Giving Preference to Prior Volunteers When Allocating Organs for Transplantation.” *Journal of Medical Ethics* 21 (4): 195–96.

Glannon, Walter. 1998. “Responsibility, Alcoholism, and Liver Transplantation.” *The Journal of Medicine and Philosophy* 23 (1): 31–49. https://doi.org/10.1076/jmep.23.1.31.2595.

Goering, Sara, and Annette Dula. 2004. “Reasonable People, Double Jeopardy, and Justice.” *The American Journal of Bioethics* 4 (4): 37–39. https://doi.org/10.1080/15265160490906583.

Gruenbaum, B.F., and A. Jotkowitz. 2010. “The Practical, Moral, and Ethical Considerations of the New Israeli Law for the Allocation of Donor Organs.” *Transplantation Proceedings* 42 (10): 4475–78. https://doi.org/10.1016/j.transproceed.2010.09.146.

Hartogh, Govert den. 2010. “Priority to Registered Donors on the Waiting List for Postmortal Organs? A Critical Look at the Objections.” *Journal of Medical Ethics*, jme-2010.
Iyer, T.K.K. 1987. “Kidneys for Transplant — ‘Opting out’ Law in Singapore.” *Forensic Science International* 35 (2–3): 131–40. https://doi.org/10.1016/0379-0738(87)90048-X.
Jarvis, R. 1995. “Join the Club: A Modest Proposal to Increase Availability of Donor Organs.” *Journal of Medical Ethics* 21 (4): 199–204. https://doi.org/10.1136/jme.21.4.199.
Kamath, Patrick S., and W. Ray Kim. 2007. “The Model for End-Stage Liver Disease (MELD).” *Hepatology* 45 (3): 797–805. https://doi.org/10.1002/hep.21563.
Kessler, Judd B, and Alvin E Roth. 2012. “Organ Allocation Policy and the Decision to Donate.” *American Economic Review* 102 (5): 2018–47. https://doi.org/10.1257/aer.102.5.2018.
Kessler, Judd B., and Alvin E. Roth. 2014a. “Getting More Organs for Transplantation.” *The American Economic Review* 104 (5): 425–30.
Kessler, Judd B, and Alvin E Roth. 2014b. “Loopholes Undermine Donation: An Experiment Motivated by an Organ Donation Priority Loophole in Israel.” *Journal of Public Economics* 114: 19–28.
Kolber, Adam J. 2002. “Matter of Priority: Transplanting Organs Preferentially to Registered Donors, A.” *Rutgers L. Rev.* 55: 671–740.
Ladin, Keren, Rui Wang, Aaron Fleishman, Matthew Boger, and James R. Rodrigue. 2015. “Does Social Capital Explain Community-Level Differences in Organ Donor Designation?: Social Capital and Community Differences in Organ Donor Designation.” *Milbank Quarterly* 93 (3): 609–41. https://doi.org/10.1111/1468-0009.12139.
Lavee, Jacob. 2013. “Ethical Amendments to the Israeli Organ Transplant Law.” *American Journal of Transplantation* 13 (6): 1614–1614.
Lavee, Jacob, T. Ashkenazi, A. Stoler, J. Cohen, and R. Beyar. 2013. “Preliminary Marked Increase in the National Organ Donation Rate in Israel Following Implementation of a New Organ Transplantation Law: Increase in National Organ Donation Following New Law.” *American Journal of Transplantation* 13 (3): 780–85. https://doi.org/10.1111/ajt.12001.
Lavee, Jacob, Tamar Ashkenazi, Gabriel Gurman, and David Steinberg. 2010. “A New Law for Allocation of Donor Organs in Israel.” *The Lancet* 375 (9720): 1131–33. https://doi.org/10.1016/S0140-6736(09)61795-5.
Levush, Ruth. 2012. “Israel: Amendment to Organ Donation Law Passed | Global Legal Monitor.” Web page. November 8, 2012. //www.loc.gov/law/foreign-news/article/israel-amendment-to-organ-donation-law-passed/.
Levy, Mélanie. 2018. “State Incentives to Promote Organ Donation: Honoring the Principles of Reciprocity and Solidarity Inherent in the Gift Relationship.” *Journal of Law and the Biosciences* 5 (2): 398–435. https://doi.org/10.1093/jlb/lsy009.
Li, Danyang, Zackary Hawley, and Kurt Schnier. 2013. “Increasing Organ Donation via Changes in the Default Choice or Allocation Rule.” *Journal of Health Economics* 32 (6): 1117–29. https://doi.org/10.1016/j.jhealeco.2013.09.007.
List, Justin M. 2004. “‘Opting-In’ and Unnecessary Penalties for Non Kidney Donors.” *The American Journal of Bioethics* 4 (4): 39–41. https://doi.org/10.1080/15265160490906628.
Marmot, M. G, and Richard G Wilkinson. 2006. *Social Determinants of Health*. Oxford; New York: Oxford University Press.
Marmot, Michael G. 2015. *The Health Gap: The Challenge of an Unequal World*. London: Bloomsbury.
Morgan, Susan E., Jenny K. Miller, and Lily A. Arasaratnam. 2003. “Similarities and Differences Between African Americans’ and European Americans’ Attitudes, Knowledge, and Willingness to Communicate About Organ Donation.” *Journal of Applied Social Psychology* 33 (4): 693–715. https://doi.org/10.1111/j.1559-1816.2003.tb01920.x.
Moss, Alvin H., and Mark Siegler. 1991. “Should Alcoholics Compete Equally for Liver Transplantation?” *JAMA: The Journal of the American Medical Association* 265 (10): 1295–98. https://doi.org/10.1001/jama.1991.03460100097032.

Mossialos, Elias, Joan Costa-Font, and Caroline Rudisill. 2008. “Does Organ Donation Legislation Affect Individuals’ Willingness to Donate Their Own or Their Relative’s Organs? Evidence from European Union Survey Data.” *BMC Health Services Research* 8 (1). https://doi.org/10.1186/1472-6963-8-48.

Nadel, Mark S, and Carolina A Nadel. 2005. “Using Reciprocity to Motivate Organ Donations.” *Yale Journal of Health Policy, Law, and Ethics* 5: 293–325.

Nelson, James Lindemann. 2004. “Utility, Fairness, and What Really Matters in Organ Provision.” *The American Journal of Bioethics* 4 (4): 27–29. https://doi.org/10.1080/15265160490906673.

Nicholas, Susanne B., Kamyar Kalantar-Zadeh, and Keith C. Norris. 2015. “Socioeconomic Disparities in Chronic Kidney Disease.” *Advances in Chronic Kidney Disease* 22 (1): 6–15. https://doi.org/10.1053/j.ackd.2014.07.002.

Nielsen, Lasse. 2013. “Taking Health Needs Seriously: Against a Luck Egalitarian Approach to Justice in Health.” *Medicine, Health Care and Philosophy* 16 (3): 407–16. https://doi.org/10.1007/s11019-012-9399-3.

Nielsen, Lasse, and David V. Axelsen. 2012. “Three Strikes Out: Objections to Shlomi Segall’s Luck Egalitarian Justice in Health.” *Ethical Perspectives* 19 (II): 307–16.

Nielsen, Lasse, and David V Axelsen. 2021. “Being Responsible and Holding Responsible: On the Role of Individual Responsibility in Political Philosophy.” *Res Publica*, 1–19.

Preda, Adina. 2018. “‘Justice in Health or Justice (and Health)?’—How (Not) to Apply a Theory of Justice to Health.” *Public Health Ethics*, May, phy008–phy008. https://doi.org/10.1093/phe/phy008.

Price, David P. T. 2000. *Legal and Ethical Aspects of Organ Transplantation*. Cambridge [England] : New York: University of Cambridge ; Cambridge University Press.

Quigley, Muireann, Linda Wright, and Vardit Ravitsky. 2012. “Organ Donation and Priority Points in Israel: An Ethical Analysis.” *Transplantation Journal* 93 (10): 970–73. https://doi.org/10.1097/TP.0b013e31824e3d95.

Richards, Janet Radcliffe. 1998. “Equality of Opportunity.” In *Ideals of Equality*, edited by Andrew Mason, 52–78. Oxford, England; Malden, MA: Blackwell.

Roemer, John E. 1993. “A Pragmatic Theory of Responsibility for the Egalitarian Planner.” *Philosophy and Public Affairs* 22 (2): 146–66.

———. 1998. *Equality of Opportunity*. Cambridge [u.a.]: Harvard Univ. Press.

———. 2001. “Three Egalitarian Views and American Law.” *Law and Philosophy* 20 (4): 433–60.

———. 2003. “Defending Equality of Opportunity.” *Monist* 86 (2): 261–82.

———. 2012. “On Several Approaches to Equality of Opportunity.” *Economics and Philosophy* 28 (02): 165–200. https://doi.org/10.1017/S0266267112000156.

Saunders, Ben. 2012. “Altruism or Solidarity? The Motives for Organ Donation and Two Proposals.” *Bioethics* 26 (7): 376–81. https://doi.org/10.1111/j.1467-8519.2012.01989.x.

Schmidt, Volker H., and Chee Han Lim. 2004. “Organ Transplantation in Singapore: History, Problems, and Policies.” *Social Science & Medicine* 59 (10): 2173–82. https://doi.org/10.1016/j.socscimed.2004.03.014.

Segall, Shlomi. 2010. *Health, Luck, and Justice*. Princeton, NJ: Princeton.

———. 2012. “Health, Luck, and Justice Revisited.” *Ethical Perspectives* 19 (II): 326–34.

———. 2013. *Equality and Opportunity*. 1st edition. New York, NY: Oxford University Press.

Shaw, David, Denie Georgieva, Bernadette Haase, Dale Gardiner, Penney Lewis, Nichon Jansen, Tineke Wind, Undine Samuel, Maryon McDonald, and Rutger Ploeg. 2017. “Family Over Rules? An Ethical Analysis of Allowing Families to Overrule Donation Intentions:” *Transplantation* 101 (3): 482–87. https://doi.org/10.1097/TP.0000000000001536.

Shaw, David M. 2016. “The Consequences of Vagueness in Consent to Organ Donation: The Consequences of Vagueness in Consent to Organ Donation.” *Bioethics*, December. https://doi.org/10.1111/bioe.12335.

Steinberg, David. 2004. “An ‘Opting In’ Paradigm for Kidney Transplantation.” *The American Journal of Bioethics* 4 (4): 4–14. https://doi.org/10.1080/15265160490518557.

Stoler, A., J. B. Kessler, T. Ashkenazi, A. E. Roth, and J. Lavee. 2016. “Incentivizing Authorization for Deceased Organ Donation With Organ Allocation Priority: The First 5 Years.” *American Journal of Transplantation* 16 (9): 2639–45. https://doi.org/10.1111/ajt.13802.

Stoler, Avraham, Judd B. Kessler, Tamar Ashkenazi, Alvin E. Roth, and Jacob Lavee. 2016. “Incentivizing Organ Donor Registrations with Organ Allocation Priority.” *Health Economics*. https://doi.org/10.1002/hec.3328.

Teo, Bernard. 1991. “Organs for Transplantation The Singapore Experience.” *The Hastings Center Report* 21 (6): 10. https://doi.org/10.2307/3562357.

UNOS. 2018. “New Form for Prior Living Donor Waiting List Priority.” UNOS. January 24, 2018. https://unos.org/news/reminder-to-transplant-clinical-coordinators-prior-living-donors-get-waiting-list-priority/.

Wainright, Jennifer L., David K. Klassen, Anna Y. Kucheryavaya, and Darren E. Stewart. 2016. “Delays in Prior Living Kidney Donors Receiving Priority on the Transplant Waiting List.” *Clinical Journal of the American Society of Nephrology* 11 (11): 2047–52. https://doi.org/10.2215/CJN.01360216.

White, Sarah L., Kevin McGeechan, Michael Jones, Alan Cass, Steven J. Chadban, Kevan R. Polkinghorne, Vlado Perkovic, and Paul J. Roderick. 2008. “Socioeconomic Disadvantage and Kidney Disease in the United States, Australia, and Thailand.” *American Journal of Public Health* 98 (7): 1306–13. https://doi.org/10.2105/AJPH.2007.116020.

Wilkinson, Martin, and Stephen Wilkinson. 2016. “The Donation of Human Organs.” In *The Stanford Encyclopedia of Philosophy*, edited by Edward N. Zalta, Winter 2016 Edition. https://plato.stanford.edu/archives/win2016/entries/organ-donation.

Wilkinson, T. M. 2011. *Ethics and the Acquisition of Organs*. Issues in Biomedical Ethics. Oxford ; New York: Oxford University Press.

Wright, Linda, and Diego S Silva. 2010. “Incentives for Organ Donation: Israel’s Novel Approach.” *The Lancet* 375 (9722): 1233–34. https://doi.org/10.1016/S0140-6736(09)61520-8.

Zaltzman, Jeffrey. 2018. “Ten Years of Israel’s Organ Transplant Law: Is It on the Right Track?” *Israel Journal of Health Policy Research* 7 (1). https://doi.org/10.1186/s13584-018-0232-1.

Zambrano, Alexander. 2016. “Why Alcoholics Ought to Compete Equally for Liver Transplants.” *Bioethics* 30 (9): 689–97.

———. 2017. “Patient Autonomy and the Family Veto Problem in Organ Procurement.” *Social Theory and Practice* 43 (1): 180–200.

Zúñiga-Fajuri, Alejandra. 2015. “Increasing Organ Donation by Presumed Consent and Allocation Priority: Chile.” *Bulletin of the World Health Organization* 93: 199–202.

fr 12-06-2020 02:13

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Re: Resubmission: JM173E17R (Priority to organ donors)

Til Andreas Brøgger Albertsen

Opfølgning. Fuldført den 15. september 2020.
Du svarede på denne meddelelse den 19-06-2020 10:37.

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All the best,

Elizabeth

Elizabeth Bohn
Managing Editor
The Journal of Medicine and Philosophy