Views of leaders in under-represented and equity-denied communities on organ and tissue donation in Nova Scotia, Canada, in light of the Human Organ and Tissue Donation Act: a qualitative descriptive study

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ABSTRACT

Objective To explore the views of underserved and equity-denied communities in Nova Scotia, Canada, regarding organ and tissue donation and deemed consent legislation.

Design A qualitative descriptive study was undertaken, employing both interviews and focus groups.

Setting The province of Nova Scotia, Canada—the first jurisdiction in North America to implement deemed consent legislation for organ and tissue donation.

Participants Leaders of African Nova Scotian, Lesbian, Gay, Bisexual, Trans, Queer, Two Spirit and Faith-based communities (Islam and Judaism) were invited to participate (n=11). Leaders were defined as persons responsible for community organisations or in other leadership roles, and were purposively recruited by the research team.

Results Through thematic analysis, four main themes were identified: (1) alignment with personal values as well as religious beliefs and perspectives; (2) trust and relationships, which need to be acknowledged and addressed in the context of deemed consent legislation; (3) cultural competence, which is essential to the roll-out of the new legislation and (4) communication and information to combat misconceptions and misinformation, facilitate informed decision-making, and mitigate conflict within families.

Conclusions Leaders of African Nova Scotian, LGBTQ2S+ and Faith-based communities in Nova Scotia are highly supportive of deemed consent legislation. Despite this, many issues exemplify the need for cultural competence at all levels. These findings should inform ongoing implementation of the legislation and other jurisdictions considering a deemed consent approach to organ and tissue donation.

INTRODUCTION

Until recently, consent to donate organs and tissues in all Canadian provinces and territories operated under an ‘opt-in’ or explicit consent model, meaning an individual must express their intention to become an organ or tissue donor. This changed on 18 January 2021, when Nova Scotia, Canada, became the first jurisdiction in North America to enact a deemed consent or ‘opt-out’ approach to donation, where every adult Nova Scotian is considered to have consented for deceased organ donation unless they explicitly registered to the contrary. The change was prompted by the fact that Nova Scotia’s organ donation rate had remained stagnant while rates increased in other provinces that invested resources into supporting their organ donation programmes. As a result, the provincial Human Organ and Tissue Donation Act (HOTDA) was modified to incorporate a deemed consent model (also referred to as a ‘presumed’ consent model in other jurisdictions), in an effort to increase organ and tissue donation.

Many international jurisdictions have adopted deemed consent approaches.
to organ and tissue donation. However, there are conflicting reports in terms of whether opt-out consent models improve donation and transplantation rates compared with opt-in consent models as well as examples wherein deemed consent approaches failed due to widespread public concerns and mistrust. Regarding the former, a recent study comparing data from 35 countries found no significant difference between countries using opt-in versus opt-out consent models in terms of the number of deceased donors and rates of solid-organ transplantation, though lower rates of living donation were associated with opt-out consent models. A systematic review from the same year contradicted these findings, reporting that an opt-out consent models increased deceased donation and transplantation rates. Regardless, experiences in various jurisdictions that have enacted opt-out legislation have shown that changes to the legislation alone are insufficient to bring about the desired changes in organ donation and transplantation rates. While the inability to achieve the desired changes has been linked to insufficient infrastructure, public perceptions of and trust in deemed consent approaches are essential to operating such a model. In Brazil, less than 1 year after implementation of deemed consent legislation, the legislation was revoked due to widespread mistrust in the donation and transplantation system. In Chile, the introduction of deemed consent legislation actually led to a decrease in donor rates, driven by a high percentage of individuals who opted out and family refusals, which was also thought to be related to mistrust of the healthcare system.

Given these challenges, and in light of recent research out of the UK examining public perceptions of opt-out consent, it is critical to examine how the public views the introduction of the recent changes to Nova Scotia’s organ and tissue donation legislation. In the UK, where opt-out consent has been enacted in Wales, England and Scotland, studies have shown that some members of the public regard opt-out consent as threatening to individual autonomy, and identified fears around bodily integrity and medical mistrust as barriers to donation. These issues may be more pronounced for particular groups. For example, many studies of deceased donation have found that members of certain communities (eg, Faith-based or racialised communities) are less likely to consent to organ donation, due in part to high levels of distrust of the healthcare system both in general and specifically related to organ donation. It is vital to better understand these factors, particularly from the perspective of under-represented communities if we are to enact opt-out legislation in ways that restore and/or maintain trust in the system and optimise our capacity to implement these policies in safe and effective ways. The objective of this study was to explore the views of leaders of under-represented and equity-denied communities in Nova Scotia on organ and tissue donation, including HOTDA.

**METHODS**

**Study design**

This was a qualitative descriptive study, as described by Sandleworski, employing both interviews and focus groups, in Nova Scotia, Canada.

**Patient and public involvement**

This study was carried out as part of broader programme of research about the implementation of HOTDA. Patient partners were involved in the overarching programme of research and in the conceptualisation of the study presented in this manuscript.

**Participants and recruitment**

Participants were leaders of African Nova Scotian, LGBTQ2S+ (Lesbian, Gay, Bisexual, Trans, Queer, Two Spirit and others) and Faith-based (Islamic, Jewish) communities. Understanding the view of leaders from these communities is particularly important given: (1) a long and well-documented history of racial discrimination against African Nova Scotians by public institutions within the province; (2) Health Canada’s decades-long and recently abandoned policy restricting sexually active men who have sex with men (MSM) from donating blood; and (3) questions surrounding the religious permissibility of organ and tissue donation in Muslim and Jewish faiths.

By the term leader, we sought to recruit persons who held leadership roles in community organisations such as places of worship, health and social organisations, and community advocacy organisations. We performed online searches to identify organisations serving each of the aforementioned communities, and identified individuals in leadership roles within those organisations. Thus, recruitment was purposive with known (public) leaders contacted by an investigator or member of the research staff via email and asked to participate.

**Data collection**

Data collection occurred from November 2020 to February 2021. All individuals provided written informed consent before participation. The interviews and focus groups were conducted by female researchers experienced in qualitative methods (RU and CK). These researchers had no prior relationship with any of the study participants. Similarly, participants had no prior knowledge about the researchers. Interviews and focus groups were conducted via videoconferencing technology (Zoom for Healthcare), due to the global COVID-19 pandemic. All interviews and focus groups were audiorecorded using a separate digital audio recorder placed on the researcher’s desk during the video call. No interviews or focus groups were videorecorded.

The researchers used an interview guide, created based on the study objectives, using the guidance of Patton and Rubin and Rubin. Open-ended questions and prompts were crafted by RU (methods expertise in semistructured interviews) and SB (content expertise in organ donation),
and sought to understand participants’ general awareness and attitudes on organ and tissue donation, awareness and attitudes on deemed consent, and recommendations for implementing deemed consent. The audio files were securely sent to an authorised transcriptionist and transcribed verbatim within 2 weeks of the data collection opportunity. Field notes were made during interviews/focus groups.

Analysis
Thematic analysis, as outlined by Braun and Clarke, was used to analyse the data. Analysis began by reading and rereading the transcripts and field notes. Two researchers (RU and CK) then coded the transcripts by identifying salient and recurring concepts. Together, they developed a coding scheme to guide coding and categorisation of data. One additional researcher (WC) coded a subset of transcripts to optimise dependability. During analysis, the researchers met regularly to review coding, collapse codes into broader categories, and ultimately to identify, agree on and finalise themes. Any uncertainties or disagreements were resolved through discussion and, if needed, re-examining the coded data.

RESULTS
A total of 11 participants took part in this study; 8 in individual one-time interviews (interview duration ranged from 25 min:18 s to 52 min:45 s) and 3 in focus groups (2 focus groups were held with the same 3 individuals due to their request for additional time; focus group duration ranged from 51 min:47 s to 1 hour:29 min:43 s). Although recruitment sought leaders of specific communities, there was a high degree of intersectionality among participants. That is, many participants identified as being a member of multiple communities (eg, a leader in a Faith-based and African Nova Scotian community or a leader in the LGBTQ2S+ and African Nova Scotian community). Several participants were also immigrants to Canada with leadership roles in the newcomer community. Four overarching themes were identified, as described below. These related to alignment, trust and relationships, cultural competence, and communication and information.

1. High alignment with personal values as well as religious beliefs and perspectives
All participants were supportive of organ and tissue donation, as it aligned with their personal values. This sentiment was described by one participant, who said: I have always thought that it would be the ultimate gift. I always thought that it would be, you know, a beautiful thing [P1]. Organ donation also aligned with religious beliefs and perspectives, which was critical for participants who came from Faith communities (Jewish, Islam, and Christian). One participant described it this way:

Saving lives is a very noble cause. Very noble. Even Quran, you know, encourage people to save lives. He said if you save the life of one person, it’s as if you give life to the whole humanity. [P4]

Participants discussed how deemed consent for tissue donation is a much more complex issue for members of Jewish and Islamic communities. They described the rituals done after death, common to both faiths and questioned how these rituals would happen if certain tissues were removed (eg, bones). There was a clear desire for very specific and detailed information around tissue donation to ensure it aligns with their beliefs and customs. As one participant said:

We don’t really have an issue with the organs. The question was really regarding the tissues, other than the organs itself. As [participant] just said, that we do have rituals we do follow after death, of washing and praying and burying and all this stuff. So the organs is okay. But we need also to know the limitations or the maximum that one can donate when it comes to tissues. [P5]

Participants also noted that tissue donation also adds a complexity because, unlike organ donation that will save lives, many tissues are donated to improve people’s quality of life. Thus, tissue donation was a much more nuanced issue for these participants to consider compared with that of organ donation. Despite the complexities of tissue donation, participants emphasised a real desire to do what is best for everyone, in ways that respect the person, their families and their faith. This was described by one participant in this way:

In our tradition, the most important thing is saving a life. Now, where you run into a lot of debate within the Jewish community, among Jewish scholars, for example, is at what point is enhancing life also in a similar way. You know, blindness? And there’s consensus that if you’re going to restore somebody’s sight, that’s almost to the point of saving their life. But then it becomes more complicated, obviously. And so that’s really part of the discussion. But I want you to understand that from our perspective, … we’re in a complete agreement that the most important thing is saving and even perhaps enhancing life. [P3]

2. Trust and relationships are paramount and need to be acknowledged and addressed in the context of deemed consent legislation
Participants discussed many issues related to trust and damaged relationships that need to be acknowledged and addressed in the context of deemed consent legislation. For the African Nova Scotian community, systemic racism within healthcare, and prior experiences of racism within the healthcare system, have led to high mistrust of the system. From an organ donation perspective, several participants discussed feelings that providers might allow them to die to procure their organs for someone else. One participant described it this way:
I’ve always felt that why should I go to my death with something that’s useful for somebody else? It doesn’t make sense. So I’ve always filled out my driver’s license for organ donation and what have you. Now, at the same time, I’m an African Nova Scotian. I’ve always been warned by other people, and I’m conscious of myself, because of the racism and discrimination that exists. And I also know that it exists within the medical practice. So I, at the same time, have recognized in me the reservations around they’ll kill me so they can get my organs. So that is certainly a general sentiment. And my philosophy has been ‘what the heck, they’re going to discriminate anyway so I still may help somebody along the way.’ [P2]

Participants from the LGBTQ2S+ community discussed how the harms that MSM have experienced with the blood donation system have implications for deemed consent for organ and tissue donation. Many expressed confusion about why the system would want their organs and tissues but not their blood. Although participants understood the differences in jurisdiction and organisations, these differences did not negate their experiences or perspectives. Although participants discussed being very supportive of organ donation itself and being excited to be able to donate, they also described their fear that when the opportunity to donate occurs (ie, on death), they will again be rejected by the system once it is known that they were MSM. This was reflected by one participant who said:

I do genuinely worry if I sign up as an organ donor and then they’re going through the thing, and they’re like, ‘Oh, that dude was gay. Maybe we’re not going to take his organs after all.’ Because if they’re not going to take my blood, my organs are bathed in my blood. Like am I going to be rejected? … I want to donate. And it’s very disheartening that I cannot donate blood because I would. Like I’ll give my organs when I can. So there is this sort of, like it’s this weird dichotomy. Like I’m very excited that I can donate my organs, but I’m also frustrated that my organs are okay but my blood is not. And it creates this real tension. [P7]

Participants from the Jewish and Islamic communities also discussed issues of trust around organ donation. From their perspective, participants discussed needing to trust that healthcare providers will do everything possible to save a person’s life, but if that person dies, they must also do everything possible to respect the deceased in the same way that the community would respect it.

We want to take all the resources, save as many people as possible, which is also a religious imperative, I think, from all traditions. But the other side of it is something that we in the religious traditions express, which is to be respectful of the dead. And that’s something that we really can’t expect doctors to do for us. We have our own ideas of what is respectful of death. So I think that what we all need to sign off on is the understanding that we are entrusting these physicians to treat our dead with the respect that we consider to be essential. [P3]

Several participants also noted there may be mistrust among newcomers to Canada, particularly if one comes from a country with a history of illegal organ procurement. As one Faith-based leader said:

I do have people in the community coming from China, actually. Muslims, they are coming from China. They are here as refugees. And they can tell you about the one-day waiting list of any organ. … So taking this out of their minds and out of their thinking is not an easy job, and requires lots of patience and understanding and choosing the right words. [P4]

3. Cultural competence is essential to the roll-out of the legislation

In various ways and using different language, all participants noted that cultural competence is essential to the roll-out of the new legislation. Some participants expressed disappointment and frustration that their communities were not engaged prior to drafting the legislation to ensure that the legislation incorporated cultural competency. Several also discussed the need for provisions within the legislation to support and protect certain communities. One participant said:

I feel that there should be equity provisions go into the law, which there are not, to protect certain groups of people. For example, groups of people that experience racism. I think new immigrants who don’t understand law or the medical system … We should be made aware of what provisions have been put in place to protect them from abuse around this law. [P2]

Participants highlighted numerous issues that call for cultural competence at the level of the legislation and ensuing policies. One is the complexity that tissue donation holds for members of the Jewish and Muslim communities (discussed above). For the LGBTQ2S+ community, several participants discussed that the definition of family is very different for many in the LGBTQ2S+ community. The extent to which this was addressed in the legislation and/or will be understood by clinicians on a person’s death was unknown. One participant said:

By family member, here’s the thing. I’m going to guess they mean biological, legal family. But a lot of queer and trans people are not connected to their biological or legal families, right? They have chosen family. They have logical versus biological families… There is that concern for me. You know, like who decides what family is? And that’s always a fraught discussion. [P7]

Another issue of concern to participants from the LGBTQ2S+ community was that of bodily autonomy
within the trans community, underscoring the need for informational supports to empower individuals in their decision-making relevant to organ donation. As a result, participants from the LGBTQ2S+ community discussed the need for governments and those in the health system to recognise the concerns of their community and to respond to these needs to ensure no further harm is done. One participant described it this way:

"You can’t come into these marginalized communities that have very real issues, current issues with government and its many systems. You can’t come into those communities with your cherry-picked issue without understanding that you’re going to have to open up the whole spectrum of issues and to discuss the issue of organ donation within the context of Pride Health. You know, the disproportionate amount of addiction in the queer community. Like I said, trans health issues, medical support for trans folk, you know, PrEP and PEP, and whether or not these things are being promoted and funded. You know, all of these things are on the Pride Health agenda. And if you want to come to talk about [organ donation], then you need to do so within the context of those conversations. [P8]"

Most study participants also discussed the need for a culturally competent approach in the implementation of the legislation, including cultural competence on the part of the organisations and clinicians who are tasked with roll-out and with interacting with patients and families.

4. Communication and information are necessary to combat misconceptions, facilitate informed decision-making, and mitigate conflict with families

All participants discussed the need for communication and education around the new law. In addition, participants continued to ask their own questions throughout the interviews, demonstrating a real desire to learn. Most participants felt that communication was lacking, particularly around the specifics of the law and the processes related to organ donation and transplantation.

Others discussed an obligation for government to communicate about the new law and its implementation, and to do this communication in ways that people require. For example, to provide information that is widely available, accessible (in terms of language, literacy and compatible with assistive technologies) and easy to navigate. Community events such as town halls were mentioned by many participants as a helpful way to communicate to their community members. Making information available was seen as critical to combating misconceptions and misinformation, facilitating informed decision-making, and mitigating conflict within families. Communication was also seen as playing an important role in establishing positive relationships between ‘the system’ and under-represented communities. One participant emphasised the need for tailored and meaningful communication in this way:

"You know, I’m sure those communications people have tons of experience and all that, and do a great job. But, you know, are we doing enough to ensure that the information is conveyed in a way that resonates with particular communities and what their perspective on things will be, and from folks who understand the history of those particular populations, and so forth, right? It may fall on deaf ears, as they say, you know, if it’s coming from a person who has no understanding of the lived realities of particular communities. And it’s going to land on them totally wrong, right? [P11]"

**DISCUSSION**

This study sought to understand the views of leaders of under-represented and equity-denied communities in Nova Scotia on organ and tissue donation as well as deemed consent legislation. The findings demonstrate high support for donation and HOTDA, but point to several issues that require concerted action to facilitate HOTDA and heighten trust with the donation system. Indeed, the systemic racism experienced by racialised minorities, including African Nova Scotians, the long-standing harms MSM have experienced with the blood donation system, and the complexities around tissue donation and respecting religious beliefs and teachings exemplify the need for cultural competence at all levels: the providers who are on the ground implementing the legislation and having conversations with patients and families, institutional policies and procedures related to the legislation, and the legislation itself. Moreover, public education and ongoing communication were perceived as critical to alleviating concerns and enabling informed decision-making around the new legislation.

These findings provide important insight for Nova Scotia as it continues to operationalise deemed consent as well as other jurisdictions considering deemed consent legislation.

At its core, organ and tissue donation relies on the public’s trust in donation systems. In this study, specific issues differed across communities, yet the findings clearly demonstrate the need to build and maintain trust in many communities as it relates to deemed consent legislation. Although participants viewed organ donation in a positive light, their concerns cannot be disregarded. While religious and cultural reasons are often cited as barriers to organ donation, a systematic review on the factors that influence a person’s decision to become a donor found that religion and culture are often connected to complex issues such as mistrust of medical systems and a lack of understanding of the organ donation process. The movement to ‘opt-out’ systems may heighten mistrust in some communities, especially in the absence of community engagement and comprehensive communication about organ and tissue donation processes, as occurred in Brazil. In jurisdictions where...
members of under-represented groups are not adequately represented in decision-making (eg, government), meaningful engagement is with these communities is even more important.

Nova Scotia’s organ and tissue donation system must acknowledge the injustice and trauma that some communities have disproportionately experienced within the healthcare system and respond to the specific concerns of under-represented communities as the legislation continues to be implemented. Specific actions include partnering with communities to ensure that culturally appropriate resources are available and that healthcare providers receive training in cultural competence (eg, training in antiracism, antipressure and decolonisation). Similar recommendations have been put forward by other organisations attempting to improve healthcare for under-represented and racialised communities.

From a communications perspective, it is imperative that information is comprehensive and tailored to the specific concerns of various communities. For example, grassroots approaches to education, including the participation of donors, recipients and their families, have been shown to increase participation in donation programmes in African American communities. In the UK, the National Health Service has begun to address the unique concerns of Faith-based communities through websites that were created with input from communities themselves. Instead of being prescriptive, our findings would suggest that optimal engagement and communication activities may differ across communities. Therefore, governments and health system entities should engage communities early in the legislative process and work with them on their terms. This will allow authorities to identify the specific concerns of communities and how to address them.

Although this study provides important insight that should inform Nova Scotia’s ongoing implementation of HOTDA as well as other jurisdictions that are considering transforming its organ donation and transplantation system through a deemed consent model, there are some limitations worth noting. First, the small number of participants may limit the transferability of the findings. The aim of qualitative research, however, is not to achieve results that are generalisable in a quantitative sense but to gain a rich understanding of people’s views and experiences. In this regard, the overarching categories were consistent across community groups and no further substantive information was gathered in the final interviews, strengthening the trustworthiness of findings. Moreover, the findings are consistent with prior research on barriers and decision-making related to organ donation, supporting their transferability. Second, the views and experiences of additional under-represented communities were not captured, but represent an important area of future engagement and inquiry. We are particularly interested in engaging Indigenous communities, who were not included in the current study. Research involving Indigenous communities requires an established relationship between the community and the researcher or research team, which can take years to establish. Unfortunately, we did not have the relationships necessary to engage Indigenous communities in the current study; however, we intend to work with local Indigenous researchers regarding the appropriate next steps for engaging Indigenous communities in initiatives to inform the implementation of deemed consent in Nova Scotia. Despite these limitations, our findings provide a foundation to conduct additional research to more fully examine the attitudes and perspectives of members of under-represented communities.

In conclusion, this study demonstrated high support for organ and tissue donation, including deemed consent, among leaders of African Nova Scotian, LGBTQ+ and Faith-based communities in Nova Scotia. Although unique concerns existed for different communities, with different historical and cultural contexts, issues related to mistrust, cultural competency, and communication and education were prevalent across the entire dataset. These findings should inform the ongoing roll-out of the HOTDA in Nova Scotia, including meaningful engagement with communities, cultural competency training for healthcare providers, and comprehensive communication and education to dispel myths and fears about organ and tissue donation and ensure citizens are fully informed about donation and transplantation processes.

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REFERENCES
gl=“1”&p2gcg_qr=MTA0NTgyMG5OC4xNjM3MjQ2NTQ0_qga_YHRMDXXVvDMTY2n0lNJU4yLkEoMTY2n0lNjM5NSw&ga=2.188968347.127881871.163724564-140582299.1637246544
10 Miller J, Currie S, O’Carroll RE. “If I donate my organs it’s a gift, if you take them it’s theft”: a qualitative study of planned donor decisions under opt-out legislation. BMC Public Health 2019;19:1463.