Organ donation after MAid: it's not that simple

I read with interest the *CMAJ* article on guidance for policy on donation after medical assistance in dying (MAiD) and other conscious and competent donors,[1] and the accompanying commentary.[2] Broad discussion and consultation are essential for an issue of this complexity, and I would like to contribute to what I hope will be an ongoing debate.

First, I think that it should be recognized that MAiD and withdrawal of life-sustaining measures (WLSM) are not equivalent ethical entities and should be addressed separately in the context of organ donation. Although both involve conscious and competent potential donors, the withdrawal of perhaps increasingly invasive active interventions that are prolonging an inevitable death (WLSM) is very different from the deliberate and active termination of life in MAiD. Although cases of donation after WLSM bring some different practical issues to those after circulatory determination of death (DCD), for me WLSM and DCD are similar (and far less problematic) ethical issues; therefore, the rest of my remarks will apply only to donation after MAiD.

I have concerns that organ donation after MAiD has the potential to influence substantially the decision of individual patients to proceed with MAiD and also to increase the number of requests for MAiD. Patients contemplating MAiD are "vulnerable and susceptible to influence"[2] and exposure to, for example, the national broadcasting in the Netherlands of the first domestic case of organ donation after MAiD,[3] might be the proverbial thumb on the scale that tips the balance toward a decision for MAiD.

The authors of the guidance on policy acknowledged that, "it would be difficult to exclude the possibility that the decision regarding organ donation had driven the request for MAiD, either to facilitate the donation process or to enhance the function of the transplanted organ."[1] This statement refers to directed deceased donation, but I respectfully suggest that it is equally applicable to all cases of donation in association with MAiD. They suggest that this "should be managed by ensuring that any discussion about organ donation takes place only after the decision for MAiD … is made." However, the widespread availability of relevant information (about organ donation and the shortage of suitable organs) makes it unlikely that the request for MAiD and the decision to donate can be such a linear process. I also agree with Dr. Mulder that this "ignores the dynamic nature of the patient's decision-making process … sometimes people change their minds about MAiD right up until the end,"[2] and I am concerned that once an initial decision to donate has been made, subsequent discussions and the process of donor testing may unduly influence patients to follow through with MAiD to avoid disappointing expectations raised by their earlier decision to donate.

The inevitable intertwining of the choice for MAiD and the decision to donate means that any participation in the subsequent transplant process has the potential both to validate and promote MAiD. Dr. Downar and colleagues suggest that it is not logical to object to organs from patients undergoing MAiD but then be willing to use those from victims of suicide and homicide.[2] However, there are crucial differences between these scenarios: no one is motivated to proceed with suicide or homicide because of the subsequent opportunity to donate organs, and, as physicians, we actively strive to prevent both suicide and homicide whenever possible rather than facilitate death as is done with MAiD.

As an anesthesiologist working at a major transplant centre, I have recently informed my department that I am not willing to be involved in the transplantation of organs from donors who have undergone MAiD, and collegial discussions are underway about the implications for me and the rest of the department. The number of such cases is currently low, and for the reasons outlined above, if it were to rise substantially, this should be viewed with deep concern.

The already inconsistent application of criteria for MAiD in Canada,[4] the more liberal euthanasia guidelines in some other countries, and the discussion about antemortem harvesting happening not only in the public domain[5] but also in a high-impact medical journal,[6] must surely give everyone in the transplant community (including organ recipients) pause for thought.

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