Euthanasia and organ donation still firmly connected: reply to Bollen *et al*

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ABSTRACT

Bollen *et al*, replying to my own article, describe, in great detail, administrative and logistical aspects of euthanasia approval and organ donation in the Netherlands. They seem to believe that no useful lessons can be drawn from experiences of related groups such as euthanasia patients (typically patients with cancer) who cannot donate organs; patients who chose assisted suicide as opposed to euthanasia; patients in intensive care units and their relatives and suicidal young people as if we can only learn about organ donation in euthanasia patients by studying this exact group and no other, no matter how closely related and obviously relevant. However, it is not only permissible but also absolutely essential to gather evidence that goes beyond immediate point of interest and carefully study groups that share important features with it. Also, groups eligible for euthanasia are constantly expanding, theoretically, legally and practically, and it would be irresponsible to not foresee what are likely future developments. Finally, myopic focus on the technicalities of the procedure misses psychological reality that drives decisions and behaviours and which rarely mimics administrative timelines. Patients proceeding through euthanasia pipeline already face substantial situational pressure and adding organ donation on top of it can make the whole process work as a commitment device. By allowing euthanasia patients to donate their organs, we are giving them additional reason to end their lives, thus creating an unbreakable connection between the two.

Bollen *et al*,[1] replying to my own article,[2] describe, in great detail, administrative and logistical aspects of euthanasia approval and organ donation in the Netherlands. They insist, based on the relatively small number of such donations so far in the Netherlands, that great care is taken to separate euthanasia and organ donation so that euthanasia patients do not feel pressured to donate their organs. They also repeatedly emphasise that organ donation merely satisfies patient's own wishes, leading to a death experience that 'might even be improved, because the patient gets the opportunity to convert his own suffering into something positive for others' and that we should consider 'whether it would be unjust if children would be denied the possibility to donate their organs following euthanasia when they have made a well-considered decision, based on their right of autonomy'. Here, I want to address some of the points they make.

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CURRENT CASES OF ORGAN DONATION IN EUTHANASIA PATIENTS ARE THE BEGINNING, NOT THE END

Bollen *et al* focus on a handful of actual organ donation cases in the Netherlands to draw their conclusions about this practice. They object to me drawing lessons about euthanasia patients eligible for organ donation from experiences of other groups such as euthanasia patients (typically patients with cancer) who cannot donate organs; patients who chose assisted suicide as opposed to euthanasia; patients in intensive care units and their relatives and suicidal young people. For example, when I use data about terminal patients in the UK to argue that most patients prefer to die at home, they point out that these patients are patients with cancer, who are ineligible for organ donation, and that this is based on data from the UK, where euthanasia is still illegal.

However, unless we have a good reason to think that euthanasia patients eligible for organ donation have fundamentally different preferences from this group of patients, none of these differences are relevant. It is certainly important to understand immediate clinical and legal environment of organ donation in euthanasia patients, as it is currently performed. However, it is not only permissible but also absolutely essential and is a fundamental part of good scientific practice, to gather evidence that goes beyond immediate point of interest and carefully study groups that share important features with it.

Nor should we entirely limit ourselves to the point in time and legal framework that currently happens to be in place. Euthanasia landscape is changing fast. Just a decade ago, euthanasia was approved by only a handful of countries. These days, barely a month passes by without another country legalising it. Groups eligible for euthanasia are constantly expanding, theoretically, legally and practically, leading to a number of foreseeable complications.[3] Canada is a notable example—a relative newcomer to euthanasia, it now has some of the most expansive laws and is one of so far only three countries that permit organ donation in euthanasia patients. As for the Netherlands, a recent article reported that it is already unexceptional for very elderly non-terminal patients with decreased quality of life to be approved for euthanasia.[4]

Suicidal young people are, due to their numbers and quality of organs, a potentially significant source of candidates for the combined procedure. Bollen *et al* do not want to talk about them because suicidal young people 'often do not fulfil the due diligence requirements of a voluntary and repeated euthanasia request, based on hopeless and unbearable suffering'. But this merely describes what currently happens to be the case, in a legal environment that is changing with lightning speed and in the direction that German Supreme Courts has already taken.[5] In fact, one can reasonably expect that these very same authors will be on the frontlines of the battle to extend euthanasia to precisely this group of patients, just like they advocate euthanasia and organ donation in children and defend Dutch practice of euthanising very elderly non-terminal patients with diminished quality of life.[6] The principle of autonomy, on which the authors rely in justifying these other cases, simply provides no grounds on which suicidal young people should be excluded from the benefits of both euthanasia and organ donation.

PSYCHOLOGICAL PROCESSES DO NOT MIRROR ADMINISTRATIVE PROCESSES

Myopic focus on the technicalities of the procedure misses psychological reality that drives decisions and behaviours and which rarely mimics administrative timelines. Bollen *et al* put a lot of weight on the fact that euthanasia patients are repeatedly asked to confirm their wish to die. 'Even just before the euthanasia drugs are administered, the treating physician providing euthanasia is obliged to and does question the patient regarding his wish to die and to firmly confirm this wish (again)', they write, as if persons in this situation face no expectations regarding their answers and can change their decision without

embarrassment or concern about future of their care.

This approach takes administrative and technical aspects of the procedure at face value and assumes that perceptual and decision-making processes in the minds of patients mirror these formalities: if the doctor never literally demanded that the patient proceed with euthanasia, the patient therefore felt no pressure to do so.

However, psychological—as opposed to administrative and logistical—reality of these interactions is such that they combine some of the most powerful factors known to influence human behaviour, including social desirability (desire for others' approval), behavioural consistency (desire to appear consistent) and obedience to authority (tendency to do what one is expected to or demanded by an authority), all working in the same direction and making it difficult for people to reverse their euthanasia decisions even when they do not involve organ donation.

Adding organ donation on top of euthanasia can make the whole process work as a commitment device—a nudge mechanism used to ensure that decision will be carried through despite changes of mind. This psychological tool, where one makes a public commitment to a socially desirable goal, such as saving money or losing weight, leverages public expectations as a counterweight in the face of temptation: a person who publicly promised to, say, exercise regularly, feels shame when others are witnesses to their failure to live up to the promise, prompting them to resume exercise. The presence of others is, therefore, the key to this mechanism.

The process of euthanasia combined with organ donation shares some important features with commitment devices. It, too, involves socially desirable goals (organ donation and, increasingly, ending one's 'unbearable suffering') and a somewhat elaborate process for approval that involves a number of different people becoming witnesses to the stated intent. It is very difficult to walk back one's public decisions even, and, paradoxically, especially so, when one is repeatedly asked to confirm them.

Bollen *et al* emphatically say that 'the situation as described by Wong, in which a patient was scared to refrain from euthanasia because of what her family might say should never occur'. But, evidently, they do—despite rarity of this procedure, Wong alone had apparently witnessed four such cases.[7]

Finally, in my original article, I argued that logistics of organ donation complicate dying experience of the donor and undermine 'death with dignity'—a major public rationale and individual motivation for euthanasia—they once envisioned. Here, at least, we seem to agree, as they, too, say that 'if the patient chooses to donate, his dying experience might be different from what he first envisioned'. However, the authors then proceed to argue that 'despite this, the process of dying might even be improved, because he gets the opportunity to convert his own suffering into something positive for others'. But once again, this mistakes accounting bottom line (lives saved, suffering shortened) for an actual, lived experience. As an experience, suffering is an emotionally intense, time-consuming process that cannot, in the psychological space, be easily substituted by a much less emotionally charged awareness of the fact that one is helping others.

CONCLUSION

Human decision-making processes are very dynamic and complex and do not follow a tidy timeline where organ donation, say, is considered only when medical staff brings up that possibility. In this respect, the exact point where organ donation is technically introduced to the patient is irrelevant—unless it is explicitly forbidden, its possibility can freely enter decision-making process at any point, thus making it an incentive to request euthanasia in the first place.

Organ donation is a widely embraced value, to the point where live kidney donation is commonly advertised as a safe way to help others. At the same time, the norm of ending one's life to end one's suffering is also increasingly embraced, as seen through growing acceptance of euthanasia across the globe. Both of these societal values therefore freely figure in individuals' decision-making. Conceptualising their combination as a win–win, as the authors do, further validates consideration of organ donation in one's decision to end their life.

People generally, and vulnerable individuals facing life-ending decisions particularly, want to be liked and respected; they want to be considered brave and generous rather than iffy and selfish. Patients have difficulty resisting doctor's authority when they are at their strongest, much less when they already feel as a burden to others and question the value of their own lives. By allowing euthanasia patients to donate their organs, we are giving them an additional reason to end their lives, thus creating an unbreakable connection between the two.

Contributors The author herself did everything in this work.

Funding This study was funded by Ministarstvo Prosvete, Nauke i Tehnološkog Razvoja, grant no. 47010.

Competing interests None declared.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; internally peer reviewed.

To cite Buturovic Z. *J Med Ethics* 2022;**48**:488–489.

Received 12 April 2021
Accepted 19 April 2021
Published Online First 7 May 2021

Linked

► http://dx.doi.org/10.1136/medethics-2021-107230

J Med Ethics 2022;**48**:488–489.
doi:10.1136/medethics-2021-107498

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