Canada. In Belgium, the Netherlands and Canada, combining euthanasia and subsequent organ donation in a so-called donation after circulatory death (DCD) procedure is feasible on legal and medical grounds, and is increasingly gaining social and ethical acceptance. Heart transplantation after DCD is currently not performed in Belgium and the Netherlands after euthanasia due to concerns surrounding the prolonged warm ischemia time associated with DCD and its effect on subsequent heart function. A number of patients who undergo euthanasia however explicitly express their wish to donate their organs in a "living organ donation" procedure, which would then cause death. Assuming that euthanasia is permitted, as expressed in Dutch and Belgian legislation, it is discussed whether it is legally and ethically sound to donate organs, especially the heart, as a living donor and to perform euthanasia in the same procedure in a patient who fulfills the due diligence requirements for euthanasia. Organ donation euthanasia (ODE) would then cause death by the associated surgical procedure, and in addition would improve the quality of the other donated organs. This combined procedure fully meets the principles of biomedical ethics, especially respecting the patient's autonomy.

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3203

ORGAN HARVESTING FROM DONORS KILLED BY EUTHANASIA MAY UNDERMINE PUBLIC TRUST IN TRANSPLANTATION

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Ethical controversies in transplantation are mainly the consequence of organ shortage. Organ trading and use of organs from executed prisoners are condemned by transplant community. However, in align with euthanasia legalization and expansion, there is a growing interest in another controversial issue, organ harvesting from donors killed by euthanasia. Eurotransplant has embraced use of organs from euthanasia donors more than a decade ago. In 2012 ethicists from Oxford has proposed a step further compared to Eurotransplant approach: instead of first killing the patient by euthanasia, declare death and then harvest the organs, they have suggested to put euthanasia candidate into general anesthesia, start organ harvesting while the patient is still alive, harvest the heart as the last organ and actually perform euthanasia by harvesting the heart. Such approach requires abandonment of a long-standing principles of transplantation "dead-donor rule" meaning that the person should be declared dead before vital organ is removed. Calls for abandoning dead-donor rule are fully mainstreamed with a recent article in New England Journal of Medicine arguing that number and quality of organs will be maximized if harvesting begins while the donor is still alive (Ball IM et al, NEJM September 6,2018) and implying that suicidal thoughts about being more valuable dead than alive should be encouraged rather than treated. At the same time, criteria for euthanasia is becoming ever more lax and more expansive. While initially advertised as a procedure for the sickest of the sick, euthanasia is now available to psychiatric patients, disabled and children. It was reported that a significant number of euthanasia procedure in Belgium is performed without signed consent (Smets T et al, BMJ October 5, 2010). In short, euthanasia may rapidly become a tool for getting rid of the weak, confused and expensive. Transplant community should not ignore alternatives like regenerative medicine, artificial organs, xenotransplantation and prevention of end-stage organ failure. Slovenian ethics committee in 2012 has declared against the use or organs from euthanasia donors. Slovenian model of transplantation, assuring enough organs from brain dead donors with acceptable waiting time, focused on quality and long-term survival is a proof that transplantation program can be sustained without resorting to ethically controversial practices. Harvesting organs from euthanasia

donors and abandoning dead-donor rule will not solve the problem of organ shortage and may open Pandora's box.

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ORGAN DONATION AFTER EUTHANASIA: AN EXPERIENCE BASED ETHICAL PERSPECTIVE

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In countries with a legal framework, the most recent evolution in DCD donation is organ donation after euthanasia, also referred to as DCD-V. Whereas feasibility of transplantation after euthanasia has been reported, important ethical controversies arise. Here, we report how legal, ethical and practical aspects are handled in an individual roadmap for every potential DCD-V candidate and provide an experience-based perspective on the ethical dilemmas involved, based on 11 procedures done in our center. In our experience, 3 principles are utterly important in DCD-V donation. Firstly, any pressure on both the patient and the treating physician should be avoided at all times. The possibility of organ donation should not put any pressure on the patient to prefer euthanasia above other means of end of life care. The same applies for the treating physician who should not feel any pressure to agree with the euthanasia because of the possibility of organ donation. Euthanasia is rooted in the patient's right to an autonomous decision regarding end-of-life in the context of unbearable suffering from an irremediable illness as stipulated by the Belgian Act on Euthanasia. However, we believe that the decision process for euthanasia should evolve as a dialogue between patient and physician, and between patient and relatives. The physician's dilemma -whether or not a physician should always inform a patient on the possibility of donation- could be guided by the legal opt-in or opt-out donation structure thus proposing DCD-V donation to registered or non-opposed donors. However, we would not support this as a formal practice: social pressure on the patient should be avoided, and a person's values and beliefs may change, especially at the end of life. Instead, clinical reporting, to inform the medical community on developments in the field and to encourage public awareness, will safeguard the patient-physician dialogue on DCD-V donation. A second principle is the strict separation between the euthanasia and donation procedure on 3 levels: time, place and team. The process of euthanasia decision precedes the organ donation discussion at all times to ensure that all end of life care can be discussed freely with the patient. The euthanasia is done by a different team and in a location different than the operating theatre. Thirdly, organ allocation is done according to the standard allocation rules. Despite the moral and ethical distress that such a procedure arouses, debriefing feedback from donors, relatives and team members was always unanimously positive.

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SHOULD WE ACCEPT DIRECTED ORGAN DONATION AFTER MEDICAL AID IN DYING? QUEBEC HEALTHCARE PROFESSIONALS' PERSPECTIVES

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Background: Deceased organ allocation is based on medical criteria and ethical principles such as justice and utility. Organs from deceased donors are donated to unknown recipients and are considered as public goods. Directed deceased donations to an identified recipient or a member of a social group is a controversial topic whereas living organ donation is usually directed to an