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ORGAN DONATION AFTER EUTHANASIA. REVIEW AND CRITICISM OF FOREIGN PRACTICE

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This paper analyzes the problem of euthanasia, gives the history of this phenomenon, presents traditional ethical arguments for and against this practice, critically evaluates the practice of organ donation after euthanasia or euthanasia as a consequence of organ donation as established in some countries of the European Union, the US and Canada. The current status of this controversial practice is assessed.

Keywords: euthanasia, organ donation, organ donation after euthanasia.

INTRODUCTION

Despite the emerging disengagement between Russia and the West, scientific ideas, their interpenetration and cooperation among professionals have always remained a priority of scientific life, especially in the field of high medical technologies, which, of course, includes transplantation medicine. An example of such exchange of ideas is the West's implementation of Sergei Brukhonenko's discoveries in the field of artificial blood circulation and the practice of organ "revitalization", as well Vladimir Demikhov's surgical techniques for organ transplantation [1]. In turn, the Russian medical community adopted the concept of brain death 25 years after the international recognition of the protocol for its establishment according to the Harvard Medical School criteria [2]. The interpenetration of ideas is expedient while preserving the ethical basis of transplantation technology, regardless of the cultural codes of different countries and civilizations.

The philosophical, ethical, and moral foundations of providing transplant care are as important as surgical technologies. The following problems are well known to hinder systematic development of transplantation everywhere: the appearance in the patient/doctor relationship, for the first time in the history of medicine, of an additional subject – donor organs, which are "therapeutic means" for patients in need of transplantation. Obtaining donor organs is a difficult task not only in the context of surgical and other medical aspects, such as the work of multidisciplinary teams in the process of diagnosing brain death and organizing organ removal, but also in terms of everyday awareness activities with the society, with the general public. Gaining and maintaining the public's trust and confidence in transplant physicians is a major challenge. As a result of the above-mentioned problems, organ shortage remains the main obstacle to widespread dissemination of transplant care.

According to reports from the Global Observatory on Donation and Transplantation, presented in the annual Newsletter Transplant 2023, 102,090 transplants were performed worldwide, and 361,197 patients were on the waiting list (by the example of kidney transplantation, information from reports of 86 countries, including China, India, Spain and the United States of America (USA), current as of December 12, 2022) [3]. The situation in Russian transplantation is regularly reported in the Registry of the Russian Transplant Society, and according to its 15th report, 2,555 transplants were performed in Russia in 2022 [4], and there were 8,378 people on the transplant waiting list (2019 data from the Report of the Chief Freelance Specialist Transplantologist of the Russian Ministry of Health, Sergey Gautier) [5].

Traditional sources of donor organs are brain-dead donors, donors after irreversible cardiac death, living donors of organs or organ parts (kidneys, part of liver, pancreas or lung).

However, some countries of the European Union, 8 states in USA and Canada, have recently developed some practices of overcoming the organ shortage crisis, which is ultra-liberal in nature. This specifically involves deceased organ donation after euthanasia (ODE) and including implementation of euthanasia as a consequence of organ donation.

Despite the ban on euthanasia in the Russian Federation, the ethical dangers of organ donation after voluntary assisted dying require careful analysis, since such well-developed methods of solving the problem of organ shortage can undermine the altruistic basis of this type of medical care.

This study of scientific literature is aimed at critically highlighting the historical perspective of euthanasia, tra-

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cing its formation and transformation into an integral component of modern medical practice abroad, and assessing the controversial technology of ODE.

HISTORY OF THE DILEMMA OF VOLUNTARY ASSISTED DYING

Debates about the ethical justification of euthanasia – ending the life of a hopelessly ill or unbearably suffering person by his or her will – has been going on for almost three thousand years, dating back to ancient times. For example, Plato and Socrates considered it completely acceptable to end the lives of those who were not fit for it. The Stoics, from Zeno to Seneca, saw the act of voluntarily leaving life as a brave step and a noble alternative to passively accepting the dire consequences of a long illness or the actions of others. Aristotle argued that seeking death to escape from suffering or pain was an act of cowardice and therefore rejected euthanasia, while Pythagoras and his followers believed in the sacred nature of life and disapproved of any voluntary termination of life by man. Even then, *active* euthanasia was distinguished, which Hippocrates opposed directly in the text of his Oath ("*I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan*"), and passive euthanasia, which he also supported, considering it acceptable if a doctor does not treat "*a patient over whom the disease has taken over*" [6–8].

The philosophical dilemma of euthanasia identified in ancient times is still relevant today, with a remarkable change in the tone of the debate about euthanasia: instead of abstract philosophical inquiries, today's bioethicists see this controversial practice as inextricably linked to modern medical activity.

In his definitive work, *Medicine and Care of the Dying: A Modern History*, public health expert Professor Milton J. Lewis thoroughly explores the attitudes of society and individuals toward death, tracing how, over the centuries, the phenomenon of human death gradually lost its sacred and religious basis, lost its status as a major ritual, and, as medicine evolved, turned into an increasingly routine phenomenon, until, finally, dying and death became a part of medical practice, and first became a medical routine, and then acquired a utilitarian component [9].

Euthanasia as *mercy killing* was first seriously advocated by a member of the British medical profession in 1901. Dr. C.E. Goddard, a public health doctor, not a clinician, who identified two classes of patients that need their lives to be terminated: the hopelessly ill and patients with hereditary pathologies, whose *useless* lives were proposed to be forcibly terminated. When philosopher Maurice Maeterlinck joined in this rhetoric, criticizing physicians for seeking to prolong patients' lives at any cost, practical medicine, represented by physician, writer, and pain management researcher Robert W. McCann, responded: "*abstract arguments about mercy killing of incurable patients are easily picked up when their author has no dealings with such patients and bears no personal responsibility for such actions – medicine is the art of healing, not dealing with death; ultimately, the prize is the death of the patient*" [9]. This excerpt illustrates how far apart practitioners and abstract thinkers can be when discussing techniques and practices not only indirectly affecting the patient but also directly related to his or her life and death. Let us consider in general the main arguments in favor of and against euthanasia.

Arguments in favor of euthanasia

In a 1994 review article, "*Euthanasia. Historical, Ethical, and Empirical Perspectives*", practicing oncologist, bioethicist, and euthanasia opponent, Ezekiel J. Emanuel, concluded that the arguments in favor of euthanasia have remained remarkably constant since they were first articulated in 1870. According to him, they are: 1. Individual autonomy – since there is no universal right to a dignified life for all people and everyone is free to live according to his or her own definition of dignity, society has no choice but to delegate to an individual the right not only to live with dignity, but also to leave life preserving dignity, i.e. to refuse treatment if he or she really wants to; 2. The principle of beneficence/charity, like individual autonomy, is one of the fundamental bioethical principles that equates to "do no harm" and enjoins the physician to act in the best interest of the patient by ending the patient's suffering when it comes to euthanasia; 3. Euthanasia is no different from withholding or withdrawing life-sustaining therapy in terminally ill patients, since the patient eventually dies in both cases. The only difference is that in euthanasia, the doctor himself administers the drug that ends the patient's suffering, and in this the proponents of euthanasia see no moral contradiction, noting, however, that the doctor's actions are fundamentally different in nature; 4. Finally, it is argued that the likely negative consequences of allowing euthanasia are abstract and too speculative to be the basis for public policy on the practice. For example, allowing euthanasia in the Netherlands did not lead to the expected fall in citizens' trust in medical professionals [10].

Arguments against euthanasia

Opponents of euthanasia, selecting counterarguments, turn to the already mentioned basic principles of bioethics. 1. For example, it is believed that individual autonomy does not justify euthanasia. Personal autonomy as an ethical principle is valid only in "ideal conditions", when it is assumed by default that someone's choices, decisions, beliefs and desires are not influenced from the outside, and he/she is not the object of manipulation and/or coercion [11]; 2. The principle of charity/beneficence is also not a sufficient reason for euthanasia, since neither physicians nor the health care system in general currently offer complete protocols for sufficient pain management in hopelessly ill patients, nor are there algorithms to relieve suffering sufficiently, and therefore it is premature to resort to euthanasia; 3. Opponents of euthanasia clearly distinguish, from an ethical standpoint, between "medical homicide", when a physician takes active steps towards ending a patient's suffering, and the termination of the physician's participation in the natural course of an incurable disease that will definitely lead to the patient's death eventually, considering as inappropriate any interventions and as acceptable any passive observation of the death of a terminally ill patient; 4. Finally, opponents of euthanasia consider its legalization as a "perilous public policy", which can have detrimental effects both on the doctor-patient relationship and on medical activity in general. In addition, legalization of euthanasia may undermine the compassionate and humanistic basis of care for the terminally ill, when instead of thoughtful control of the manifestations of the disease, the choice of "alleviating" the patient's suffering and "solving" the doctor's problems, up to the point of ultimately equating killing with healing, is made [10].

The "sloping plane" or "slippery slope" argument is often used when discussing euthanasia. The meaning was conveyed by Justo Aznar, Director of the Bioethics Observatory of the Institute of Life Sciences at the Catholic University of Valencia, in a recent article as follows: "*When a door is opened to give way to an issue with a significant bioethical burden, we know that it will go through it at that time. What we do not know is what will continue to go through that door over time and whether, at some point, what may go through will be ethically illicit.*" [12]. The above paper cites three questionable consequences of legalizing euthanasia: 1. Euthanasia techniques could be applied in non-terminal psychiatric patients who are not in unbearable suffering; 2. It could also be carried out in adolescents, children and neonates; 3. Involuntary euthanasia may be performed [12].

In the book "*Euthanasia, Ethics and Public Policy: An Argument Against Legislation*", the relevant chapter entitled "The Slippery Slope Arguments" begins with this definition: "*… the "slippery slope" is that if a proposal is made to accept A, which people do not agree is immoral, it should nevertheless be rejected because it would likely lead to B, which people universally or generally agree to be immoral*" [13]. The authors further conclude that euthanasia is unacceptable, providing empirical and logical arguments in favor of this position. If euthanasia is acceptable for the "hopelessly ill" who are in "unbearable pain" and who have also given "voluntary and informed consent" by expressing it in the form of a "last wish", then there is no obstacle to "relaxing" the law in the future by allowing those who are "non-terminally ill" but "in chronic pain", for example, "physical discomfort" or "existential crisis", because the autonomy of the individual "does not know" the conditional boundaries defined by the law, and the state, according to the authors, is not able to provide appropriate guarantees and/or make detailed recommendations to ensure the realization of socially acceptable "ideal euthanasia" [13]. The book "*Euthanasia and Assisted Suicide: Lessons from Belgium*" explores the possibility of legalizing voluntary withdrawal from life for people who are dissatisfied with life, without having a terminal illness or unbearable suffering, but do not want to continue living for subjective reasons. As an example, a case is given when a British citizen, "tired of life in modern society" turned to the Swiss organization "Dignitas", where she received medical assistance in dying (MAiD) [14].

As will be shown later, bioethical reflection has traditionally lagged behind medical progress, nevertheless managing to accurately predict the consequences of the "slippery slope".

CLASSIFICATION OF EUTHANASIA: FROM "MEDICAL SUICIDE" TO "DEATH WITH DIGNITY"

As an illustration, we present a classical classification of euthanasia and then trace the evolution of terminology.

1. Voluntary active euthanasia. Intentional administration of drugs or use of other medication leading to the death of a patient, which is carried out at the patient's explicit request and is done after obtaining fully voluntary informed consent;
2. Involuntary active euthanasia. Intentional administration of drugs or use of other medication leading to the death of a patient, which is carried out when the patient was capable but did not expressly request and/or did not give voluntary informed consent to the procedure, e.g. when not asked;
3. Non-voluntary active euthanasia. Intentionally administering drugs or using other medications leading to the death of a patient when the patient is incapacitated and therefore unable to request euthanasia, such as being in a coma or suffering from a psychiatric illness;
4. Termination of life-sustaining treatment (passive euthanasia). Refusing or terminating life-sustaining medical care to allow a patient to die;
5. Indirect euthanasia (indirect euthanasia). Administration of narcotic or other drugs to relieve pain at doses sufficient to depress respiration and cause the patient's death;
6. Physician-assisted suicide. The physician provides the patient with medication or expresses a willingness to intervene, realizing that the patient is thus planning to commit suicide [10].

The last paragraph is of interest, since it is the first time that direct involvement of medical professionals in ending the lives of patients is articulated. There is a characteristic change in the tone of the discourse on "physician-assisted suicide", which is characterized by a shift in emphasis from the potentially disturbing terms "suicide" and "homicide" towards medical *assistance* or *aid in dying*. As defined by the American Medical Association, physician-assisted dying is the "means and/ or information" to facilitate the decision to end one's life [15]. A publication in the pages of the Yale Journal of Biology and Medicine also cites synonyms such as: "right to die", "physician-assigned death", "death with dignity", abbreviations "AiD" ("Aid in Dying") and "MAiD" ("Medical Aid/Assistance in Dying"), which are read as "aid" or derivative of "attendance" and allow euthanasia supporters not only to talk about death, but also to participate directly in it, avoiding negative interpretation of their actions [16]. The authors, taking a neutral position, express concern about the implicit or unintended consequences of legalizing the practice of voluntary death.

First, it is the "suicide contagion" ("suicide infection"), a phenomenon first described by sociologist David Phillips in 1970, which boils down to the following: the suicide of a famous person is followed by a spike in suicides among ordinary members of society [17]. The case of Brittany Maynard, an American activist who suffered from the last stage of glioblastoma, promoted "assisted dying" and voluntarily passed away on November 1, 2014, at the age of 29, is cited as an example. In the months that followed, the number of "deaths with dignity" in Oregon, where euthanasia has been legalized since 1997 by the aptly named Death with Dignity Act [18], doubled [16]. The existence of such organizations as Death with Dignity National Center [19] and Dying With Dignity Canada [20] in the USA and Canada [19], respectively, reflects a targeted policy to popularize voluntary dying. For example, the homepage of the American resource welcomes the user with the slogan "We should all have the right to die with dignity", while the Canadian resource opens with the slogan "It's your life. It's your choice." These resources are not only informational in nature, but also suggest taking an active stance on voluntary death, literally offering to "fight" for the right to euthanasia.

Second, attention is being paid to the problem of clinical depression. Up to half of patients diagnosed with cancer and older adults considering voluntary death have evidence of a depressive disorder, yet they are not specifically screened for depression. These categories of people account for more than 70% of the total number of voluntary deaths in Oregon, with professional psychiatric or psychotherapeutic care offered to less than 5% of them [16]. Official sources provide the following information: for 2021, 383 euthanasia cases were reported in Oregon, and psychiatric evaluation was performed in only 2 patients [21]; in 2020, out of 188 patients, psychiatric care was offered to only 1 patient [22]. In Canada, where euthanasia is also legalized, there were 10,064 cases of voluntary death in 2021, with psychiatric consultation in only 644 of them [23]. Performance of euthanasia in nonterminal psychiatric patients is reflected in the practice of voluntary death by Belgian citizens [24]. In addition to Canada, Belgium, Switzerland, and Oregon, MAiD is now legal in the Netherlands, seven more US states (Washington, California, Montana, Colorado, New Mexico, Maine, Vermont; in Pennsylvania, Michigan, New York, and Massachusetts, bills on legalization of euthanasia are under consideration), Australia, Colombia, Luxembourg, Portugal, Spain, and New Zealand [25].

The above examples allow us to judge about the liberalization of the practice of euthanasia, when a sufficient reason for voluntary death may not be an incurable illness or unbearable suffering of a capable person, but psychiatric disorders, such as depression, schizophrenia, autism spectrum disorders, post-traumatic stress disorder, attention-deficit/hyperactivity disorder, anorexia [26, 27], as well as subjective dissatisfaction with life, "fatigue from it" [14]. A comprehensive review from the first roundtable on ODE, published in the pages of the American Journal of Transplantation in 2022, summarizes the indications for "voluntary medically assisted dying". These include: 1. Unbearable suffering with no prospect of improvement in the patient's condition, 2. Intolerable physical or mental suffering, 3. Persistent physical or mental suffering with no prospect of improvement in the patient's condition, 4. Intolerable physical or mental suffering that cannot be alleviated in a manner acceptable to the person experiencing it, 5. Suffering that cannot be alleviated in a manner acceptable to the person experiencing it (but not necessarily intolerable), 6. Persistent and intolerable physical or psychological suffering (without specifying the possible means of alleviating it), 7. Intense suffering with no available means of alleviating it. The review also specifies under which special medical conditions euthanasia is possible: 1. Incurable disease or condition, 2. Severe illness or disability, 3. Severe progressive illness, 4. Severe, progressive disease that will inevitably lead to the patient's death. However, special medical conditions are not required in the Netherlands, Belgium and Colombia [28]. This information indicates that there is no consensus in the expert community, and the questions remain open as to whether psychological and/or mental suffering can be objectively assessed, whether it is really impossible to cure a severe (not incurable) disease, whether palliative care resources are fully utilized for patients in need of it, and finally, whether civil society representatives are not manipulated by interested professionals.

The popularization of the concept of euthanasia in the Western society indirectly confirms the possibility of such manipulation and creates preconditions for rash and potentially dangerous decisions concerning issues of life and death by representatives of vulnerable social groups. For example, according to the World Health Organization, about 280 million people in the world have depression, more than 700,000 people die due to suicide every year, which, in addition, is one of the leading causes of death in 15–29-year-olds [29].

In connection with the above, the practices of post-euthanasia organ donation in Belgium, Canada, the Netherlands and Spain require special attention, where the humanistic idea of saving the lives of patients in need of transplantation using the organs of those who have decided to die voluntarily may hide a utilitarian desire to radically expand the pool of available donor organs through ethically unsound methods that undermine the altruistic basis of transplantation.

A CRITICAL LOOK AT THE PRACTICE OF ODE

The pioneering experience of ODE belongs to Belgium, where the first such case was recorded in 2005, 3 years after its legalization. While in 2002, only 24 cases of euthanasia were recorded in Belgium, in 2022, 2,966 people voluntarily died, and a total of 30,185 people turned to this practice during the 10-year period [30]. The Netherlands is the leader in terms of the number of people who voluntarily die – euthanasia was approved for 82,963 people between 2002 and 2021 [26]. In Canada, euthanasia was legalized in 2016 and according to the Third Annual Report on Medical Assistance in Dying, which was "proudly" announced by the Minister of Health of Canada, 31,664 people voluntarily died in the country in 2021 [23]. It can be stated that the steady increase in cases of euthanasia in countries where it is legalized has become an epidemic in recent years.

Back in 2017, on the pages of the JAMA Network, a prominent researcher of ODE, Jan Bollen, suggested that about 10% of those who died after euthanasia could become organ donors and praised the prospects of promoting voluntary ODE as an effective way to combat the organ shortage crisis [31]. The practice is in its infancy, as evidenced by the modest rates of organ donation following euthanasia, with only 286 cases of organ donation following voluntary death until 2021 [28]. The unrealized pool of donors in the above countries, if we use the proposed estimate, was approximately 14,500 patients, which cannot be out of the sight of transplant specialists.

In 2016, a team of authors led by J. Bollen, published an article entitled "Organ Donation After Euthanasia: A Dutch Practical Manual" in the American Journal of Transplantation [32], which thoroughly describes the organizational basis of ODE. Special attention is paid to the ethical component of the procedure. The doctor is instructed to find out whether the patient's wish to die is not the result of pressure from the patient in need of transplantation, to try not to interfere with the altruistic intentions of the future donor; it is also indicated that the doctor is obliged to have a conversation about possible ODE in cases where the patient is not aware of such a prospect, appealing to the patient's right to self-determination as a special case of personal autonomy, and forming in him a noble image of the act of donation [32].

In 2023, JBI Evidence Synthesis published a fundamental analysis of the scientific literature on ODE, presented in two parts. The first part focuses on the ethical and legal bases of this practice (these have been discussed above). The second part is devoted to the existing clinical algorithms of ODE. The choice of the publication is characteristic, because "JBI", as follows from the description on its official website, is a global organization that promotes and supports evidence-based solutions and best practices that improve health and health care delivery [33]. It is assumed, apparently, that ODE is an evidence-based solution and the best practice to overcome the organ shortage crisis. So how is the practice of ODE actually implemented?

Organ donation following MAiD is a process that requires implementation of multistep procedures, and this process can occur in the hospital setting, in the patient's home, or start at home and be completed in a hospital setting. Patients who express a desire to become donors after euthanasia are usually hospitalized, as this allows specialists to continuously monitor the patient's condition, moving him or her to the operating room in time to minimize ischemic organ injury. The main stages of voluntary death with subsequent organ donation in the hospital setting are: 1. Receiving a request for MAiD, 2. Processing and confirmation of the request, 3. Discussing the possibility of organ donation at length, 4. Obtaining informed voluntary consent, 5. Conducting the necessary research to confirm the possibility of donation, 6. Planning the procedure for organ donation, 7. Determining the date of the procedure, 8. Hospitalization, 9. Re-affirmation of consent for voluntary death, 10. Actual MAiD, 11. Confirmation of death, 12. Removal of organs [34].

An alternative and, according to the authors, a more humane algorithm for ODE, is the initiation of the procedure of dying at home, in a familiar environment, among relatives. This provides additional comfort and supports the autonomy of the patient's personality. In this case, after receiving a request for MAiD, a special committee is sent to the patient's home, whose members talk to the patient and his relatives about the prospect of organ donation, provide, if necessary, information materials about the euthanasia procedure and the subsequent removal of donor organs, answer questions and express their willingness to provide the necessary support at all stages of the procedure. After receiving voluntary informed consent, the date of the procedure is determined. On the appointed day, the doctor puts the patient into medically induced sleep, conducts physical monitoring for the absence of reaction to external stimuli, then, at home, endotracheal anesthesia is performed, and only after that the future donor is transferred to the hospital, where, without regaining consciousness, he dies with the assistance of doctors and, after death is confirmed, becomes an organ donor [25]. In some cases, the patient's death may occur at home, in which case tracheal intubation is performed after death is confirmed and the deceased is then transported to the hospital for organ donation.

In countries where ODE is possible, the desire to voluntarily pass away is now inextricably linked to the need to decide to carry out organ donation. It is specifically stated that it is not inappropriate to talk to the patient and/or relatives about donation before a final decision on voluntary death has been made. At the same time, emphasis is placed on the correct coverage of both the practice of voluntary death and the prospect of ODE in the mass media since the success of the procedure depends on its perception by the public and awareness of its citizens [34]. It is emphasized that consent to ODE is a dignified and noble expression of the "last will" of the person who has decided to voluntarily leave life, which has an altruistic basis, correlates with the individual autonomy, is fully consistent with the idea of "death with dignity" and allows "*to give the gift of life to those who need it*" [35].

The legitimization of organ donation after euthanasia as a well-established and ethically acceptable practice has laid the foundation for a new, bolder concept – euthanasia following organ donation. This approach is actively debated as "the optimal way to preserve the quality of donor organs" [36, 37]. In this case, the patient dies from organ removal conducted in compliance with almost all the necessary ethical principles: the patient, based on the autonomy of his or her personality, voluntarily agrees to euthanasia by organ donation, acting at the final stage of his or her life for altruistic reasons. One of the fundamental rules of deceased donation remains unresolved: the dead-donor rule, which states that patients must be declared dead before the removal of any vital organs for transplantation.

Solutions, however, are being proposed. In 2021, Gardieu et al. published a contemporary view of the dead-donor rule in the British Journal of Anesthesia. The authors point out the ambiguity of this principle, citing, for example, the regularly changing neurological criteria for death, which have undergone 7 major revisions since the formulation of the Harvard criteria in 1968, and the World Brain Death Project launched in 2019 further confirms the lack of consensus in the professional community [38]. Ultimately, according to D. Gardieu, rules remain rules exactly as long as professionals are willing to follow them.

The American Medical Association Journal of Ethics in 2020 published an article titled 'Reexamining the Flawed Legal Basis of the "Dead Donor Rule" as a Foundation for Organ Donation Policy', which proposes a radical rethinking of it as a flawed way to protect transplant physicians from legal liability and a move toward developing a legal framework for organ donation that would allow organ donation from still-living patients and make "*medically justifiable homicide*" possible, citing the practice of euthanasia as an example of such "*acceptable forms of homicide*" [39]. To support their position, the authors cite the results of a small sociological study conducted in 2015 in the United States, in which participants were asked to answer a hypothetical question about how acceptable they thought it would be for a patient in a coma to die as a result of removal of their organs for transplantation. This practice was considered legally acceptable by 778 out of 1096 respondents [40]. Now it is necessary to wait for the results of similar sociological studies that would consider a hypothetical scenario of euthanasia due to organ donation in patients experiencing not always unbearable suffering, physical or mental, and in some cases feeling dissatisfied with life.

CONCLUSION

Proponents of euthanasia and, among others, the practice of organ donation after voluntary death regard it as a progressive practice based primarily on compassion. At the same time, they are actively criticized by oncologists and palliative care specialists. In their daily practice, these doctors encounter patients whose chances of recovery are slim, so why do they oppose such a humane way of alleviating suffering as voluntary death?

In a critical article published in the Journal of the American Society of Clinical Oncology, Mark A. O'Rourke et al. oppose the legalization of voluntary physician-assisted dying, viewing the practice as perverse and based on the phenomenon of "extreme autonomy," which boils down to the desire of a terminally ill person to control the timing and circumstances of his or her death, with the basis for the demand to end his or her life with the assistance of a physician being not unbearable suffering, but loss of dignity and the inability to engage in "enjoyable activities". The authors refer to the main postulate of palliative care – there is no situation in which nothing can be done, and they consider the practice of medical suicide as fundamentally contrary to the physician's role as professional vocation, who is obliged to use all his or her strength, knowledge and skills to aid the patient, but in no way to kill the patient [41].

In a publication entitled "*Assisted suicide a 20th century problem, Palliative care a 21st century solution*", palliative care physician, Matthew Dore, also strongly criticizes euthanasia, calling it a regressive practice that has nothing to do with "dignity" and "compassion". Here is a short quote from his work, "*Dr Matt, you know, my dad taught me how to use a spoon, ride a bike, wash and dress, to be fair and generous. He taught me how to be a good husband and father, he taught me how to graciously age… he taught me everything I know, and, you know what, he has now taught me how to die as well.*" [42] In this somewhat naïve quote, the true nature of euthanasia is guessed; the recourse to it competes with the natural course of life, deprives it of fulfillment, of finality, when, through tragic experience, we ultimately realize that dying and death are intimate and integral parts of life. Medical suicide appears in this sense as a surrogate way of "dignified" exit from life, creates an unfounded fear of the dying process and deprives us of the understanding that the only way to cope with this fear is to preempt it.

When analyzing the scientific literature on the problem of euthanasia and organ donation after euthanasia, the ambiguous nature of practices established in Europe and the United States becomes evident. There is a degradation of the institute of bioethics, which has turned from a moral guardian of medicine in several countries into an “ethical screen” covering the exploitation of vulnerable individuals and forcing them, in fact, to die (“with dignity”) under the noble pretext of saving someone else’s life. Individual autonomy, altruism, personal dignity and the principle of beneficence are purposefully transformed from the fundamental principles of bioethics into surrogate ethical norms that justify “medical murder” in order to solve the organ shortage crisis.

Back in 2012, Australian philosopher and bioethicist Julian Savulescu and Dominic Wilkinson, Professor of Medical Ethics at the University of Oxford, in their article “Should we allow organ donation euthanasia? Alternatives for maximizing the number and quality of organs for transplantation” urged the professional community to follow the ethical principle of maximum utility in order to “maximize the number of organs for transplantation” [43]. It must be stated that the principle of utility is strictly observed, but, unfortunately, it is not mentioned in publications about the noble “dying with dignity” of not always hopeless patients. The decision to end a person’s life today, with subsequent organ donation or as a result of organ donation, is increasingly delegated to medical specialists, who rely on a detailed legal framework [35] and therefore have no doubts about the ethical justification of their actions, forcing already vulnerable people to die through the temptation of being useful at least in death.

In Russia, euthanasia is prohibited by law and is not recognized by the Russian Orthodox Church [44]. Criticism of euthanasia and organ donation after euthanasia is necessary as additional confirmation of the correctness of the chosen educational policy in our country. Dialogue with society is focused on the basic principles of bioethics, which form the basis of the cultural code of our society. It is aimed at building public consensus in an atmosphere of trust in such a sensitive issue as organ donation and transplantation.

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REFERENCES

1. *Ivanyushkin AY, Yudin BG, Popova OV, Reznik ON.* First human heart transplantation in the national and foreign history of medicine. *Russian Journal of Transplantology and Artificial Organs.* 2017; 19 (3): 104–115. (In Russ.). doi: 10.15825/1995-1191-2017-3-104-115.
2. A Definition of Irreversible Coma: Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death. *JAMA*. 1968; 205 (6): 337–340. doi: 10.1001/jama.1968.03140320031009.
3. *Dominguez-Gil B*. International figures on organ, tissue & hematopoietic stem cell donation & transplantation activities. Documents produced by the Council of Europe european committee (partial agreement) on organ transplantation (cd-p-to). *Council of Europe and Organización Nacional de Trasplantes.* 2023.
4. *Gautier SV, Khomyakov SM.* Organ donation and transplantation in the Russian Federation in 2022. 15th Report from the Registry of the Russian Transplant Society. *Russian Journal of Transplantology and Artificial Organs*. 2023; 25 (3): 8–30. [In Russ, English abstract]. doi: 10.15825/1995-1191-2023-3-8-30.
5. minzdrav.gov.ru [Internet]. Otchet glavnogo vneshtatnogo spetsialista transplantologa Minzdrava Rossii S.V. Gautier ob itogakh raboty v 2020 godu. [cited 2023 Nov 02]. Available from: https://static-0.minzdrav.gov.ru/system/attachments/attaches/000/057/001/original/%D0%9E%D1%82%D1%87%D0%B5%D1%82_%D0%B7%D0%B0_2020_%D0%B3%D0%BE%D0%B4_%D0%93%D0%BE%D1%82%D1%8C%D0%B5.pdf?1625044703.
6. *Gourevitch D*. Suicide among the sick in classical antiquity. *Bulletin of the History of Medicine.* 1969; 43 (6): 501–518. PMID: 4904692.
7. *Momeyer RW*. Western philosophical thought. In Encyclopedia of bioethics. Vol. 1. Ed. W.T. Reich. New York: Macmillan Library Reference, 1995: 498–504.
8. *Papadimitriou JD, Skiadas P, Mavrantonis CS, Polimeropoulos V, Papadimitriou DJ, Papacostas KJ.* Euthanasia and suicide in antiquity: viewpoint of the dramatists and philosophers. *J R Soc Med.* 2007; 100 (1): 25–28. doi: 10.1177/014107680710000111. PMID: 17197683.
9. *Lewis MJ*. Medicine and Care of the Dying: A Modern History. New York; 2006. doi: /10.1093/acprof:oso/9780195175486.002.0003.
10. *Emanuel EJ.* Euthanasia. Historical, ethical, and empiric perspectives. *Arch Intern Med*. 1994; 154 (17): 1890–1901. doi: 10.1001/archinte.154.17.1890. PMID: 8074593.
11. *Varelius J.* The value of autonomy in medical ethics. *Med Health Care Philos.* 2006; 9 (3): 377–388. doi: 10.1007/s11019-006-9000-z. PMID: 17033883.
12. *Anzar J.* The slippery slope of euthanasia. *Medicina e Morale.* 2021; 1: 111–120.
13. *Keown J.* Euthanasia, Ethics and Public Policy An Argument against Legalisation. 1st ed. Cambridge University Press; 2002.
14. *Jones DA, Gastmans C, MacKellar C.* Euthanasia and Assisted Suicide (Lessons from Belgium). Cambridge University Press; 2017.
15. www.ama-assn.org [Internet]. Opinions on caring for patients at the end of life. AMA Code of Medical Ethics, 2016 [cited 2023 Nov 13]. Available from: https://www.ama-assn.org/sites/default/files/media-browser/code-of-medical-ethics-chapter-5.pdf.
16. *Dugdale LS, Lerner BH, Callahan D.* Pros and Cons of Physician Aid in Dying. *Yale J Biol Med.* 2019; 92 (4): 747–750. PMID: 31866790.
17. *Phillips DP.* The influence of suggestion on suicide: substantive and theoretical implications of the Werther effect. *Am Sociol Rev*. 1974; 39 (3): 340–354. doi: 10.2307/2094294.

18. www.oregon.gov [Internet]. Oregon's Death with Dignity Act [cited 2023 Nov 13]. Available from: https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/index.aspx.
19. https://deathwithdignity.org/ [Internet]. Death with Dignity [cited 2023 Nov 13]. Available from: https://deathwithdignity.org/.
20. https://www.dyingwithdignity.ca/ [Internet]. Dying with Dignity [cited 2023 Nov 13]. Available from: https://www.dyingwithdignity.ca/.
21. www.oregon.gov [Internet]. Oregon Death with Dignity Act 2021 Data Summary [cited 2023 Nov 13]. Available from: https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year.
22. www.oregon.gov [Internet]. Oregon Death with Dignity Act 2020 Data Summary [cited 2023 Nov 13]. Available from: https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year.
23. www.canada.ca. [Internet]. Medical assistance in Dying in Canada 3rd annual report [cited 2023 Nov 13] Available from: https://www.canada.ca/en/health-canada/services/medical-assistance-dying/annual-report-2021.html.
24. *Thienpont L, Verhofstadt M, Van Loon T, Distelmans W, Audenaert K, De Deyn PP.* Euthanasia requests, procedures and outcomes for 100 Belgian patients suffering from psychiatric disorders: a retrospective, descriptive study. *BMJ Open*. 2015; 5 (7): e007454. doi: 10.1136/bmjopen-2014-007454. PMID: 26216150.
25. *Silva E Silva V, Silva AR, Rochon A, Lotherington K, Hornby L, Wind T et al.* Organ donation following medical assistance in dying series: a scoping review – Part 2 – existing processes and procedures. *JBI Evid Synth*. 2023. doi: 10.11124/JBIES-22-00140. PMID: 37489247.
26. *Van Dijk N, Stärcke P, de Jongh W, Jansen N, Shaw D, Bollen J et al.* Organ Donation After Euthanasia in Patients Suffering From Psychiatric Disorders: 10-Years of Preliminary Experiences in the Netherlands. *Transpl Int*. 2023; 36: 10934. doi: 10.3389/ti.2023.10934. PMID: 36846601.
27. *Trachsel M, Jox RJ.* Suffering is not enough: Assisted dying for people with mental illness. *Bioethics*. 2022; 36 (5): 519–524. doi: 10.1111/bioe.13002. PMID: 35045199.
28. *Mulder J, Sonneveld H, Van Raemdonck D, Downar J, Wiebe K, Domínguez-Gil B et al.* Practice and challenges for organ donation after medical assistance in dying: A scoping review including the results of the first international roundtable in 2021. *Am J Transplant.* 2022; 22 (12): 2759–2780. doi: 10.1111/ajt.17198. PMID: 36100362.
29. www.who.int [Internet]. Depressive disorder (depression) [cited 2023 Nov 13]. Available from: https://www.who.int/news-room/fact-sheets/detail/depression.
30. www.statista.com [Internet]. Number of registered euthanasia instances in Belgium from 2002 to 2022 [cited 2023 Nov 13]. Available from: https://www.statista.com/statistics/1098051/number-of-euthanasia-instances-registered-in-belgium.
31. *Bollen J, van Smaalen T, ten Hoopen R, van Heurn E, Ysebaert D, van Mook W.* Potential Number of Organ Donors After Euthanasia in Belgium. *JAMA*. 2017; 317 (14): 1476–1477. doi: 10.1001/jama.2017.0729.
32. *Bollen J, de Jongh W, Hagenaars J, van Dijk G, Ten Hoopen R, Ysebaert D et al.* Organ Donation After Euthanasia: A Dutch Practical Manual. *Am J Transplant*. 2016; (7): 1967–1972. doi: 10.1111/ajt.13746. PMID: 26842128.
33. https://jbi.global/ [Internet]. About JBI [cited 2023 Nov 13]. Available from: https://jbi.global/about-jbi.
34. *Silva E Silva V, Silva AR, Rochon A, Lotherington K, Hornby L, Wind T et al.* Organ donation following medical assistance in dying: a scoping review – Part 1 – legal and ethical aspects. *JBI Evid Synth*. 2023. doi: 10.11124/JBIES-22-00143. PMID: 37477350.
35. *Tajaate N, Dijk N, Pragt E.* Organ donation after euthanasia starting at home in a patient with multiple system atrophy. *BMC Med Ethics*. 2021; 22: 120. doi: 10.1186/s12910-021-00686-4.
36. *Bollen J, Shaw D, de Wert G, Hoopen R, Ysebaert D, van Heurn E et al.* Organ donation euthanasia (ODE): performing euthanasia through living organ donation. *Transplantation.* 2020; 104 (S3): S298. doi: 10.1097/01.tp.0000700004.43157.0a.
37. *Shapiro M.* Euthanasia by Organ Donation. *Dal LJ.* 2018; 41 (1): 153.
38. *Gardiner D, McGee A, Shaw D.* Two fundamental ethical and legal rules for deceased organ donation. *BJA Educ.* 2021; 21 (8): 292–299. doi: 10.1016/j.bjae.2021.03.003. PMID: 34306730.
39. *Schweikart SJ.* Reexamining the Flawed Legal Basis of the "Dead Donor Rule" as a Foundation for Organ Donation Policy. *AMA J Ethics*. 2020; 22 (12): 1019–1024. doi: 10.1001/amajethics.2020.1019. PMID: 33419501.
40. *Nair-Collins M, Green SR, Sutin AR.* Abandoning the dead donor rule? A national survey of public views on death and organ donation. *Journal of Medical Ethics.* 2015; 41: 297–302. doi: 10.1136/medethics-2014-102229.
41. *O'Rourke MA, O'Rourke MC, Hudson MF.* Reasons to Reject Physician Assisted Suicide/Physician Aid in Dying. *J Oncol Pract.* 2017; 13 (10): 683–686. doi: 10.1200/JOP.2017.021840. PMID: 28850311.
42. *Doré M.* Assisted suicide a 20th century problem, Palliative care a 21st century solution. *Ulster Med J.* 2023; 92 (1): 4–8. PMID: 36762139.
43. *Wilkinson D, Savulescu J.* Should we allow organ donation euthanasia? Alternatives for maximizing the number and quality of organs for transplantation. *Bioethics*. 2012; 26 (1): 32–48. doi: 10.1111/j.1467-8519.2010.01811.x. PMID: 20459428.
44. Osnovy sotsial'noy kontseptsii Russkoy pravoslavnoy tserkvi. M.: Izdatel'stvo Moskovskoy patriarkhii, 2001.

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