OPINION

# Why We Should be Wary of Organ Donation After Assisted Dying

Dr John Kleinsman

When it is freely offered, the donating of organs to another human represents a rich gesture of generosity – a true and deeply personal gift that brings life to others and alleviates suffering.

When it is practised within ethical systems that uphold the act of donation as a gift rather than a transaction, it is at the same time an expression of human solidarity that serves the common good of society.

Often as not, the availability of organs for transplant is the result of a tragic situation such as a motor accident, or similar, that leaves a person 'brain-dead'.

The gift of organs to others against this sort of backdrop ensures some good comes from an otherwise tragic situation.

Some will think that this also applies in the case of assisted dying by organ donation (ADOD) – an opportunity for good in the face of the untimely premature death of another.

There is, no doubt, a shortage of organs for donation in Aotearoa New Zealand. For this reason, and following the logic above, many welcome and embrace the opportunities for greater availability of organs as a result of ADOD.

Simply put, there is the potential to increase the number of organs that will be available, albeit a very small increase – as few as one or two a year.

Put otherwise, many will argue that denying patients opting for AD the opportunity to donate their organs deprives others of a life-saving transplant. This utilitarian way of framing the issue is the only factor considered by Organ Donation New Zealand (ODNZ) in adopting this new practice.

It is, however, inadequate by itself as a criterion for deciding if assisted dying by organ donation is a societally good practice to be encouraged.

From my perspective, there are additional societal consequences that arise from ADOD, including its potentially negative impact on medical practice as well as the potential to perceive people who are dying in a more objectified and less dignified way – as a source of 'body-parts', something that will potentially create a new and coercive dynamic around death.

A key ethical concern, readily recognised, is the need to ensure that the process of applying for an assisted death is kept strictly separate from any decision to donate one's organs.

The two actions, it is generally accepted, should be kept separate so that the act of donating does not become part of the motivation for an assisted death.

It is easy to understand how organ donation could become a significant motivator for an assisted death and, perhaps in time, even an expectation.

If people are persuaded, even with their own clear consent, to do something they would not have otherwise done, this slips closer and closer to coercion.

Further, and of great concern, is the impact of the process of decision making and the retrieval of a person's organs on the many, many health professionals involved in the transplantation process.

Those doctors and nurses involved in the assisted death process will only be doing so because they have no opposition to intentionally ending a person's life. The law in our country ensures that no doctors with a conscientious objection need ever be involved in AD – that is an inviolable right that is guaranteed in law. That right, however, will potentially be threatened for doctors who are part of the teams directly associated with the retrieval and transplanting of the organs. While we might think of the two processes (ending a patient's life and retrieving their organs) as separate, the reality in practice is that the different medical teams have to collaborate closely. In other words, the organ retrieval team, whether they like it or not, will be intimately involved in the way the patient dies; they become inherently linked with the act of directly, intentionally and prematurely ending a patient's life. This is anathema to many doctors who enter medicine and stay in medicine to save lives and who, in conscience, could never be party to directly ending a person's life.

Ultimately, ADOD amounts to an erosion of the legally guaranteed rights of doctors caring for patients outside of assisted dying.

Organ donation is critically dependent on Intensive Care Specialists in NZ. If organ donation after assisted death is to become part of their 'scope of practice', this will exclude people who would add much needed diversity to their numbers, including doctors from minority ethnic or religious groups that are generally uncomfortable with assisted dying.

As far as I am aware, this was not considered by ODNZ who have made the decision to proceed after consulting with only a small group of 'insiders'.

Finally, as I understand it, the recipients of the organs will not be told if their potential donor died from ADOD; from an act that 35% of New Zealanders regarded as wrong and/or too dangerous to legislate in the 2020 Referendum. This violates the autonomy of

the organ recipients. To argue that the way in which the organs were obtained somehow does not matter is to take a narrow and objectified view of body parts – to treat them no differently to the way one might purchase used parts for one's vehicle, for example.

ADOD is not a straight-forward decision, although it has arguably been treated as if it is by ODNZ. It is unfortunate, and from an ethical perspective seriously inadequate, that the broader medical profession, as well as the wider public, were not given any opportunity for input into assessing the introduction of ADOD in Aotearoa New Zealand.

**Dr John Kleinsman** is Kaitohu/Director of the Nathaniel Centre for Bioethics.