

‘A last act of grace’? Organ donation and euthanasia in Belgium

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Introduction

Since the very first successful kidney transplant in 1954, (Merrill *et al.* 1958), organ transplantation has become one of the great success stories of modern medicine. It is highly cost-effective (Machnicki *et al.* 2006) and with many of its technical and immunological challenges largely overcome¹, the primary limiting factor preventing more patients benefiting from transplantation is the shortage of organs.

Belgium is one of eight countries² collaborating together as Eurotransplant³, an organization that aims to ‘ensure an optimal use of available donor organs’⁴ between member states. There were 14,928 patients on the Eurotransplant organ-transplant waiting list as of 1st January 2015, with only 7,194 transplants from deceased donors having taken place during the preceding year and 1,299 patients dying whilst still waiting.⁵

The total number of patients on the transplant waiting list in Belgium at the start of 2015 was 1,248 (of whom 821 were awaiting a kidney), with 819 deceased donor transplants taking place and 80 patients on the list dying during 2014.⁶ In terms of the total number of transplants (from deceased and living donors) carried out per million population, Belgium (82.6 in 2014) is in the top three Eurotransplant countries after Austria (92.5 in 2014) and Croatia (83.1 in 2014).

As well as being highly successful, transplantation has also been one of the most universally accepted of modern medical advances. Such ethical issues as do arise, as with those considered in this chapter, are to do with the sourcing of organs rather than on the practice of transplantation *per se* which is endorsed in principle at least, by all the major world faiths (Oliver *et al.* 2011).⁷

¹ Rejection (Kim *et al.* 2014) and thrombosis (Harraz *et al.* 2014) however do still present ongoing challenges

² The others are Austria, Croatia, Germany, Hungary, Luxembourg, the Netherlands and Slovenia.

³ <https://www.eurotransplant.org>

⁴ https://www.eurotransplant.org/cms/index.php?page=about_brief

⁵ <https://www.eurotransplant.org/cms/index.php?page=home> (accessed 8/4/2015)

⁶ <http://statistics.eurotransplant.org/> (accessed 8/4/2015)

⁷ Though some minority groups, notably Jehovah’s Witnesses, do not support it in principle.

It is not surprising then that the default mode of many clinicians and ethicists, when considering any means to enlarge the pool of donors is to ask ‘Why not?’ rather than ‘Why?’ After all ‘*Careless Thought Costs Lives*’, as the title of a recent book advocating (*inter alia*) payment for organs, presumed consent and abandoning the dead donor rule bluntly puts it (Radcliffe Richards 2013). Organ donation following euthanasia (hereafter ODfE) has been practiced in Belgium for quite some time. More recently euthanasia by vital organ removal has been suggested as an improvement over ODfE for maximizing both the number and quality of organs for transplantation. This latter procedure (which at the time of writing remains entirely hypothetical and is not currently practiced) has been dubbed variously organ donation euthanasia (ODE) by Wilkinson and Savulescu (2011) and euthanasia by removal of vital organs (RVO) by Coons and Levin (2011). I will refer to it here as euthanasia by removal of vital organs (ERVO) to clearly distinguish it from the already established current practice of ODfE. As Wilkinson and Savulescu observe, inasmuch as both of these options ‘conflict with ethical norms governing transplantation to varying degrees, the cost of preserving those norms will be the death or ongoing morbidity of many individuals’ (2011, p. 33). A utilitarian ethical analysis will always tend to gravitate towards expanding the pool of donors from whom organs can be taken.

The Belgian act on euthanasia and organ donation

In October 2001, the Belgian Senate passed the proposal of a report approved by a Senate commission to legalise euthanasia. This resulted in the *Belgian Act on Euthanasia*⁸ of May 28th 2002. This Act was amended on February 13, 2014, to legalize euthanasia by lethal injection for children with no lower age limit. There are a number of elements of both the original 2002 Act and the 2014 amendment which are especially relevant with respect to organ donation. Section 3.1 of the 2002 Act states that (*inter alia*) euthanasia may be carried out on his or her request if

⁸<http://www.ethical-perspectives.be/viewpic.php?TABLE=EP&ID=59> gives an English translation of the 2002 Act

the adult or emancipated minor patient is in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, and that results from a serious and incurable disorder caused by illness or accident.

This means that the patient does not have to be terminally ill and indeed may be in perfect physical health, since mental illness and suffering are specified as being sufficient grounds in themselves for euthanasia to be legally carried out. This increases the pool of potential organ donors amongst euthanasia cases considerably as many terminally ill patients, including most of those with malignant disease would not be suitable as organ donors because of the risk of transplanting cancerous cells to the recipient. The documented rise in euthanasia for 'neuropsychiatric' conditions (including depression) from 6 reported cases in 2004 to 67 in 2013 and the increase in percentage of euthanasia for non-cancer patients from 6% to 15% of the total of reported cases in the same years, both imply an increase in the potential ODfE donor pool (FCECE 2006, FCECE2014).

If the donor organs are taken from children and adolescents, this would be even better for organ quality and in addition expands the availability of organs for transplants for sick children. Section 3.1 of the 2014 amended Act also now permits euthanasia when

the minor with the capacity of discernment is in a medically futile condition of constant and unbearable physical suffering that cannot be alleviated and that will result in death in the short term, and that results from a serious and incurable disorder caused by illness or accident.

This clause, however, imposes three additional restrictions for minors– the child must have 'the capacity of discernment', he or she must have a terminal illness, and mental suffering is excluded as sufficient criterion. In practice, this is likely to restrict greatly the pool of children who would be suitable to be organ donors following euthanasia. Furthermore, Section 3. 2.7 states the euthanizing doctor must, '*when the patient is an unemancipated minor, consult, in addition, a child psychiatrist or a psychologist, and inform him about the reasons for this consultation.*'

However, this is only for the purposes of written certification of the child's capacity of discernment.

The second specialist is *not* required to offer an independent opinion on whether they consider euthanasia appropriate in the specific case.

In addition, the wording of the Act only specifies that the *legal representatives* of the child have to *agree with the request of the minor*. The child's parents are not specifically mentioned at all.

Section 3.1 also specifies that for euthanasia to be legal, '*the request is voluntary, well-considered and repeated, and is not the result of any external pressure*'.

This criterion applies equally to both adults and children and it should be noted that the legality of organ donation after euthanasia may constitute an external pressure *in itself* and one to which children are especially vulnerable. Children with capacity of discernment may, never the less, not be competent to evaluate the conflicting motivations and emotions surrounding the possibility of saving the lives of others by their own death. The ethics and practicalities of separating the request for euthanasia from consent to organ donation are fraught with complexity in adults let alone in children whose decision only has to meet with the agreement of their legal representatives who sometimes will not be their parents but representatives of the State.

One final relevant point to note about the text of the *Belgian Act on Euthanasia* is that there is no requirement in the reporting on individual cases of euthanasia to specify if organs for transplant were taken from the deceased. Hence information on this practice is absent from official reports on euthanasia in Belgium.

Impact of the *Belgian act on euthanasia* on organ transplantation

Since the introduction of the Act, the number of cases of euthanasia has risen sharply. A recent analysis (Chambaere *et al.* 2015a) of records of almost 4000 doctors in Flanders (the northern, Dutch-speaking part of Belgium) showed that one in twenty people died by euthanasia in 2013. The percentage of euthanasia deaths increased from 1.9% of all deaths in 2007 to 4.6% of all deaths in 2013. The authors state that 'the overall increase relates to increases in both the number of

requests (from 3.5 to 6.0% of deaths) and the proportion of requests granted (from 56.3 to 76.8% of requests made).'(2015, p. 1179)

Though many of these cases will be in patients with advanced malignant disease, not all of them will be and as the numbers of cases with organs suitable for transplantation rise so, the utilitarian moral pressure for not letting these organs 'go to waste' inevitably rises in parallel. This is well-illustrated by Dr David Shaw, a bioethicist at the University of Basel who, in a recent interview (Wurz 2014), stated in response to a question about using organs from physician-assisted-suicide (PAS) cases in Switzerland:

This is a situation where you have people who want to die, you know when they're going to die, and many of them are probably registered organ donors. So it's also more respectful to the people to let them do this final kind of parting gift to humanity. The trouble when you have an idea like this is that some people might get a hold of it and say, 'These crazy ethicists. They want to kill everyone and take their organs out.' Not the case at all. I'm just saying, people are dying because we don't have enough organs.

While I am sure it is the case that Dr Shaw does not want to 'kill everyone', it is equally true that he is not *just* saying that people are dying because of organ shortages. He is actively advocating that the organs of at least registered donors should be taken from PAS cases and is also on record that he does not consider the family should have any right of veto where donors have clearly stated their wishes in advance (Shaw 2012).

Detry *et al.* from the University of Liege, describe the case of a 44 year old woman with locked-in syndrome who, the day before her euthanasia in 2007, 'expressed her will of after-death organ donation' (Detry *et al.* 2008, p. 915). Her liver and kidneys were removed and transplanted and one year later all three recipients were 'enjoying normal graft function'. The authors conclude that the case 'demonstrates that organ harvesting after euthanasia may be considered and accepted from ethical, legal, and practical viewpoints in countries where euthanasia is legally accepted.'(2008, p.

915). It is important to note they offer no moral argument for its acceptance but rather assume and assert acceptance of such surgery as the inevitable consequence of its effectiveness.

Eurotransplant has been accepting organ donations from euthanasia cases since 2007 (Detry *et al.* 2008; Ysebaert *et al.* 2009) and in 2011, a team from the thoracic surgery department at the University Hospitals, Leuven (Van Raemdonck *et al.* 2011) favoured the suggestion that euthanasia donors should have their own classification code- controlled DCD (Donor after Circulatory Death) Category 5, added to the four existing categories of DCDs identified in the 1995 Maastricht classification.⁹ (Koostra *et al.* 1995). The reason they advanced for this new category is that, though euthanasia donors resemble Maastricht Category 3 donors (awaiting cardiac arrest in a non-brain-dead patient), in that their organs will inevitably undergo a period of warm ischemia following death, most euthanasia donors will not be on life support on a ventilator (indeed if they were, euthanasia would almost always not be necessary). The mode of death by lethal injection in euthanasia is completely different from (and more certain than) the hypoxic cardiac arrest following ventilator switch-off. This means that with even greater control of the process of death, the state of the organs can be optimized for transplantation with even greater precision. It was therefore considered important to classify them in a different Maastricht Category so that, over time, the anticipated better survival rates and lower morbidity from organs from euthanasia cases could be confirmed or refuted.

At the 21st European Conference on General Thoracic Surgery in Birmingham UK in 2013, a Belgian team reported that 6 (12.8%) of their patients undergoing lung transplants from controlled DCDs, received their organs from Category 5 donors between January 2007 and December 2012 (Van Raemdonck *et al.* 2013). At five years post-op, only one of the 6 recipients had died (3 months after surgery from an unrelated cardiac problem). The authors concluded 'Immediate post-transplant graft function and long term outcome in recipients was excellent. *More euthanasia donors are to be*

⁹ In the latest version (4.1 February 16th 2015) of the Eurotransplant Manual however it specifically states in Chapter 9 The Donor that 'DCD after euthanasia is reported as DCD III and documented as euthanasia'.
https://www.eurotransplant.org/cms/mediaobject.php?file=Chapter9_theonor29.pdf #

expected with more public awareness' (Italics mine). It is not clear if this greater public awareness is expected to increase the number of offers to donate organs from a steady state of euthanasia requests or if the authors expect that the total numbers of requests for euthanasia might also increase.

The procedure of Organ Donation following Euthanasia (ODfE)

The most detailed account to date of the actual mechanism and procedure of organ donation after euthanasia (Van Raemdonck *et al.* 2011) is interesting. The transplant team stress their 'independence' from both the physicians granting the euthanasia request and the 'three independent physicians as required by Belgian law for every organ donor' (2011, p. 41) who pronounce and certify the donor's death. The nature of these other physicians' 'independence' is not specified but presumably only extends to their not working on the same team. It does not seem practicable that they would all have to come in from other hospitals.

An ambivalence in the Van Raemdonck paper raises further concerns. The authors state, 'Only patients suffering from a debilitating benign disease such as a neurological or muscular disorder are considered suitable for donation' (2011, p. 45). This is probably specified to make clear that most patients with malignant disease would not be suitable donors. However what is not spelled out is that though three of the four cases they describe, fall into the '*only*' suitable categories they mention, the remaining one is stated to have been euthanized at the age of 52 for an unspecified *mental* illness.

Whether then euthanasia is requested for mental or physical illness, a few hours before being carried out, the donors had a central venous line inserted in a room adjacent to the operating theatre. They were then heparinised 'immediately before a cocktail of drugs was given' (Van Raemdonck *et al.* 2011) by the euthanasing doctor. What the 'cocktail' consisted of is not specified in the paper. This is curious since lethal injections may have a variety of toxic effects which may be of no importance if euthanasia is the only aim. Drugs given to stop the heart in euthanasia are

usually intended to stop it beating forever; with hearts to be used for transplantation, this would however be counter-productive. This is a principal reason why currently, hearts from cases of euthanasia, are *not* suitable for transplant. Written details of the precise lethal injection protocol in Belgium prior to organ donation are remarkably elusive, though it is likely to parallel the Dutch protocol for euthanasia (Royal Dutch Society for the Advancement of Pharmacy 1994).

Immediately after certification of cardiopulmonary death, the donor was moved into the operating theatre, intubated, shaved, cleaned, disinfected and draped and a sterno-laparotomy performed. The abdominal aorta was cannulated to enable a rapid flush cooling of the abdominal organs to preserve the liver and kidneys. The pleural cavities were then opened and topical cooling of the lungs initiated with ice cold saline. The lungs were then prepared for explantation and removed before being transported to the recipient hospital.

The ethics of organ donation following euthanasia

One of the features that has undoubtedly facilitated the increase in organ donation worldwide has been the element of altruism involved and the freedom from coercion. This is perhaps why in discussing ODfE, Cohen-Almagor states that it might also, along with other categories of donation, be viewed as a 'last act of grace' (2013, p. 517)

In 2008, the Ethics Committee of Eurotransplant passed six recommendations on organ donation after euthanasia (Eurotransplant 2008) which state: _

1. Euthanasia has to be an accepted procedure in the legal framework of the donor country.
2. The euthanasia procedure and the determination of death after the euthanasia procedure have to be in line with national law and national practices.
3. The euthanasia procedure itself and the explantation should follow a clear protocol.
4. The euthanasia procedure and the organ retrieval as well as the organ allocation should be kept as separate as possible.
5. All donors have to be reported to Eurotransplant (ET), the allocation should follow the NHBD (non-heart beating donor) allocation rules in the recipient's country.

6. Organs from donors after a euthanasia procedure shall only be allocated to patients registered on the waiting list for organ transplantation in ET, and within ET, in countries that accept the transplantation of this type of donor organ. In addition the possibility to indicate the acceptance of organs from donors after a euthanasia procedure should be added to the center- and patient-specific donor profiles in ENIS (Eurotransplant Network Information System)

Apart from listing these criteria, the only other two ethical concerns emphasized by the Leuven transplant team are 1) organ donation should not be discussed with (and presumably not raised by) the physician intending on performing euthanasia until after the 'request for euthanasia is granted according to law' and 2) the request for and execution of euthanasia should be clearly separate from the organ procurement in order 'to exclude any conflict of interest between the donor and the recipient and between the teams involved.' (Van Raemdonck *et al.* 2011, p. 45)

The separation between granting the request for euthanasia and the discussion of organ donation in this way may, however, be much more difficult in practice than in theory. Firstly it is completely contrary to the increasing trend of raising the possibility of organ donation at as early a stage as possible in most other situations where such donation can be foreseen. In the first reported case of donation after euthanasia (Detry *et al.* 2008, p. 915) it is stated that the patient only raised her intention of organ donation the day before her planned euthanasia. Whilst this would indeed indicate, in this case, a clear temporal separation between the two intentions, it does raise questions about why the desire to donate suddenly arose only 24 hours before death and a possibly indecent haste to make the necessary donation arrangements rather than postponing the euthanasia for a day or two.

However, at the other end of the time spectrum from last minute decisions, a dossier from the European Institute of Bioethics, *Euthanasia in Belgium: 10 years on* questions a new practice of accompanying a request for euthanasia with a form for organ donation to be filled out by the patient. To what extent does this possibility risk weighing on the decision taken by a patient who

believes that his or her existence is worthless? Does the patient still meet the conditions required by the law – i.e. without any external pressure – in order to formulate a request for euthanasia, when he/she is invited at the same time to agree to organ donation?’ (de Diesbach *et al.* 2012, p. 7)

As well as the timing of discussion about organ donation, there is also the question of who first raises the issue. In the 2011 report of Van Raemdonck *et al.*, almost a quarter of their lung donors after cardiac death from 2007-2009 were from euthanasia donors whereas reported euthanasia cases only accounted for 0.49% of deaths in 2007. Drawing attention to this striking disparity, Cohen Almagor comments:

More research needs to be conducted as to who raised the issue of organ transplantation. Is it the patient or someone else? If not the patient, questions need to be raised regarding the motives for raising the issue with the patient..... The concern is that patients might be motivated to consider euthanasia for the purpose of organ procurement and that the planning of the death procedure might be against the wishes of the patient, against her best interests, premature and possibly for profit. Adequate checks need to be squarely in place to ascertain that such abuse does not happen (2013, pp. 517-8).

The language used by the authors of a recent paper supporting organ acquisition after euthanasia shows that such abuse could easily happen when they affirm that euthanasia, as in the Detry case (2008), would ‘make organ donation possible for some patients who would not otherwise be able to donate. In an extreme case, they might choose to undergo euthanasia *at least partly to ensure their organs could be donated*’ (Wilkinson and Savulescu 2012, p. 42). The ease with which one can move from euthanasia *followed by* organ donation to euthanasia (at least in part) *for* organ donation could not be clearer.

As we have seen, the numbers of reported cases of ODfE in Belgium are very small so far and even if the rising trend for euthanasia continues at its current rate from 1.9% of deaths in 2007 to 4.6% in 2013 (Chambaere *et al.* 2015a, p. 1179), they are likely to remain low, since as already noted ‘the majority of patients requesting euthanasia do not fulfil the criteria for organ donation because of

terminal cancer' (Van Raemdonck *et al.* 2011, p. 45). However the numbers of suitable donors could be much larger and hence many more lives saved by their organs, if both the mode and scope of euthanasia for organ donation were to change. It is such future possibilities that will now be considered as Belgium is well-placed to be the first country to change its euthanasia Act to incorporate them, just as readily as it has already amended it to permit euthanasia of children.

Euthanasia by Removal of Vital Organs (ERVO)

In their paper quoted earlier, Wilkinson and Savulescu propose that since all methods used so far to increase the number of organs donated, whether changes to consent arrangements or improvements to optimize the donation infrastructure within hospitals and nations as well as internationally, have failed to relieve the shortage, a more radical alternative is needed. As the centrepiece of seven specific *Options for increasing the number and quality of organs from LSW¹⁰ donors*,¹¹ they advocate the use of cardiac and neuro- euthanasia followed by organ donation, and ERVO as 'rational improvement(s) over current practice regarding *withdrawal of life support*' (2012, p. 32) (Italics mine).

Though Wilkinson and Savulescu note that 'organ donation after cardiac euthanasia has been described in a patient¹² in Belgium' (2012, p.42), they immediately recognise that this would lead to a lower overall total of available organs than is possible from a heart-beating donor. They therefore proposed what they term neuro-euthanasia in which (after general anaesthesia *if* there were 'concerns about possible discomfort to the patient' (2012, p. 42)) bilateral catheter occlusion of the internal carotid and vertebral arteries would be carried out to cause brain death while life support was continued to preserve the other vital organs. Though the number of organs (and specifically hearts) suitable for donation from neuro-euthanasia would be likely greater than from cardiac euthanasia, brain death can also compromise organ function and quality. For this reason, they prefer

¹⁰ Life Support Withdrawal (LSW)

¹¹ The other four are changes to consent processes, organ donation prior to natural death, non-brain ante-mortem ECMO (Extracorporeal Membrane Oxygenation) and reducing the asystolic period prior to cardiac death.

¹² The case described by Detry *et al* see page X of this chapter

ERVO¹³ over neuro-euthanasia as a means of maximising organ availability as well as pointing out that in those countries that already permit euthanasia, it is unlikely that neuro-euthanasia would be widely undertaken when ERVO serves the purpose of organ optimization far better.

The logic of Wilkinson and Savulescu's argument appears irrefutable from a utilitarian perspective. Since it is both permissible a) to withdraw life support from a patient in whom further treatment is considered futile and b) to remove their organs after they have died, why they then ask 'should surgeons have to wait until the patient has died as a result of withdrawal of advanced life support or even simple life prolonging medical treatment?' (2012, p. 41).

Far better they suggest, both from the point of view of organ optimization and less suffering for the patient, to carry out euthanasia by anaesthetising and removing the requisite organs including the lung and heart *to cause* death. A win-win scenario they claim, since no one dies 'who would not otherwise have died (Wilkinson and Savulescu 2012, p. 41) and more organs can be taken in total, as even the heart can be used and there will be less ischaemic time before all organs are removed.

Furthermore patients and their relatives could rest assured that their organs would actually be more likely to be transplanted rather than in donation after circulatory death (DCD) cases following withdrawal of life support, when many patients do 'not die sufficiently quickly.... for organ retrieval' (Wilkinson and Savulescu 2012, p. 41).

These claims however ignore the fact that we will *all* die 'otherwise', if we are not given ERVO!; it is not only the mode of death which is affected but the *timing* of death. The fact that the life is being ended earlier than would otherwise be the case with withdrawal of life support, should at least be acknowledged, even if its importance ethically or practically is disputed.

Furthermore, the assumption is made that if relatives are fully informed about what is being proposed, they will be reassured. Trust in medicine is crucial; without it, relatives may be concerned that they agreed to the hastening of the death of their loved one for the sake of acquisition of their

¹³ Though they refer to this as organ donation euthanasia (ODE) I have used the term ERVO (euthanasia by removal of vital organs) following Coons and Levin's terminology to avoid confusion with ODfE.

organs. One needs time to process such decisions and when a match for the organs is found, the recipients' need could easily trump making time available to the donor's relatives to decide in an unpressured environment. It would only take one case where relatives instead of feeling relieved were left feeling litigious, to severely damage trust in the whole transplant system.¹⁴

It is important to note that what Wilkinson and Savulescu are advocating is ERVO not just for terminally ill patients or patients capable of giving consent to euthanasia but also for patients who are 'permanently unconscious, for example those in a permanent vegetative state, or anencephalic infants...whose organs can be removed because they have no prospect of regaining consciousness and continued life cannot benefit them' (2012, p. 40). They cite with approval Rachels' (1986, p. 24) famous assertion about such cases that 'while their biological life continues their biographical life has ended'.

Wilkinson and Savulescu's coup de grace is their suggestion that 'although most arguments for euthanasia are distinguished from questions of organ donation, it may be that the benefits of donation, for the individual and for others, provide the *strongest case* for euthanasia' (2012, p. 41). Though this may well be a perfectly acceptable argument for those who favour both euthanasia and organ donation, for any who do not support the former and *all* who are contemplating the latter, it is a very disturbing suggestion that having one's life taken by euthanasia is of benefit to the individual providing the organs.

In spite of the serious issues just raised, there is considerable utilitarian moral pressure to accept ERVO for life support withdrawal cases since its utilitarian benefits are undeniably impressive. Wilkinson and Savulescu (2012, p. 41) calculate that its introduction in the UK would potentially result in up to another 2201 organs per year becoming available from an extra 655 heart-beating donors¹⁵, thus totally eliminating the current UK organ shortage with organs to spare. They note,

¹⁴ There are precedents of analogous situations in e.g. Japan (Toshiro 1989, Singapore (Berger 2007) and Brazil (Csillag 1998).

¹⁵ They assume a yield of 3.9 organs per heart-beating donor and consent rates 'similar to current levels in the UK' (Wilkinson and Savulescu 2012, p. 47).

however, that this would depend on the consent rate for donation but of course if organ 'conscription', which they also suggest, (2012, pp. 44-45) were introduced, such consent would not matter anyway.

The practice of ERVO is not going to be introduced in the near future in the UK, since both euthanasia and physician assisted suicide are currently illegal there. If however we consider the most recent analysis of modes of death in Belgium (Chambaere *et al.* 2015a), we find that whilst euthanasia accounted for 4.6% of deaths in 2013, withholding or withdrawing life supporting treatment (called life-prolonging treatment in the table in the paper) accounted for 17.2% of the 6188 deaths in the sample. With a total of all deaths of 61,621 in 2013, this would increase the number of potential candidates for ERVO in Belgium to around 10,600 per annum - though not all of those would be suitable to be donors and not all of those who are suitable would consent.

Wilkinson and Savulescu acknowledge that ERVO clearly conflicts with the dead donor rule (DDR) as well as the principle of not killing and it also could conflict with both patient and family autonomy (2012, p. 39). Nevertheless, they justify ERVO on the grounds that it results in a Pareto improvement (i.e. at least one person is better off and no one is worse off) because 'more lives are able to be saved by harvesting functioning organs' (2012, p. 41) with ERVO.

Coons and Levin (2011, p. 237) are quite explicit in their view that the DDR is not justified 'either in principle or in practice' in the first place. The DDR 'states that organ donation must not kill the donor; thus, the donor must first be declared dead' (Bernat 2013, p. 1289) but Coons and Levin claim there is a broad class of cases in which it is not only morally acceptable but sometimes 'perhaps *obligatory* to procure vital organs from living individuals' (2011, p. 237 *Italics mine*).

Execution by lethal injection and euthanasia by removal of vital organs

Though Coons and Levin state they 'take no stand on the permissibility of either voluntary active euthanasia (VAE) or capital punishment (CP)' (2011, p. 238) they admit that CP is 'less clear' and consider it at greater length. They express their particular concern that using ERVO 'to execute will

require that a *doctor* kill: if the executions were carried out by some other method, no doctor need be implicated in the killing. Arguably policies that allow doctors to participate in executions threaten professional values and may indirectly alarm or threaten the public' (2011, p. 238 *Italics theirs*). What they mean of course is that using ERVO to carry out executions will require that a doctor *executes* rather than kills. They seem not to recognise that doctors kill, whether carrying out executions or ERVO. Therefore policies that allow doctors to participate in euthanasia may also threaten professional values and may indirectly alarm or threaten the public as well. Any ethical boundaries that they seek to draw between the participation of doctors in executions and euthanasia *with regard to voluntary consent to use of organs after death* seem to be very tenuous as there are far more similarities between the two procedures than there are differences. They themselves even acknowledge that 'execution by lethal injection mirrors euthanasia in the Netherlands and often uses the same drug combinations', a fact confirmed by a more recent discussion on why doctors should not act as executioners – 'Thiopental followed by pancuronium forms the basis of today's Dutch euthanasia protocol, pancuronium having been introduced because prolonged death and writhing with thiopental alone distressed families' (Dyer 2014). As outlined earlier, the Belgian euthanasia protocol is very similar to the Dutch¹⁶ and a widely reported case in Belgium has recently drawn into focus some striking ethical dilemmas and disconnects concerning euthanasia, CP and subsequent organ donation.

Frank van Den Bleeken, having already served 30 years of a life sentence for murder and serial rape, requested that his life be ended by euthanasia on the grounds of 'unbearable psychological anguish' (Bacchi 2014). A request which is completely understandable in view of the treatment of sex offenders by other inmates in prison, quite apart from any other considerations. Since mental suffering is a valid reason for euthanasia in Belgium, the Belgian justice minister, Koen Geens, eventually granted his request and euthanasia was scheduled for Jan 11th 2015.

¹⁶ Though differences in the law and practice between the two countries have been outlined by Nys (see chapter 1 of this book) and Smets *et al* 2009.

However, the week before the planned euthanasia, Geens declared that he would instead allow Mr Van Den Bleeken to be transferred to a psychiatric treatment facility in the Netherlands - a request previously denied Van Den Bleeken until he was facing euthanasia. The doctor who was to carry out euthanasia then withdrew for 'confidential personal reasons'. Van Den Bleeken's lawyer stated '... it is always the doctor who must decide in all conscience. His freedom of conscience must be respected' (RTBF 2015). However, this does not resolve the problem of some 15 other Belgian prisoners who are reported also to have requested euthanasia. Such a possibility prompts profound ethical questions for a country which, though it abolished the death penalty in 1996, is carrying out euthanasia in rapidly increasing numbers.

Again and again in the context of state execution of prisoners, ethicists who oppose the death penalty but are either open to, or advocates of, legalised euthanasia, find themselves in a difficult place when trying to justify the moral inconsistency between these two positions. For example Gerald Dworkin states:

I believe it is incontrovertible that there is sufficient explicit text, whether in specific oaths taken by physicians or in the principles adopted by the medical community or in the code literature, to ensure that participation in lethal injections by physicians would be contrary to their professional code of ethics (Dworkin 2002, p. 183).

and

At this point I cannot think of a plausible non ad-hoc set of principles to support the following three judgements: euthanasia is under certain conditions legitimate; it is illegitimate for doctors to participate in lethal injection even if the prisoner has a choice about his mode of execution; and organ donation surgery¹⁷ is sometimes permissible (Dworkin 2003a, p. 214).

Silver likewise considers that

¹⁷ The reason that organ *donation* surgery is specified is that short term harm (and possibly longer term) is done to the donor for the sole benefit of others and not the actual donor.

We can fruitfully compare the autonomous choice of the condemned prisoner for lethal injection to the autonomous choice of the terminally ill patient for physician assisted suicide. As far as autonomy is concerned, there is no reason to think that the patient's choice in the manner of her death is more significant than the choice of the condemned prisoner over the manner of his death (Silver 2003, p. 207).

Varelius (2007) believes that he has found a way out of the impasse both Dworkin and Silver find themselves in, by formulating a principle that would permit both organ donation surgery and euthanasia and yet make a doctor's participation in execution by lethal injection impermissible even if the method is the prisoner's choice. He states his principle as follows:

(T)he proper ends of medicine are to use medical skills and training to maintain or improve the condition of the persons affected, subject to their autonomous consent and causing minimal possible harm (Varelius 2007, p.145).

This principle differs from a similar principle proposed by Silver (2003, p.209) in its significant extension from an individual person (whether patient or prisoner) to relevant others, such as the recipients of organs removed from the terminated individual. In his argument as to why he believes this rules out execution by lethal injection even by autonomous choice by the prisoner, Varelius simply asserts that such execution 'would not be a minimally harmful way of serving the prisoner's medical interests.' In the Van den Bleeken case however, the prisoner claims that it would be. Moreover he is not under a state-imposed death sentence but is choosing death for himself rather than continue his 'unbearable psychological suffering' in prison.

Varelius does actually acknowledge that his principle, by introducing other parties in to the moral equation, opens the way for execution by lethal injection to be permissible when the execution would be the minimally harmful way of serving the interests of those other parties. He appears to be unaware of the full logical implications of his argument however when he further insists:

In such a case, in addition to being given the lethal injection, the prisoner would also have to consent to being used to serve the medical interests of third parties and the physician would

have to administer the injection with the intention of helping others, not of punishing the prisoner. Consequently, a physician's giving this kind of lethal injection would not I think count as execution (Varelius 2007, p. 146).

On this premise then, the death penalty is not an execution if the prisoner consents to donate their organs afterwards and the executing physician need not trouble his conscience that he is doing anything other than serving the proper goals of medicine.

One can easily see where this might lead if the treatment Mr Van den Bleeken receives in the Netherlands does not relieve his unbearable suffering. Should this be the case, and his subsequent renewed requests for euthanasia continue to be denied on the grounds that it is not the minimally harmful way of serving *his* interests, all he has to do is to consent to organ donation after death in order to make the moral argument for acceding to his request irrefutable according to Varelius.

Furthermore, Savulescu and Wilkinson's claim, considered earlier, that 'the benefits of donation, for the individual and for others, provide the *strongest case* for euthanasia' (2012, p. x italics theirs) would seem to imply that those same benefits would also provide the strongest case for the death penalty, were both the lethal injection and the subsequent organ donation to be carried out with the prisoner's consent.

Organ donation and euthanasia in Belgium: future trends

Belgium legalised euthanasia in 2002 and the first reported case of successful organ transplantation using organs acquired following euthanasia was carried out in 2007 (Detry *et al.* 2008). Since then, the total number of such transplants reported have remained in single figures and the actual numbers suitable for organ transplantation are likely to remain low.

In contrast, Wilkinson and Savulescu have estimated that the implementation of ERVO for those having life support withdrawn, would completely eliminate the organ shortage in the UK. There is little doubt that it would do the same in Belgium and, since euthanasia is already legal there, the utilitarian pressure to introduce ERVO is sure to increase.

Eurotransplant (2008) are on record on their website for the condemnation of the acquisition of organs from prisoners in China:

The commercial exploitation of organs from executed prisoners is considered a breach of human rights and is an unacceptable practice. Aware of the burden of human suffering that flows from the worldwide shortage of ethically acceptable organs, any act that risks calling the practice of transplantation into disrepute is to be regretted.

It is worth asking whether similar acts risk transplantation being brought into disrepute in Belgium.

In view of the suggested moral obligation to use the organs of those requesting euthanasia (Wilkinson and Savulescu 2012), if as reported there are fifteen Belgian prisoners currently requesting euthanasia, how long will it be before another such request is granted, as it was originally for Van den Bleeken? Is there then not a moral obligation to seek consent at least ODfE in such cases? Indeed, if Varelius were correct, that such consent more or less makes euthanasia obligatory and it does not even constitute execution in these circumstances, then surely ODfE or even ERVO for prisoners would seem the inevitable consequence of current practice.

It would of course be the ultimate irony if a country which no doubt prides itself (rightly in my view) on abolishing the death penalty as an inhumane practice, ended up having reintroduced it (at least for prisoners requesting it) to relieve the organ shortage. Then again, though it would be couched in different language, is not organ donation after euthanasia as performed in Belgium since 2007 already effectively equivalent to this? There appear to be a very thin line between a 'last act of grace' and a final act of desecration.