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## Sounding board: is mandatory recovery of organs for transplantation acceptable?

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*'Just because someone dies, it doesn't mean we can loot their house'*

Suppose one of your loved ones is admitted to an ICU with a subarachnoid haemorrhage and you are sitting next to her bed, overwhelmed by emotions and holding her hand. She is deeply comatose, connected to a ventilator; intravenous vasopressors are needed to keep her blood pressure stable. You are hoping for the best, but fear the worst. And the worst comes. The intensivist tells you her brain is dead. Then he asks you for permission to take out her organs. You, and your loved one, had never thought about this scenario of dying. You had heard about brain death, but you don't have a picture of it in your head. You ask the doctor: "when will she die"? He answers: "she is already dead". You don't believe him because there are so many signs of life. Her skin is warm, her heart is beating, which is, so you think, the seat of the soul, the place of emotions. Taking out her organs while her heart

is still beating seems like a scene from a cheap horror film. Blurred by emotions, you try to think things over. When death is inescapable, you just want to sit beside her, feeling that her life has passed while she dies, feeling that her body cools down. Emotions overwhelm you and cause you to refuse organ donation, because death in this scenario is too technical with too little dignity.

Organ donation definitely has great benefits, as anyone with a transplanted organ will tell you. We are, as most intensivists, greatly in favour of organ donation for transplantation. However, the gap between need and demand for organs is increasing. Refusal by relatives is one of the most important reasons why brain-dead patients do not proceed to organ donation. Recently [1], this journal published criteria for ethical persuasion of bereaved family members, thus hoping to remove misunderstandings and biases surrounding brain death. This should allow family members to make an informed decision about organ donation of their loved one. Policy makers have considered many organ donation systems in the hope of increasing the number of organ donations: opting in; opting out; opting in with family consent; required consent; presumed consent and mandatory recovery of organs.

Mandatory recovery of organs is the most extreme proposal for reducing the gap between need and demand. Mandatory recovery of organs makes the owner of the organs a custodian of his organs until death. After death, so say the advocates of mandatory organ recovery, you lose the ownership of your body because you can no longer exercise your rights over it, and nor does your family. Between death and burial or cremation, the government can claim your organs for transplantation. Mandatory organ recovery changes the act of organ donation from something that is altruistic, 'a gift of life', 'the most useful gift' and an attitude of charity that should be vital in our society, to a cold, clinical practice of interchangeable bodies of dead people, from which useful organs can be harvested.

The nephrologist Spital and ethicist Taylor vigorously advocated mandatory recovery of donor organs [2]. In their publications, they use words as ‘cadaveric’ and ‘dead person’, but does the public also see brain-dead patients, without any doubts, as ‘cadavers’ or ‘dead’? The whole concept of mandatory organ recovery is founded on the concept that the potential organ donor is really dead at the moment that brain death is declared. This is pivotal in order to gain even remote public acceptance of organ conscription, especially in the case of mandatory organ recovery. They have to be ensured that their loved one is dead before the organs are taken out. But, the bare fact that many brain-dead patients can continue to perform a variety of integrative functions over indefinite time periods, including maintaining body temperature, persistent and adequate hypothalamic hormonal function, regulating salt and water homeostasis, digesting administered food, healing wounds, increase of infection markers and healing infections, stress responses to bodily interventions such as surgery and gestating fetuses in pregnant brain-dead women, makes some wonder whether a brain-dead patient is as ‘dead’ as the doctors say. Or they mistrust the statement that the patient has been pronounced ‘dead’. For example, it is very difficult to see a ‘brain-dead’ pregnant woman, in whose womb a fetus grows over a time period for 2–3 months after the determination of brain death, as ‘a cadaver’. There are just too many signs of life. Declaring these patients ‘dead’ solely on the basis of ‘a definition’ seems to contradict our common sense of what it is to be alive [3]. Brain death is, since the first definitions in the scientific literature in 1968, closely related to organ donation. This means that some view equating brain death to death as a moral and legal fiction. [4]. Although there are good moral reasons to treat patients with irreversible brain (stem) failure as if they were dead, the unease about considering brain death as equal to death is hard to eliminate, and ‘brain-dead’ patients are not so obviously ‘dead’ that we can legitimate mandatory organ donation. Without the needs of transplantation medicine, ‘brain death as death’ would not exist at all, but would be seen as the most extreme and irreversible form of coma (Coma dépassé). Then, we would not still call it ‘brain death’, but

‘irreversible brain failure’. ‘Brain death’ is, according to some authors, no more than a useful (legal) fiction [4].

Furthermore, how sure are we about predictions? Predictions in neurocritical care seem to be extremely difficult. We only have to look back to the recent case in Denmark where a young ‘brain-dead’ potential organ donor fully recovered [5]. Although these cases usually reflect inadequate determination of brain death, the effect on the public can be dramatic. With such cases in mind, mandatory organ retrieval would only fuel the distrust of society about the intentions and practice of organ donation.

Treating everyone in society with respect and dignity is fundamental. Placing the needs of one patient (the recipient) over those of another (the dying or dead donor) and his family is something we should not wish for, because it reduces people to little more than carriers of useful organs and does not reflect principles of equality and dignity. Hence, when patients or relatives say no to organ donation, this should be respected, no matter for what reason. Organ conscription could lead to a conflict for the treating physician. He or she has the moral duty to treat the patient and its relatives with respect and empathy. On the other hand, that same patient is a potential organ donor with valuable organs.

Which organ is most relevant to the concept of death appears to be a matter of contingency, affected more by custom, emotion and tradition, rather than being based on empirical clinical evidence, but for many it is still the beating heart. In this sense, removing organs from the body of a loved one whose heart is still beating, and whose body is warm, can be perceived as fundamentally wrong and unnatural. This should always be respected. That is why organ donation from brain-dead patients is, and should always be, translated into something that is in line with high values and beliefs as ‘the gift of life’ and ‘the most useful gift’, as something that is without any doubt positive and charitable. For relatives of possible organ donors, the balance between a peaceful and dignified death and the social obligation to help another sick patient is delicate. Mandatory retrieval of organs has no place in this line of thought. Never.

**Conflicts of interest** The authors declares no conflict of interests.

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