Organ Donation and Medical Assistance in Dying: Ethical and Legal Issues Facing Canada

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In June 2016, the Government of Canada enacted legislation to regulate the practice of medical assistance in dying (MAID) in response to the Supreme Court of Canada's 2015 decision striking down the prohibition against assisted dying in particular circumstances. One issue that has not been addressed in depth in the Canadian debate is whether those accessing MAID would be eligible to donate organs and tissues, as well as the ethico-legal issues this may pose. This is a challenging question that brings together the controversial introduction of MAID with

En juin 2016, le gouvernement du Canada a promulgué une loi pour réglementer la pratique de l'aide médicale à mourir (AMM) en réponse à l'arrêt de la Cour suprême du Canada en 2015 abrogeant la prohibition contre la mort assistée dans certaines circonstances. Un problème qui n'a pas été abordé en profondeur dans le débat canadien est si ceux qui accèdent à l'AMM seraient éligibles à faire un don d'organes ou de tissus, ainsi que les problèmes éthico-légaux que cela poserait. Il s'agit d'une question difficile rassemblant l'introduction contro-

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the ethically sensitive practice of organ donation. This paper analyzes the ethico-legal issues raised in four possible scenarios for donation to occur in the context of MAID: living donation of non-vital organs before MAID, extended living donation of vital organs in anticipation of MAID, posthumous donation following MAID, and MAID by removal of organs. Extended living donation of vital organs and MAID by removal of organs are unlikely to be accepted and, indeed, we recommend against them. However, these possibilities have been raised in the medical ethics literature and we address them as part of a full review of this topic. In conclusion, we provide recommendations to address the combination of organ donation and MAID within what we believe to be acceptable ethical parameters.

versée de l'AMM avec la pratique éthiquement sensible du don d'organes. Cet article analyse les problèmes éthico-légaux soulevés par quatre scénarios de don effectués dans le contexte de l'AMM: le don vivant d'organes non-essentiels avant l'AMM, le don vivant d'organes essentiels en anticipant l'AMM, le don d'organes après décès suite à l'AMM, et l'AMM par enlèvement d'organes. Le don vivant d'organes essentiels en anticipant l'AMM et l'AMM par enlèvement d'organes ont peu de chances d'être acceptés et, effectivement, nous recommandons contre ceux-ci. Cependant, ces possibilités ont été soulevées dans la littérature sur l'éthique médicale et nous les abordons dans le cadre d'une revue complète de ce sujet. En conclusion, nous fournissons des recommandations pour aborder la combinaison du don d'organe et l'AMM dans les limites de ce que nous croyons être des paramètres éthiques acceptables.

Introduction

In June 2016, the Canadian Parliament passed *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*[1] (the *Act*) to regulate voluntary euthanasia and assisted suicide – together termed medical assistance in dying (MAID). The *Act* was a response to the Supreme Court of Canada's unanimous 2015 ruling in *Carter v Canada (AG)*, which declared the *Criminal Code* provisions prohibiting MAID unconstitutional for competent adults suffering from grievous and irremediable conditions causing intolerable suffering.[2] Prior to *Carter*, only Québec had enacted legislation to address voluntary euthanasia.[3] The *Act* was passed following a protracted national debate over the scope of eligibility for MAID, particularly whether access should be permitted pursuant to an advance request, for mature minors, and for people suffering from mental rather than physical illnesses.[4] Currently, the *Act* does not allow MAID by advance requests or for mature minors. Most people suffering solely from mental illness also appear to be ineligible for MAID due to the eligibility requirement that natural death be reasonably foreseeable, although there has been debate on this point.[5] Parliament has committed itself in the *Act* to further review of these issues.[6]

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1 SC 2016, c 3 [*MAID Act*]. While both voluntary euthanasia and assisted suicide involve the provision by a medical professional of a substance which causes death, in voluntary euthanasia the substance is administered by the medical professional and in assisted suicide it is self-administered.

2 2015 SCC 5 at para 147, [2015] 1 SCR 331 [*Carter*].

3 See *An Act respecting end-of-life care*, CQLR, c S-32.0001.

4 See Parliament, Special Joint Committee on Physician-Assisted Dying, *Medical Assistance in Dying: A Patient-Centred Approach* (February 2016) at 14, 21, 24 (Joint Chairs: Hon Kelvin Kenneth Ogilvie and Robert Oliphant) (in which the Special Joint Committee of Parliament recommended MAID be available in each of these circumstances).

5 See Jocelyn Downie & Justine Dembo, "Medical Assistance in Dying and Mental Illness under the New Canadian Law", online: (2016) 9 J Ethics Mental Health VI(iv) at 3 <www.jemh.ca/issues/v9/documents/JEMH_Open-Volume_Benchmark_Medical_Assistance_in_Dying_and_Mental_Illness_Under_the_New_Canadian_Law-Nov2016.pdf>.

6 See *MAID Act*, *supra* note 1, Preamble, s 9.1.

The introduction of MAID occurs at a time when Canada is also experiencing a shortage of organs for transplant.[7] The question of whether people accessing MAID would be eligible to donate their organs has not been addressed in depth in the Canadian debate so far. The combination of this controversial change in Canadian law and the ethically sensitive practice of organ donation may give rise to ethical discomfort and legal uncertainty. Throughout the Canadian debate over MAID, concerns have been raised that vulnerable people may be pressured to consent to MAID or that they may consent due to neglect that leaves them little reasonable alternative to relieve unendurable suffering.[8] As will be discussed, issues of vulnerability, coercion, and conflict of interest also arise in the context of organ donation. The combination of MAID and organ donation may raise fears that the decision to seek or provide MAID is influenced by the possibility of benefit to others through organ donation.

In order to reduce the risk that the decision to withdraw life-sustaining treatment might be influenced by the prospect of obtaining transplantable organs, medical and organ donation organization professionals attempt to separate the discussions regarding withdrawal of life-sustaining therapies and donation.[9] However, unlike most other deceased organ donors, MAID patients will be competent immediately before the death and donation and will therefore be able to give first-person informed consent.[10]

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7 See Canadian Institute for Health Information, *Deceased Organ Donor Potential in Canada* (Ottawa: CIHI, 2014) at 4, online: <www.cihi.ca/web/resource/en/organdonorpotential_2014_en.pdf>.

8 See e.g. Advocacy Centre for the Elderly, "Submission of the Advocacy Centre for the Elderly to the Joint Special Committee on Physician-Assisted Dying" (2 February 2016) at 3, online: <www.advocacycentreelderly.org/appimages/file/PAD%20Submissions%20to%20JSC.pdf>; Council of Canadians with Disabilities, "CCD Submission to Special Joint Committee on Physician Assisted Dying" (28 January 2016), online: <www.ccdonline.ca/en/humanrights/endoflife/SJCPAD-28jan2016>.

9 See Sam D Shemie et al, "Donation after Cardiocirculatory Death in Canada" (2006) 175:8 CMAJ S1 at S10.

10 The legal criteria for valid first-person consent are that the patient be capable and that the consent be voluntary. Under the law, patients are entitled to disclosure of information that is relevant to deciding whether or not to consent to the proposed treatment. See generally Patricia Peppin, "Informed Consent" in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds, *Canadian*

This will allow for careful inquiry into the reasons for their decisions both to request MAID and to donate organs, providing insight into the person's wishes and voluntariness beyond what can be ascertained from the presence or absence of an earlier expressed intention to donate, such as a signed donor card.

Cases of organ donation after MAID are not expected to be common, as some of the medical conditions that may lead people to seek MAID, namely terminal cancer, rule out the possibility of organ donation.[11] However, other conditions such as neurodegenerative diseases are not currently considered an absolute contraindication to transplantation.[12] Neurodegenerative disease transmission through organ donation has not been demonstrated, although there is ongoing debate as to the possibility of disease transmission to the recipient.[13] In addition to the risk of disease transmission, another risk factor crucial to the success of a transplant is the length of time the transplanted organs and tissues are deprived of oxygen, resulting in ischemic damage to the organ.[14] Despite these challenges, requests to donate

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Health Law and Policy, 4th ed (Markham, Ont: LexisNexis Canada, 2011) 153 at 153–54.

[11] See Elizabeth Trice Loggers, Moreen Shannon-Dudley & Frederick R Applebaum, "Implementing a Death with Dignity Program at a Comprehensive Cancer Centre" (2013) 368:15 New Eng J Med 1417 at 1418 (close to 80% of those seeking assisted suicide in Washington and Oregon between 2009 and 2011 had a terminal cancer diagnosis); Julie Allard & Marie-Chantal Fortin, "Organ Donation after Medical Assistance in Dying or Cessation of Life-Sustaining Treatment Requested by Conscious Patients: The Canadian Context" (2017) 43:9 J Med Ethics 601 at 605.

[12] See Karim Serri & Pierre Marsolais, "End-of-Life Issues in Cardiac Critical Care: The Option of Organ Donation" (2017) 33:1 Can J Cardiol 128 at 130. For case reports from the US of organ donation by patients with amyotrophic lateral sclerosis, see Shahed Toossi et al, "Organ Donation after Cardiac Death in Amyotrophic Lateral Sclerosis" (2012) 71:2 Ann Neurol 154; Thomas J Smith et al, "Organ Donation after Cardiac Death from Withdrawal of Life Support in Patients with Amyotrophic Lateral Sclerosis" (2012) 15:1 J Palliat Med 16.

[13] See Brandon B Holmes & Marc I Diamond, "Amyotrophic Lateral Sclerosis and Organ Donation: Is There Risk of Disease Transmission?" (2012) 72:6 Ann Neurol 832.

[14] See AR Manara, PG Murphy & G O'Callaghan, "Donation after Circulatory Death", online: (2012) 108:Suppl 1 Br J Anaesth i108 at i112 <https://acade

organs following MAID have been made and granted in the Netherlands[15] and in Belgium.[16]

The bioethics literature mentions several possible scenarios in which MAID and organ donation may be combined. These scenarios may emerge before, during, or after death by MAID, and include: (1) living donation of non-vital organs before MAID; (2) extended living donation of vital organs in anticipation of MAID; (3) MAID by removal of organs; and (4) posthumous donation following death by MAID. The last scenario, in which donation occurs after cardiac arrest is brought about by MAID, is the most likely option in our view, since the other three encounter significant legal and practical obstacles. This is in fact the practice described in recent Dutch practice guidelines.[17] We seek to contribute to the health law and bioethics literature by offering an ethico-legal analysis of these four options in the order outlined above. We conclude with recommendations for addressing the combination of organ donation and MAID within what we suggest are acceptable ethical parameters. This analysis is timely given the introduction of the *Act* and the fact that patients are already asking to donate following MAID.[18] For policy makers to leave the issue unaddressed is to leave the matter for local health practitioners and hospital bioethicists to decide –

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mic.oup.com/bja/article/108/suppl_1/i108/237453> (the maximum tolerable period of ischemia varies by organ and tissue type).

15 See AKS van Wijngaarden, DJ van Westerloo & J Ringers, "Organ Donation after Euthanasia in the Netherlands: A Case Report" (2016) 48:9 Transplant Proc 3061; Jan Bollen et al, "Organ Donation after Euthanasia: A Dutch Practical Manual" (2016) 16:7 Am J Transplant 1967 at 1967 [Bollen et al, "Manual"].

16 See D Van Raemdonck et al, "Initial Experience with Transplantation of Lungs Recovered From Donors after Euthanasia" (2011) 15:1 Appl Cardiopulm Pathophysiol 38 at 39; D Ysebaert et al, "Organ Procurement after Euthanasia: Belgian Experience" (2009) 41:2 Transplant Proc 585 at 586; Olivier Detry et al, "Organ Donation after Physician-Assisted Death", Letter to the Editor, online: (2008) 21:9 Transpl Int 915 at 915 <onlinelibrary.wiley.com/doi/10.1111/j.1432-2277.2008.00701.x/full>; Jan Bollen et al, "Legal and Ethical Aspects of Organ Donation after Euthanasia in Belgium and the Netherlands" (2016) 42 J Med Ethics 486 at 486 [Bollen et al, "Legal"].

17 See Bollen et al, "Manual", *supra* note 15 at 1968.

18 See Sharon Kirkey, "Doctors Harvesting Organs from Canadian Patients Who Underwent Medically Assisted Death", *National Post* (20 March 2017),

possibly in urgent circumstances, as was the experience in Belgium when a patient asked to donate her organs the day before her assisted death was to take place.[19]

Since laws are jurisdiction-specific, our legal discussion will be based on the *Act* and Ontario's provincial laws governing organ donation.[20] However, the ethical issues addressed are broadly relevant and the legal analysis may be adapted to other legal jurisdictions as appropriate.

I. Living donation before MAID

A competent adult may seek to make a living donation of non-vital organs – a kidney or part of a liver – in advance of MAID. Allowing living donation before MAID would offer competent patients a way to donate should they wish to do so. There are documented psychological benefits which accrue to living organ donors, and although these benefits will not be long-lasting for a person who will soon die through MAID, it may still be of comfort to know that a donation has indeed gone ahead successfully.[21] This knowledge is evidently impossible in the case of post-mortem donation. There is also a potential benefit from the perspective of medical utility, as organs donated by a living donor do not suffer as much risk of anoxic damage as in post-mortem donation, thereby increasing the chance of a successful transplantation. A living donation also avoids one of the practical difficulties associated with donation after circulatory death (DCD), namely that DCD requires death to occur near an operating room so that organs may be swiftly removed. A living donation could allow a patient to both donate organs and select the location of their death by MAID, which could occur in an unhurried manner with friends or family near.[22]

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online: <news.nationalpost.com/health/doctors-harvesting-organs-from-canadian-patients-who-underwent-medically-assisted-death>.

19 See Detry et al, *supra* note 16 at 915.

20 *Trillium Gift of Life Network Act*, RSO 1990, c H.20 [*TGLNA*]; *Health Care Consent Act, 1996*, SO 1996, c 2, Schedule A.

21 See e.g. Allison Tong et al, "'It Was Just an Unconditional Gift: Self-Reflections of Non-Directed Living Kidney Donors" (2012) 26:4 Clin Transplant 589 at 597.

22 See Paul E Morrissey & Anthony P Monaco, "Donation after Circulatory Death: Current Practices, Ongoing Challenges, and Potential Improvements"

Legal and ethical considerations

Ontario law permits a mentally competent person who is 16 years old or older to make a living donation, provided the individual gives free and informed first-person consent in writing and donation takes place immediately thereafter.[23] However, the *Act* currently restricts access to competent adults aged 18 years or older.[24]

There do not appear to be legal obstacles to making a living donation ahead of MAID for those 18 years or older in Canada. The standard of capacity for consent to both is likely to be similarly high given the significance of the two decisions. However, it is possible that different capacity assessment procedures for MAID and organ donation may result in divergent opinions on a person's capacity, even if the same standard of capacity is applied. This is because different decision makers and decision-making processes, perhaps producing assessments at different times, may produce divergent results. For example, the *Act* requires that two medical or nurse practitioners independently approve the request and assess the patient's capacity,[25] while no similar duplicative procedure is required for evaluating capacity to consent to living donation in Ontario.[26] Therefore it is possible that a person could be found capable of consenting to one of these procedures, but incapable with respect to the other.

The *Act* excludes minors and the use of advance requests,[27] although these exclusions are sources of controversy,[28] and Parliament has commit-

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(2014) 97:3 Transplantation 258 at 262–63 (the authors outline the benefits to living donation as an alternative to donation after circulatory death [DCD] following withdrawal of life-sustaining therapies).

23 See *TGLNA*, *supra* note 20, s 3(1).

24 *Supra* note 1, s 3, amending *Criminal Code*, RSC 1985, c C-46, s 241.2(1)(b).

25 *Supra* note 1, s 3, amending *Criminal Code*, *supra* note 24, s 241.2(3)(e).

26 See *TGLNA*, *supra* note 20, s 3.

27 *Supra* note 1, s 3, amending *Criminal Code*, *supra* note 24, s 241.2(1).

28 See e.g. Special Joint Committee on Physician-Assisted Dying, *supra* note 4 at 21, 24 (the Joint Committee recommended that a provision for mature minors come into force within three years of the provisions for adults, and that advance requests be permitted at any time following a diagnosis likely to cause loss of competence or of grievous or irremediable condition; Parliament did not follow either of these recommendations).

ted to further exploring both.[29] Both the Netherlands and Belgium permit MAID for minors,[30] and it is possible that Canada might move to include mature minors in its own legal framework – not least since a total exclusion of mature minors, without regard for their actual circumstances, may impair their rights under section 7 of the *Canadian Charter of Rights and Freedoms* (*Charter*).[31]

Depending on the age of eligibility for MAID, there may be inconsistencies with the age requirements for living donation, which vary across the country.[32] It would be difficult to justify divergent laws that allow a person below 16 years of age to access MAID but not to make a living organ donation. Challenges would also arise if Parliament permits MAID by advance request. For example, if consent to MAID by advance request were permitted, it would follow that MAID could be administered to a person lacking the capacity to consent at the time. Since Ontario law does not permit substitute or advance consent to living donation,[33] this would preclude living organ donation for those whose consent to MAID was given by advance request.

II. Extended living donation before MAID

A more controversial possibility for donation has been raised as an alternative to DCD, namely extended living organ donation.[34] In this scenario,

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29 See *MAID Act*, *supra* note 1, Preamble, s 9.1.

30 See Giulia Cuman & Chris Gastmans, "Minors and Euthanasia: A Systematic Review of Argument-Based Ethics Literature" (2017) 176:7 Eur J Pediatr 837 at 838.

31 See Constance MacIntosh, "*Carter*, Medical Aid in Dying, and Mature Minors" (2016) 10:1 McGill JL & Health S1 at S22, citing Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 [*Charter*].

32 See e.g. *Human Tissue Gift Act*, RSBC 1996, c 211, s 3(1) (establishing 19 as the minimum age for living donation in British Columbia); *The Human Tissue Gift Act*, SM 1987-88, c 39, CCSM c H180, s 10(1) (establishing 16 as the minimum age for living donation in Manitoba); *TGLNA*, *supra* note 20, s 3(1) (establishing 16 as the minimum age for living donation in Ontario); *The Human Tissue Gift Act*, RSS 1978, c H-15, s 4(1) (establishing 18 as the minimum age for living donation in Saskatchewan).

33 See *TGLNA*, *supra* note 20, s 3.

34 See Dominic Wilkinson & Julian Savulescu, "Should We Allow Organ Do-

essential organs are procured from a living person. While this would eventually result in the person's death, death instead occurs before that point due to subsequent removal of life-sustaining treatments, independent of organ procurement.

The literature suggests that living donation of a greater number of organs, including both kidneys, the liver, and pancreas, could be permitted since the donor would die of cardiorespiratory failure resulting from removal of the ventilator, prior to death by loss of organ function.[35] Generally, living donation of essential organs is prohibited by the dead donor rule, an ethical norm which provides the foundation for organ donation law. The dead donor rule stipulates that vital organs can only be procured from persons who are dead.[36] In order to coexist with the dead donor rule, allowing for extended living donation hinges on an understanding of the rule as requiring that the donation *must not cause death* – a subtle variation from the common understanding that the donor *must be dead* before essential organs can be removed.

In theory, these arguments could likewise apply to patients who will undergo MAID. Patients approved for MAID could donate essential organs – including both kidneys, the liver, and the pancreas – the loss of which does not cause immediate death. Provided the procurement of these organs does not cause the patient's death before MAID occurs, this procedure would seem not to violate the dead donor rule, understood as a proscription on causing death by removal of organs.

Legal and ethical considerations

To best uphold law, ethics, and public confidence in the medical system, we strongly recommend against permitting extended living donation before MAID, even where a patient wishes to do this and where it may allow for the greatest protection of organs from anoxic damage.

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nation Euthanasia? Alternatives for Maximizing the Number and Quality of Organs for Transplantation" (2012) 26:1 Bioethics 32 at 42.

35 See *ibid*.

36 See K Rusinova & J Simek, "Should We Relax the Definition of Death or the Dead Donor Rule?", Letter to the Editor, (2014) 40:6 Intensive Care Med 917 at 917.

An overarching legal problem with extended living donation before MAID stems from the possibility of loss of capacity between the donation and the subsequent administration of MAID. The *Act* requires that immediately before the administration of MAID, a patient be asked to reconfirm their consent.[37] Depending on the interpretation of "immediately before" and the amount of time between the donation and the administration of MAID, a person may have capacity to consent to extended living donation but subsequently lose capacity to give the required confirmation of consent between the donation and MAID. This would leave the medical team that had removed the essential organs in the position of having either inflicted great harm on the donor, who would now require substantial medical support to replace organ function where possible, or having brought about the death of the donor contrary to the *Act* and the established rules relating to organ donation if organ function could not be replaced (as in the case of a liver or pancreas donation).[38]

Furthermore, once essential organs are removed, a person's freedom to change their mind about MAID may cease, depending on whether there are artificial substitutes for the lost organ function. Even if the initial requests for MAID are carefully considered and non-impulsive, people may change their minds.[39] If they have made a living donation of an essential organ, they may no longer be able to change their minds about the timing of their deaths, which could cause great distress for the patients, their families, and the medical teams involved.

From the perspective of trust in the medical and organ donation systems as well as transplant professionals, these kinds of cases would likely be disastrous. Even if the donors intended to undergo MAID, the idea that they would lose the ability to change their minds would be very troubling. The *Act* reveals concern about the stability of decisions to seek MAID, with a legislated delay of 10 days between the request and the administration of MAID[40] and the requirement that consent be reconfirmed immediately be-

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37 *Supra* note 1, s 3, amending *Criminal Code*, *supra* note 24, s 241.2(3)(h).

38 See Rusinova & Simek, *supra* note 36 at 917. As discussed in more detail in Part III, the dead donor rule in organ donation holds that the removal of organs for transplant must not cause the death of the donor.

39 See Elaine Chen, "Organ Donation after Assisted Suicide: Practically and Ethically Challenging" (2014) 98:3 Transplantation 252 at 252.

40 *Supra* note 1, s 3, amending *Criminal Code*, *supra* note 24, s 241.2(3)(g).

fore MAID is given.[41] Therefore, for the sake of patients, health care teams, and public trust, extended living donation would be most unwise in the context of MAID.

III. MAID by Removal of Organs

Another possible scenario raised in bioethics literature would be to merge MAID and organ donation into a single procedure, whereby death would be caused by the removal of organs from an anaesthetized patient rather than by the administration of lethal medications.[42] This scenario does not fit the traditional distinction between living and posthumous donation, as it brings death and donation together in time. This idea is unlikely to be accepted, given the firm adherence in the organ donation and transplantation community to the dead donor rule. However, we address it here given that it has been raised in the literature as a scenario by which MAID and organ donation could theoretically proceed.

The idea has been proposed as an alternative to DCD following the withdrawal of life-support therapies, under the names "organ donation euthanasia" or "death by donation."[43] Given the language of the *Act*, we adopt the term "MAID by removal of organs." These proposals have not been given wide consideration because they violate the dead donor rule, according to which organ donation must not bring about the death of a person. However, the question that must be asked is whether the dead donor rule should continue to apply in the context of MAID. Are there reasons to insist on the dead donor rule for organ donation in the context of MAID? To put it another way, are there reasons to restrict the manner in which MAID may be administered?

Legal and ethical considerations

The legality of proceeding with MAID by removal of organs is presently uncertain. The rules regulating donation in Ontario differ according to

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41 *Supra* note 1, s 3, amending *Criminal Code*, *supra* note 24, s 241.2(3)(h).

42 See e.g. Wilkinson & Savulescu, *supra* note 34 at 40–41; Antonia J Cronin, "Death by Donation: Reflections on Individual Authorization, Assisted Suicide and Organ Donation" (2014) 98:3 Transplantation 254 at 254.

43 See Wilkinson & Savulescu, *supra* note 34 at 38; Cronin, *supra* note 42 at 254.

whether the donation is living or posthumous,[44] and as noted above, MAID by removal of organs does not fit either category. If it is to be regarded as a form of posthumous donation, then the legal requirement that the physicians determining death be separate from those recovering organs[45] does not seem possible. Those bringing about death and recovering organs will necessarily be the same, and the determination of death will be made at the same time. If it is considered a form of living donation, as the donor is still living at the moment of donation, then the existing rules governing living donation might be said to apply.

The *Act* defines "medical assistance in dying" as the act of administering, prescribing, or providing "a substance" that causes the patient's death.[46] This seems to preclude bringing about death surgically, although it would perhaps not preclude other methods of bringing about death via the administration of substances that are adapted more specifically to organ donation procedures.

Autonomy and vulnerability

Several authors have argued that the dead donor rule should be abandoned, as it denies some patients the opportunity to donate despite their clearly expressed wishes to do so.[47] For example, patients who consent to donation by DCD may be precluded from donating if they do not die quickly enough after the removal of the ventilator.[48] Truog, Miller, and Halpern argue that organ donation euthanasia should be permitted in order to allow patients in this situation to donate.[49] They contend that the ethics of organ donation should not rest on the dead donor rule but instead on principles of

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44 *TGLNA*, *supra* note 20, Parts I, II.

45 *Ibid*, s 7(3).

46 *Supra* note 1, s 3, amending *Criminal Code*, *supra* note 24, s 241.1.

47 See e.g. Robert D Truog, Franklin G Miller & Scott D Halpern, "The Dead-Donor Rule and the Future of Organ Donation" (2013) 369:14 New Eng J Med 1287 at 1287–88; Wilkinson & Savulescu, *supra* note 34 at 41; Franklin G Miller, "Heart Donation without the Dead Donor Rule" (2014) 97:4 Ann Thorac Surg 1133 at 1134.

48 See Truog, Miller & Halpern, *supra* note 47 at 1287.

49 *Ibid* at 1288.

autonomy and non-maleficence, and that honouring a person's autonomy necessitates providing choices, including the opportunity to donate.[50]

This argument is weaker in the context of MAID than in the context of standard DCD, as death will occur rapidly and predictably, making successful donation more assured than in the case of removal of ventilation. However, a patient may still have an interest in being permitted to pursue MAID by removal of organs: by avoiding the required observation period prior to removal of organs in DCD, the risk of anoxic damage to organs is reduced and the chances of successful transplantation are increased.[51]

One of the persistent worries voiced during Canada's decades-long national debate over MAID is that vulnerable people will be encouraged to request MAID, either directly or by neglect that leaves them with few options.[52] Combining organ donation with MAID might exacerbate these concerns because it introduces a clear benefit for others when someone chooses MAID and so increases the risk of actual or perceived conflict of interest. Organ donation practices, policies, and participating clinicians are already met with distrust by some members of the public[53] and combining MAID and organ donation is unlikely to build trust. Media headlines such as "Doctors Harvesting Organs from Canadian Patients Who Underwent Medically Assisted Death"[54] indicate that the issue is already on the media radar. Given that organ donation via DCD *after* MAID appears to be an ethically and legally permissible option that allows for the dead donor rule to be upheld and for the teams bringing about and determining death to be separated from those recovering organs, it seems that any benefit to permitting MAID by organ removal is not justified by the associated risks.

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50 *Ibid*.

51 See Wilkinson & Savulescu, *supra* note 34 at 41. The necessity of observing the waiting period before procuring organs is discussed more fully in Part IV below.

52 See e.g. Advocacy Centre for the Elderly, *supra* note 8; Council of Canadians with Disabilities, *supra* note 8 (submissions to the Joint Special Committee on Physician Assisted Dying).

53 See Joshua D Newton, "How Does the General Public View Posthumous Organ Donation? A Meta-Synthesis of the Qualitative Literature" (2011) 11:791 BMC Public Health 1 at 9.

54 Kirkey, *supra* note 18.

IV. Posthumous Donation following MAID

The fourth scenario involves organ donation following MAID via accepted procedures for DCD. This scenario minimizes the risk of anoxic damage to organs, since cardiac arrest occurs rapidly after euthanasia is administered using coma-inducing and muscle relaxant drugs.[55] Donation after DCD also requires MAID occur in or close to a hospital operating room so that organs may be removed swiftly after death, which may or may not be acceptable to patients seeking MAID.

Posthumous donation following MAID is currently practised in Belgium and the Netherlands.[56] The Dutch government indicated its support for organ donation following MAID in 2014, after public controversy had erupted when a man's desire to donate after voluntary euthanasia was initially refused.[57] Bollen and colleagues recently proposed logistical guidelines for combining MAID and organ donation.[58] Proposals for combining MAID and organ donation have also emerged in other countries, including Switzerland, which does not allow donation following assisted suicide primarily for practical reasons.[59] We have not found any reported cases of organ donation following assisted suicide in the American jurisdictions where it is legal.

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55 See Bollen et al, "Manual", *supra* note 15 at 1968.

56 See *supra* notes 15, 16.

57 See Pieter de Meer, "The Only Thing I Want Is to Donate My Organs" (26 February 2015), *Philosophy, Politics and Economics of Health* (blog), online: <ppeofhealth.weebly.com/blog/archives/02-2015>; Janene Pieters, "Euthanasia Should Lead to Organ Donation: Health Minister", *NL Times* (26 November 2014), online: <www.nltimes.nl/2014/11/26/euthanasia-lead-organ-donation-health-minister/>.

58 "Manual", *supra* note 15.

59 See David M Shaw, "Organ Donation after Assisted Suicide: A Potential Solution to the Organ Scarcity Problem" (2014) 98:3 Transplantation 247 at 247–48 (the author describes the primary practical obstacle as the fact that assisted suicides do not occur at or near a hospital and further notes that Switzerland has not fully developed its DCD capacity).

Legal and ethical considerations

Ontario law permits posthumous organ donation where the donor or the donor's substitute has consented according to the specified procedures.[60] The law further provides that the physicians determining death must be separate from those involved in removing and transplanting the organs.[61] There is no reference in Ontario's organ and tissue donation legislation to MAID and, so long as the requirements for posthumous donation are followed, the law does not appear to prevent donation following MAID.

1. Consent and capacity

Donations following MAID are different from the typical case of posthumous donation in that the potential donor is able to provide first-person informed consent shortly before the donation, directly to the organ and tissue donation coordinator who is not a member of the MAID team. This consent may confirm prior expressed wishes to donate, where an individual earlier signed a donor card, or it may be the first expression of the patient's intention. It is therefore similar in principle to cases in which conscious competent patients – such as those with amyotrophic lateral sclerosis (ALS) or high cervical spine injury – consent to have their ventilators removed, resulting in natural death and followed by organ donation.[62] Given the significance of the decision to seek MAID, the level of capacity required to consent to MAID is likely to be greater than or equal to what is required for first-person consent to posthumous donation.

Indeed, the Ontario legislation does not state any requirement for capacity for first-person consent to posthumous donation, requiring only that the consenting party be 16 years or older.[63] In the usual non-MAID context where a person has registered consent to donate at some point in the past, little or no attention is paid to whether their registered consent was capable or informed. In the case of MAID, the discussion of donation takes place with

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60 *TGLNA*, *supra* note 20, s 4.

61 *Ibid*, s 7(3).

62 See e.g. Toossi et al, *supra* note 12; Smith et al, *supra* note 12; Gregory Comadira et al, "Do You Have a Right to Decide? Or Do We Have a Right to Acquiesce?" (2015) 28 Aust Crit Care 72.

63 *TGLNA*, *supra* note 20, s 4(1).

a living patient with a high level of capacity, thus providing an opportunity for a more informed discussion than is typically the case with posthumous donation. Physicians and transplant coordinators should therefore provide all necessary information to support informed consent to donation.

An additional consent-related challenge has to do with whether organ donation may put undue pressure on a patient not to change their mind about MAID. This pressure may increase as the process of being assessed as a potential donor moves along. At a minimum, it will be important to be sensitive to this possibility and to reassure patients that any steps taken to prepare for organ donation should not prevent them from changing their minds about both MAID and organ donation. Similar sensitivity is also required for conscious patients with ALS who have requested organ donation following removal of the ventilator.[64]

2. Consent pursuant to an advance request

MAID is not currently available by advance request under Canadian law. However, Parliament has indicated that it will examine this issue in the future.[65] Voluntary euthanasia by advance directive in the case of dementia is legal in the Netherlands.[66] It is worth noting that the Canadian government's Special Joint Committee on Physician-Assisted Dying recommended allowing MAID by advance request when the request is made following the diagnosis of a condition which will cause a loss of competence or of a grievous or irremediable condition.[67] Yet Parliament did not ultimately follow this recommendation.[68]

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64 See Toossi et al, *supra* note 12 at 154–55.

65 See *MAID Act*, *supra* note 1, Preamble.

66 See Eva E Bolt et al, "From Advance Euthanasia Directive to Euthanasia: Stable Preference in Older People?" (2016) 64:8 J Am Geriatr Soc 1628 at 1628; Marike E de Boer et al, "Advance Directives for Euthanasia in Dementia: How Do They Affect Resident Care in Nursing Homes? Experiences of Physicians and Relatives" (2011) 59:6 J Am Geriatr Soc 989 at 989; Pauline SC Kouwenhoven et al, "Opinions about Euthanasia and Advanced Dementia: A Qualitative Study among Dutch Physicians and Members of the General Public" (2015) 16:7 BMC Med Ethics 1 at 1.

67 *Supra* note 4 at 24.

68 See *MAID Act*, *supra* note 1, s 3, amending *Criminal Code*, *supra* note 24, s 241.2(3)(h).

If Canadian law is changed to allow consent via advance request, MAID could then be administered to a person lacking the capacity to consent at the time of the procedure. This raises questions as to how organ donation would fit within this scenario. Presumably, the current approach to obtaining consent to organ donation in the context of incapable patients would be followed: where the wishes of the patient are unknown, the law allows for substitute consent,[69] and where the wishes of the patient are known through their registered consent, it is the usual practice to ask the patient's substitute decision makers to confirm that consent was not subsequently withdrawn and to authorize the donation.[70] Thus, a procedure is in place regardless of whether the patient has indicated their wishes regarding organ donation. However, it seems preferable to ask all patients who request MAID through an advance request to specify their wishes regarding organ donation. This would promote patient autonomy and potentially reduce distress for families. Where the wishes of the patient are not captured in an advance request, the current practice of consent could be followed.

3. Sequence of decisions on MAID and organ donation

In order to avoid actual or perceived conflict of interest, it is advisable to create a strict separation between the clinical teams providing MAID and those removing organs for transplantation. Ontario law and Canadian practice guidelines for DCD already require that the teams determining death be separate from those who recover organs.[71]

Further, the decision regarding MAID should be taken prior to and independently of the decision to donate organs. This is crucial to avoid the perception that people are being persuaded to consent to MAID in order to obtain organs for transplant.[72] In the usual practice of DCD (i.e., not involving MAID), the decision to withdraw life-sustaining therapies is made prior to any decision regarding donation, in order to ensure that end-of-life decisions are not influenced by the possibility of obtaining organs for trans-

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69 See *TGLNA*, *supra* note 20, s 5.

70 See Maeghan Toews & Timothy Caulfield, "Evaluating the 'Family Veto' of Consent for Organ Donation", online: (2016) 188:17–18 CMAJ E436 at E436 <www.cmaj.ca/content/188/17-18/E436>.

71 *TGLNA*, *supra* note 20, s 7. See Shemie et al, *supra* note 9 at S8–S9.

72 See Bollen et al, "Legal", *supra* note 16 at 489.

plantation. When families independently raise the possibility of donation before or during discussions about withdrawing life-sustaining therapies, the health care teams for end-of-life care and potential donation are careful to keep the decisions separate.

In the context of MAID, it is advisable that physicians reach a decision with the patient on MAID before any discussion of organ donation is broached, irrespective of whether the patient had earlier registered as an organ donor or not. This is a logical sequence of events that also ensures the focus remains solely upon the patient's interests. Additionally, it would help to assuage public concerns that the possibility of benefiting transplant recipients may encourage MAID. Should a patient independently raise the question of donation in anticipation of MAID, care must be taken to keep the discussions and decisions separate.

4. Should the option of organ donation be raised if the patient does not raise it?

Once a patient's request for MAID has been approved, should a health care team raise the possibility of organ donation? For now, the authors of this paper are divided on the best answer to this question. While some argue that a patient is entitled to know all of the reasonable medical possibilities in order to make a fully informed end-of-life decision, others feel that the request appears to seek benefit for others from a patient's death by MAID.

Bollen and colleagues warn that if a doctor raises the possibility of organ donation in this context, it may put pressure on the patient to consent to it.[73] However, they suggest that it would be acceptable to raise it if the patient were registered as an organ donor.[74] They also note that the promotion of patient autonomy and the possibility that the option to donate may provide comfort both justify raising the option of donation with patients who are not registered donors.[75] Others, however, may consider it inappropriate to raise this with patients who are suffering severely and who may feel pressured to consent or may feel others are seeking to benefit from their death.

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[73] *Ibid* at 488.

[74] *Ibid*.

[75] *Ibid*.

In Ontario, designated hospitals are currently required to notify the organ donation organization (ODO) when a patient has died or death "is imminent by reason of injury or disease."[76] The ODO then applies screening criteria to determine whether to approach the patient's family regarding donation. The legislation does not address death by MAID and therefore it is unclear whether notification is required in these cases. Practice guidelines could direct hospitals to treat MAID similarly to death by injury or disease. This approach would recognize the opportunity to donate as a meaningful decision to be contemplated by the individual seeking MAID and would respect the individual's full autonomy in making that decision.

Alternatively, it may be argued that in dealing with a patient contemplating MAID, the sensitive judgment of the health care team should be the basis upon which the decision is made of whether or not to raise the topic of organ donation. This approach, while cautious, acknowledges the complexity and uncertainty experienced by health care teams as MAID is introduced in Canada, as well as the voices of those who fear individuals will be pressured too easily to seek MAID for reasons unrelated to their own suffering. During these early days of MAID in Canada, a discretionary approach might be reassuring and a firmer policy recommendation may be formed after experience with MAID increases. Conversely, there is a risk that once the habits of medical practitioners are formed in relation to these cases, it will be challenging to change practice to ensure ODOs are notified of cases of MAID.

5. The waiting period between cardiocirculatory arrest and the removal of organs

The Ontario statute governing transplants requires that death be determined "in accordance with accepted medical practice."[77] In DCD practice in Canada, after a patient experiences cardiac arrest, a no touch period (typically of five minutes) is observed, following which death is declared if the patient has no observable pulse or respiration.[78] The purpose of the waiting and observation period is to verify that death has indeed occurred, so an appropriate period should also be observed in cases of MAID. In MAID, death

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[76] *TGLNA*, *supra* note 20, s 8.1(1).

[77] *Ibid*, s 7(1).

[78] See Serri & Marsolais, *supra* note 12 at 130; Shemie et al, *supra* note 9 at S6.

is brought about with a combination of drugs that make the death rapid and irreversible. In the usual DCD scenario, the timing of death is uncertain and may take longer.[79] This might suggest that shortening the waiting period is reasonable in the MAID context. However, there is a risk that any movement in this direction could harm public confidence in the donation system.[80] In Belgium and the Netherlands, death following MAID is determined by the same criteria used for any other organ donor and the usual observation period is respected.[81] This seems to be a wise approach, given the sensitivity of bringing organ donation together with the new and controversial practice of MAID.

6. Should recipients be informed that the donor died by MAID?

Another issue that may arise is whether recipients should be entitled to know that their donors died through MAID. The concern is that those who are strongly morally opposed to MAID would not wish to benefit from it, even at the potential cost of their own lives. Presently, only increased medical risks associated with a particular organ must be disclosed to recipients, such as an increased risk of contracting an infectious disease.[82] Medically irrelevant factors – that is, those that are unrelated to increased medical risk,

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79 See Jeffrey Kirby, "Organ Donation after Assisted Death: Is It More or Less Ethically-Problematic than Donation after Circulatory Death?" (2016) 19:4 Med Health Care Philos 629 at 631–33.

80 See e.g. Tom Rawstorne, "How Doctors Want to Harvest Euthanasia Patients' Organs before They Die: Campaigners Warn of 'Deeply Worrying' Trend as Donors Feel Pressured to End Lives so Others Can Benefit through Their Deaths", *Daily Mail* (8 April 2016), online: <www.dailymail.co.uk/news/article-3530935/How-doctors-want-harvest-euthanasia-patients-organs-die-Campaigners-warn-deeply-worrying-trend-donors-feel-pressured-end-lives-benefit-deaths.html>.

81 See Van Raemdonck, *supra* note 16 at 41; Bollen et al, "Manual", *supra* note 15 at 1970.

82 See The CST/CNTRP Increased Risk Donor Working Group, "Guidance on the Use of Increased Infectious Risk Donors for Organ Transplantation" (2014) 98:4 Transplantation 365 at 367. This is also the approach followed in the US. See United States, Department of Health and Human Services, "Guidance for Donor and Recipient Information Sharing" (17 February 2012), online: Organ Procurement & Transplantation Network <https://optn.transplant.hrsa.gov/resources/guidance/guidance-for-donor-and-recipient-information-sharing>.

including race, religion, or manner of death – are not disclosed, since these factors will not impact the recipient's health and may disclose the donor's identity. Interestingly, Bollen and colleagues take the position that recipients should be able to refuse organs donated by patients who have died by MAID intervention.[83] It strikes us as unwise to make an exception to current Canadian practice of limiting disclosure to information related to increased medical risk. As there is no evidence that organs procured after an assisted death create any additional health risk for the recipient, it is unclear why information about MAID should be treated differently from other facts about donors that recipients may wish to know. For example, recipients may also have a moral objection to suicide (as opposed to MAID), but the fact that a donor died in this way is not currently disclosed.

7. Should patients seeking MAID be permitted to direct their donations to specific recipients?

If directed donation is permitted, a patient may seek MAID in order to donate to a specific person or group of people. Directed posthumous donation occurs when a donor directs their organs, post-mortem, to an identified recipient. While generally accepted in living donation, this is more controversial in posthumous donation as it is inconsistent with the principles of justice, equity, and medical utility, which drive the allocation of organs from deceased donors.[84]

The Canadian Medical Association policy on organ donation and transplantation contemplates directed posthumous donation in limited circumstances,[85] while Ontario permits it when the potential recipient is a family member or relative, or a close friend of the donor or donor family.[86]

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83 "Manual", *supra* note 15 at 1969.

84 See Antonia J Cronin & James F Douglas, "Directed and Conditional Deceased Organ Donations: Laws and Misconceptions" (2010) 18:3 Med L Rev 275 at 276–77; Canadian Medical Association, "CMA Policy: Organ and Tissue Donation and Transplantation (Update 2014)", s 9, online: <https://www.cma.ca/Assets/assets-library/document/en/advocacy/PD14-08-e.pdf>.

85 *Supra* note 83, s 9.4.

86 See Ontario, Trillium Gift of Life Network, "Clinical Process Instruction Manual: Directed Donation Process Instruction" (2014) [unpublished, archived at TGLN].

Thus, directed donation may be possible in the case of organ donation following MAID if the current practices of living donation or posthumous donation are applied.

However, there is a risk that a conscious, competent adult seeking MAID may be influenced in making those decisions by the desire to help a sick family member or friend. While a directed donation may provide tremendous psychological comfort for a patient in these circumstances, the challenge is to balance the autonomy of patients eligible for MAID and wishing to end their lives earlier than necessary to save a family member or friend with the desire to protect vulnerable patients who may be induced to do so.[87] The psychological screening undertaken to determine eligibility for MAID should explore this possibility in these cases, as the *Act* requires that the request not be made "as the result of external pressure."[88]

8. Would the refusal to consider a medically suitable patient for donation after MAID contravene the patient's rights?

If a patient's request to be considered as an organ donor after MAID were refused for a reason connected to MAID, there is a possible argument that the refusal violates human rights legislation by denying the patient access to the psychological benefits of donation on discriminatory grounds related to disability. We do not develop this argument fully here in part due to space constraints and because this issue is speculative at this point in time. However, it is worth noting that multiple legal claims have been brought across Canada in which claimants have alleged that the refusal of their offer to donate blood constituted discrimination. The majority of these claims argued that the prohibition on donations by men who have had sex with men violates their right to be free of discrimination based on sexual orientation.[89]

To date, none of these claims have been successful. *Canadian Blood Services v Freeman* illustrates some of the complexities and challenges in

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87 See Bollen et al, "Manual", *supra* note 15 at 1968.

88 *Supra* note 1, s 3, amending *Criminal Code*, *supra* note 24, s 241.2(1)(d).

89 See e.g. *Canadian Blood Services v Manitoba (Human Rights Commission)*, 2011 MBQB 312, 272 Man R (2d) 289; *Neudorf v Canadian Blood Services*, 2005 BCHRT 265, [2005] BCHRTD No 265 (QL).

successfully bringing a claim for discrimination.[90] The claimant argued that Canadian Blood Services' policy of refusing donations from men who have had sex with other men was discriminatory under the *Charter*.[91] The court held that Canadian Blood Services was not a government actor and therefore the *Charter* did not apply.[92] In *obiter*, the court went on to consider the substance of the claim, stating that donation in this context is a gift and not the provision of a service in which discrimination is prohibited by the *Charter*.[93] While the law remains underdeveloped on this point, the existing case law demonstrates that some who wish to donate perceive the refusal of their donation as a harm unjustifiably inflicted upon them.

The language adopted by the Canadian donation and transplantation community is consistent with the idea that denial of the opportunity to donate inflicts harm on a person. The national recommendations on DCD open with the statement that "as an important part of end-of-life care, patients who die should be provided the opportunity to donate organs and tissues."[94] Some Canadian health authorities and organ donation organizations also emphasize a "right" to make the choice to donate.[95] Although these statements are likely intended to encourage health care providers to support organ donation rather than to declare a legally enforceable right for donors, they point to a widely perceived sentiment that it is a benefit to donors and families to have the opportunity to donate.

While this issue remains unsettled, any policy maker proposing a policy to categorically refuse donations following MAID should consider and address the possibility that would-be donors might perceive the refusal as discriminatory.

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90 2010 ONSC 4885, 217 CRR (2d) 153 [*Freeman*].

91 *Ibid* at para 224, citing *Charter*, *supra* note 31, s 15.

92 *Freeman*, *supra* note 89 at para 3.

93 *Ibid* at para 403.

94 Shemie et al, *supra* note 9 at S1.

95 See e.g. Transplant Manitoba, Gift of Life, "Planning for End-of-Life Decision Making", online: <www.transplantmanitoba.ca/news/read,article/32/planning-for-end-of-life-decision-making>; Saskatoon Health Region, Director for Saskatchewan Transplant Program, "Organ and Tissue Donor Referral Policy", Policy No 7311-60-031 (29 November 2013), online: <https://www.saskatoonhealthregion.ca/about/RWPolicies/7311-60-031.pdf>.

Conclusion and Recommendations

Canadians contemplating MAID are already requesting to donate solid organs and tissues. The issue of organ donation following MAID has been addressed in Belgium and the Netherlands; it would be wise for Canadian policy makers and health care providers to give thoughtful consideration to the combination of these sensitive procedures.

In *Carter*, the Supreme Court of Canada signalled the central importance of patient autonomy in Canadian law.[96] The Court also acknowledged the need to protect the vulnerable from being pressured into MAID, as well as the rights of physicians not to be compelled to provide MAID contrary to their consciences.[97] All of these interests must also be accommodated in determining whether and how organ donation should be incorporated into the practice of MAID as it develops in Canada. In order to ensure that MAID and organ donation are combined in an ethical manner, we propose the following recommendations:

1. Living donation of non-essential organs prior to MAID should be permitted where a competent and medically suitable patient wishes to do so;

2. Posthumous organ donation after MAID should be permitted for competent patients who are medically eligible;

3. If MAID is permitted pursuant to advance requests, posthumous organ donation should also be permitted where the desire to donate was specified within the advance request or where the patient had previously registered their consent to donate;

4. If MAID is permitted pursuant to advance requests and the patient's wishes regarding donation are unknown, current practice should be followed in allowing for substitute consent;

5. The topic of posthumous organ donation should not be raised until after the patient has provided informed consent to MAID;

6. Care should be taken to ensure patients feel free to change their minds about MAID, even after steps have been taken to prepare for organ donation following MAID;

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96 *Supra* note 2 at paras 64–69.

97 *Ibid* at paras 99, 132.

7. The usual protocols and safeguards in the case of DCD should be applied following MAID, including (1) the separation of the teams involved (a) in bringing about and declaring death and (b) in removing organs and (2) the observation of the specified waiting period between asystole and removal of organs;

8. The fact that the donor died by MAID should be kept confidential and not shared with the organ recipient;

9. In the event that a policy prohibiting posthumous donation following MAID by otherwise medically suitable donors were to be adopted, the perception of discriminatory refusal should be considered and addressed;

10. MAID by removal of organs should not be permitted.

As Canada develops experience assisting patients through the process of MAID, organ donation organizations should collect information about the prevalence of organ donation in this context. In addition, it would be beneficial to conduct further research on the experiences of patients, families, and medical staff in order to more effectively guide policy development in this area.