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Organ Donation After Medical Aid in Dying: An Ethical Overview

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ABSTRACT

Organ Donation after Medical Aid in Dying (OD-MAiD) is currently practised in four countries: Belgium, Canada, the Netherlands, and Spain. While OD-MAiD shares some similarities with MAiD (absent the possibility of organ donation) and with standard organ donation protocols, the combination of OD and MAiD involves unique circumstances that present novel ethical challenges. These challenges revolve around donors' consent and protection, the *dead donor rule*, and organ allocation. This paper explores these moral challenges and proposes strategies to ensure ethical safeguards in the context of OD-MAiD. An underlying question is whether OD-MAiD, if permitted, should follow the ethical guidelines of living donation or deceased donation, as these two practices commonly operate under distinct moral paradigms. While the living donation paradigm is centred on the protection of donors' interests and emphasises individual choice by allowing donors to decide who receives their organs, the deceased donation framework places more emphasis on enabling recipients to benefit from transplant, and organ allocation is typically based on impartiality. OD-MAiD also raises ethical concerns about how the possibility of donation could influence a patient's decision to seek euthanasia and/or interfere with optimal end-of-life care. Proposing organ donation to individuals considering MAiD could conceivably create pressure to proceed with euthanasia, either to realise a social good or to satisfy the needs of loved ones (if a family member requires an organ). This may undermine the patient's autonomy or well-being at the end of life.

1 | Introduction

Medical Aid in Dying (MAiD) is the practice of a physician providing or administering a lethal medication to a competent, suffering patient at his or her request. Often, the patient has a terminal diagnosis, although legal eligibility requirements vary by jurisdiction [1]. There are two forms of MAiD: (a) a healthcare professional administers to a patient a lethal substance that causes death, (commonly called *euthanasia* or *MAiD by drug administration*); and (b) a health professional prescribes

a drug that the eligible person self-administers to bring about his or her death (commonly, *assisted suicide* or *MAiD by drug prescription*).

Organ donation after MAiD (OD-MAiD) refers to the practice of procuring organs for transplantation after death via either form of MAiD. Its present practice is limited to four countries where MAiD is typically provided *by drug administration* and controlled donation after circulatory determination of death (cDCDD) is also legally permitted: Belgium, Canada, the Netherlands, and Spain. One reason why OD-MAiD by drug prescription has not developed is likely pharmacological: self-administered medications (e.g., amitriptyline) that enter the gastrointestinal tract may compromise the integrity of organs. Despite this, some have pointed to its potential benefits in countries where donation after circulatory death (DCD) after withdrawal of life-sustaining therapies is practised, including substantial increases in organ availability, improving organ matching and scheduling of transplantation, maximising patient autonomy by enabling donation, and reducing the risk of family veto to organ donation [2].

In current OD-MAiD protocols, patients undergo circulatory arrest resulting from lethal injection, falling into category V of the Maastricht organ donor classification schema. Protocols require an observation period following circulatory arrest—commonly 5 min—*before* organ retrieval starts [3]. As some patients request that MAiD be practised at home (OD-MAiD-H), some protocols have been adapted to accommodate that preference [4]. According to recent data, in Belgium, 2656 people received MAiD in 2019, of whom 10 donated their organs (0.37%) [5]. In Canada, in 2021, there were 10,064 MAiD provisions, of which 49 were OD-MAiDs (0.48%) [6, 7]. In the Netherlands, in the same year, there were 7666 MAiD provisions and 12 OD-MAiDs (0.15%) [8]. As most MAiD involves patients with cancer, thus precluding organ donation, it has been calculated that at most 10% of all patients undergoing MAiD could potentially donate at least 1 organ [9]. However, Spain exceeded that figure in 2022 with 42 OD-MAiDs out of 288 MAiD cases (14.6%), possibly due to a high rate of MAiD requests by patients with neuro-degenerative diseases [10]. Current OD-MAiD protocols share some characteristics with, but can be distinguished from, three less frequent—or just theoretical—modalities of organ procurement:

Imminent death donation [11] has been proposed to allow non-vital organ procurement—single or double nephrectomy—to start *before* death is certified (abandonment of the 5 min 'no-touch rule'), on the basis that its occurrence is imminent [12]. After the removal of non-vital organs—typically, one kidney—the patient is returned to intensive care, where extubation proceeds. Similarly, Morrissey proposed in 2018 [13] premortem nephrectomy to avoid organ loss due to ischaemia while satisfying the *dead donor rule* (DDR) [14]. Imminent death donation can be implemented in countries in which MAiD is not allowed.

Removal of vital organs with life-sustaining therapy replacement, suggested by Wilkinson and Savulescu [15], would involve placing the patient on extracorporeal membrane oxygenation (ECMO), removing organs including the heart and lungs while the person remains alive on ECMO, and then discontinuing the ECMO after multiorgan retrieval has been conducted in optimal circumstances. Arguably similar to *imminent death donation*, in this protocol organ retrieval itself would not directly cause death, as effective circulation is preserved along the process, therefore not formally violating the DDR. However, given the temporal limits of ECMO as a substitute for heart and lung function, the patient's death is foreseeable following the removal of multiple organs. We are not aware of any hospital with a protocol of this kind.

Finally, these two procedures can be distinguished from *death by organ procurement*, the possibility—also described by Wilkinson and Savulescu, and labelled as 'organ donation euthanasia'—of intentionally causing the death of a patient *through* vital organ procurement [15]. Such a procedure would involve sedating a patient who is eligible to euthanasia and who wants to donate, and proceeding with vital organ procurement before they have been declared dead. This would also minimise organ deterioration while involving an explicit violation of the *dead donor rule*. We propose 'euthanasia by organ procurement' as a clearer term for this practice, conveying that organ removal is causal of, and not merely incidental to, the patient's death [16].

These three modalities have the common characteristic that organ procurement starts, unlike OD-MAiD, before, rather than after, death by circulatory arrest has happened. Another differential aspect of OD-MAiD is that death is caused by lethal injection rather than organ procurement itself, or enabled by the withdrawal of life sustaining therapies [17].

In this paper, we aim to identify and understand the specific moral challenges posed by OD-MAiD. To do so, we begin by discussing whether OD-MAiD more closely fits the prevailing moral and regulatory paradigms governing living or deceased donation. Then, we address three moral and policy challenges: a. respecting donors' autonomy; b. donor protection and the *dead donor rule*; and c. partiality versus impartiality in organ allocation. After examining the primary ethical challenges, we examine how overlooking them could undermine public trust in end-of-life care and organ donation. Finally, we draw some conclusions and recommendations to mitigate risks and uphold ethical standards in OD-MAiD protocols.

1.1 | OD-MAiD. Halfway Between Two Moral Paradigms

Living and deceased donation are governed by two distinct moral paradigms that affect the type of consent required and the role of families, the safeguards to ensure donors' protection from harm [18], and the principles guiding organ allocation [19].

First, living donation can only be conducted with first-person consent. Prospective donors are healthy individuals who provide consent after being given full information about the nature and risks of the intervention, and screened for any potential pressure they may be undergoing. The support of family members can be considered during psychosocial evaluation of donors, but their authorisation is not necessary to proceed with non-vital organ removal. By contrast, deceased donors are individuals who either fulfil neurological criteria (donation after brain death, DBD

protocols) or cardiorespiratory criteria for death determination (donation after circulatory determination of death, DCDD protocols). Most DCDD cases involve unconscious patients who undergo a withdrawal of life-sustaining therapy. In opt-out countries, deceased donors need not have explicitly consented for organ donation, but are deemed to have consented if they have expressed no opposition. Despite the common assumption that family/surrogate granting of permission for deceased organ donation should be based upon the presumed or explicit organ donation wishes of the terminally ill patient [20], in both opt-out and opt-in jurisdictions, when the preferences of the deceased are unknown, families typically have full decisional capacity to authorise and to oppose organ recovery [21–23].

Second, living and deceased donations differ in the safeguards required to ensure adequate donor protection. Living donors undergo a series of controls, including assessment of health risks, psychosocial evaluation, and post-donation follow-up. In the United States of America, the involvement of an independent donor advocate is required to ensure that prospective donors are properly informed and protected [24]. Deceased donation, by contrast, typically involves permanently unconscious patients who are considered to be beyond meaningful recovery, which explains why harm to donors remains a secondary or even absent concern. Controversially, pre-mortem interventions such as heparin administration, that offer no physiological benefit to the donor but are solely intended to optimise organ transplantation, have sometimes been endorsed on the basis of the presumed absence of harm [25]. However, some recent analysis suggest that DCDD organ donors can be harmed or wronged by alterations of the timing, location, or method of withdrawal of life-sustaining therapy that are introduced with the purpose of optimising organ preservation [14].

Finally, living and deceased donation commonly follow different allocation paradigms. Living donation is based on a *partiality scheme* [19] —where donors can choose who receives their organs, often a family member or close friend—which may even be considered as evidence of voluntariness. In contrast, deceased donation follows an *impartiality scheme*—where donors cannot typically choose the recipient—so their organs are treated as a common resource. One possible rationale for restricting directed deceased donation is to prevent any incentives—such as helping a loved one or receiving a reward—that might influence a person to refuse life sustaining therapies, or to request MAiD, as a means to become an organ donor. However, even when directed deceased donation is not permitted, if a person eligible for MAiD had a family member or friend waiting for an organ, it would be difficult to exclude the possibility that the decision regarding organ donation may have prompted the request for MAiD [26].

OD-MAiD is neither a prototypical case of living nor deceased donation, but shares some characteristics with both DCDD and living donation. To the extent that organs are procured after the expected permanent cessation of circulatory arrest, it can be considered as a subcategory of controlled DCDD, where circulatory arrest is enabled by lethal injection instead of the withdrawal of life-sustaining treatment. However, while most DCDD protocols involve unconscious patients with serious brain damage who undergo circulatory arrest resulting from withdrawal of life support, OD-MAiD concerns conscious and competent patients who can decide, after their MAiD request has been accepted, whether or not to donate their organs. This has led some authors to consider OD-MAiD as an instance of living donation [27].

The fact that OD-MAiD shares key features with both the living and deceased donation paradigms (see Figure 1) creates ambiguity and heightened moral challenges as compared with either type of organ donation. Awareness and the capacity to decide up until the very last moment are characteristics of living organ donation that deceased donation protocols typically lack. Consciousness enables—and warrants—full and current consideration of donors' preferences, thus making presumed consent or surrogate decision-making inappropriate, and potentially exposing prospective donors to pressure and some harms that cadaveric donors do not prototypically face. OD-MAiD donors and living donors are vulnerable to similar kinds of undue influence, but the fact that multiple vital organs can be procured in OD-MAiD increases the risk of harm. Additionally, the desire to help a loved one may motivate a person to request

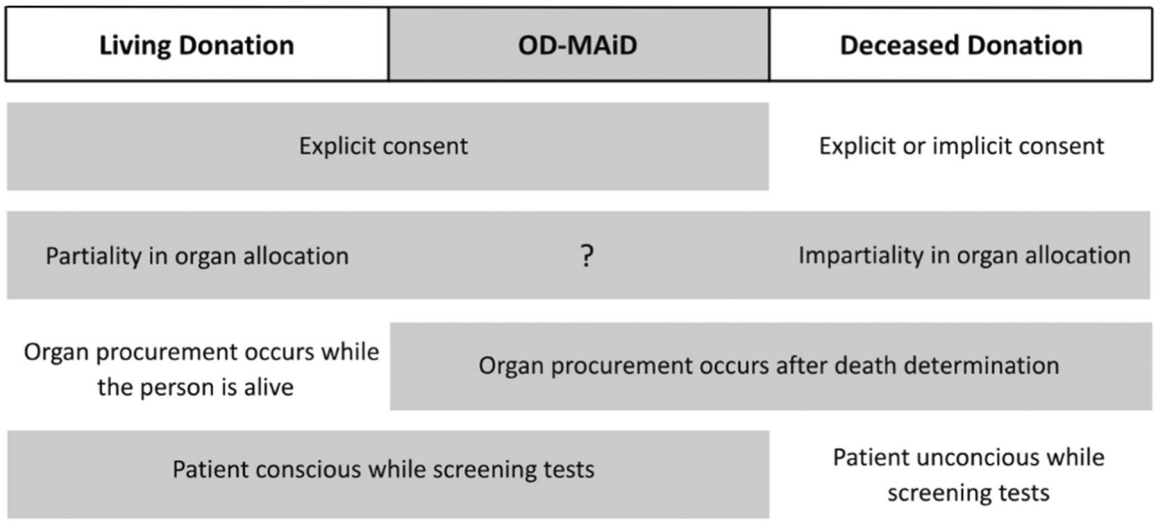

FIGURE 1 | Intersection between LD, OD-MAiD and DD.

MAiD, potentially leading to sacrificial decisions where autonomy may be compromised.

OD-MAiD also raises novel ethical challenges when compared to standard MAiD. Organ donation can interfere with optimal end-of-life care if maximising donor's comfort is not compatible with optimising organ preservation. For instance, the process of organ donation requires preparatory exams and premortem interventions (cannulation, endotracheal intubation) that depart from standard MAiD procedures and are exclusively intended to optimise organ donation. On the one hand, the availability of an organ procurement team, operating room availability, or general convenience, may alter a patient's choice of date for MAiD. On the other hand, OD-MAiD-H often involves patients being sedated at home and then transferred to the hospital where MAiD is administered [7], which may cause distress to families who wish to be with the patient when they die.

Finally, OD-MAiD may or may not violate the DDR, depending on the delineation of the rule [14], if donors' vital functions are not irreversibly lost at the time of organ removal, if organ donation can be considered a proximate cause of donor's death, or if donors are killed for the purpose of them becoming organ donors. We explore these challenges in more depth in the next section.

2 | Major Moral and Policy Challenges in OD-MAiD

2.1 | Respect for Donors' Autonomy

The unique dynamics of OD-MAiD may compromise the ethical standards usually required to ensure that people who make health decisions with no direct benefit for themselves are truly making voluntary decisions, free from overbearing external pressures. Protecting patient autonomy, per Beauchamp and Childress [28], involves preventing undue influence—whether through coercion, subtle manipulation (e.g. nudges) [29], or pressure, including economic and emotional incentives[1]. OD-MAiD candidates can experience varying levels of influence, depending on factors like the origin and timing of the proposal to become organ donors, or whether a directed donation is possible.

When donation appears to be encouraged by healthcare providers or family members, it may create a sense of obligation or otherwise shape a patient's decision to proceed with MAiD. This influence can reach the level of coercion, for example, if patients within a system committed to universal, high-quality healthcare feel that rejecting organ donation could affect the quality of care they receive. Additionally, moral expectations placed on patients might deter them from reconsidering their decision, fearing disappointment from those around them. Although respect for personal autonomy is an ethical cornerstone of both voluntary organ donation and MAiD, Buturovic [32] argues that allowing OD-MAiD may inadvertently encourage patients to proceed with MAiD, entwining the two practices in ways that could complicate the patient's autonomy in end-of-life decisions [33]. In particular, OD-MAiD would raise ethical concerns if (1) organ donation becomes the primary motivation for requesting MAiD, or (2) patients feel pressured or obligated to donate organs while considering on MAiD. In the first scenario, some individuals might request MAiD who would not have if organ donation was not an option, because they wish to help others through donation and have found in MAiD an opportunity to accomplish that purpose. This kind of motivation would shift the focus of MAiD from a tangible personal interest in end-of-life decisions to the more remote objective (for the patient) of achieving organ donation. In the second scenario, a patient might feel morally obligated to donate organs after choosing MAiD, driven by personal or societal values like altruism, social duty, or the desire to 'be a good citizen' [34]. This internalised sense of duty could make organ donation feel like an unwritten requirement, creating ambiguity and tension around the voluntariness of the MAiD request.

Patients may also receive *external* pressures from family, society, or healthcare professionals that unduly influence them toward donation. Some patients who decide on MAiD may feel obligated to donate organs, either out of gratitude or reciprocity toward medical staff or from a belief that their MAiD request will be taken more seriously if they agree to donate. As illustrated by a case report, patients experiencing second thoughts about MAiD may feel pressured to proceed, believing: 'I'd better do this because people are waiting for my organs' [12]. External pressure from family members could also influence patients, particularly if there's an expectation or implied need for a directed donation.

2.2 | Donors' Protection and the Dead Donor Rule

Unlike ordinary MAiD, OD-MAiD protocols involve a series of actions to ensure that the death of the patient occurs in conditions that facilitate optimal organ preservation and procurement for transplantation. Altering procedures for the sake of optimising organ donation and transplantation may interfere with living patients' interests at the end of life. Following Michael Nair-Collins' taxonomy of potential donors' interests, patients' *welfare interests* can be compromised—regardless of their preferences—if the necessary conditions of living well, including adequate nourishment, hydration, and rest are jeopardised [18]. Patients' *investment interests* may be thwarted if their preferences cannot be honoured *due to* organ donation. Finally, patients' *experiential interests*, which require sentience, are menaced if donors are exposed to unpleasant or painful experiences, or deprived of pleasant ones. Patients are *harmed* if, by either infliction or deprivation, their interests are set back, and *wronged* if harm results from a morally culpable behaviour. Based on this analysis, OD-MAiD would compromise prospective donors' *welfare* interests if the process of organ donation (distinct from the debatable nature of MAiD itself) involves depriving organ donors of basic care, which is unlikely. Organ donation could set back some of their *investment* interests, if it hinders the fulfilment of their end-of-life preferences, such as dying at home and surrounded by their loved-ones. Finally, OD-MAiD could *experientially* harm donors only to the extent and insofar as they preserve sentience. Arguably, *pre-mortem* interventions, including obtaining samples and catheterisation, while being conscious, can experientially harm donors. Donors' experiential interests may also be set back if drug administration, including anaesthesia and sedation, were altered, for the sake of organ preservation, in ways that are unsafe for patients. Finally, patients may experience discomfort if they

maintain or recover brain function after circulatory arrest as a result of the introduction of extra-corporeal membrane oxygenation intended for organ preservation [14, 35]. Importantly, recovering brain function, including consciousness, after death determination following circulatory-respiratory criteria, would not only expose potential donors to harm, but would also critically challenge the DDR.

The DDR starts from the basic premise that patients must be dead before their vital organs are removed [36, 37]. This simple idea can involve different practical obligations depending on whether the focus is on respecting the *letter* of the rule—that organ retrieval itself does not count as the proximate cause of donors' death—or its *purpose*, variously construed—that vital organ procurement doesn't compromise due care, instrumentalize patients, or harm donors in any way. By honouring the letter or the spirit of the rule, OD-MAiD may avoid spreading societal mistrust in organ donation [38]. Whether or not OD-MAiD involves literal violations of the DDR also depends on the formulation of the rule itself [14] (Figure 2). The DDR has been interpreted/formulated in at least three different ways, delineated as follows:

a. *Death must be declared properly before vital organ procurement starts*

   This guideline safeguards the legal integrity of health professionals performing vital organ procurement, with death determination being used as a 'firewall' or policy barrier signalling the moment of death as a red line that organ procurement teams cannot cross. Before death, all interventions need to be done by a healthcare team, rather than an organ procurement organisation (OPO), for the sake of patients' interests. Fulfilling this interpretation of the rule may both satisfactorily protect donors from harm and foster societal trust, only if death determination is safe and rules out the possibility of organ donors retaining or recovering sentience [39].

b. *People should not be killed* by *organ procurement*

   This formulation emphasises the moral prohibition of a *behaviour*—killing—instead of a purportedly biological *fact*—that is, death. Killing is a thick concept—both descriptive and evaluative—that many people, including health professionals, use normatively—not simply descriptively—to refer to life-ending behaviours they disapprove of [17]. The aforementioned protocols for *imminent death* and *removal of vital organs with life-sustaining therapy replacement* share the premise of procuring organs from a patient without organ procurement itself directly causing death. Conversely, protocols of *euthanasia by organ donation* put forward by Dominic Wilkinson and Julian Savulescu [15] would clearly break this delineation of the rule. Whether contemporary OD-MAiD protocols also violate this version of the DDR depends on the stand one takes on two contentious problems: whether permanent circulatory arrest is sufficient for death determination, or a brain-based determination is necessary and, if the latter, whether potential OD-MAiD donors have irreversibly lost all brain function at the time of organ removal [14, 40].

c. *People should not be killed* to *facilitate organ procurement*

   In addition to complying with the two previous guidelines, this formulation of the rule requires that the procurement of a patient's organs should not be the driving motive that triggers the actions undertaken to cause the patient's death. Some practices involving patients with severe brain injury that have been described as facilitating brain death instead of death by circulatory criteria, for the sake of fostering multiorgan procurement and optimising the utility of a donor [14, 41], may violate this delineation of the DDR. OD-MAiD would also challenge this version of the rule if patients choose MAiD partially or mainly with the purpose of becoming organ donors. This concern suggests that the detailed personal conversation about organ donation should always follow, and never precede, a patient's decision to receive MAiD. Figure 2 shows how the various protocols presented here may or may not violate each of the delineations of the DDR.

2.3 | Organ Allocation

The allocation of organs in OD-MAiD also presents ethical challenges that blend elements of both living and deceased donation frameworks. Treating organ allocation as with living donation emphasizes respect for patients' autonomy, allowing donors to actively and voluntarily choose what happens to their

Delineations of DDR / Protocols	Death Must Be Declared Before Vital Organ Procurement Starts	People Should Not Be Killed by Organ Procurement	People Should Not Be Killed for Organ Procurement
OD-MAID	✓	✓	?
IDD	✓*	✓	?
RVO-LSTR	X**	✓	?
EOD	X	X	?

FIGURE 2 | EOD, Euthanasia by organ donation; IDD, imminent death donation; OD-MAiD, organ donation after MAiD; RVO-LSTR, removal of vital organs with life-sustaining therapy replacement. *While organs are procured before death, IDD concerns *non-vital* organs, resulting in a non-violation of this interpretation of the DDR. **While both vital and non-vital organs are removed before the declaration of death, these organs are replaced by medical devices (e.g., ECMO) capable of preserving all vital functions.

organs. In this autonomy-centric approach, the donor's wishes would not only determine whether and when to donate, but could also guide the allocation process, enabling the donor to specify particular recipients, such as family members or friends. This can be especially beneficial in cases of close biological matches [42]. However, the donor-directed allocation of organs that would likely be donated anyway may introduce concerns around fairness, as the donor's preferences are likely to bypass standard allocation criteria based on medical urgency, compatibility, waiting time, and geographic proximity. Moreover, allowing directed donation may create an opening for unwanted pressures on potential donors, undermining the autonomy it is intended to promote in the first place. In the context of legal MAiD, a particular concern is that the desire to help a loved one may become the primary motivation behind an MAiD request.

On the other hand, if OD-MAiD organs are allocated following deceased donation standards, they would enter the general organ allocation system, based on established medical and logistical criteria. This approach aligns with principles of equity and impartiality (ensuring equal access for all patients on the waiting list), utility maximisation (optimising health outcomes through urgency and compatibility), and consistency (following established protocols). This would limit the donor's autonomy, as they would no longer be able to directly choose who receives their organs.

The challenge lies in finding the right balance between these two approaches. An ideal solution may involve a hybrid model that respects donor autonomy and intent while prioritising societal notions of fairness and maximising health outcomes. For instance, guidelines could permit limited directed donation requests with checks against undue interpersonal influence or coercion, in a broader framework designed to ensure equitable distribution and optimise the impact of each donated organ.

3 | Trust at Risk: Consequences of Overlooking the Moral Challenges

Trust and trustworthiness are essential in both end-of-life care and organ donation [43]. Failing to address ethical complexities—such as those outlined above—can create perceptions of coercion, insensitivity, or unfairness. These perceptions can undermine trust not only in individual providers but also in healthcare institutions and the organ donation system as a whole. Ultimately, a loss of trust may deter people from considering organ donation or MAiD, not because they are opposed to these practices in principle but because they are worried that their interests will be killed in the implementation.

Trust plays a critical role in the decision-making process for the families of deceased organ donors, and this is further complicated by the legal and ethical controversies surrounding MAiD. In Spain, for example, MAiD has faced legal challenges and opposition from both political and medical sectors, with nearly 9300 healthcare professionals objecting to participation [44]. These societal disputes create additional ethical complexities. As mentioned before, OD-MAiD involves specific procedures that may disrupt standard end-of-life care, making it even more contentious than conventional MAiD.

The implementation of OD-MAiD, especially if undertaken in an ill-considered way, poses foreseeable reputational risks for health professionals and institutions involved in organ recovery, allocation, and transplantation, even if these activities seem tangential to the provision of MAiD itself. Several factors contribute to this precarity, including the relative opposition to the practice of MAiD in some societies (with approximately 15% of the population in Spain opposed [45]), longstanding anxieties about the possibility of premature declaration of death, tensions between ideals of a peaceful death and the exigencies of organ retrieval, and the suspicion that organ donation and transplant coordinators might have a vested interest in 'encouraging' potential OD-MAiD candidates to request MAiD (or at least, to persevere in their request and complete the process).

Organ donation and transplant organisations may need to develop procedures to protect public trust, especially as some public voices (specifically, in Spain) have suggested that MAiD is being encouraged to make organ donation possible, or that organ donation 'pinkwashes' what is considered by some to be an otherwise abhorrent practice [46]. The protocol for OD-MAiD developed by Spanish National Transplant Organization recognises that all patients requesting MAiD have the right to be organ donors on equal terms as any other patient, if they so wish [4]. A transplant coordinator must inform the patient of the details of the donation and clarify the reasons why the person wishes to be a posthumous organ donor to rule out that the donation is a means or an incentive to carry out MAiD. Notably, this protocol effectively grants the coordinator the ability to stop the donation process if they have reasonable doubts about the independence of the two decisions, and assigns to the coordinator a duty to ensure that donation is not facilitating MAiD [4].[2]

Donation can be regarded as beneficial in coping with death (both for the person who is going to die and for his/her family) insofar as it is considered to be a continuation of life [47]. While it is crucial to ensure there is no external pressure or coercion for organ donation, it is equally important to facilitate individuals' voluntary wishes to donate. For those who actively wish to be donors, principles of autonomy and beneficence favour professionals' supporting this intention in a way that is both respectful and safe. Spain's protocol represents one attempt to navigate these shoals. A somewhat different approach, reflective of the same concern for respecting patient's wishes at the end of life, has been outlined in recent guidance from a multidisciplinary Canadian working group [48].

4 | Conclusions

This paper has sought to conceptualise the major moral and policy challenges raised by OD-MAiD. We posit that OD-MAiD occupies a unique space between living and deceased organ donation, raising novel ethical concerns or new variations on old concerns. While OD-MAiD involves considerations of vulnerability and autonomy typically associated with living donation, it also involves the procurement of vital organs that are

only legally retrieved postmortem. This ambiguity presents challenges in safeguarding patient autonomy with respect to MAiD and ensuring that the decision to donate itself is free from coercion, particularly when significant social pressures may be present. The potential for organ donation to influence or expedite decisions regarding MAiD necessitates careful consideration and discernment. Coordinating MAiD 'purely' to optimise organ procurement may contravene the *dead donor rule*. These ethical challenges have the potential to erode public trust, as has been discussed. While acknowledging the necessity for further exploration of these intricacies, we identify some specific friction points where steps can be taken to mitigate ethical risks:

Managing conflicts of interest and separating MAiD from OD: The prospect of organ donation influencing a patient's decision about MAiD is distressing if MAiD, with its existential stakes, is understood as a personal response to intractable suffering from a medical condition. While patient autonomy may not require independent decision-making about MAiD and donation, on an organisational level it may nonetheless be critical for maintaining the integrity in both processes. Clear role separation is recommended to mitigate conflicts of interest and commitment on the part of healthcare professionals, especially while communicating the possibility and specifics of organ donation. Transplant coordinators and OPOs clearly identified as such, not the MAiD team, should manage organ donation discussions. *If the goal is maximise decisional independence*, these discussions should logically happen *after* a patient's request for MAiD has been approved.

Effective and timely communication: Countries have adopted various approaches to communicating the donation option (e.g., Belgium/Netherlands: patient-initiated; Spain: patient-initiated; Canada: patient and doctor initiated) [7]. In broad terms, the goal is to balance multiple values, including transparency, utility, and sensitivity, ensuring patients are well-informed without feeling pressured. From what we know about transplant decision-making generally, timing and protocols for sharing information about potential recipients are also likely to be important. These aspects of the discussion of OD-MAiD with individual patients warrant further research and deliberation.

Enhanced consent: A progressive informed consent process could be valuable in OD-MAiD, as it allows patients to make informed, thoughtful decisions over time, particularly in complex situations. This approach provides information gradually, in stages that match the patient's emotional and psychological readiness, reducing the risk of overwhelming them. It would also ensure that patients have time to ask questions, reflect on their choices, and understand the implications of both MAiD and organ donation, with the option to retract their decision until the last moment. However, the approach must also respect the realities of patients undergoing MAiD, who may be experiencing rapid physical decline and may not want to spend their remaining time in lengthy clinical discussions.

OD-MAiD donor advocate: An independent donor advocate might help protect patients' interests by supporting informed, pressure-free decision-making. This advocate could operate similarly to donor advocates or ethics committees in living organ donation, balancing protection of patient interests with any potential administrative difficulties.

We have shown that OD-MAiD shares characteristics of both living and deceased organ donation and that such ambiguity engenders unique ethical challenges. To address these concerns, separating MAiD and OD processes to prevent conflicts of interests, implementing effective and timely communication and enhanced consent, and introducing the figure of a donor advocate could help safeguard and advance donors' interests in optimal end-of-life care and organ donation.

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Conflicts of Interest

The authors declare no conflicts of interest.

Endnotes

[1] Robert Veatch and Lainie Friedman Ross [30] have distinguished undue influence—receiving a non welcomed, irresistible offer (e.g., one that is too good to refuse)—from coercion—which involves a threat in the case of noncompliance. Drawing from Alan Wertheimer, Glenn Cohen [31] has provided a detailed account of coercion in the context of organ selling: that notion would require that a) the patient does not have an alternative choice but to accept the offer to sell, and b) the buyer or the broker does not have a right to make such an offer to the donor. While limiting the sale of organs to only cadaveric organs might be considered a bulwark against coercion, Cohen acknowledges that people might be more susceptible to being coerced to sell after dead, as they assume fewer negative consequences, and concludes: '[t]his may mean that [prospective deceased donors] are more subject to coercion [than prospective living donors] but the coercion has fewer negative effects when it does occur'. Due to the inherent ambivalent status of OD-MAiD as living or deceased donation, we wonder whether Cohen's conclusion also applies to OD-MAiD.

[2] According to the protocol, to ensure that the donation request is independent of Medical Aid in Dying (MAiD), the sequence should be as follows: when a person has submitted their first MAiD request, the attending physician, within the framework of the deliberative process established by the Spanish Law, may inform the patient, if the patient accepts to receive such information, about the possibility of becoming an organ donor following the MAiD. If, after receiving such information, the patient expresses an interest in organ donation, the responsible physician will notify the transplant coordination team at their hospital to provide the necessary information, along with any clarifications the patient may need. According to the Spanish National Transplant Organization (ONT) this guarantees that those requesting MAiD can receive information about donation if they express the desire, and that it's not only individuals with direct access to this information who have the option to consider organ donation. The purpose of the ONT is to ensure adequate information about the donation option, whenever the applicant desires, so that no one excludes themselves as an organ donor by assuming, due to insufficient and accurate information, that the MAiD process or their illness prevents donation.

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