DOI: 10.37708/jsca.swu.v12i1.3

DOCTORS AND DEATH: WHY DECEASED ORGAN DONATION AND ORGAN TRANSPLANTS ARE RARE IN BULGARIA

Ilina Marinova

Abstract

The prerequisites for a functional transplant system in Bulgaria, comparable to those in other European countries, are present. Despite two decades of development, Bulgaria continues to lag behind its counterparts in terms of transplant rates.

To identify the causes of this disparity, a study was conducted between early 2023 and mid-2024. This included a review of existing literature, observations of hospital practices, and informal discussions with medical specialists, administrators, and representatives of public institutions.

It is widely believed that Bulgarian citizens are unwilling to donate organs. However, this assumption remains unproven, as in most potential donor cases, the brain death is not established and the families are not informed about the donation. Brain dead patients exist in a liminal state, between life and death. Faced with this ambiguity, hospital personnel often deny their presence. Cultural attitudes, structural factors, power dynamics, and social contexts, shape the behavior of medical staff and administrators.

Keywords: *medicine, end-of-life practices, brain death, deceased organ donation, organ transplants, rites of passage*

Introduction

Anthropology has studied organ transplantation since its emergence in modern medicine, focusing on issues such as organ donation and the ethical complexities of brain death (Ikels, 2013).

Despite over two decades of development, Bulgaria's transplant system remains significantly behind its European counterparts in terms of transplant rates. Efforts to organize deceased organ donation processes at a public hospital in Bulgaria prompted a broader study revealing discrepancies between the official narratives – emphasizing the low public awareness and the reluctance to donate – and the field findings of the study. Experts pointed out "donor identification" as the real barrier.

This study covers mid-2022 to mid-2024 healthcare regulations and practices in Bulgaria and compares: 1) existing literature (e.g., psychosocial, ethnographic and interdisciplinary studies, medical practices, statistical data, media content, and regulatory frameworks); 2) observations of hospital practices, including staff interactions, and 3) informal conversations with donor coordinators, medical specialists, and former and current representatives from the Executive Agency of Transplantation (EAT), the Ministry of Health (MH), and the Executive Agency Medical Supervision (EAMS).[1]

Literature review

Margaret Lock (2002) examines the 30-year discourse that shaped the new death criteria in North America, driven by the demands of organ donation and transplantation and readily accepted, contrasting with Japan, where brain death still remains narrowly applied. Death is neither obvious nor fixed but historically and culturally constructed, flexible, and open to debate (Lock 2002, Yang & Miller 2015).

Van Gennep's (1909) classical concept of rituals mediating life transitions is relevant to brain death, deceased organ donation and transplantation. As liminal states between life and death, they must be explicitly ritualized to successfully integrate change. Otherwise the ambiguity may evoke unsettling and unuttered fantasies. Brain dead and deceased donors may be perceived as not being "truly dead", and recipients as not "truly alive" and thus fundamentally changed after transplantation (McCormack 2021). Liminality is applicable also to geographic, symbolic, and conceptual boundaries which are increasingly blurred in the global process of exchange of cultural, political, and spiritual meanings (Howarth 2000, Thomassen 2009).

Philippe Ariès (1977) traces „Western" attitudes toward death from early Christianity to modernity, revealing shifts in the perception of life and death redefining human nature. Up to the first millennium, death was seen as ordinary and unthreatening. A major shift began in the 11th century, when it came to signify the end of the personality rather than a temporary weakening of the community. Over time, death was increasingly perceived as the sole source of evil. By the 20th century, it had become so unbearable that it was "banished" from daily life, transforming into a hidden but relentless threat.

Robert Burt (2002) examines the consequences of a radical shift in the American culture of death in the 1970s. The responsibility for life-and-death decisions was legally withdrawn from doctors and passed on to patients, granting them the

[1] Since the topic is sensitive, participants' names are either not cited or have been changed and I have made an effort to remove any information that could be linked to a specific hospital. As a result, some sections may appear vague.

“right to die” by refusing treatment and later, the right for assisted suicide. This new approach rested on two premises: that death might be preferable to unbearable suffering, and that it is an inevitable, morally neutral biological event. Burt argues that these rights caused suffering in many cases, as people instinctively viewed death as both material and moral evil. Burt points out that those efforts to rationalize death failed to suppress deeper beliefs, affecting both patients and professionals making life-and-death decisions.

The analyses of Lock, Van Gennep, Ariès, and Burt provide insight into the deep cultural, social and psychological tensions surrounding the life-death transition underlying the “inability” of Bulgarian intensive care unit (ICU) doctors to identify brain dead patients.

Methods

1) I conducted participant observation in a state hospital. I gathered information on the hospital’s internal regulations and structure, as well as on the practices related to donation and transplantation. The team led by Dr. Stoyanov including myself, held weekly meetings in the first four months from January 2023 to April 2023. I was invited to the team as a psychological consultant in communication with the relatives of potential donors and, at a later stage, as an anthropologist. My roles allowed me to be present during conversations with the relatives of potential donors, 10 internal meetings for discussing procedures and negotiating internal rules, and a session on the procedure for determining brain death. I was unable to record the conversations as audio files, but I took notes during or after the meetings. After April 2023, I was not present at the hospital but I was informed about the developments through regular meetings and phone calls with Dr. Stoyanov.

2) I familiarized myself with the relevant legal framework and then, together with the rest of the team, conducted an *ad hoc* study—tracing the implementation of regulations in reverse, from outcomes back to the legal formulations they are associated with. In some cases, I tracked retrospectively regulatory changes and related media coverage.

3) In the period from May 2023 to June 2024 at my suggestion and with the initiative and mediation of Dr. Stoyanov, he and I jointly conducted 14 unstructured interviews, formal and informal conversations with donation and transplantation coordinators, other medical professionals, former employees of the Executive Agency for Transplantation, two members of the Parliament, high rank officials in the Ministry of Health and EAMS, patients with transplanted organs, and their relatives. We consulted three bioethics specialists, one of whom was also an expert in bio legislation.

4) I proposed and Dr. Stoyanov conducted a brief survey (three questions) among his colleagues donation coordinators regarding the legal regulations and practices related to determining brain death in six other countries.

5) In October 2024 on the basis of the qualitative study conducted I created and carried out online survey about brain death determination among 39 emergency and intensive care specialists from 11 out of 28 Bulgarian regions.

Context

Organ donation and transplantation are global practices affected by diverse cultural, historical, and healthcare contexts. As of 2022, 91 out of 194 countries, members of the WHO, have submitted information on organ donation and transplantation activities (GODT 2022). The following review briefly examines the concept of brain death, the industrial principles of organ transplantation, and the transplant system in Bulgaria.

Fantasies about separating and reuniting body parts have roots in ancient mythologies. Historical records suggest skin grafting in ancient Egypt and India. Modern organ transplantation began with the first successful kidney transplant between identical twins, where genetic similarity prevented rejection. The practice became widespread in the mid-20th century with the advent of effective immunosuppressants, the development of modern intensive care technologies and the resulting emergence of the phenomenon of "brain death" (Nordham & Ninokawa 2021).

Brain death

Biologically, death is the irreversible cessation of all physiological processes and cellular activity in the body. It is a gradual, rather than instantaneous, process.

From a legal perspective, death is the moment when an individual loses their status as a legal subject. In Bulgaria, the brain is considered the morphological substrate of the human personality and its death marks the end of the personality (Stavru 2008). When the process of brain death becomes irreversible, it is established by the appropriate medical diagnosis and documented by a death certificate. **Therefore, death is always brain death.**

Cessation of cardiac activity becomes the cause of death, as in its absence the brain dies completely within 5–10 minutes. If blood circulation is restored in time, the process can be reversible. Coma is characterized by a lack of consciousness, with most of the basic brain functions preserved. Breathing and blood circulation can be artificially maintained for a long time in modern ICUs, which often allows the restoration of brain functions.

While death is always brain death, the widespread term "brain death" refers to the **permanent and irreversible loss of brain functions in the presence of cardiac activity** which is only possible in the ICUs. Such cases account for an average of 10% of the deaths occurring in ICUs (Navarro 1995). The equipment continues to support the rest of the body and the cardiac activity is still present in the deceased.

Brain-dead people look confusingly similar to patients in a coma – their skin color and temperature are normal, they breathe and have a pulse. This condition can be maintained for up to decades (e.g. Repertinger, S.K. *et al.* 2006). Death can only be determined through a neurological examination of the brain. Organs for transplantation are harvested from patients in this condition. The term "brain death" will be used below in this sense.

The storage of corpses in the ICU is inappropriate. The diagnosis of death is grounds for terminating the treatment and releasing the body. However, the first legal definitions of brain death in France, the UK and the USA (Beecher *et al.* 1968) were adopted under pressure from surgeons experimenting with organ transplantation. With time, the establishment of death by neurologic criteria began to be applied in ICUs in many countries as part of end-of-life care. To date, there are no uniform standards and criteria (Greer *et al.* 2020, Greer 2020, Wijdicks 2002). In Croatia, Oman, Greece and Turkey (Ceylan *et al.* 2019), for example, brain death determination is mandatory when signs are present. In the Netherlands, Latvia and Japan – it is not mandatory. In Romania, as of 2017, brain death was only diagnosed in potential organ donors (Mitre 2017).

In Bulgaria, according to Art. 5 of the *Regulation No. 14 of 15 April 2004 on the medical criteria and procedure for establishing death,* death has occurred upon fulfillment of one of the two conditions: "1. permanent and irreversible cessation of the functions of blood circulation and respiration;" or "2. permanent and irreversible cessation of all functions of the brain and ongoing cardiac activity". While the first diagnostic procedure (after cardiac arrest) is performed by a single physician, the second procedure involves three medical experts. It is mandatory to establish death whenever there are signs of such (Art. 3 of the same regulation) but in practice brain death is established in few cases, discussed below.

Transplant systems as industries

Successful organ transplantation depends on efficient, large-scale systems. The size of the donor pool critically affects the number of available organs. Ideally, all brain-dead patients in the ICUs are evaluated as potential donors. The narrow time window for organ utilization requires strict quality standards and well-coordinated organizational procedures.

The EU and Bulgarian policies are based on the concept of an organ "shortage," defined by the gap between organ availability and demand. This shortage, recognized globally, is largely attributed to public reluctance and familial opposition to donation. Efforts to increase organ availability focus on strategies addressing psychological and social factors. Research prioritizes identifying best practices from countries with higher transplantation rates and sharing them with those performing fewer transplants. Data-driven public awareness campaigns target three key barriers to organ donation (Scholz, 2020): insufficient public awareness – a lack of understanding about organ donation and transplantation processes; “inadequate” family communication – limited discussions within families about individual preferences for or against organ donation; healthcare system concerns – distrust in healthcare systems, medical professionals, and the organ donation process.

The shortage is exacerbated by the increasing demand due to advancements in transplantation technology and expansion of the scope of possible transplants, and improvements in vehicle safety leading to a decline in the number of victims of traumatic brain injuries, a primary source of potential donors (Council of Europe 1999).

The transplant system in Bulgaria

Medical technologies, developed within global innovation hubs, are disseminated to Bulgaria through specialist training and the importation of equipment and materials. Concurrently, the regulatory framework undergoes updates.

During socialism the Bulgarian healthcare system, modeled after the Soviet system, established by N.A. Semashko, adhered to the principles of universal healthcare, managed and financed by the state. While organ transplantation was conducted in the Soviet Union since the 1960s, it was primarily experimental and driven by the interests of individual specialists rather than a systematic approach (Shok 2024). Bulgaria, closely aligned with the Soviet Union’s political and administrative model until the late 1980s, followed a similar trajectory in its transplantation history. In the 1960s in both countries kidney transplantation programs were started due to the relative technical simplicity compared to liver or heart transplants. The concept of patient rights and the imperative of informed consent were absent during this period (Shok 2024). As one doctor, a contemporary witness, recalled: *“…In socialism, what is brain death, whether it has a place in our country or not, did not exist: “Hey, this patient looks like this to me, very bad, why don’t we take his kidneys.”*

Following the official end of socialism in 1989 the Bulgarian healthcare system underwent significant reforms: a gradual transformation of medical institutions into commercial entities, the establishment of the National Health Insurance Fund (NHIF) as an independent financing body, and the emergence of the private healthcare sector. The current healthcare system has a mixed public-private structure, with state hospitals operating as commercial entities while remaining reliant on state funding to prevent bankruptcy.

A defining characteristic of the Bulgarian healthcare system is the pervasive discrepancy between regulatory requirements and actual practices, including the frequent mismatch between documented clinical pathways and the actual diagnoses and treatments provided. As one doctor remarked: *“We are the ones depleting the NHIF. However, it allows us to provide treatment to those who truly need it.”* This disconnect between documented and actual activities is also prevalent within the transplant system. According to Atias, Sharkova and Tsekulova (2024) *“… practices for allocating limited health resources in Bulgaria are based primarily on implic-*

it models, associated with a lack of transparency, accountability and systematicity. Although there are normative bases for explicit allocation, in practice it is applied to a limited extent…"

The Bulgarian public health system has a fragmented structure and the power is acquired through kinship, personal acquaintances and dependencies. There is a *"so-called medical feudalism. Directors of hospitals and clinics stay in office for decades, and the careers of young doctors are based on family ties or other dependencies"* (Bozukova 2022). *"... there is no such thing as a unified position of the medical guild, it is fragmented. Of specific interests in specialties, of the possibility of someone taking a bigger piece of the cake."* – Dr. Petŭr Moskov, Minister of Health from 2014 to 2017 (clinica.bg 2023). *"In Stara Zagora, in the same building there were the university hospital and the city hospital. And despite the fact that there was literally a plywood partition between some departments, they were like two different countries, like the North and the South Korea. They didn't talk to each other, no matter how many ministers tried to reconcile them, and couldn't accept, that they were formally united…"* – a long-time physician.

Like elsewhere, hospital staff must navigate relationships, personal uncertainty about their skills (especially if they are still training or lack experience), jurisdictional disputes, and power struggles within the medical and nursing hierarchies (Lupton 2012).

In 2001, the "eye bank" at Queen Joanna University Hospital – ISUL was transformed into the National Transplant Management Center "Bultransplant," which was re-designated as the "Executive Agency for Transplantation" in 2004. In 2019, the EAT was dissolved, and its responsibilities were transferred to the EAMS, the current governing body.

The key stakeholders within the transplant system include: **1) the EU; 2) the Republic of Bulgaria; 3) government institutions (Ministry of Health, Executive Agency Medical Supervision); 4) medical institutions, including hospital administration, donor coordinators, surgeons transplantologists, ICU staff; 5) patients, relatives, treating physicians, and patient organizations; 6) international organ exchange organizations; 7) media; 8) citizens of Bulgaria.**

The level of active participation varies among the stakeholders. Administrators and medical specialists play a crucial role in the process activation.

The regulations and organization are aligned with the EU standards. According to the provision of Art. 168, par. 7 of the *Treaty on the Functioning of the European Union*, Bulgaria as a Member State has exclusive competence in determining its health policy.

Relevant EU documents:

● *Directive 2010/53/EU of the European Parliament on standards of quality and safety of human organs intended for transplantation* of 7 July 2010;

● *Directive 2012/25/EU on the exchange of organs between EU Member States* from October 9, 2012;

● *Action plan of the European Commission on Organ Donation and Transplantation (2009–2015)* for enhanced cooperation between the Member States. The Plan identifies three distinct challenges in this area: increasing the quantity of organs available for transplantation, improving quality and safety, and ensuring greater accessibility of transplantation systems.

Relevant Bulgarian regulations:

● *Organ, Tissue and Cell Transplantation Act*[2] (OTCTA) in force since 1 January 2004 regulates the conditions and procedure for performing organ, tissue and cell transplantation in human medicine in Bulgaria. The Act defines transplantation as "a set of medical and other activities related to the removal of organs, tissues and cells from a human or animal corpse or from a living person and their transplantation into another person for therapeutic purposes." – OTCTA. Art. 2. (1).[3] The "dead donor rule" (Robertson 1999, EDQM 2022) and the prohibition on organ trafficking are established: "Removal of organs, tissues and cells for the purpose of transplantation may be carried out from a human corpse after death has been established in accordance with the medical criteria and procedure determined by a Regulation of the Minister of Health." – OTCTA, Art. 18. (1). "Human organs, tissues and cells may not be the subject of a pecuniary transaction."– OTCTA, Art. 5. Debated issue worldwide is whether individuals should actively consent to become donors after death ("opt-in") or their consent should be presumed unless they "opt-out". In Bulgaria, the system operates under the opt-out approach, "presumed consent," allowing relatives to object after death (Stavru 2008).

● *Regulation No. 14 of 15 April 2004 on the medical criteria and procedure for establishing death*[4] was issued by the Ministry of Health on the basis of Art. 18 para. (1) of the OTCTA.

● *Regulation No. 13 of December 6, 2021 on the reimbursement of costs and the relative share of labor resources for transplantation activities financed by the Ministry of Health*[5] was issued by the MH on the basis of Art. 16 para. (5) of the OTCTA.

Internal regulation aligned with regulatory framework is delegated to hospitals.

Contradictions

A significant portion of the Bulgarian population expresses support for organ transplantation, with less than 4% opposing transplants, over 70% willing to receive an organ transplant, and over 30% willing to donate organs (Alpha Research 2019). Regulations of system's structure and operation have been established, ad-

[2] Available at https://www.mh.government.bg/upload/168/zakon-za-transplantaciya-na-organi-takani-i-kletki_07-08-2012.pdf.

[3] Our focus is the transplantation of human organs from cadaveric donors.

[4] Available at: https://iamn.bg/нормативни-актове/наредби/.

[5] Available at: https://iamn.bg/нормативни-актове/наредби/

ministrative structures have been created with personnel appointed to key positions, and the requisite medical expertise and technical capabilities are available. Financial resources have been allocated to support transplantation efforts, with over 101,388,804 BGN invested in the *National Program 2019–2023*, funded by the MH and the EU. Prerequisites for a transplant system comparable to those in other European countries are present.

However, Bulgarian transplant system, despite two decades of development, significantly lags in terms of transplant rates (e.g. Statista 2025). According to Eurotransplant, an international organ donation and transplantation organization, a well-functioning national transplant system should achieve a minimum of 10 donors per million population (pmp) annually (Eurotransplant 2025). While in some periods in Bulgarian transplantation history, under the leadership of specific administrators, the rates were approaching 3 pmp, these peaks have been followed by periods of decline. Since 2019, a downward trend in donor rates has been observed.

A 2019 study commissioned by the EAMS and conducted by Alpha Research on attitudes towards transplants among Bulgaria's adult urban population suggests minimal negative sentiment towards organ donation, but a "gap between trust in transplants as a life-saving opportunity and low willingness to donate". Drawing upon a pre-existing Eurobarometer study (EU 2010), the researchers attribute the gap to three primary factors: lack of information, logistical and emotional barriers, and insufficient empathy motivation. These interpretations influence resources allocation from state budgets and programs, primarily campaigns for raising public awareness including a dedicated website (http://zajivot.bg), educational visits to schools and universities, and media outreach.

For years, the official narrative has attributed the low number of organ donors to a high number of refusals from families (e.g. EAMS 2022). These claims lack support:

First, a report of MH & EAMS (2019) indicates that family refusals in Bulgaria "accounted for up to **20%** of the total number of potential donors (both realized and unrealized) annually between 2010 and 2018", rising slightly to **24%** during the period 2019–2023.[6]

Second, donor coordinators claim that data on the number of refusals has not been collected.

Third, transplant system officials attribute the low rates to other factors. In a 2021 interview with BTV News Dr. Mariana Simeonova, former Director of the EAT (2013–2018) emphasizes a near nine fold increase in brain-dead donors between 2013 and 2015, attributing this progress to the positive attitudes of Bulgarian citizens: *"The same clichés should not be repeated. I constantly hear and continue to say now: "people in Bulgaria are not willing to donate". This is absolutely not true… We cannot make such a rapid leap unless people really carry this feeling of donation within themselves. Of course, institutions must work."* (bTV Media Group 2021) Dr. Evelina Tsvetkova, the current head of the Transplantation Directorate

[6] *National Program 2019–2023.*

at EAMS, pinpoints the delayed identification of potential donors within medical facilities as the key obstacle in a 2021 interview with SKAT Television (Televiziya SKAT 2021). Dr. Sibila Marinova, a prominent and long-serving donor coordinator, asserts that at her ward the refusals from relatives are "counted on the fingers*"* and that the main reason for the few donors is the *"lack of donor identification"* in hospitals (e.g. Podkast: Bŭdi svetlina 2023).

Regulatory framework presents contradictions:

Regulation No. 14 of 15 April 2004 on the medical criteria and procedure for establishing death was issued **on the basis of Art. 18 para. (1) of the Organ, Tissue and Cell Transplantation Act.** This is paradoxical legislative logic leading to wrong categorisation: death establishment in total is subordinated to transplantation activities.

As of 2024, Bulgaria has a total of **188 Intensive Care Units** (ICUs). According to *Regulation No. 14,* Art. 8, para. 1. "Death in the event of permanent and irreversible cessation of all brain functions and available cardiac activity is permitted to be established in medical institutions where organs, tissues and cells are taken." In this way, establishing brain death is legally restricted to only **31 hospitals**, although brain death cases can occur in every ICU.

In addition, while ostensibly authorising the establishment of death by neurologic criteria, the regulatory framework creates disincentives for this activity. Reimbursement for establishing brain death is contingent upon organ donation (*Regulation No. 13*, Art. 2, item 2 and Art. 21). Few of the 31 hospitals determine brain death in practice and none of them in all cases. As an ultimate result, instead of nationwide, organ donation is performed locally, initiated by individual specialists, heads of ICUs or clinics within specific medical centers like it was in the period of transplant experimentation. Narrowing determination of death by neurologic criteria to cases when organs are taken for transplantation is a violation of the "dead donor rule" leading to erosion of public trust (e.g. Barnes & Greer 2020).

The organ transplant system in Bulgaria is an illusion

A major factor contributing to the transplant "underperformance" is the inconsistent establishment of brain death.

Between January 2020 and December 2023, a total of 173,750[7] deaths occurred in Bulgarian hospitals. Applying the findings of an US study on brain death epidemiology (Seifi 2020), it could be established in at least 2% of the lethal cases in hospitals, the estimated **3,475** brain deaths could have been identified during this period (*Figure 1*). Official data from the National Center for the Prevention and Control of Diseases reveals that brain death was established in only **103** cases during this timeframe (*Figure 2*) and data from the EAMS indicates the total of **91** organ donors (*Figure 3*).

[7] Sources: RHI, NHIF.

Figure 1. Determination of death by neurological criteria. Statistically expected number of cases in Bulgaria, by region

January 2020 - December 2023

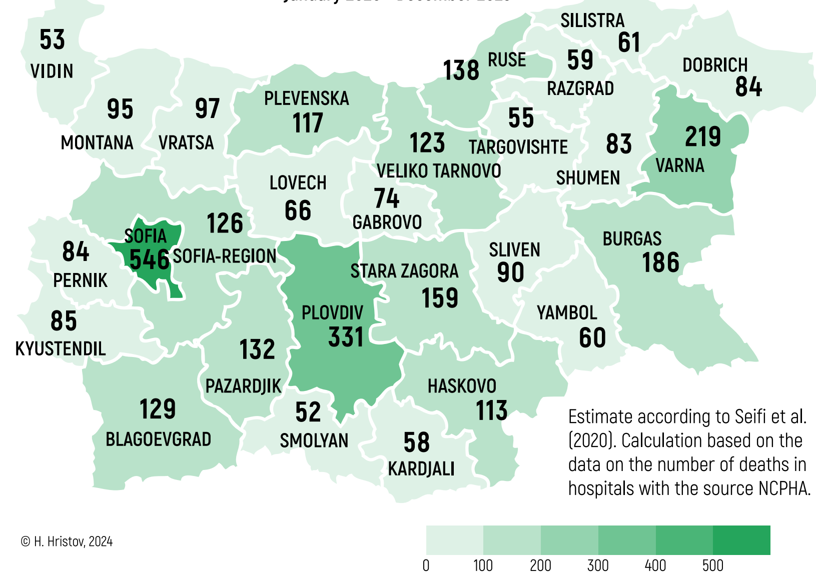


Figure 2. Number of deaths determined by neurological criteria in Bulgaria, by region*

January 2020 - December 2023

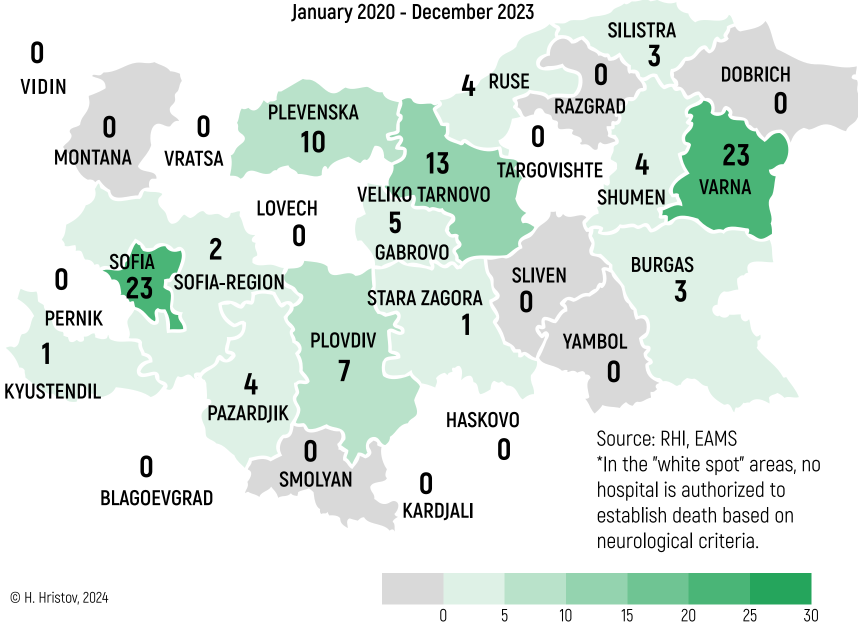
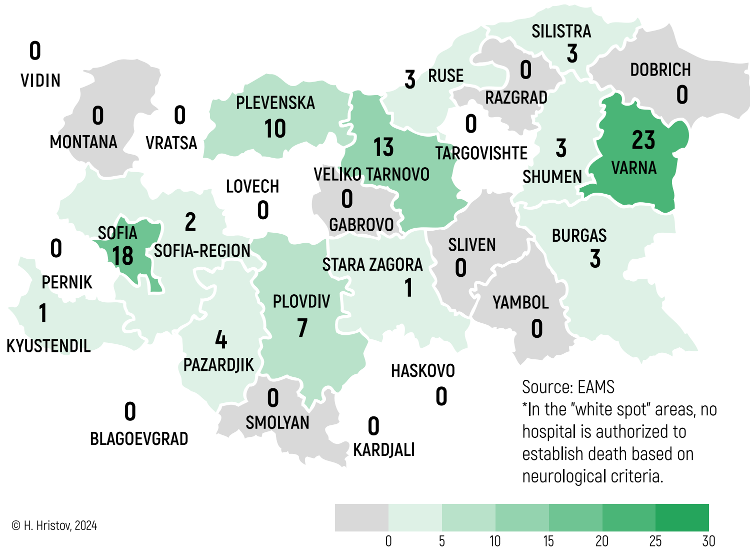


Figure 3. Number of deceased organ donors in Bulgaria, by region*

January 2020 - December 2023



During a meeting with EAMS staff, I asked about the motivation of hospitals seeking permits for organ donation and transplantation activities, given the potential for financial losses. They replied that it was *"good for the image of the hospital to carry out such activities, especially if it is a university hospital."* Former employees of the EAT confirmed the significant role of transplantation activities in enhancing the professional image of surgeons and hospitals. Sporadic instances of successful donor procurement and transplants are evidently sufficient to cultivate a positive public image.

Hospital observation

Between early 2023 and mid-2024, I was observing the re-initiation of organ donation and transplantation activities at a public Bulgarian hospital, one of the 31 authorised medical facilities in the country. Following a five-year hiatus, Dr. Stoyanov, the newly appointed donor coordinator, was trying to renew the program.

Donation activities

The requirements for hospitals to obtain a license include appointing a donation coordinator, an anaesthesiologist or intensive care specialist, and forming a Standing Commission for the Determination of Brain Death (SCDBD). These roles are added to employees' existing workloads, and the hospital director can replace them without consultation. Since organ donation activities often result in financial losses, hospital directors are generally reluctant to support them. Coordinators focus mostly on mandatory reporting, neglecting proactive donor identification. At the observed hospital, the director was not overtly opposing donation efforts but was not actively supporting them either.

Dr. Stoyanov emotionally explained his motivation for stepping into the coordinator role after his predecessor's resignation: *"... corpses are being treated in the hospital, relatives are suffering and wondering why we are treating them and we are explaining that there is no hope, and treating them further. On top of all that* [the relatives] *ask me: "can he become a donor?" And I tell them, look, if he was in another hospital, he could have become a donor, but here I have tried many times and nothing works. I will try to talk to the coordinator again... You see a healthy child who is brain dead, 17 years old, without accompanying diseases, and you just see how week after week his body is rotting... and there are... 800 waiting* [for a transplant]*, and… it just doesn't work..."*

From the outset, Dr. Stoyanov faced significant challenges, including his own lack of experience, insufficient knowledge of regulations and training for hospital staff, unclear internal rules, and resistance from colleagues. Some of them were passively uncooperative, while others actively opposed his efforts in the absence of active support from the hospital director.

Formation of the SCDBD was particularly difficult. Although the executive director eventually appointed three members and their deputies, securing full participation proved challenging. Only three out of nine members attended a meeting to draft working rules, a process that took nearly a year.

Dr. Stoyanov initiated numerous meetings with hospital personnel at various levels, including physicians, IT specialists, lawyers, orderlies, and administrators, to facilitate the activation of organ donation. While some meetings were readily scheduled, others proved more challenging to arrange, and in some instances, Dr. Stoyanov was unable to secure a meeting at all. Some of his colleagues expressed verbal support for his efforts while others were tacitly or openly resisting participation in the meetings and in the organ donation process.

Discussed topics*:*

Lack of familiarity with regulations. Many hospital specialists were unaware of the relevant legal requirements. Despite being mandatory, no procedures for establishing brain death were in place. Some physicians expressed skepticism about "brain death as biological death." Two physicians opposed a SCDBD member during the examination of a potential donor, later remarking, "*We saved him, the boy.*"

Staff issues and overwork. Staff reluctance was often attributed to the additional workload: "*there is no one to deal with it*". The shortage of nurses was cited as a critical issue[8]. In some wards, *"sometimes there are two and a half nurses left – the senior nurse cannot be engaged."* Years ago, doctors *"had time to sit down and have a calm conversation, but that's no longer possible."* While in the past there was initial enthusiasm for transplantation activities, it gradually declined as staff began to recognise the significant demands it involved, including the frequent need to work double, triple, or even quadruple shifts during donor situations.

Financial strain. Although only one physician raised the issue of payment, when Dr. Stoyanov explained that he had arranged additional payments, most agreed that *"this is very important for the nurses and orderlies."* One physician stated, *"it is a sin for so many people to die in the transplant queue and nothing is done."* However, the same physician also noted that *"declaring brain death is very expensive and too much of an expense for the hospital."*

Quality concerns. One informant questioned whether the hospital could provide high-quality organs. He contrasted Bulgaria's inadequate infrastructure with France's efficient system, which includes dedicated planes and police escorts to ensure timely transplants. In Bulgaria, organs are often transported slowly and under suboptimal conditions, leading to rejections by transplant centers and risks for recipients. He also stressed the role of the donor coordinator, who *"must be diplomatic"*, *"have agents everywhere in the hospital to succeed getting things done", "being friends with everyone"*, understanding interpersonal dynamics, and carefully considering *"who to approach and how to approach."* He criticised Dr. Stoyanov's line of action, noting that it tends to make people *"defend themselves"* rather than fostering cooperation.

Internal communication and logistics. Poor communication and inefficient information management compounded these issues. Many staff lacked access to internal regulations and documentation. Internal correspondence was primarily handled manually. The hospital's outdated archival system caused delays, significant in time-sensitive situations like organ donation. We visited the hospital morgue, a location occasionally visited by donor relatives. The morgue hasn't been renovated in a long time, but it was clean and there was clarity and order. An energetic orderly was in charge. He showed us his notebook. To ensure the preservation of information, everything important was written down by him personally in this notebook.

The EAMS system was similarly outdated, and communication between coordinators and EAMS staff was suboptimal. Dr. Stoyanov described his situation as exhausting and chaotic: *"...The whole process that I'm involved in, just me to a large extent, it's quite a long working day, usually two shifts, but sometimes three or more, I lose track of time… and the workload, and the emerging things don't help at all, and when we put it in light of the cases when this thing isn't paid, the lack of organisation, the conflicts... Anyone who finds themselves in such a situation, wonders whether to give up and not do it anymore…"*

Dr. Stoyanov's insistence to do properly his job as a coordinator irritated some of his colleagues. They coined a nickname for him – "the cutter".

[8] National Health Strategy 2030.

A sensitive aspect of the coordinator's role involves notifying families of their loved one's death and discussing organ donation. Initially, Dr. Stoyanov experienced tension about these discussions.

He took a proactive approach by contacting families at the very start of the brain death determination process maintaining open communication. Families reacted in varied ways. Some displayed intense emotional reactions, while others remained composed. Over 18 months, he received no complaints. Instead, one family sent a letter of gratitude for his compassion and professionalism. His ability to handle these interactions have led colleagues to seek his assistance in other sensitive cases.

Coordinators are implicitly expected to actively persuade families for donation. This aligns with the prevailing ethos in many countries, including Spain, the world transplant leader. Detailed recommendations for the "donor interview" process are included in the Spanish National Transplant Organisation's 2011 manual of good practices (ONT 2011). The guidelines on the website of EAMS, based on Spanish recommendations, encourage persistent negotiations with families (IAT 2011). The decline to reimburse expenses in cases of donation refusals is an (ethically controversial and unsuccessful) attempt by the EAMS to engage hospital staff in negotiations.

As Mongoven (2003) points out, the simultaneous expectation of treating relatives with respect and actively seeking consent for organ donation is inherently contradictory.

Dr. Stoyanov initially struggled, experiencing internal conflict regarding the appropriateness of actively persuading families to consent. He concluded that this approach was ethically problematic and informed families about the possibility of organ donation as part of the formal discussion procedure, leaving the decision entirely to them.

The doctors and death

> "*Death as a phenomenon in human life always brings sorrow, sadness and disappointment.*" – Dr. Stoyanov.

Culture, as Garnizov (1994) states, is a dynamically adjusted order expressed through spatial and temporal arrangements. In traditional rural societies, the living and the dead occupy distinct realms, often separated by boundaries such as rivers or hills. Cemeteries, resembling villages of "houses for the dead," mirror the world of the living. This spatial separation and the precise time framing of all elements of the funeral ritual and care for the dead create a clear symbolic boundary between life and death.

In the past, death was "domesticated," as Ariès (1977) describes. Communities collectively engaged in rituals surrounding death, which were public and marked the transition in societal space and time. Death was gradually redefined since the 11th century to become in the 20th century a concealed, solitary event confined to hospitals. Dying is now invisible, restricted in space and no time is committed for its expression in public.

In the observed hospital, one “entrance to the afterlife” is in the corridor where the morgue is located. The orderlies who transport the bodies of the deceased at night leave them by the elevators instead of bringing them to the corridor because they are afraid. People in charge of the morgue complain because this causes problems. But the morgue is not the only place where worlds meet. In the timelessness of the ICU, many find themselves between life and death. Screens with flashing lights and sounds show “how far they have come”. Some of these people return to life, others die. Some of them may become donors of organs to be transplanted into other people. Thus, parts of their bodies will continue toward death, other parts – back to life.

Medical professionals operate exclusively in this “border zone,” where only medical aspects of dying are deemed relevant. Physicians are enlightened in the secrets of the dying body. They study on corpses, perform dissections. Medicine encloses dying as part of itself, but does not continue beyond the boundary. When patients are *“without prospects”,* they continue on their own. Traditionally, spiritual figures guided individuals through illness and death, but modern medicine focuses on “winning back from death” rather than accompanying patients in their final journey. Medical students are taught to separate their personal beliefs from professional duties, emphasizing rationality over spiritual support (Sajja & Puchalski, 2016). While expected to communicate with relatives and involve them in decisions, many physicians distance themselves emotionally, particularly in terminal cases. Some of them announce death by phone to avoid direct encounters with grieving families.

By the 17th century, according to Ariès (1977), beliefs in sin and hell begin to fade. By the 19th century, the fear of hell no longer existed. All varieties of spiritual and moral evil are viewed not as givens of man, as they once were, but as errors of society, which in the future could be analysed and eliminated through the scientific approach. For the "non-religious" there is no hell and no heaven. Heaven becomes a pleasant memory of the deceased and a fantasy that the living is once again with those they loved. Advancements in medicine and technology fuel the hope of overcoming aging and disease, distancing society from death. Efforts to combat aging through healthcare, fashion, and cosmetic surgery, the isolation of the seriously ill, are directed to defy the natural aging process and mortality. For some, like B.O., a 28-year-old organ recipient, death is not natural before advanced old age: *“Death from a stroke or heart attack is not a natural death. Diseases occur because of a poorly maintained organism, not paying attention to ourselves, when we do not follow the medical instructions.”*

The desire to control mortality is at the heart of the separation of death from life. Scientific progress aims to eliminate suffering and death, but since it fails, denial becomes the norm. Death is now turned into a total taboo and silenced in everyday life, contributing to societal anxiety around mortality. The ideology of separation is expressed in legal requirements such as the death certificate, which officially documents the separation from life, and the order of burial and cremation, and is implicit in the practices of separating the sick from the dead, the «hygienic» treatment of corpses, the use of professional funeral agencies, and the work of psychologists who «help» the bereaved «letting go» of their dead (Howarth 2000).

Illich (1976) notes that the rationality of science positions death as an enemy to be conquered. The medical profession epitomizes this struggle, often portrayed as "waging a battle against death." A TV show encapsulates this narrative: *"They race against time to outrun death. Miracles happen in their hands."* Physicians are seen as tireless, heroic figures sacrificing personal lives in their pursuit of life-saving victories (Publitsistikata na NOVA, 2023).

In hospitals, the "battle against death" is most visible, with organ transplantation standing as one of its greatest triumphs. Transplants reaffirm societal faith in medicine's power and reinforce the perception of physicians as leaders in the fight against mortality. Dr. Sibila Marinova, donor coordinator, states, *"Organ donation is the only thing that really defeats death."*

The living dead

When a patient becomes brain dead, they enter a liminal, indefinite status. Physicians recognise the irreversibility of the condition. 92.3% of 39 surveyed ICU physicians (in October 2024) affirmed their ability to identify signs of brain death. Though, formally death is not established until the diagnostic process is completed. In most cases formal procedure is not followed and the patient remains legally "alive," forcing doctors into a paradoxical role. They are obliged to continue futile treatment for someone they know to be deceased. The temporal boundary between life and death remains unmarked.

For such patients medical staff use euphemisms such as *"he took it – gave it," "he left," "he's over," "causa perduta," "prognosa pessima," "patient without prospects,"* or *"hopeless patient."* Communication with families often involves vague language, leaving relatives unaware of the true situation, and clinging to false hope that the patient might recover for days, weeks or even months. A high-ranking official from the Ministry of Health commented, *"We* [in the hospital she had previously worked] *have been informing them that their relatives are in a coma. How do you convince them that their loved one is deceased while they are still "breathing" and their heart is still beating?"*

Following brain death, the human presence around the body of the deceased gradually withdraws. Doctors do not approach, nurses – less and less often. Engagement levels among medical staff vary: some continue providing care out of obligation, while others oppose it. Conflicts sometimes arise. Dr. Stoyanov observed a practice of tacit withdrawal of treatment for the *"hopeless patients"*, including reduced monitoring and infusion of drugs, delayed tests, and overall decline in care intensity. Death is marked hesitantly, until cardiac arrest confirms it. Under such conditions, the heart stops in a few days or weeks.

Robert Burt (2002) links neglect and abuse in end-of-life care to humanity's denial of mortality, as outlined by Freud (1915): *"at bottom no one believes in his own death, or, to put the same thing in another way, that in the unconscious every one of us is convinced of his own immortality."* (Freud 1915) Burt suggests that this denial impedes rational decision-making, increasing the risk of maltreatment emphasising the role of human cognitive limitations. He advocates for transparency, collective deliberation, and acknowledgment of ambivalence toward death to mitigate these risks.

Hospital rules governing staff behaviour in brain death cases lack clarity and transparency. In contrast, the Standing Commission for the Determination of Brain Death (SCDBD), composed of three qualified physicians, follows a strict protocol requiring unanimous agreement on all criteria (*Regulation No. 14,* Annex 1 to Art. 11, para. 1). If even one member has doubts, the diagnosis cannot proceed.

Dr. Stoyanov championed the consistent application of brain death criteria, personally monitoring patient conditions via the hospital's information system and pressuring SCDBD members to participate. Despite having no formal grounds to refuse, members often delayed involvement, citing various excuses. During one of the first procedures, three seasoned emergency specialists – new to the procedure – were visibly tense, repeating tests unnecessarily, speaking loudly, and stayed to talk for a while after completing the protocol to alleviate their stress.

The liminal state as described by Arnold van Gennep (1909), inspires uncertainty and fear overcome through public rituals. In Bulgarian hospitals a publicly established ritual of brain death determination is not practised consistently, escalating the anxiety. Even after the death is established by neurologic criteria, both the deceased donor and the recipient continue their existence in a paradoxical liminal state, neither "fully living" nor "fully dead". The process of organ donation contains the implicit symbolism of human sacrifice (Mongoven 2003). The perspective of organ transplantation may be even scarier than brain death establishment itself.

The doctors and power

> *"Perhaps all doctors are prone to abusing the power that their profession gives them.The modern organisation of medicine is still like that, especially in Bulgaria. A patient in need comes and the doctor saves them or tells them what to do: that's the treatment, that's how things happen. The patient is not expected to be an active party in their own treatment. So this is some form, perhaps, of abuse of power."* – Dr. Stoyanov.

Healers have traditionally had a high status among Bulgarians. According to Dimitar Marinov (1891), in Bulgarian folk belief, magic and enchanted medicinal herbs were used to drive away diseases, supplemented by sacrifices, rituals and religious customs. There were people who, through the power of spiritual means, drove away evil spirits or appeased them. They constituted *"a class, separated from other people. Everyone looks at such people with a certain respect, religious veneration, even awe… with their knowledge and arts, these people stand above them, higher than everyone else"* (Marinov 1891).

The World Health Organization (WHO) defines health as *"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"* (WHO 1946). A similar definition is adopted in Bulgarian legislation.[9] This definition is criticized, since, as defined, health is completely unattainable. According to it, all people are sick and cannot exercise personal control over their health (Armitage 2023). Sartorius (2006) argues that if health is defined as the absence of disease, the medical profession is the only authority that can define an individual as healthy.

Given this, results of a survey are not surprising: "83% of Bulgarians tend to or completely agree with the statement that doctors are obliged to make infallible decisions, 73% believe to some extent that they are obliged to always be available and react immediately, and 72% – that they are obliged to provide immediate solutions to complex problems." "54% are of the opinion that doctors should sacrifice their personal time for the care of patients, and 51% expect them to know everything about every issue" (Trend 2024).

The emphasis on "evidence-based medicine" and the rejection of "miraculous" interventions reinforce the image of medicine as a purely rational and scientific endeavour, devoid of any spiritual or metaphysical considerations. And yet medical specialists don't object for non-medics to believe that they have miraculous capabilities. Many aspects of the medical environment, such as the mysterious behavior and special language, the restricted access to hospital spaces, the exclusive access of medics to the human body, particularly in life-and-death situations, contribute to an aura of awe surrounding the medical professionals, provoke the sense of power and mystique of a cult.

Transplantation is often described as a "medical miracle". The transplantation of human organs, particularly the procurement and utilization of these "spare parts," contributes to the image of doctors as fearful "mad magicians" or "mad scientists," exemplified by the fictional character of Dr. Frankenstein. "Urban legends" about organ theft, involving "organ mafias", have further reinforced this image. These narratives, while often exaggerated, contribute to a complex public perception of medical specialists (Verrips 2003).

As M.V., a 37-year-old female potential recipient, observes, *"Bulgarians are not brilliant at transplants."* A recipient, B.O., 28 years old, comments, *"But we have doctors."* A former employee of the EAT describes transplants as *"the high-tech in medicine"*. The fact that Bulgaria performs transplants, fosters an illusion

[9] *Health Act.* Art. 2. Available at: https://old.mh.government.bg/media/filer_public/2018/02/27/zakon-za-zdraveto.pdf.

of control, reinforcing the belief among citizens that challenges can be effectively managed. From the perspective of power in society, the few transplants performed – magnified by the media coverage – reinforce the perception of doctors and the state as magical figures (Meyer and Pels 2003). The rarity of these procedures may even be amplifying their dramatic effect.

The doctors and order

As Radev (2011) points out, Bulgaria has been undergoing a so-called "transition" since the late 1980s. The term itself is challenging to define, and there is no consensus on whether this process has ended or is still ongoing. During this time, Bulgarians have navigated various "transitions": the move from totalitarianism to democracy, from central economic planning to a market economy, the Balkan region's shift toward European integration, humanity's transition to globalisation, among others.

Stoychev and Borisova (2022) argue that in Bulgaria the gap between political ideologies and individual everyday experiences is increasing. This disconnect challenges the moral integrity. In a corrupt environment, daily experiences often steer people *"towards pre-modern solutions, relying on communities, interpersonal relationships, faith in providence, universal reason, etc., rather than institutions and the rule of law, which fail to guarantee individual inviolability or foster constructive interests and development."* Adapting to constant change appears to be a more viable personal strategy than adhering to principles. Legitimate power is perceived as something imposed "from above," detached from individual will and responsibility. Instead, power is frequently appropriated by influential individuals or groups, resulting in both overt and covert forms of authoritarianism.

One physician at the observed hospital described the challenges in the transplant system as stemming from *"deep and Balkan"* issues. Having extensive experience in both "central" and "peripheral" hospitals, he concluded that employees *"may or may not work,"* as *"there are no rules, no control, and everyone does whatever they want."* The above enclosed review of regulations and institutional practices corroborates his claims.

In October 2024 I conducted an online survey among 39 emergency and intensive care specialists from 11 out of 28 Bulgarian regions. To the question "What are the reasons why the hospital where you work or have worked does not establish death by neurologic criteria in all cases of its occurrence?" I got the following answers[10]:

- **53.8%** – There is no clear procedure.
- **51.3%** – The practice is to treat patients "until the last moment" (until cardiac arrest occurs).

[10] Total percentage exceeds 100 because respondents selected more than one answer.

• **33.3%** – Specialists are worried about the reactions of relatives if they find out that the patient is dead.

• **28.2%** – Specialists are worried that relatives will not believe in the death of a brain-dead patient.

• **17.9%** – Specialists do not recognise brain death.

• **15.4%** – The hospital I work for is not authorised to take organs, tissues and cells, and respectively, to establish death by neurologic criteria.

• **15.4%** – It is to save effort.

• **10.3%** – Some physicians want to appear to the relatives of patients as "saviours".

• **10.3%** – Interest in not doing so.

Bulgaria is perceived by its own citizens as a borderland – between continents, cultures, and the West and East – in constant liminal state. Official order is often seen as something "imposed from above," distant and detached, even when nominally respected. Both interviewed doctors and administrators acknowledge the lack of a clear and consistent order, as well as the widespread violations and weak controls, as "normal" and expected, and admit to sometimes disregarding formal rules themselves. Participants express disapproval of the "lack of order," shaking their heads, but simultaneously affirm it by repeating, *"This is how it is here."*

Mary Douglas (1986) posits that the beliefs people claim to reject often shape prevailing social trends. As she states, *"… the jointness in the construction of the thought style disguises from each member of the thought world the consequentiality of his own small action. Each will be accusing his neighbour of treachery without suspecting that a commonly shared belief pattern is thereby strengthened."*

As noted by Todorova (2022), transplantation acts as a "magnifying glass" for a country's medical development, as it involves interdependent processes – from critical care and donor identification to surgery and postoperative care – where deficiencies at any stage can jeopardize outcomes. Furthermore, transplantation activities are not confined to a single institution but involve multiple hospitals, laboratories, and other entities, sometimes even across international borders. In Bulgaria, the implicit social order includes a tolerance for the "lack of order," and undermines the transplant system heavily relying on integration and synchronisation between multiple participants.

Conclusion

The analysis of literature, media content and informal conversations with medical specialists, administrators and officials reveals that Bulgarian laws and healthcare practices treat brain death determination as a step for organ procurement rather than confirmation of irreversible death. This is also reflected in the inadequate funding conditions for brain death determination, organ donation and transplantation. Ethical aspects remain largely undiscussed. Symbolically, the healthcare systems of modernity “wage war against death”, perceived as the main “enemy” of humanity. In the absence of established rituals for life-death transition, the ultimate coping mechanism is denial. The vague procedure for establishing brain death leads to its occurrence being denied in Bulgarian ICUs until cardiac arrest. Fieldwork highlights conflicting views among physicians: some of them consider brain death determination a professional duty, others passively avoid or openly reject it, citing doubts about brain death as biological death, many are uninformed. The incompleteness and inconsistency of the brain death establishment ritual extend the liminal state of the brain dead patients raising mistrust and anxiety. The controversial policies and practices precondition low transplant rates.

Bulgarian healthcare system is described as a collection of “medical feudal units” lacking cohesion. In the shared beliefs of its members, the fragmented structure, obscure and inconsistent rules of Bulgarian society allow its fast adaptation on the imagined geo-political and cultural border, where changes are constant. This further impedes the efficient organ procurement and transplantation activities that require trust, integration, precise coordination in space and time.

While being last in the EU for organ transplant rates, Bulgaria still views its limited transplants as “miraculous” technological achievements, effectively affirming societal power and faith.

Transplantation serves as a “magnifying glass” for systemic issues in healthcare, governance, and values. Deeper and more representative research into the ethical, religious, and spiritual beliefs of medical and institutional actors could reveal broader dynamics on national and supranational level.

The author declares no conflict of interest.

With gratitude to all project supporters, and to the participants in the conversations during the research process.

References

Алфа Рисърч 2019. *Обществени нагласи към донорството на органи.* [Alpha Research 2019. *Obshtestveni naglasi kŭm donorstvoto na organi.*] Available at: https://alpharesearch.bg/api/uploads/Articles%202019/November/Донорство/1019_AR_Donorstvo_survey.pdf.

Атиас, К., Шаркова, М., Цекулова, Н. 2024. *Механизми за разпределение на ограничени ресурси в системата на здравеопазване в България.* Български хелзинкски комитет. [Atias, K., Sharkova, M., Tsekulova, N. 2024. *Mehanizmi za razpredelenie na ogranicheni resursi v sistemata na zdraveopazvane v Bŭlgariya.* Bŭlgarski helzinkski komitet.] Available at: https://www.bghelsinki.org/bg/reports/mehanizmi-za-razpredelenie-na-ogranicheni-resursi-v-sistemata-na-zdraveopazvaneto-v-bylgarija.

Бозукова, М. 2022. Заплати, условия на труд, феодализъм. МЗ ударно ще набелязва мерки за задържане на младите медици. *mediapool.bg*. [Bozukova, M. 2022. Zaplati, usloviya na trud, feodalizŭm. MZ udarno shte nabelyazva merki za zadŭrzhane na mladite meditsi. *mediapool.bg*.] Available at https://www.mediapool.bg/zaplati-usloviya-na-trud-feodalizam-mz-udarno-shte-nabelyazva-merki-za-zadarzhane-na-mladite-meditsi-news334085.html. (Accessed 9 January 2025)

bTV Media Group 2021. 120 минути: Марияна Симеонова: Трансплантациите са много комплексна дейност. [bTV Media Group 2021. 120 minuti: Mariyana Simeonova: Transplantatsiite sa mnogo kompleksna deĭnost.] Available at: https://youtu.be/ehV9Be5Hem8?si=N9VnB7QzC0uhgH2r&t=655. (Accessed 9 January 2025).

Гарнизов, В.1994. *Смърт и погребение у българите: Дис.* София: БАН. [Garnizov, V. 1994. *Smŭrt i pogrebenie u bŭlgarite: Dis.* Sofia: BAN.]

Да! За живот. Попълването на донорската карта може да спаси човешки живот. *zajivot.bg*. [Da! Za zhivot. Popŭlvaneto na donorskata karta mozhe da spasi choveshki zhivot. *zajivot.bg*.] Available at: http://zajivot.bg/donorska-karta. (Accessed on 9 January 2025).

Закон за здравето. [*Zakon za zdraveto.*] Available at: https://old.mh.government.bg/media/filer_public/2018/02/27/zakon-za-zdraveto.pdf.

Закон за трансплантация на органи, тъкани и клетки. [Zakon za transplantatsiya na organi, tŭkani i kletki.] Available at https://www.mh.government.bg/upload/168/zakon-za-transplantaciya-na-organi-takani-i-kletki_07-08-2012.pdf.

ИАМН 2022. *Доклад за междинна оценка за изпълнение на дейности по Национална програма за насърчаване на донорството и подпомагане на трансплантацията в Република България 2019-2023 г.* [IAMN 2022. *Doklad za mezhdinna otsenka za izpŭlnenie na deĭnosti po Natsionalna programa za nasŭrchavane na donorstvoto i podpomagane na transplantatsiyata v Republika Bŭlgariya 2019–2023 g.*]

клиника.бг 2023. По следите на здравната реформа с д-р Петър Москов. *clinica.bg.* [clinica.bg 2023. Po sledite na zdravnata reforma s d-r Petŭr Moskov. *clinica.bg.*] Available at: https://youtu.be/DZV3oz8BlXc?si=SF_gwbAUBsX-_UjO&t=984. (Accessed 9 January 2025).

МЗ, ИАМН 2019. *Анализ на трансплантационната дейност в България – състояние, проблеми, перспективи*. [MZ, IAMN 2019. *Analiz na transplantatsionnata deĭnost v Bŭlgariya – sŭstoyanie, problemi, perspektivi.*]

Маринов, Д. 2003. [1891] *Избрани произведения в 5 тома. Том 1, част 1. Народна вяра.* Изток-запад. [Marinov, D. 2003. [1891] *Izbrani proizvedeniya v 5 toma. Tom 1, chast 1. Narodna vyara.* Iztok-zapad.]

Наредба № 14 от 15 април 2004 г. за медицинските критерии и реда на установяване на смърт. [*Naredba №14 ot 15 april 2004 g. za meditsinskite kriterii i reda na ustanovyavane na smŭrt.*] Available at: https://iamn.bg/нормативни-актове/наредби/.

Наредба № 13 от 6 декември 2021 г. за възстановяване на разходите и за относителния дял на средствата за труд за дейности по трансплантация, финансирани от Министерството на здравеопазването. [*Naredba №13 ot 6 dekemvri 2021 g. za vŭzstanovyavane na razhodite i za otnositelniya dyal na sredstvata za trud za deĭnosti po transplantatsiya, finansirani ot ministerstvoto na zdraveopazvaneto.*] Available at: https://iamn.bg/нормативни-актове/наредби/.

Национална програма за насърчаване на донорството и подпомагане на трансплантацията в Република България 2019-2023 г. [*Natsionalna programa za nasŭrchavane na donorstvoto i podpomagane na transplantatsiyata v Republika Bŭlgariya 2019 – 2023 g.*] Available at: https://strategy.bg/StrategicDocuments/View.aspx?lang=bg-BG&Id=1298.

Национална програма за насърчаване на донорството и подпомагане на трансплантацията в Република България 2024–2028 г. [*Natsionalna programa za nasŭrchavane na donorstvoto i podpomagane na transplantatsiyata 2024–2028 g.*] Available at: https://www.mh.government.bg/bg/politiki/programi/aktualni-programi/.

Платиканов, В. 2002. *Мозъчна смърт, медицински и правни аспекти.* Плевен. [Platikanov, V. 2002. *Mozŭchna smŭrt, meditsinski i pravni aspekti.* Pleven.]

Подкаст: Бъди светлина 2023. Д-р Сибила Маринова – светлината в донорството у нас! ЕП.3 Подкаст: Бъди светлина. [Podcast: Bŭdi svetlina 2023. D-r Sibila Marinova – svetlinata v donorstvoto u nas! EP.3. Podkast: Bŭdi svetlina.] Available at: https://youtu.be/li7S1ao_a_E?si=vSIQPBGxKd74riWh&t=444. (Accessed 9 January 2025).

Публицистиката на NOVA 2023. МЕЖДУ ЖИВОТА И СМЪРТТА: Четири дни с лекарите от „Пирогов“. *Нова телевизия.* [Publitsistikata na NOVA (2023) MEZHDU ZHIVOTA I SMŬRTTA: Chetiri dni s lekarite ot „Pirogov“. *Nova Televiziya.*] Available at: https://youtu.be/WGM5jPh6JoY?si=0hWVhFevZx7Gumuc. (Accessed 9 January 2025).

Радев, Н.,2011. Социалната цена на прехода (разказ за „изгубеното време», или за „бягането на място»). *Изследвания по история на социализма в България. Преходът.* Център за исторически и политологически изследвания. [Radev, N., (2011) Sotsialnata tsena na prehoda (razkaz za „izgubenoto vreme», ili za „byaganeto na myasto»). *Izsledvaniya po istoriya na sotsializma v Bŭlgariya. Prehodŭt.* Tsentŭr za istoricheski i politologicheski izsledvaniya.] Available at: https://library.fes.de/pdf-files/bueros/sofia/08772.pdf. (Accessed 9 January 2025).

Ставру, С. 2008. *Човешкото тяло като предмет на вещни права.* Сиби. [Stavru, S. 2008. *Choveshkoto tyalo kato predmet na veshtni prava.* Sibi.]

Стойчев В., Борисова, С. 2022. *За разширената онтология на ценностите, или защо демокрацията у нас е само в бирата. Пилотно проучване на актуални граждански и политически ценности в България.* Български център за нестопанско право. [Stoychev V., Borisova, S. 2022. *Za razshirenata ontologiya na tsennostite, ili zashto demokratsiyata u nas e samo v birata. Pilotno prouchvane na aktualni grazhdanski i politicheski tsennosti v Bŭlgariya.* Bŭlgarski tsentŭr za nestopansko pravo.] Available at: https://beta.bcnl.org/analyses/za-razshirenata-ontologiya-na-tsennostite-ili-zashto-demokratsiyata-u-nas-e-samo-v-birata-doklad-izgotven-ot-silviya-borisova-i-venelin-stoychev.html. (Accessed 9 January 2025).

Телевизия СКАТ 2021. гост д-р Евелина Цветкова. [Televiziya SKAT 2021. gost d-r Evelina Tsvetkova.] Available at: https://youtu.be/zbQzleAztT0?si=5Xq2DYjhzpf2bMOo&t=340. (Accessed 9 January 2025).

Тодорова, П. 2022. Трансплантациите, с които изоставаме, и успешният модел на Хърватия, *medicalnews.bg.* [Todorova, P. 2022. Transplantatsiite, s koito izostavame, i uspeshniyat model na Khŭrvatiya. *medicalnews.bg*.] Available at: https://medicalnews.bg/2022/11/08/трансплантациите-с-които-изоставаме/. (Accessed on 9 January 2025).

Тренд 2024. *Нагласи на обществото относно насилието към лекарите.* [Trend 2024. *Naglasi na obshtestvoto otnosno nasilieto kŭm lekarite.*] Available at: https://blsbg.com/bg/download/file/page-section/23118.

ИАТ 2011. *Указания на Изпълнителна агенция по трансплантация за органно и тъканно донорство. Част: разговор със семейството.* [EAT 2011. *Ukazaniya na Izpŭlnitelna agentsiya po transplantatsiya za organno i tŭkanno donorstvo. Chast: razgovor sŭs semeĭstvoto.*] Available at: https://iamn.bg/download/conversation-with-the-family/?wpdmdl=5181.

Action plan of the European Commission on Organ Donation and Transplantation (2009–2015). Available at: https://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2008:0819:FIN:EN:PDF.

Aries, P. 1977. *The Hour of Our Death.* Knopf Doubleday Publishing Group. Kindle Edition.

Armitage R. 2023. The WHO's definition of health: a baby to be retrieved from the bathwater? *The British journal of general practice: the journal of the Royal College of General Practitioners*, 73(727), 70 – 71. https://doi.org/10.3399/bjgp23X731841.

Barnes, E., & Greer, D. 2020. Inconsistency in Brain Death Determination Should Not Be Tolerated. AMA journal of ethics, 22(12), E1027–E1032. https://pubmed.ncbi.nlm.nih.gov/33419503/.

Burt, R. 2002. *Death Is That Man Taking Names: Intersections of American Medicine, Law, and Culture.* Berkeley: University of California Press.

Douglas, M. 1986. *How Institutions Think*, Syracuse University Press, New York.

Freud, S. 1915. Thoughts for the Times on War and Death. In Einstein, A., Freud, S. *Why War? A Correspondence Between Albert Einstein and Sigmund Freud (Warbler Classics Annotated Edition).* Warbler Classics. Kindle Edition.

Beecher, H., Adams, R., Barger, C., et al. 1968. A definition of irreversible coma: Report of the Ad Hoc Committee of the Harvard Medical School to examine the definition of brain death. *JAMA.* 1968;205(6): 337–40. https://jamanetwork.com/journals/jama/article-abstract/340177.

Ceylan, İ., Seven, S., Baltalı, S. 2019. Evaluation of Non-donor Brain-Dead

Patients. *Istanbul Medical Journal*, 20(2), 144-147. https://doi.org/10.4274/imj.galenos.2018.54926.

Council of Europe 1999. *Meeting the organ shortage.* Available at: https://www.coe.int/t/dg3/health/source/organshortage_en.doc.

European Directorate for the Quality of Medicines and Healthcare (EDQM) 2022. *Guide to the quality and safety of organs for transplantation. 8th Edition.* European Committee on Organ Transplantation. Available at: https://www.edqm.eu/en/guide-quality-and-safety-of-organs-for-transplantation.

European Union 2010. *Organ donation and transplantation. Special Eurobarometer 333a.* Available at: https://europa.eu/eurobarometer/surveys/detail/804.

Eurotransplant. New member states: Accession procedure. *eurotransplant.org*. Available at: https://www.eurotransplant.org/region/new-member-states/. (Accessed on 9 January 2025).

Gennep, A. van 1960. [1909] *The Rites of Passage*, Chicago: Chicago University Press.

Global Observatory on Donation and Transplantation (GODT) 2022. *International Report on Organ Donation and Transplantation Activities 2022*. Available at: https://www.transplant-observatory.org/wp-content/uploads/2023/11/2022-data-global-report_VF_2.pdf.

Greer, D. M., Shemie, S. D., Lewis, A., Torrance, S., Varelas, P., Goldenberg, F. D., Bernat, J. L., Souter, M., Topcuoglu, M. A., Alexandrov, A. W., Baldisseri, M., Bleck, T., Citerio, G., Dawson, R., Hoppe, A., Jacobe, S., Manara, A., Nakagawa, T. A., Pope, T. M., Silvester, W., … Sung, G. 2020. Determination of Brain Death/Death by Neurologic Criteria: The World Brain Death Project. *JAMA*, 324(11), 1078–1097. https://doi.org/10.1001/jama.2020.11586.

Howarth, G. 2000. Dismantling the boundaries between life and death. *Mortality*, 5(2), 127 – 138. https://doi.org/10.1080/713685998.

Hristov, H. 2024. *Determination of death by neurological criteria. Statistically expected number of cases in Bulgaria, by region. January 2020 – December 2023.*

Hristov, H. 2024. *Actual number of deaths determined by neurological criteria in Bulgaria, by region. January 2020 – December 2023.*

Hristov, H. 2024. *Number of deceased organ donors in Bulgaria, by region. January 2020 – December 2023.*

Ikels, C. 2013. The anthropology of organ transplantation, *Annual Review of Anthropology*, 42: 89 – 102.

Illich, I.1976. *Medical Nemesis: the Exploration of Health*, London: Marion Boyars.

Lock, M. 2002. *Twice dead : organ transplants and the reinvention of death.* University of California Press.

McCormack, D. 2021. The Haunting Temporalities of Transplantation. *Body & Society*, 27(2), 58 – 82.

Lupton, D. 2012. *Medicine as culture: Illness, disease and the body.* SAGE Publications Ltd, https://doi.org/10.4135/9781446254530.

Meyer, B. & Pels, P. 2003. *Magic and Modernity: Interfaces of Revelation and Concealment*. Redwood City: Stanford University Press. https://doi.org/10.1515/9781503620056.

Mitre, C., Mitre, I. 2017. Diagnosing "Brain Death" in Intensive Care. *Journal of critical care medicine.* (Universitatea de Medicina si Farmacie din Targu-Mures), 3(3), 128 – 130. https://doi.org/10.1515/jccm-2017-0016.

Mongoven, A. 2003. Sharing Our Body and Blood: Organ Donation and Feminist Critiques of Sacrifice. *Journal of Medicine and Philosophy*, 28(1), 89–114. https://doi.org/10.1076/jmep.28.1.89.14175.

Navarro, A. 1995. Potential donors and brain death epidemiology in the region of Madrid. In: Touraine, JL, Traeger, J., B é tuel, H., Dubernard, JM, Revillard, JP, Dupuy, C. (eds) *Organ Shortage: The Solutions. Transplantation and Clinical Immunology, vol 26.* Springer, Dordrecht. https://doi.org/10.1007/978-94-011-0201-8_20.

Nordham, K. & Ninokawa, S. 2021. The history of organ transplantation. *Proceedings* (Baylor University. Medical Center), 35(1), 124–128. https://doi.org/10.1080/08998280.2021.1985889.

Organización Nacional de Trasplantes (ONT) 2011. *Good practice guidelines in the process of organ donation.* Available at: https://www.declarationofistanbul.org/images/stories/Downloads/ONT-BENCHMARKING%20GUIDE-eng-red.pdf.

Repertinger, S.K., Fitzgibbons, W.P., Omojola, M.F., & Brumback, R.A. 2006. Long Survival Following Bacterial Meningitis-Associated Brain Destruction. *Journal of Child Neurology*, 21, 591–595. https://doi.org/10.1177/08830738060210070401.

Robertson, J.A. 1999. The Dead Donor Rule. *The Hastings Center Report*, 29 (6), 6 – 14. https://doi.org/10.2307/3527865.

Sajja, A., & Puchalski, C. 2018. Training Physicians as Healers. *AMA journal of ethics*, 20 (7), E655 – E663. https://doi.org/10.1001/amajethics.2018.655.

Sartorius N. 2006. The meanings of health and its promotion. *Croatian medical journal*, 47(4), 662 – 664.

Scholz, N. 2020. *Organ donation and transplantation: facts, figures and European Union action*; EPRS: European Parliamentary Research Service. Belgium. Available at: https://policycommons.net/artifacts/1337208/organ-donation-and-transplantation/1944888/.

Seifi, A., Lacci, J. V., & Godoy, D. A. 2020. Incidence of brain death in the United States. *Clinical neurology and neurosurgery*, 195, 105885. https://doi.org/10.1016/j.clineuro.2020.105885.

Shok, N. 2024. Expert commentary.

Statista 2025. *Rate of patients receiving a transplant per million population in Europe in 2022 to 2023, by country*. Available at: https://www.statista.com/statistics/537926/total-number-of-patients-transplanted-in-europe/. Accessed on 9 January 2025.

Thomassen, B. 2009. The Uses and Meaning of Liminality. *International Political Anthropology*, 2(1), 5-28.

Treaty on the Functioning of the European Union. Available at: https://eur-lex.europa.eu/EN/legal-content/summary/treaty-on-the-functioning-of-the-european-union.html.

Verrips, J. 2003. Dr. Jekyll and Mr Hyde: Modern Medicine Between Magic and Science. In: Birgit Meyer & Peter Pels (eds), *Magic and Modernity. Interfaces of Revelation and Concealment.* Stanford: Stanford University Press, pp. 223-241.

Wijdicks, E.F. 2002. Brain death worldwide: accepted fact but no global consensus in diagnostic criteria. *Neurology*, 58 (1), 20–25. https://doi.org/10.1212/wnl.58.1.20.

World Health Organization (WHO) 1946. *Constitution of the World Health Organization.* Basic Documents, Geneva. Available at: https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1.

Yang, Q., & Miller, G. 2015. East-West differences in perception of brain death. Review of history, current understandings, and directions for future research. *Journal of bioethical inquiry*, 12(2), 211–225. https://doi.org/10.1007/s11673-014-9564-x.

Ilina Marinova
Department of Anthropology, NBU, Sofia
1618 Sofia, Bulgaria 21 Montevideo Str.
e-mail: ilieva.ilina@gmail.com