The surgeon places the scalpel below the larynx, cuts only a few millimeters deep into the skin, and lets the blade glide over the rib cage, down the abdomen to the pubic bone. It's the most extended incision there is in surgery - and the last. This operation does not prolong the life or cure the person lying here on the table before the surgeon. It serves other people whose organs are in danger of failing. This is the multiorgan explantation of an accidentally brain-dead 39-year-old man who is an organ donor like me.

On this day, January 2019, I am on night duty. I've worked as a positioning nurse in the OR for seven years. It´s safe to say that I've seen almost everything, including transplants of this type. Dead children, too. But what awaits me in the following hours will keep me busy for weeks beyond that.
This night is different because I consciously decide to let the situation get to me. Where this impulse comes from, I can't say. I have always had a tendency to deal with life's big questions. Questions about it´s possible meaning and the end. That's probably why I ended up in medicine - working on the pulse of life. In seven years in the operating room, I have been confronted with entirely different human conditions and emotions: the daily patients at seven o'clock in the morning, who have become routine and are sometimes extremely frightened, parents who collapse while I am getting their daughter to heart surgery, older people with dementia, babies with open backs, suicide victims. Don't look - you can't do that here. All this is life, too—just the unattractive back rooms of our existence.
Maybe that's why I decided spontaneously this time: no "professional distance" to protect my emotions but complete involvement. Not out of curiosity but to consciously deal with a topic we all like to repress: our mortality, our knowledge of it - and the question of what we can draw from this knowledge for our lives.

The shift has just begun. It's 10 p.m. The lights in the operating room airlock, the entrance area to the surgical wing, are dimmed. A glance at the computer screen tells me: "Mr. X, 39 years old, diagnosis: brain dead; planned intervention: multi-organ explantation." Immediately I am wide awake. Implantations are a regular thing. The organs usually come from other hospitals. Even intra-family organ donations, for

example, when the father donates a kidney or parts of the liver to his son, no longer attract special attention because of their frequency.
With explantations, on the other hand, everyone notices. It is not an everyday procedure. And an almost complete explantation in a brain-dead person is an absolute rarity even for experienced colleagues.

I prepare an operating table, enter the operating room, set up working materials such as pillows and belts, and check necessary equipment such as suction devices. Having completed that, I wait in the patient lock for - yes, for whom? The patient? The dead? The inexorably dying?

In Germany the so-called irreversible loss of brain function is regulated: two experienced intensive care physicians must, independently of each other and at intervals of twelve, twenty-four, and seventy-two hours, repeatedly perform a precisely defined series of examinations. For example, a brief stop of artificial respiration would trigger the reflex of spontaneous breathing if the patient were only unconscious. Similarly, the cough reflex is tested as doctors palpate the throat with a spatula or even insert a suction catheter into the breathing tube to trigger a reflex in the airway. If such protective reflexes, which are essential for survival, fail to occur, this indicates that the brain has been damaged in no small way. The German Medical Association lays down these examination guidelines: Loss of brain function means that all essential body control functions controlled by the brain have been irretrievably extinguished. In addition, an EEG (electroencephalogram) may be written, a measurement of the electronic brain activity that must show a zero line for at least thirty minutes, a complete absence of any electrical activity. The body is kept alive by intensive medical measures. Without these, the cardiovascular system would collapse, and all other organs would fail.

There is a clicking and crashing sound, and the large double doors of the patient lock open. The anesthesiologist in charge pushes a hospital bed into the semi-darkness of the airlock. The bed is packed with medical equipment that brings its unique soundscape: the hissing of the ventilator and the beeping of the ECG monitor. Bags

of colorful liquids hang from infusion poles, and at the foot of the bed are syringe pumps, the perfusions which the necessary medications is given. Only when the anesthesiologist comes to a halt with the bed directly in front of me, next to the operating table, I see the patient, deeply sunk into the mattress. To the eye, a completely healthy, peacefully sleeping person. And yet there is nothing left. These machines communicate the life that is still there - and the note already attached to the big toe securely identifies the person who will later die. This contrast is surreal for me. It is unmistakably clear that there is nothing left to discuss here. Everyone knows what the outcome will be.

I transfer the patient to the operating table with the anesthesiologist and the anesthesia nurse. The three of us go to the preparation room opposite the operating room. And that's where things get complicated. Whether a brain-dead patient should receive general anesthesia, light anesthesia, or none at all has long been the subject of a very emotional and controversial debate.
Since a brain-dead patient can no longer feel pain, painkillers are not needed. Nevertheless, in this situation, one must also pay attention to the attending anesthesiologist. No one can demand of them in this emotionally highly stressful situation not to administer at least a mild anesthetic. Although the anesthesiologist is not obligated to do any of this, it may be ethically necessary for him as a human being to get through this situation well and to be able to concentrate on his tasks, which are mainly to monitor and maintain the patient's vital functions constantly. And so, each anesthesiologist decides how to approach the treatment of their brain-dead patient within the framework of the hospitals guidelines.

What is administered in any case is a muscle relaxant. This drug is administered because muscle twitching can occur despite the loss of brain function. The central sensors in the brain are no longer functional, yet sensors in the spinal cord can still respond.
It is similar to the increase of blood pressure and pulse. Although pain sensation is no longer possible, a pain stimulus's chemical causes can still occur in the tissues. And this can cause blood pressure and pulse to rise even in a brain-dead person.

Twenty minutes later, we push the patient into the operating room, a distance of four-meter. We go to our respective workstations. The anesthesia nurse takes care of the venous accesses, the anesthesiologist keeps an eye on the ventilation, and I devote myself to the patient.
As a positioning nurse, I position the patient on the operating table, as the name suggests. I do this after consultation with the surgeon. Since there is almost no position we cannot put a human body in (supine, prone, lateral), there are many supports, gel and foam cushions, and various belts for this purpose. No hard pressure points must be created, and the extremities are not overstretched. The patient is usually fully anesthetized or brain dead, as in our case, so he cannot give any feedback.
And, of course, the patient must always be positioned in a way that the surgeons have the best access. Be it standing or sitting. A shoulder operation is accordingly set differently than an operation on the brain. For the latter, for example, a small bench must be attached to the operating table so that the surgeon can rest his forearms and work on the brain with a steady hand. In prostate operations, a robot is now also used, requiring special positions.

This night, the positioning is very straightforward: After consulting with the anesthesiologist who secures the breathing tube in the patient's neck, I first pull the patient down a bit, straighten the somewhat twisted hip and place the arms on supports. As I secure them there, I realize that these arms will never move on their own again. For a split second, I am seized by the thought that I may be the final cause of the movement of these arms, of a last sliding of the joints, from shoulder to elbow to the wrist.

Then, one by one, the surgeons appear. The surgical nurses are already waiting for them. They put on sterile gloves and then hand them the first instruments: a scalpel for the skin incision, a bone saw for the sternum, and large retractors to prevent the abdominal flaps from collapsing. The body is opened, and all the organs present themselves to the surgical team. And everything I have ever read about the attempted definition of "life" falls apart. Biologists talk about a "closed system". Also, of the ability to self-organization and of reproduction and separation from the outside

world, in the case of the cell, for example, in form of a membrane. What ridiculous, pathetic attempts to put the inexpressible into words. I am fascinated and humbled.

Silence. Concentrated work. Quietly murmured instructions from the surgeons to the assisting scrub nurse. A glance down the corridor reveals an entirely different picture: about ten people are climbing over countless bags, Styrofoam containers, backpacks, documenting, taking calls, discussing, and delegating. A multi-organ explantation is also: an incredibly bureaucratic and organizational effort. Each organ has its own team of physicians and coordinators to ensure it arrives safely at the recipient's. Often in entirely different cities, which are reached as quickly and safely as possible via airplane.
An hour later, even the operating room is no longer quiet. An unusually large number of people are present. In addition to the four surgeons at the operating table, the active room nurses, the anesthesiologist, and the anesthesia nurse, the recipients doctors are ready to receive the organs.

And at the center of all that lies this dead yet living human being, opened up from the neck to the pubic region, the rib cage sawn open — the silent eye of a hurricane. Glaring light pours over the organs and the surgeons' working hands, a very bloody sight. I have seen students who fainted at this sight, whom I had to carry out of the room with the help of colleagues. Who didn't want to go back into the room after they had color back on their face, who said, "I can't look at that." Some young colleagues squint their eyes with their arms crossed in interest to be able to see more clearly. And there's the experienced doctor who looks in briefly, nods, and leaves.
Blood is not made to be seen. The finality of death is hard to grasp. I feel an inner revolt against what is happening. Perhaps the inability to accept death, to imagine an end, non-existence. And with a brain-dead person, it is even more surreal, as they seem to be in between these two worlds.

The all-important moment comes very early. Vessels leading to the heart and lungs are separated from the surrounding tissue, the organs are flushed with a cold infusion solution, and the blood is sucked out. The result is cardiac arrest and, finally, complete cessation of circulation. The operating room nurse hands the surgeon a

pair of curved, long, thin forceps, which the doctor places above the heart on the aorta to clamp it off. The surgeon cuts the large vessels of the heart and lungs. The latter is clamped in a distended state, and the trachea is cut to prevent the lung tissue from sticking together. The anesthesiologist steps down after this step, as he does not need to monitor vital signs anymore. The ECG shows zero, and the beeping of the heart rate stops. The monitors are muted. And muted at this moment is the entire team.
The heart and lungs have priority because they can only tolerate a short period of ischemia. Ischemia means the death of tissue cells due to decreased or absent of blood flow. Since the removed organs should reach the recipient as "fresh" as possible, the body continues to be cooled. In addition to the cold infusions, the surgeons pour up to fifteen liters of ice water into the abdomen.
Then the thoracic surgeons step away to make room for the abdominal surgeons. They then remove the liver, intestines, kidneys, and pancreas.

When I return to the OR after taking care of other patients, the chest is empty, and the abdominal surgeons are busy with the liver. One thing hits me at this point for the first time and quite unexpectedly: My gaze falls on the inner surface of the chest. On the place where a lung was nestled just a short time ago. How unbelievably perfectly this smooth tissue is worked, how everything is arranged in such a way as to prevent friction as far as possible when the lung moves while breathing! No look belongs at this place in the body of a human being! I feel that immediately. That this place goes far beyond concepts like privacy, personality, and intimacy, no one should be allowed or required to see the inside of a rib cage.

I continue to stay in the hall with the surgeons, apart from the explantation, it´s a quiet night shift, and the colleague on the other floor does not need my help. And so, despite fatigue and burning eyes, I decide to stay. Not out of curiosity but to consciously deal with death.
Usually, I rarely look dead people in the face. For one thing, it's a creepy sight, and for another, it makes it easier for me to do the job professionally. I can't always avoid the picture when transferring deceased patients from the operating table to a hospital bed, but I try. Perhaps that can be called maintaining "professional detachment". For

me, it's ultimately not a "professional" distance but an emotional one. I want to protect my emotions. The younger a patient is, the more I want to do that, especially when there is a high probability that there are children, a husband, a wife, and a circle of friends.
The patient who´s lying here in front of me is thirty-nine, just four years older than me. I feel the difference between a road accident victim and a person dying after a long illness. The latter had more time to say goodbye, settle certain matters, and conclude things. How merciful this seems, despite the greatest tragedy, compared to the accident victim and the suddenness of his death.

I approach the patient by the side of the head and glance over the drape at the increasingly empty body and the working surgeons. I wonder what is going on in the surgeons' minds. Actually they want to preserve life but in this case, they are working on a dead body. Probably they save themselves by concentration. This is the most commonly practiced method to keep yourself away from unpleasant emotions in such situations. Maybe the surgeons also think of the organ recipients whose lives can be saved save and prolonged with their work.
I decide to continue allowing emotions that night in whatever form. However, an invisible force wants to push me out of the operating room.

The patient's heart is in a plastic bag in a plastic container, pumping again. It's built into a machine that keeps it beating, called the Organ Care System. Using 1200 milliliters of donor blood and nutrient fluid, it is kept oxygenated for as long as possible to prevent tissue death.
Time suddenly stands still as I look at this heart beating outside the body. I see only this heart, everything else becomes blurred, and I ask the organ in my thoughts: "Which moments and experiences made you beat faster? Is there still a part of the first love in you, the palpitations at first sight of your future wife? Is there still something left of the excitement of the all-important job interview? It is bitter about suspecting that everything that distinguished this person is gone - at least all non-organic. I think of my own memories, precious memories. And I wonder if they, too, will eventually just be gone. Disappear into nothingness. They have no meaning for the world. Not even to my neighbors or colleagues. I understand what it can mean to

take distance from yourself in the sense of not taking yourself so seriously. I realize how small and insignificant I am in the world. Between an unimaginably long "not-having-been" and an infinitely long "not-more-being," that tiny gap opens into which we want to squeeze everything.
I am overcome with humility. Also, when I think of the development of the heart in the womb. Around the 22nd day, the first heart muscle cell of the fetus begins to twitch, to move rhythmically. And it will do this tirelessly, for many decades, until the end of this life, even when it does it outside a body, as in this case. Or even later in another body. To this day, despite intensive research, there is no scientific explanation of where the first electrical impulse for this cell comes from.

Wherever this first impulse comes from - here in the operating room, it escapes, or better: something escapes. Namely, the rosy skin color of the living. What remains is a greenish gray. I touch the patient, or rather the dead person. Only briefly and with a fingertip. Ice cold. And that's precisely how it goes down my spine. Unfamiliar, not disgusting, but wrong, creepy. I step back and survey the situation: thirty-nine years in the middle of life. And now ice cold and half empty. At thirty-nine, you have plans, ideas, future, and "dead"lines. I imagine this man at a fictitious time, a few days ago. He was still in the midst of everyday life. There were undoubtedly sentences that began with "Next week we have to ...".
And now he lyings here. Gone, dead, cold. Now he doesn't have to do anything anymore.

The finality of death is hard to grasp. We do not want to accept it. The irretrievability of everything tastes bitter. I ask myself: What does this mean for me as a living person? Where is the difference between the theoretical knowledge of our own finiteness and this direct witnessing of death? I always see the number thirty-nine in front of me. Is it a good number because the deceased was allowed to experience the happiness of having escaped non-existence for thirty-nine years? Or is it a sad number because the man would surely have liked to reach a ripe old age?
Is life ultimately banal? Or is it miracle enough in itself so that it is not necessary to reach a specific goal in it? Is it essential to reach a goal to be able to consider a life as fulfilled?

An anesthesiologist enters the room. He just wanted to stop by, after all, this is not an everyday procedure. I learned that the anesthesiologist treated this man on his duty as an emergency physician. And I understand that the man was a father. I would rather not have known. My son is a year and a half old at this point. That's the only moment I leave the room for a moment. It is too much to think of the children and their father in the present state.
Instead of following the first impulse and wandering through the aisles, I lend a hand outside the hall. I distract myself, help carry the transplant coordinators' backpacks and bags to the elevator, and prepare a fresh hospital bed for the deceased. All that feels good and makes me forget the tragedy for a moment.
Then I sit in the lounge for a short break. Operating room nurses are talking about multi-organ explantation. One says that after participating once, she has never assisted another: "I can't stand it. First, the patient looks like any other ICU patient, and then you end up with some haggard corpse. No, I´m not made for something like this." Another says she can't do explants anymore since she has a family. "I always have to imagine then what it would be like if my husband were lying there." She shakes her head. "I'm not cut out for that." I notice her swallow, her blink; she gets up and takes her coffee cup away.

After about six hours, the explantation is finished. Team after team, each carrying Styrofoam containers, leaves the OR. I help remove the covers from the dead man. We clean up the mess of equipment, tables, stools, trash cans, cables, and tubing that are standing around. The deceased is sewn up, and I wash him with the nurse. We cover him up and drive him back to the airlock. As we pull him onto a fresh hospital bed, I use too much force, and the body lands on the edge of the bed on my side. I immediately support him with my hip. I had not considered that the body is now much lighter than before. We bed him down and cover him up. Including the face. The transport service will pick him up and drive him to the pathology department. There, the relatives will have the opportunity to say goodbye.
At this time, the donor's organs may be on an airplane, in a car, or already in a new body. Hopefully, they will continue to perform their services, heal and prolong an unknown life.

Later, I sit alone again in the airlock. It is quiet. I have dimmed the light, but my eyes still burn. I could fall into a deep sleep right now. I have to think of the woman who lost her husband, of the children who no longer have a father. It touches me; how could it not? But in the end, what remains for me is simply the realization that "humans inevitably die." As simple as I was told at some point as a child, it remains as banal after that night. Whether at a ripe old age, far too early, through illness or accident. All these things have been happening for thousands of years. I wonder if perhaps we have become too sensitive in the 21st century. Technology and scientific research have considerably prolonged the quality of life and its expected length of time. Two hundred years ago, death was also tragic and sad - but it was also everyday life. Coping with a loss was correspondingly quicker, perhaps even more manageable.

In the following weeks, I experience a change in my perspective on life. I no longer look to the future and ask myself what I want to experience and achieve. Instead, I look at my life more and more from the perspective of the deathbed. What will it have been that I want to look back on and find fulfilling? This perspective has a much larger scope for me. What I don't like and can do without becomes more apparent to me. I find this sorting out more straightforward than the frantic "sorting in" of specific goals into the lifetime. What is left at the end is where I want to invest my energy.

The greek philosopher Epikur once said: "We live only once. We cannot be born twice. After that, we can no longer be for all eternity. But you are not even the master of tomorrow, yet you always miss the right moment. Above procrastination, life passes away, and each of us dies restlessly."

I take my time on the way home. It's eight o'clock in the morning my girlfriend is probably just being woken up by our son. I walk in slow motion over frozen snow, bathing in the warmth of the rising winter sun. The crunching under my feet reminds me of a phrase by the mountaineer Jon Krakauer: "It evokes feelings of happiness in me that border on the rapture."