Reference
1. Buske L. Tuition fees and medical residents. *CMAJ* 1999;161(5):479.

Non-heart-beating organ donation

We read Graham Campbell and Francis Sutherland's paper on non-heart-beating organ donation[1] with interest. Several aspects of their proposal concerned us.

We feel it is inappropriate for a physician to approach a live patient's substitute decision-maker regarding consent for organ donation. This approach would undermine confidence in the physician's (and institution's) primary commitment to optimizing the interests of the patient.

However, it is not simply the *appearance* of primary commitment to the patient that is important. Although clinicians caring for brain-injured patients may consider the potential for organ donation before declaration, criteria for brain death are firm. It is therefore straightforward at present for a physician to mentally separate the time for management in accordance with primary concern for the patient from that for potential organ donation. Under the authors' proposal, the assessment of severity of brain damage could be influenced by the prospect of organ donation. The authors retrospectively propose criteria for donation. When defining candidacy in practice, the potential for bias in recommending withdrawal of life support on the basis of irremedial damage would be far greater.

This type of bias might also affect dosage or timing of palliative medication. Under the authors' proposal, transplant physicians would have an interest in rapid deterioration of organ donors, thereby avoiding protracted hypotension and optimizing organ integrity. Over time, this interest might influence others' management of palliation following withdrawal of life support.

Another difficulty would arise in the operating room: Who would pronounce the patient dead? A physician would need to be immediately available to minimize delay in harvesting. However, there would be no reason for an anesthetist or intensivist to be involved at this stage and the harvesting team would have a conflict of interest regarding timing of the pronouncement.

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Reference
1. Campbell GMD, Sutherland FR. Non-heart-beating organ donors as a source of kidneys for transplantation: a chart review. *CMAJ* 1999;160(11):1573-6.

[One of the authors responds:]

We agree that potential ethical problems accompany this type of organ donation and they must be addressed before embarking on non-heart-beating organ donation. Cameron Guest and Hugh Devitt feel it is inappropriate for physicians to approach a family regarding organ donation while the patient is still "alive." Clearly, with brain-dead patients and with severely brain-injured patients with no hope of survival, giving the bad news to relatives should not include an immediate request for organ donation: a family needs time to digest the death of a loved one. Indeed, giving the bad news and requesting organ donation at the same time does give the appearance of a conflict of interest. Studies indicate that success in obtaining consent is improved by separating the 2 events.[1,2]

Deciding to withdraw care in the event of a hopeless situation is different from withdrawing it when brain death is declared, because the criteria are not as well defined. However, in patients with severe brain injury, there is still one more criterion to meet — cardiac arrest — before death can be declared and organs retrieved. We believe that properly informed families can understand this situation and make a decision.

With a policy for non-heart-beating organ donation in place intensivists might change the way they treat severely brain-damaged patients or change the time that they declare brain damage irremediable, to facilitate organ donation. This is a real problem that would require an oversight committee of arm's-length observers. This committee must assess every case, give timely direction to the physicians involved and review the process once completed.

The criteria for declaration of death in the operating room must not change from the normal hospital practice. The people who normally declare death — intensivists, neurosurgeons and neurologists — should do so in this circumstance. The transplant team has *no* role in the declaration of death.

Clearly there are potential ethical pitfalls associated with non-heart-beating organ donation. However, the existence of pitfalls should not prevent us from proceeding with caution. Proper and ongoing review of the process should be sufficient to check any slip down an ethical slope.

An increasing number of Canadians are dying without a lifesaving organ transplant. To ignore a source of organs because of a *potential* ethical problem creates a *real* ethical problem.

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References
1. Cutler JA, David SD, Kress JC, Stocks LM, Lewino DM, Fellows GL, et al. Increasing the availability of cadaveric organs for transplantation maximizing the consent rate. *Transplantation* 1993;56:225-7.
2. Gortmaker SL, Beasley CL, Sheehy E, Lucas BA, Brigham LE, Grenvik A, et al. Improving the request process to increase family consent for organ donation. *J Transpl Coord* 1998;8:210-7.