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Op-Ed Contributor

# A Second Look at Death

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Boston

RECENTLY, a 15-year-old girl lay in a hospital here with brain injuries from a car accident. The trauma and bleeding were extensive, and nothing could be done to save her life. Her parents agreed that she should be taken off the respirator, and then requested that she be an organ donor.

However, this child was not brain dead, the usual first step in organ donation. Although most of her brain had shut down, the brain stem, which manages unconscious functions like breathing, was working enough to set off the respirator sporadically.

So the organ donation was managed in another way. After the respirator was removed, and after the girl's heart had stopped beating and she had quit breathing, her doctors pronounced her dead by cardiorespiratory criteria. Her heart was not suitable for donation — there was no way to predict that it would resume beating after transplantation. But the doctors were able to arrange for her liver and kidneys to be transplanted.

Had the girl died at another hospital, this might not have happened, because despite evidence that this kind of donation works well, some doctors and hospital administrators remain reluctant to procure organs from patients after cardiac death.

Thanks to a redoubling of effort to look at every death in the hospital as a potential occasion for donation, the number of deceased donors has risen 23 percent since 2003, to about 700 per month, according to the federal Health Resources and Services Administration. Still, many patients on organ waiting lists die every day. And the demand has led to more donations from living donors, who then face medical risks of their own.

If donation after cardiac death were pursued as diligently as donation after brain death, the number of organs available for transplant could rise significantly.

Donation after cardiac death was once the only form of transplantation from deceased donors — until 40

years ago, when doctors began using cessation of brain activity as a way to determine death. Brain activity is a preferable measure, because it enables the deceased patient to remain attached to a respirator until moments before organs are removed. This ensures that the donor's heart continues to beat, supplying all the organs with oxygen and nutrients.

Soon after adopting the brain death protocol, doctors largely abandoned donation after cardiac death, on the assumption that the organs would fare poorly after transplant. But lungs and livers usually do remain viable after cardiac death. And kidneys, if promptly transplanted, do just as well as those recovered from brain-dead donors, according to the United Network for Organ Sharing, a nonprofit organization that manages the transplant network in the United States.

Some doctors have objected to donation after cardiac death because they are uneasy about taking organs too soon after a patient's heart stops. But an extensive Institute of Medicine study in the late 1990s confirmed that donation after cardiac death adheres to the fundamental dead donor rule: that the recovery of organs is not the cause of death.

The Institute also laid down three key guidelines for donation after cardiac death: proper consent should be obtained, the donor should be ruled dead by a doctor other than the transplant surgeon, and the ruling should be delayed five minutes after the patient's heart has stopped — to ensure that it will not revive spontaneously.

The propriety of donation after cardiac death is so well established and its potential to ease organ shortages is so great that the Health Resources and Services Administration has deemed it an important goal for the nation. In January, the Joint Commission on Accreditation of Healthcare Organizations, which sets standards for medical practice in most American hospitals, will require protocols that enable the practice. But the group has made a key exception: a hospital that is unfamiliar and uncomfortable with the practice may opt out. This makes it unlikely that the protocols will be put to widespread use.

Individual hospitals should not decide that accepted practices of medicine are improper or unimportant. As long as a segment of the medical community stands in the way of donation after cardiac death, lives will be lost unnecessarily. And families of potential donors, at a time of enormous grief, will be deprived of the comfort of knowing that their loved ones' organs can be used to save lives.

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