therapy in patients with atrial fibrillation. Anticoagulant therapy is inconvenient both for physicians and for patients. To my knowledge, there is little information about the factors that influence physician decisions to prescribe (or not prescribe) anticoagulant therapy for atrial fibrillation. Large anticoagulation services are available in many urban centres, and many of these accept referrals from physicians. This reduces the burden of caring for these patients. It would be interesting to know whether anticoagulant therapy is more readily prescribed in such areas. Would the wider availability of such a service increase anticoagulant use in atrial fibrillation?

Man-Son-Hing also draws attention to his recent analysis of the relation between anticoagulant therapy for atrial fibrillation and risk of falling among elderly people. His Markov decision analytic model suggests that the benefit–risk ratio favours using anticoagulant therapy even in elderly patients who are at high risk for falling. The reliability of decision modelling (based on literature review) is only modest. In the absence of randomized trial data pertaining to this issue, I would remain cautious about prescribing anticoagulant therapy in elderly patients with a history of repetitive falling.

Stuart J. Connolly
Department of Medicine
Hamilton Health Sciences Corporation
Hamilton, Ont.

Fear and loathing of tuition fees

I applaud Brian Cummings for identifying some of the most important issues surrounding resident tuition fees.[1] Although I understand that universities are experiencing chronic underfunding, this is no justification for the attempt at a cash grab from the newest members of the medical profession.

What will the universities offer us in exchange for this monetary outlay? Will they pay the interest on our student loans? Can they even guarantee that repayment or interest on those loans will be deferred (given our status as students)? Are they prepared to reimburse us fairly for the teaching that we do?

If more universities succeed in instituting tuition fees for residents, the postgraduate training environment will be changed drastically. The quality of training and the delivery of health care will both be at risk.

Hershl Berman
PGY2 Internal Medicine
Kingston, Ont.

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In the Pulse column in the Sept. 7 issue of *CMAJ* Lynda Buske provided a thorough comparison of 1998 tuition fees for medical residents across the country.[1] I would like to clarify the history behind her statement that "in Quebec, government grants help defray a large portion of the tuition fee."

From the time that resident tuition fees at the 4 medical schools in Quebec (namely Laval, Sherbrooke, Montreal and McGill) increased substantially about 4 years ago, the Fédération des médecins résidents du Québec (FMRQ) has been waging a battle with the universities and the government of Quebec. The universities have been unyielding in their determination to maintain the tuition fees. However, after several years of efforts (including strike days) on the part of the residents, in June 1999 the provincial government agreed to finance a portion of the tuition fees. A new article (article 13.08) was added to the residents' collective agreement: as of 1999/2000 the residents will pay $700 in tuition fees and the balance will be paid by the Ministère de la santé et des services sociaux directly to the universities. The government will also reimburse residents for the same fraction of their 1998/99 fees retrospectively. The collective agreement can be downloaded from www.fmrq.qc.ca/a-index.htm (available in French only).

This was a major victory for medical residents in Quebec. I hope residents in other provinces will achieve similar success in their negotiations.

Alexandra Tcheremenska-Greenhill
PGY1 Family Medicine
Montreal, Que.

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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.

Cameron B. Guest
J. Hugh Devitt
Critical Care Unit and
Department of Anaesthesia
Sunnybrook & Women's College Health Sciences Centre
Toronto, Ont.

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[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.

Francis Sutherland
Department of Surgery
University of Calgary
Calgary, Alta.

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