

tional delay in surgery. However, whether biliary complications, such as acute cholecystitis, obstructive jaundice, cholangitis or pancreatitis, occur more frequently in patients with comorbid conditions is unclear.

There is no doubt that risk selection (the process whereby the makeup of a population changes over time through removal of subjects at higher risk) may bias the observed risk, because of unobserved heterogeneity.<sup>2</sup> For instance, when the risk of symptoms worsening is constant over the duration of the wait, risk estimates without adjustment for heterogeneity of individual patients will probably underestimate the true risk associated with longer waiting time, and the risk associated with longer relative to shorter waits may also be underestimated. Therefore, our message to health policy-makers should be that the risk of emergency surgery while waiting for elective cholecystectomy increased by a factor of almost 3 after 20 weeks on the waiting list, and that this is perhaps an underestimate.

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## **How to improve organ donation rates**

In Canada, the primary postmortem source of transplantable organs is patients whose deaths have been determined on the basis of brain death criteria (heart-beating donors). Greg Knoll and John Mahoney<sup>1</sup> suggest that patients who die after cardiac arrest (non-

heart-beating donors [NHBDs]) should also be considered as a source of transplantable organs.

Fundamental changes to organ donation in Canada would seem most appropriate if all other conventional approaches related to brain death donation had already been optimally explored. For example, the Collège des médecins du Québec reviewed all deaths in Quebec for the year 2000<sup>2</sup> and found that, of all patients who appeared brain dead on the basis of the chart review, 23% had not been identified as potential organ donors at the time. Furthermore, for patients with a diagnosis of brain death, 24% of the families were not approached for consent to donation.

Acknowledging variability in the recognition, diagnosis and documentation of brain death, the Canadian Council for Donation and Transplantation (CCDT), which provides advice to various levels of government, sponsored a national forum on the subject in April 2003.<sup>3</sup> The forum's multidisciplinary participants developed standards to address the optimal management of severely brain injured patients who may experience brain death, including the option of organ donation as a part of standard end-of-life care.

In its position paper,<sup>4</sup> the Canadian Critical Care Society (CCCS) has called for a moratorium on NHBD protocols without prior national discussions. The CCDT is preparing to initiate such a national discussion, with input and recommendations from representatives of the relevant health care professions and society as a whole. Planning for this initiative is scheduled for 2004.

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Greg Knoll and John Mahoney<sup>1</sup> correctly point out that the use of NHBDs could increase the number of cadaver organs available for transplantation in Canada. This possibility is under consideration in Quebec, and the Canadian Council for Donation and Transplantation will discuss the topic in an upcoming forum.

However, the use of NHBDs is fraught with ethical and logistic problems, and the addition of this type of donor to the existing pool will not be sufficient to meet the increasing need. In contrast, there is definitely room for better identification of brain-dead donors, as underlined in a recent study by the Collège des médecins du Québec.<sup>2</sup> In response to that study, the Quebec government is now funding a network of in-house organ donor coordinators, whose role is to help identify potential donors and to support both families and medical personnel throughout the organ donation process.

Living related and unrelated kidney donors are also underused in Canada.

Only 391 such transplants were performed in Canada in 2002, representing 30% of all kidney transplants.<sup>3</sup> In contrast, the United Network for Organ Sharing in the United States reported 6236 live-donor kidney transplants in 2002, which accounted for 42% of all US kidney transplants in that year.<sup>4</sup>

In a climate where health care resources are scarce, NHBDs should certainly be considered, but there are clearly other areas that require attention and investment if we are to meet the needs of patients with end-stage organ failure.

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#### [The authors respond:]

We agree with both Sam Shemie and colleagues and Dana Baran that there is a need to improve the rate of brain-dead organ donation in Canada through better identification and management of potential donors. We therefore encourage physicians, or-

ganizers of local organ donation programs and provincial agencies to participate in reviewing and improving guidelines on the management of severely brain-injured patients developed by the Canadian Council for Donation and Transplantation.

However, even if every potential brain-dead donor were identified and became an actual donor, the supply would be insufficient to meet demand.<sup>1</sup> Yet it has been estimated that if the number of living and brain-dead donors were increased and NHBDs were used, the waiting list could be eliminated within 5 to 10 years.<sup>1,2</sup>

Baran states that the “use of NHBDs is fraught with ethical and logistic problems.” However, similar difficulties were overcome when heart-beating, brain-dead donors were first used in transplantation.<sup>3</sup> Despite the challenges, the concept of brain death has now become accepted both clinically and legally,<sup>4,5</sup> allowing transplantation to occur today. The Canadian medical community cannot ignore a real opportunity to improve organ donation just because of ethical and logistic problems. We<sup>6</sup> and others<sup>7</sup> have identified the important issues surrounding non-heart-beating donation. It is now time to move forward. We hope that all Canadians, not just those who experience brain death, can have the option of organ donation as a part of standard end-of-life care.

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## Surgery in palliative care

As a surgical oncologist engaged in research that explores the relation between surgery and palliative care, I was very interested in Graeme Rocker and Daren Heyland's call for new research initiatives in palliative care in Canada.<sup>1</sup>

However, I was disappointed that the authors did not mention any surgical specialties. Surgeons frequently find themselves looking after dying patients, in both acute and chronic care settings, and interest in palliative care within the surgical specialties has been growing.

A permanent Taskforce on Palliative Care is now in place within the American College of Surgeons, with membership from a broad spectrum of surgical specialties, including trauma, critical care and oncology. The general surgical residency program at the University of Toronto has participated in a North American program designed to develop a curriculum in palliative care for residents. Questions on palliative care are part of the Royal College of Physicians and Surgeons of Canada qualifying examinations for general surgery. My colleagues and I have presented a variety