irreversible and we should never stop resuscitation. Contrary to the author’s presumption, ligation of the major cerebral vessels is not intended to replace circulatory death with brain death. As argued previously, the patient is already legally dead and any process thereafter is irrelevant, as death has already occurred. Thus, one may argue that the purpose of interrupting the re-establishment of major blood flow to the brain is exactly in line with the author’s view of the principle of double effect. The purpose is to respect patient’s autonomy, relieve any potential suffering, and follow the guiding principles of nonmaleficence as the process of brain death that has already started continues. Finally, as concerning as the eighth recommendation is, the seventh may be even more unusual. The Ethics Forum appears to have taken the position that direct procurement and perfusion is the preferred method of heart procurement in cDCD. To take this position without at least noting the potential advantages that are inherent in TA-NRP (lower primary graft dysfunction rate, fewer organ discards, ability to procure lungs, improved preservation of abdominal organs) is concerning to us and should be to others. A discussion about the ethics of TA-NRP is incredibly important, and we need to have it. Hopefully that can happen before it’s too late to stop the presses.

References

Commentary: At least we still have taxes

Ashish S. Shah, MD

The traditional certainty of death was first upended in the 1970s with the concept of brain death. While organ donation was predicated on the certainty of donor demise and the hope of using the otherwise-viable organs, the reality of what that actually looks like has been and may always be difficult. The first heart donors were patients who died: hearts stopped and then a rapid recovery of organs performed—sometimes with cardiopulmonary bypass. By the 1980s, brain-dead donors could have their organs recovered despite a beating heart. In this century, a potential pool of donation after circulatory death (DCD) donors resurfaced to meet the relentless
demand for transplantable organs. For lungs, livers, and kidneys, the rapid and somewhat disturbing process has been acceptable. However, a novel paradigm, to regionally resuscitate and mechanically reanimate the heart in situ has resurrected old fears. Does restarting the heart to allow for recovery and subsequent transplant fall within acceptable medical practice? Moreover, how should a civilized society define death so that others may live? Brain death in many respects was easy. There are objective ways to prove that brain function is irreversibly terminated. However, for a donor who may not be brain dead, the regional resuscitation platform essentially allows anyone to be a donor. Anyone. At any time. The multiple opinion pieces generated by ethics panels, professional societies, and professional medical ethicists focus on many of the relevant issues, and the current document nicely outlines key concepts. It does unfortunately stray from the intention to create a framework and into unrealistic recommendations. While not a global health issue affecting millions, there are deeply troubling and complex ideas that demand more thought and discussion, much more than current parties (physicians, patients, families, television producers) who have too much to gain from the growth of transplantation are really capable of. I would submit that any new framework really should include a reassessment of the legal definition of death internationally, clarify how one can be considered a potential DCD donor, and bring in the perspectives that don’t immediately gain from more transplants. This may include the general public after informed discussions about the true nature of DCD. Perhaps the other complicating feature of DCD heart recovery is that these organs may be superior to brain death–derived hearts—at least in the short term. Now, one can’t argue that there is an equivalent alternative, so we shouldn’t need to use reanimated DCD hearts. However, what should be clear to everyone is that the fate of these potential donors is certain. They will die. They will die with hearts, lungs, livers, and kidneys that can help others not die. We really don’t have the luxury of moratoriums and randomized trials.

Dr James Hardy, the visionary transplant pioneer, wrote “Organ transplantation was beset by ethical and moral questions from its inception... When you enter a swamp, don’t expect a paved road.” At least we still have the certainty of taxes.

References