**Table 2: Approach to managing waiting lists for cardiac catheterization**

- Comprehensive assessment of key baseline risk factors
- Thorough noninvasive provocative stress testing
- Optimization of medical therapy, including evaluation of clinical response
- Systematic monitoring of waiting list, with appropriate reclassification as required
- Audit, feedback and dissemination of waiting lists and times
- Seamless movement to percutaneous coronary revascularization at the time of angiography if appropriate or triage to surgical revascularization

in the evaluation of patients awaiting cardiac catheterization. Systematic monitoring that is open and disseminated, with audit and feedback driving timely and effective triage, is the preferred method for the engagement of high-quality professionals working among rationally distributed resources. Over 5 years ago, a Canadian Cardiovascular Society national consensus conference examined this issue and called urgently for a national registry to collect accurate prospective data on performance characteristics and waiting times.[10] Both that time and some patients have since expired: the book is overdue.

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# Organ and tissue donation in the intensive care unit

**Graeme M. Rocker,**
**for the Canadian Critical Care Society Working Group on Organ and Tissue Donation**

When patients will not survive (e.g., after severe head injuries), intensive care unit (ICU) teams face the challenge of conducting empathetic, honest and compassionate discussions about organ and tissue donation with grieving families. Sometimes we fail to approach all families and neglect to seek consent for organ donation in all eligible circumstances. In consequence, alternative ways to achieve improved rates of consent to organ and tissue donation within ICUs have been proposed. In the United States, for example, these initiatives include mandating representatives of transplant procurement organizations rather than ICU or hospital-based teams to interact with families at the time of death in the ICU. In Canada, other initiatives have resulted in provincial legislation that requires ICU physicians to provide outside agencies with details of patients nearing death — details that would traditionally remain confidential. This particular requirement has proved to be the most contentious for critical care specialists.

The irony is that ICU physicians are as committed as any to the concept of successful organ and tissue donation, but we act and must act in the interests of our patient — the potential donor in the ICU — and his or her family. Transplant surgeons and transplant organizations have



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concerns that understandably focus on other patients and on the increasingly lengthy transplantation waiting lists. These inherent differences are not irreconcilable. They simply underpin the need for our respective professional organizations to collaborate on all issues of organ and tissue donation and to do so in an atmosphere of understanding, mutual trust and respect.

To this end, the Canadian Critical Care Society (CCCS) has produced a position paper on organ and tissue donation that outlines how we should proceed with these issues. In January 2001, the CCCS created a working group selected on the grounds of clearly stated interest and expertise in organ and tissue donation. It comprised 2 ethicists, one health law expert, 2 members of the public (one representing a donor family and one, a recipient) and 8 ICU physicians from geographically diverse locations representing tertiary and community centres. The participants are listed at the end of this article. An executive summary of the position paper may be found on the Web site of the CCCS (http://www.canadiancriticalcare.org).

We strongly support collaborative initiatives to develop, implement and evaluate processes to increase organ and tissue donation within sound ethical and legal frameworks. We want the option of organ and tissue donation to be offered to all eligible families and to be considered as a standard component of quality end-of-life care in the ICU. We need to obtain accurate and meaningful data on current organ and tissue donation rates. We need to know how many patients become truly eligible organ donors (taking into consideration cultural diversity) and how many patients' families are approached and consent to organ donation. These data are much more pertinent and compelling than the number of organ donors per million population, and they allow for more appropriate comparisons within Canada and between Canada and other nations. The CCCS applauds attempts to improve organ and tissue donation rates through institutional quality improvement and educational endeavours.[1] We encourage a broad approach to address difficult societal and ethical issues such as conflict between a patient's previously expressed desire to become an organ donor and the subsequent wishes of family members. We point out in the position paper some flaws in current provincial legislation regarding mandatory reporting. We continue to recognize brain death as the sole criterion for cadaveric organ donation.[2] We do not currently support non-heart-beating donor (NHBD) protocols (currently accepted practice in the Netherlands and some North American centres) that are implemented after a cardiovascular death and require urgent instrumentation and manipulation of the body of the recently deceased.[3] We question whose interest this serves.[4] We do, however, call for far more detailed public and professional debate of issues such as NHBD protocols[5] and of concepts such as extending mechanical ventilation specifically for the purpose of organ donation.[6]

We expect challenges to our position paper. This is as it should be. We need healthy debate and effective collaborative national initiatives. We are delighted that such initiatives are underway and gaining momentum (e.g., the formation of the Canadian Council for Organ Donation and Transplantation). Meanwhile we recognize that organ transplant remains a gift and not a right. Until this changes — if society ever mandates such a change — our focus in the ICU remains on achieving outcomes of quality for lives preserved[7] and, for patients who will not survive, the best possible death.[8] Within the context of aiming for excellence in end-of-life care, we are committed to the collaborative goal of optimal organ and tissue donation rates.

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