

Only 391 such transplants were performed in Canada in 2002, representing 30% of all kidney transplants.³ 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.⁴

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.

Dana Baran

Associate Professor
Faculty of Medicine
McGill University
Montréal, Que.
Medical Director, Québec-Transplant

References

1. Knoll GA, Mahoney JE. Non-heart-beating organ donation in Canada: Time to proceed? [editorial]. *CMAJ* 2003;169(4):302-3.
2. Morin JE, Baran D, Dandavino R, Marleau D, Naud A, Cloutier R. *Les donneurs potentiels d'organes dans les hôpitaux du Québec année 2000. Rapport du Comité de transplantation*. Montréal: Collège des médecins du Québec; 2003. Available: www.cmq.org/uploadedfiles/transplantation%20FINAL.pdf (accessed 2004 Jan 5).
3. Canadian Organ Replacement Register [quarterly statistics]. Ottawa: Canadian Institute for Health Information; 2003. Available: secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=services_corr_e (accessed 2003 Oct 2).
4. Transplants by donor type [table]. In: National data, Organ Procurement and Transportation Network [online]. Richmond (VA): Organ Procurement and Transportation Network; 2003. Available: www.optn.org/latestData/rptData.asp (accessed 2003 Oct 2).

[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.¹ 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.^{1,2}

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.³ Despite the challenges, the concept of brain death has now become accepted both clinically and legally,^{4,5} 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. We⁶ and others⁷ 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.

Greg Knoll

Department of Medicine

John Mahoney

Department of Surgery
University of Ottawa
and The Ottawa Hospital
Ottawa, Ont.

References

1. Sheehy E, Conrad SL, Brigham LE, Luskin R, Weber P, Eakin M, et al. Estimating the number

of potential organ donors in the United States. *N Engl J Med* 2003;349:667-74.

2. Terasaki PI, Cho YW, Cecka JM. Strategy for eliminating the kidney shortage. In: Cecka JM, Terasaki PI, editors. *Clinical transplants 1997*. Los Angeles: UCLA Tissue Typing Laboratory; 1998. p. 265-7.
3. Cecka JM. Donors without a heartbeat. *N Engl J Med* 2002;347(4):281-3.
4. Lazar NM, Shemie S, Webster GC, Dickens BM. Bioethics for clinicians: 24. Brain death. *CMAJ* 2001;164(6):833-6.
5. Dossetor JB. Death provides renewed life for some, but ethical hazards for transplant teams [editorial]. *CMAJ* 1999;160(11):1590-1.
6. Knoll GA, Mahoney JE. Non-heart-beating organ donation in Canada: Time to proceed? [editorial]. *CMAJ* 2003;169(4):302-3.
7. *Non-heart-beating organ transplantation: medical and ethical issues in procurement*. Washington: Institute of Medicine, National Academy Press; 1997.

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.¹

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