(including the brain stem) during procurement circulatory support will not fulfill the "dead donor rule."[7,8] It may be necessary to abandon the dead donor rule to permit the recovery of transplantable organs after cardiocirculatory death.

Mohamed Y. Rady
Department of Critical Care Medicine
Joseph L. Verheijde
Department of Physical Medicine and Rehabilitation
Mayo Clinic Hospital
Phoenix, Ariz.
Joan McGregor
Bioethics, Policy and Law Program
School of Life Sciences and Department of Philosophy
Arizona State University
Tempe, Ariz.

REFERENCES

1. Shemie SD, Baker AJ, Knoll G, et al. Donation after cardiocirculatory death in Canada. *CMAJ* 2006;175(8 Suppl):S1-S24.
2. Adhiyaman V, Sundaram R. The Lazarus phenomenon. *J R Coll Physicians Edinb* 2002;32:9-13.
3. American Heart Association. Management of cardiac arrest. *Circulation* 2005;112:IV58-IV66.
4. Institute of Medicine Committee on Non-Heart-Beating Transplantation II. *The scientific and ethical basis for practice and protocols. Executive summary.* Washington (DC): National Academy Press; 2000.
5. Magliocca JF, Magee JC, Rowe SA, et al. Extracorporeal support for organ donation after cardiac death effectively expands the donor pool. *J Trauma* 2005;58:1095-1101.
6. Younger JG, Schreiner RJ, Swaniker F, et al. Extracorporeal resuscitation of cardiac arrest. *Acad Emerg Med* 1999;6:700-7.
7. Menikoff J. The importance of being dead: non-heart-beating organ donation. *Issues Law Med* 2002;18:3-20.
8. Bernat, J.L. Are organ donors after cardiac death really dead? *J Clin Ethics* 2006;17:122-32.

DOI:10.1503/cmaj.1060217

Breaking bad news

I thank medical student Nir Lipsman for his insightful and touching article on the hospital's Family Room.[1] This room is usually spoken of, if at all, in hushed and sometimes reverent tones, and when one meets with family members and loved ones there, one is generally met with emotions at the polar ends of the emotional spectrum. The physician's information will lead to either complete devastation or utter elation; there is rarely a reaction in between these extremes.

Attending physicians can learn from Lipsman's advice to avoid dancing around the truth, something I have seen happen far too often. When I informed a Family Room full of people that their loved one in the intensive care unit would be paralyzed from the neck down for life, I was met not with sobs and grief, but with questions: "What is the next step? What can we do to help? When can he come home to live with us?" Like Lipsman, I never cease to be amazed by the strength and resilience of these families.

Jeff Blackmer
Executive Director, Office of Ethics
Canadian Medical Association
Ottawa, Ont.

REFERENCE

1. Lipsman N. The family room. *CMAJ* 2007;176(3):354.

DOI:10.1503/cmaj.1070026

Staffing levels in long-term care facilities

In their recent *CMAJ* commentary,[1] Kimberlyn McGrail and associates correctly noted that in British Columbia private and not-for-profit providers of long-term care have different staffing levels at their sites. However, these differences are driven not by type of ownership but by health authority funding level. Funding varies from $130 to $190 per day for each resident even though the facilities care for the same types of clients requiring complex care. With such a wide range in funding, it is expected that there would be differences in staffing levels.

The authors also state that the aggregated superiority of the not-for-profit sector in hospital admission rates was driven by "not-for-profit facilities that were attached to acute care hospitals, were amalgamated to a health authority or had more than one site." Sites that are owned and operated by health authorities have an advantage over stand-alone private and not-for-profit facilities in that they have access to additional staff.

We would expect that the ratio of staff to patients would have an impact on quality of care; the role of government should be to determine an adequate funding level for the desired staffing ratio and then to provide it to all sites, regardless of whether they are run by for-profit or not-for-profit agencies.

Ed Helfrich
Chief Executive Officer
BC Care Providers Association
Vancouver, BC

REFERENCE

1. McGrail KM, McGregor MJ, Cohen M, et al. For-profit versus not-for-profit delivery of long-term care. *CMAJ* 2007;176:57-8.

DOI:10.1503/cmaj.1070025

[Two of the authors respond:]

We are in agreement with many, but not all, of Ed Helfrich's points concerning our commentary.[1] First, he acknowledges that there are differences in staffing levels between for-profit and not-for-profit long-term care facilities in British Columbia, something that we and others have found to be true.[2,3] However, in saying that the prime reason for these differences is the variation in the amount of funding given to different types of facilities that care for similar patients, Helfrich describes the current situation, whereas the study we referred to in our commentary was based on data from the mid to late 1990s, before the complex-care patient designation was introduced. Variation in current funding levels cannot be the reason for the differences in quality of care found in that study.

Second, Helfrich argues that the better performance of facilities operated by health authorities must be driven by those facilities' access to additional staff. This is precisely the point of our commentary. Surely it is quite feasible that different forms of ownership imply different types of access to resources; the important question is whether those resources make a difference. Do multisite not-for-profit facilities do better than single-site facilities because they can share the costs of developing policies and care practices? Or is it because they can share the costs of specialized staff, such as nurse geriatri-