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CORRESPONDENCE

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"No-touch" period: no benefit for donors, high cost for recipients

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A response to these comments can be found at: doi:10.1007/s00134-014-3976-x.

Dear Editor,
Zamperetti et al. discuss the ethics of organ procurement in the setting of controlled donation after circulatory determination of death (cDCDD) [1]. A pressing issue that they do not address is the appropriateness of using mere permanence versus irreversibility of circulatory cessation as the criterion of death. The difference is that permanence is based on the clinical decision of not resuscitating the circulation and not on physiologic irreversibility per se [2]. The authors question how long should the "no-touch" period be. This is problematic since if we require irreversible circulatory cessation, the waiting period becomes prohibitively long. On the other hand, if we are satisfied with permanence of cessation, the waiting period is simply arbitrary; as the authors nicely phrase it, "we have to choose a shade of violet after which organ retrieval is allowable". This arbitrariness is reflected by the variable waiting periods across different countries and hospital protocols all the way from 75 s in Denver, Colorado to 20 min in Italy [3]. So, do we offer a service to the donor by waiting longer? Is waiting longer necessary in order to treat the donor as an "end in itself"? If the answer is no, then is a waiting period necessary at all?

Remember that in voluntary cDCDD: (1) The donor has been consented (often via surrogates) and so donation is the way to respect the donor's autonomous will, and (2) The patient will undergo withdrawal of artificial support and inevitably die, regardless of donation or not. The obvious objection here is that without a waiting period, we would be violating the dead donor rule (DDR). But if we are respecting the autonomy of the donor in the face of her/his inevitable death, and we are minimizing harms by performing the procurement under general anesthesia and by respecting patient and family's end-of-life preferences, it is hard to see how devotion to the DDR adds anything of moral significance.

The authors argue that waiting for 5 min is better than 2 min because a 5-min period ensures both confirmation of a spontaneously irrecoverable dying process and offers families sufficient time with their deceased. These reasons though are not convincing, since waiting for 5 min does not ensure irreversibility; many patients may achieve return of spontaneous circulation (with resuscitative efforts) after 5 min of arrest. The 5-min period is based on the same criterion as the 2-min period, which is again permanence of cessation and thus offers no greater moral justification. Also, it is hard to accept that three extra minutes can make a large difference for grieving families. It follows that not only the 20-min waiting period is too long but also the 5-min period is too long. I agree with the authors that in the absence of strong moral reasoning we ought to focus on efficiency in order to avoid unnecessary prolongation of ischemic organ damage; thus, I would argue that the way to achieve this is not to shorten the "no-touch" period but to abolish it.

Compliance with Ethical Standards

Conflicts of interest Christos Lazaridis is the sole author and reports no conflicts of interest in relation to this manuscript. No funding has been received in relation to this manuscript. No reprints will be ordered.

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