

Rebuttal From Dr DeCamp et al

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James et al¹ claim normothermic regional perfusion (NRP) does not violate ethical principles underlying organ procurement. They insist *pronouncement* of death, biologic reality notwithstanding, is what makes someone dead and that this declaration is sufficient to permit organ procurement. They misunderstand and misapply basic ethical principles and US law.

Others recently have described how NRP violates US law.² However, James et al¹ suggest NRP is no different than standard donation after circulatory determination of death (DCD). Their text proves our point by describing, yet not acknowledging, the morally salient differences between standard DCD and NRP. Instead of using cold perfusate before explantation, NRP restarts the circulation of warm blood that stopped moments before. Recognizing the alarming fact that this will restart brain circulation, active steps are taken to ensure brain death, improperly shifting lanes from circulatory death to brain death. But brain death could not possibly be

declared based on the timeframe and existing requirements for doing so.³

The technical details of NRP can obfuscate the straightforward point that a person is not dead based solely on a declaration. Consider a counterexample: In standard DCD, after a 5-min “hands-off period,” death is *declared*. But what if, just before explantation, autoresuscitation occurs, and the heart restarts (a known phenomenon⁴)? Would explantation proceed? It should not. Was this patient dead, then raised from the dead? No. What happened proved the prior declaration wrong. The patient was not dead. Restarting circulation invalidated the prior declaration of death. Likewise in NRP.

James et al¹ not only misstate the dead donor rule but also misapply beneficence and nonmaleficence; the donor’s best interests must be promoted and harm avoided. Even if the donor were dead, interests persist after death.⁵ How else can we explain honoring wills or burial wishes or placing limits on what can be done posthumously (eg, restrictions on research or practicing medical procedures like intubation)?

Setting aside whether a donor/surrogate actually gives fully informed consent for NRP, consent alone cannot justify NRP. We too recognize the laudable act of organ donation, but it must be achieved ethically and legally.

Doing only what the donor wants confuses autonomy with beneficence; autonomy has limits, and the ends do not justify the means.⁶ Asserting that beneficence requires doing anything and everything to maximize the number of organs through NRP reveals its absurdity: it would justify the taking of organs from any deceased individual, no matter their wishes or consent.

Transparency is key to trust, yet James et al¹ make no conflict-of-interest disclosures for their Counterpoint. The New York University website says funding for their transplantation ethics and policy program is from a company that is devoted to expanding organ availability.⁷ Transplantation physicians coauthor their ethics articles, which raises questions regarding real and/or perceived influence over ethical assessment. Independent ethical

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assessment is needed that includes, but is not dominated by, the transplantation community.

NRP is legally problematic, and the misunderstanding and misapplication of ethical principles to attempt to justify it can do harm to patients and public trust in organ transplantation.

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