

Cultural, religious and social aspects

PP01

WHAT SHOULD BE PRIORITIZED IN CANADIAN TRANSPLANTATION RESEARCH? RESULTS: OF A NATIONAL SURVEY

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Background: Involving patients in setting research priorities has been acknowledged as a way to enhance the quality, relevance and transparency of medical research. The aim of this study was to gather the views of Canadian researchers, healthcare professionals (HCPs), patients and caregivers on research priorities within the Canadian National Transplant Research Program (CNTRP). Methods: Transplant patients, candidates, caregivers and researchers were invited to attend a pilot workshop focused on key areas of uncertainty in the field of organ donation and transplantation. Following this workshop, a national web-based survey was developed to elicit the viewpoints of the wider Canadian transplant community. The survey, which included closed- and open-ended questions, was administered from April to July 2015. Descriptive statistical analyses were performed, and a qualitative content and thematic analysis was used for the open-ended questions. Results: A total of 505 people completed the survey: 40.4% patients, 24.9% caregivers and 34.7% researchers and HCPs. The following five research topics were identified as the most important: (i) how to manage psychological complications such as depression or anxiety (72.9%); (ii) the impact of presumed consent on organ donation (63%); (iii) how to increase the number of organs available for transplantation (62.6%); (iv) how to manage long-term medical complications of transplantation (58.6%); and

(v) how to develop tolerance in organ transplantation (57.2%). Conclusion: This is the first survey to explore research priorities in organ transplantation in Canada. The Results: will inform the discussion at a national workshop on patient engagement within the CNTRP, thus enabling the development of a Canadian patient-oriented research strategy in organ transplantation and donation.

PP02

WHY BADLY TREAT WHAT YOU CAN WELL PREVENT?

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Transplantation is one of the medical activities with more expectation of success. For patients with end stage renal disease, kidney transplantation provides a better quality of life compared with those on dialysis, even for those with advanced age or co-morbidities. Greater access to food since the Second World War, high exposure to chemical and toxic, associated with changes in lifestyles, increased diabetes, hypertension, obesity, cardiovascular disease, chronic renal failure and transplantation demands. The dream of replacing damaged parts in the human body materialized with the transplants, but the hope in transplantation reached much higher levels than the actual results deserve. The transplant was used as flags of technical and scientific differentiation and success. Nonetheless transplantation was faced with shortage of organs and increased demand. The claim to the right to treatment quickly was confused and understood as the right to transplantation. This distortion of values and rights created pressures on the medical profession and at the political level. The notion of time on list awaiting transplantation gained weight over the biological and medical criteria. The emergence of potent immunosuppressive agents and the increasing use of plasmapheresis has allowed allocations of kidneys less HLA compatible, with short-term satisfactory effects, although more costly to healthcare systems. Overall evaluation of indirect costs of these increasingly expensive medications and their effects on long-term (new diseases and apparently unrelated deaths with a functioning kidney) are still missing. Campaigns for living donors still not have the necessary impact. Organ commerce and trafficking have proliferated with bad results both to donors and recipients. So, for the best use of a scarce public good, we should: 1. Change allocation rules in

order to achieve more efficiency in transplantation, increased patient and organ survival, fewer side/secondary effects and lower costs. 2. Study better causes that lead to chronic diseases and transplantation, as well as the pharmacogenetic profile of patients. 3. Create prevention and education measures for the health of the population, including control of hypertension, obesity and diabetes and personalize medication by pharmacogenetic profile. 4. Create a European program of vigilance of those diseases and promote new lifestyles to prevent illness and promote health reducing the need for transplantation. The claim to the right to transplantation must be replaced by the claim to the right to health.

PP03

KNOWLEDGE AND ATTITUDE OF JUNIOR INTENSIVISTS TOWARD ORGAN DONATION AND ORGAN DONOR MANAGEMENT – SURVEY OF A SINGLE INSTITUTION

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Introduction: Solid organ transplantation is one of the best, if not the only, life-saving treatment for patients with organ failure. In Singapore, the waitlists of solid organ patients, except for the kidney, have increased gradually over the last decade. This happened despite the introduction of the presumed consent system governed by the Human Organ Transplant Act (HOTA) in 1987 and the Medical (Therapy, Research and Education) Act in 1972. However, a fast aging population and low donation rates continue to worsen the situation. In 2013, the deceased donor rate was at 5 per million population (pmp). This rate is sadly lower than that of European countries of similar population sizes like Denmark (10.4 pmp) or Finland (17.8 pmp) in 2013. One proposed solution to this problem is to garner support from healthcare professionals, particularly intensivists who play a key role in the donation process. In this study, we investigated the knowledge and attitude of junior intensivists toward organ donation and organ donor management in a major public hospital providing the most comprehensive healthcare services in Singapore. **Method:** The study was based on a voluntary survey in Singapore's largest tertiary hospital, Singapore General Hospital. Participants approached comprised of mostly medical officers/residents from anaesthesiology, internal medicine, cardiothoracic surgery, general surgery and neurosurgery. Most would have worked in one of the Hospital's intensive care units (ICU) before (Surgical ICU, Medical ICU, Cardiothoracic ICU and Neuro ICU.) The questionnaire comprised of five sections, asking for participants' de-

mographic information, knowledge of organ donation legislation, personal attitude toward legislation and donation, knowledge about donor management and personal preference of donor management. Descriptive tests were used to analyse the answers of the questionnaire. Results: Please refer to the table. Conclusions: Despite the personal beliefs of many junior intensivists to donate their organs, the majority was not familiar with local organ donation laws. This may indirectly hamper their clinical practice when talking to relatives of patients regarding organ donation. To increase buying in from the intensivists, we need various supports from hospital management such as an institution approved protocol for donor management and training opportunities to increase the knowledge and confidence of junior doctors in communicating to potential donors' next-of-kin about brain death diagnosis and obligatory organ donation.

PP04

REJECTING ORGAN DONATION – A TYPOLOGY OF RELUCTANCE

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Background: In Germany, a significant discrepancy between expressed positive attitudes towards organ donation and active willingness to donate one's organs after death is constantly stated. Current legal changes as well as media campaigns are based on this assumption and thus aim to increase the willingness to donate by targeting potential donors and appeal them to 'save lives' through their donations. **Aim:** Our presentation focuses on a better understanding and differentiated characterization of those who are uncertain or skeptical about organ donation. We assume that reluctance to donate organs is based on different reasons of 'saying no' to organ donation and discuss them as forms of reluctance. **Method:** Based on qualitative social research, we explore if and how skepticism about organ donation can be expressed and enacted against the background of moral imperatives pro donation. So far we conducted nine focus groups and ten interviews (different socio-economic background/54 participants all included) with those who are skeptic or reluctant regarding organ donation. **Results:** Four types of reluctance to organ donation can be identified: (a) The no-killing-position indicates that the brain-death is not the definite death of human beings and thus the current practice of organ donation is comparable to homicide. (b) The information-deficit-position refuses to take decisions under uncertainty and claims that true decisions can only be made if all consequences can be foreseen. (c) The mistrust-position rejects organ do-