

JOURNAL WATCH



INTRODUCTION

Welcome to the August 2026 edition of the ISODP Journal Watch.

In this edition, we have tried to draw out what we find interesting, question assumptions where warranted, and leave readers with something to think about. This reflects how we see research itself: not as a finished article, but as an ongoing act of critical reflection, where the value of any paper lies as much in the next hypothesis and research question it prompts as in the answers it offers. That is how the field keeps advancing, and how we all advance with it.

If a single thread runs through this edition's selection, it is one of the oldest and most consequential questions in our field: what do we mean by death, and how do we determine it? The papers gathered here approach that question from every direction, from donor biology and transplant outcomes, through law and international consensus, to the conversation that finally matters most: the one at the bedside with a grieving family.

We open at the circulatory end of the spectrum, with a study that challenges a piece of DCD dogma that has gone largely unquestioned for decades – that a shorter time to asystole is always better – and in doing so uncovers a more intriguing signal at the opposite end of the curve, where very rapid progression may identify a biologically distinct group of donors. From there we turn to the neurological determination of death, where the UK's first major revision to its Code of Practice in 17 years has prompted two complementary papers: one on what has changed and how to apply it, and another on how those criteria have acquired legal authority and where uncertainty still remains.

The collection then widens to practice and ethics. From Japan comes an unusually detailed look inside one of the world's most distinctive donation systems, with a lesson that unsettles easy assumptions: the hospitals doing more donation were not faster, but more multidisciplinary, more experienced, and apparently more successful. A systematic review asks why, two decades on, the same ethical concerns about DCD keep returning. Are these concerns barriers to overcome or enduring tensions that mature systems must learn to manage?

The final papers take that question to the international stage. Two Bucharest ESOT consensus papers ask how much of controlled DCD practice the world can actually agree on, and whether global consensus can do more than identify broad common ground between different donation systems.

We close where it all begins, and where all our efforts as donation professionals are put to the test. A study working with families rather than clinicians arrives at a quietly profound reframing: that families asked to accept a determination of death using neurological criteria may need less a transfer of knowledge than a transfer of trust, and that the most important tool remains the clinician who knows the words, uses them consistently, and has practised how to explain death.

As always, we hope these papers inform, provoke and occasionally unsettle. We welcome your thoughts and correspondence.

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Donor Time to Death and DCD Liver Transplant Outcomes: Challenging the Dogma That Shorter Is Better

Amarnath, Dharesh Raj et al.

Transplantation Direct, February 2026

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This study examines an assumption that has shaped controlled DCD practice for decades: that the longer a patient takes to die following withdrawal of life-sustaining treatment (WLST), the greater the risk of organ injury and the worse the transplant outcome.

A terminology problem comes first. The authors use “time to death” (TTD) to describe the interval from WLST to mechanical asystole. But asystole is not death. In DCD, and modern medical practice, death is determined only after a required period of absent circulation. In a field where the distinction between circulatory arrest and death is fundamental, this terminology lacks scientific precision. **Time to asystole** would be more accurate.

Using US registry data, the authors studied 8,489 DCD liver recipients and more than 41,000 potential DCD donors. They found no evidence that prolonged time to asystole was associated with worse post-transplant outcomes, whether or not normothermic regional perfusion (NRP) was used.

Yet liver utilisation fell rapidly once the interval exceeded 10–15 minutes. The authors estimate that, had livers from donors reaching asystole at 15–30 minutes been considered in the same way as those reaching asystole within 10 minutes, utilisation might have increased by 17.1%.

This is a striking finding. Why should 15 minutes matter? The outcome data provide no evidence that livers are harmed simply because asystole occurs beyond this point, yet utilisation falls sharply. The apparent threshold may therefore tell us more about clinical decision-making and established practice than about donor biology.

But we in the donation community all knew that anyway. A more intriguing finding in the paper lies at the opposite end of the curve.



Livers from donors who progressed very rapidly to asystole had worse graft survival. The authors hypothesise that some may represent patients with severe brainstem injury who might otherwise have progressed to donation after brain death. Their focus on the brainstem is unnecessarily narrow. The systemic consequences relevant to donor organ injury arise from severe brain injury and its progression, not simply injury to the brainstem.

A broader and perhaps more interesting hypothesis is that very rapid progression to asystole identifies a subgroup with particularly severe brain injury. Such donors may combine the systemic consequences of devastating brain injury with the additional warm ischaemia-reperfusion injury of the DCD pathway.

This is biologically plausible—but it was not tested. The study cannot tell us how severe the brain injury was, whether neurological determination of death had been considered or attempted, or whether the proposed mechanism explains the observed association. If very rapid progression to asystole identifies a subgroup exposed to the systemic consequences of severe brain injury, should these DCD donors be considered for methylprednisolone before withdrawal, much as is routine in DBD donors?

The NRP findings add another layer. Following super-rapid recovery, short time to asystole was associated with worse transplant outcomes. With NRP, it was instead associated with lower liver utilisation. The authors suggest that NRP may allow these injured livers to be identified through viability assessment and therefore not transplanted. Again, this is an interesting hypothesis rather than a demonstrated mechanism.

The study therefore raises a more interesting question than simply whether prolonged withdrawal-to-asystole intervals are safe: do some very rapidly progressing DCD donors represent a biologically distinct donor phenotype, perhaps closer to the DBD population, in whom severe brain injury and the DCD pathway combine to produce a dual insult? If so, could interventions used routinely in DBD donor optimisation have a role before withdrawal in this subgroup of DCD donors?

That hypothesis now deserves testing.



Diagnosis of Death Using Neurological Criteria in Adults

Jain, Priyanka; Barrass, Lynne; Gardiner, Dale

BJA Education, May 2026

Journal of Anesthesia, Analgesia and Critical Care, November 21, 2025

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The UK criteria for diagnosing death: what has changed and where to find the resources.

In January 2025, the UK introduced its first major revision to the national Code of Practice for the Diagnosis and Confirmation of Death in 17 years. Two recent papers provide complementary guides to what has changed. One focuses on the practical application of neurological criteria; the other places the new Code within the wider clinical and medicolegal development of the UK definition of death.

For readers seeking to understand what has changed and how to apply the new criteria, Jain and colleagues provide a practical clinical guide (full disclosure: DG was one of the authors and co-chaired the working group that produced the Code of Practice).

The UK retains one definition of death: the permanent loss of the capacity for consciousness combined with the permanent loss of the capacity to breathe. However, several important aspects of how death is diagnosed have changed.

“Irreversible” has been replaced by “permanent”, bringing the language closer to clinical reality and international consensus.

The Code also makes explicit a principle that is sometimes poorly understood: there is only one definition of death, but three sets of diagnostic criteria: somatic, circulatory and neurological. Each establishes the permanent cessation of brainstem function and therefore satisfies the same definition of death.

Many diagnostic requirements in the updated Code have also been deliberately aligned with international practice, including the apnoea test targets, minimum temperature and greater use of ancillary investigations.



The Code also changes the UK's previous anachronistic practice of retrospectively recording the time of death as the completion of the first set of neurological tests. Two sets of neurological tests, including two apnoea tests, remain mandatory in the UK. Death is now recorded once all relevant diagnostic criteria have been met, typically after the second set of tests, unless ancillary investigations are required following clinical testing. Other changes include adult criteria applying from 2 years of age, clearer guidance following hypothermia, and much greater attention to difficult situations such as residual drugs, decompressive craniectomy, high cervical cord pathology and isolated posterior fossa lesions.

Unfortunately, the Jain paper is currently behind a paywall.

Scott and Thomas, however, provide a freely available companion paper. They trace how successive UK Codes of Practice have become woven into the common law definition of death, from Malcherek and Bland through to recent challenges involving death diagnosed using neurological criteria.



20th - 23rd October 2027





Dear Organ Donation Colleagues,

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- **Anthony Clarkson,**
Director of Organ and Tissue
Donation and Transplantation, UK



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The Code of Practice 2025 and the Medicolegal Definition of Death in the UK

Scott, Liam; Thomas, Ian

BJA Education, March 2026

Corresponding author: Liam Scott- liam.scott@nbt.nhs.uk

Importantly, the 2025 Code itself has already been accepted by the UK courts as the current authoritative medical standard. The High Court also specifically commended the Academy's lay summary as "accessible" and "sensitive", encouraging clinical teams to make families aware of it.

One question remains unresolved: whether consent is legally required before testing for death using neurological criteria. The Code does not require consent, but the issue has never been definitively determined by the UK courts. Scott and Thomas conclude that discussion and agreement with families remains best practice, while significant disagreement would probably require legal resolution. On at least two occasions, UK courts have directed doctors to carry out neurological death testing.

The two papers are best read together: one explains what has changed and how to apply the updated criteria; the other explains how those criteria have acquired legal authority and where uncertainty remains.

But the papers are not the end of the story. The full 2025 Code is freely available from the Academy of Medical Royal Colleges, together with a lay summary for patients, families and the public. The College of Intensive Care Medicine also provides practical implementation and educational resources, including the nationally endorsed testing forms and stabilisation for testing aid.

Further resources:

Academy of Medical Royal Colleges — 2025 Code of Practice and supporting resources, including the lay summary ([Link here](#))

College of Intensive Care Medicine — Diagnosing Death Using Neurological Criteria ([Link here](#))



Institutional Variability in Brain-Dead Organ Donation Processes and Practices: A Multicenter Cohort Study

Yumoto, Tetsuya; Naito, Hiromichi; Hayakawa, Mineji; et al.

Critical Care Medicine, June 2026

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Slower, more multidisciplinary, more successful? Lessons from organ donation in Japan

At the end of last year, ISODP 2025 brought the international donation community to Kyoto. Japan's distinctive donation system and the wider challenges facing donation across Asia ran throughout the Congress programme. Yumoto and colleagues now provide a rare look inside that system.

Their multicentre study examined 204 donors after brain death from 16 Japanese hospitals between 2010 and 2023, accounting for more than one fifth of all Japanese donors after brain death during the study period. The authors compared five highly active hospitals with 11 moderately active hospitals to ask a deceptively simple question: what do hospitals that donate more actually do differently?

The context matters. Japan has one of the lowest deceased donation rates among developed countries. There is no mandatory referral system, and legal determination of death using neurological criteria takes place only when organ donation is intended. Although more than 900 institutions are designated to facilitate donation after brain death, around half were not fully prepared to do so, most commonly because of limited staffing or the absence of local protocols.

The findings challenge some easy assumptions.

The more active hospitals were not faster. The median time from admission to family consent was eight days, compared with five days in moderately active hospitals. Time to organ recovery was also longer, at 12 days compared with nine.

The clearest difference was organisational. Highly active hospitals held a median of two multidisciplinary meetings during the donation process. Moderately active hospitals held none. In a 2023 subanalysis, just over half of families presented with the option of donation in highly active hospitals proceeded to donation, compared with around a quarter in moderately active hospitals.

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What, then, does “efficient” organ donation actually look like?

Donation systems often focus on speed, referral triggers and reducing delay. All are important. But this study suggests that greater donation activity may also be associated with something less easily measured: hospitals taking time, bringing professionals together and developing organisational experience around complex decisions.

The study cannot show that multidisciplinary meetings caused higher donation activity, and it includes only patients who ultimately became donors. Even so, it provides an important counterpoint to the idea that lower donation rates are explained mainly by national culture, religion or public attitudes. Of Japan’s 906 institutions designated to undertake donation after brain death, more than two thirds had no DBD cases during the 13-year study period. Institutional readiness, clinical engagement and local practice may matter just as much.

For those who joined ISODP in Kyoto, this paper provides data behind many of the questions discussed at the Congress. For those who did not, it offers an unusually detailed window into one of the world’s most distinctive donation systems.

Perhaps the most interesting lesson is also the simplest. The hospitals doing more donation were not necessarily quicker. They were more multidisciplinary, more experienced and, apparently, more successful.

[Link to ISODP 2025 Kyoto](#)



Ethical Tensions and Professional Attitudes Toward Circulatory Death Organ Donation in the ICU: A Systematic Review

Grossi, Alessandra A.; et al.

Intensive Care Medicine, September 2026

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Twenty years of DCD. Why do the same concerns keep coming back?

Donation after circulatory death (DCD) has changed enormously over the past two decades. In several countries, it has moved from a relatively unusual practice to a major source of deceased donor organs. Clinical practice, professional guidance and legal and ethical frameworks have all evolved.

So why do the same concerns keep coming back?

Grossi and colleagues reviewed 25 studies involving 3,878 intensive care professionals, published over a 20-year period and conducted across Europe, North America, Australia and Brazil. Yet despite broad overall support for DCD, the same concerns repeatedly emerged across different countries and over time: uncertainty about death determination, potential conflicts between withdrawal of life-sustaining treatment and donation, pressure created by procedural timelines, balancing end-of-life care with donation processes, gaps in knowledge, and the absence of clear protocols.

At first sight, the 20-year span is a major limitation. DCD practice today bears little resemblance to practice in 2005. Studies from different countries, different eras and very different donation systems are difficult to compare.

But perhaps the timespan is also the paper's most interesting finding.

Despite the expansion and increasing normalisation of DCD, similar concerns recur in studies conducted across two decades. The authors suggest that education, standardised protocols, institutional support and positive team culture can improve attitudes. Yet these are essentially the same solutions that have been proposed for years.

Why, then, do the concerns persist?

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One possibility is that education and protocols have simply not been implemented well enough. Another is that these concerns are concentrated among a minority of professionals and have been outweighed by broader professional support, allowing DCD to expand despite their persistence.

But there are other possibilities.

Perhaps research keeps finding the same concerns because it keeps asking the same questions. Perhaps some studies fail to distinguish concerns about DCD from wider tensions around withdrawal of life-sustaining treatment and end-of-life care. Or perhaps some ethical tensions are intrinsic to DCD itself.

Controlled DCD deliberately brings two legitimate processes into close proximity. One is the care of a dying patient following a decision to withdraw life-sustaining treatment. The other is the time-sensitive preparation for organ donation. Good systems separate the decision to withdraw treatment from the decision to donate, but they cannot completely separate the two processes that follow.

That may explain why concerns about timing, conflicts of interest, death determination and the quality of end-of-life care continue to reappear even in mature DCD systems. The answer may not be more education designed to make those concerns disappear. It may be to recognise that some tensions are real and require continuing attention, good safeguards and space for professional discussion.

The paper also leaves an important unanswered question. Have attitudes actually changed over time? The included studies span 20 years, but the evidence does not allow us to follow that evolution reliably. We know that DCD practice has transformed. We know that DCD activity has expanded. What we do not know is whether the concerns are becoming less common, changing in nature, or simply being repeatedly identified in different groups of professionals.

Perhaps the most useful conclusion is not that DCD still has a problem with professional attitudes. It is that successful expansion does not make ethical tension disappear.

Twenty years on, the same concerns keep coming back. The next question should be whether they represent barriers to overcome, safeguards to preserve, or enduring tensions that mature donation systems need to learn to manage.



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Seeking Global Agreement on Controlled Donation After Circulatory Determination of Death: Methodology and Definitions of the Bucharest International European Society for Organ Transplantation (ESOT) Consensus

Martin, Dominique E.; et al.

Transplant International, May 2026

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Can the world agree on how to do controlled DCD?

In October 2024, the European Society for Organ Transplantation (ESOT) brought an international group of donation and transplantation professionals to Bucharest with an ambitious aim: to see how much of controlled DCD practice the world could actually agree on.

Although ESOT-led, this was not simply a European consensus. Experts from across Europe were joined by colleagues from Australia, Canada, the United States, Latin America, Asia and Africa. Four groups considered adult and paediatric DCD pathways, normothermic regional perfusion and the determination of death.

The meeting itself was fascinating. Whether the resulting consensus papers will change practice is a harder question.

These two papers begin the larger body of work. The first explains the consensus process and establishes a common language. The second asks what good adult controlled DCD practice should look like. (Full disclosure: DG participated in the Bucharest meeting, organised a multinational role play on the DCD family approach, and was an author of the second paper.)

Language matters. The consensus recommends “donation after circulatory determination of death” (DCDD) rather than simply “donation after circulatory death”. The distinction is deliberate. There are not different types of death, but different ways of determining death.

Though it does raise the question of why every letter needs to be abbreviated. Why can’t donation after circulatory determination of death simply remain DCD? Go on, try saying DCDD five times in a row without twisting your tongue!

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Establishing Standards for Controlled Donation After Circulatory Determination of Death in Adults: The Bucharest International European Society for Organ Transplantation Consensus

Opdam, Helen; et al.

Transplant International, June 2026

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The adult consensus then moves from common language to common standards. Thirty-seven experts from 15 countries considered how controlled DCD programmes should identify potential donors, assess suitability, communicate with families, manage withdrawal of life-sustaining measures and approach interventions before death.

Some recommendations are deliberately strong. Donation opportunities should be routinely identified and communicated to donation professionals. Supportive treatments should be maintained until donation can be discussed or excluded. Treating clinicians should not unilaterally decide that a patient is unsuitable to donate. Programmes should also preserve opportunities for donation following neurological determination of death.

Yet the consensus is equally clear about the other side of the equation. Decisions to withdraw life-sustaining treatment must remain independent of donation. Patient comfort and dignity remain central. When choices about the timing or location of withdrawal affect the likelihood of successful donation, patients or families should be given the information and make an informed choice.

But how much of this did we not already know?

That is the difficulty with international consensus exercises. Agreement is easiest where recommendations are broad and already widely accepted. The genuinely difficult areas are often those where laws, ethical frameworks and established practices differ most, and where global agreement may be neither possible nor necessarily desirable.

Perhaps the greatest value of Bucharest was not finding statements on which 75% of experts could agree. It was bringing different donation systems into the same room and making their similarities and differences visible.

The consensus papers capture some of that common ground. Whether they move us closer to genuinely better practice remains to be seen. We hope so.

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Discussing Death by Neurologic Criteria in Pediatrics: Opportunities and Challenges for Families and Clinicians.

Wolfe Amy et al.

Pediatric Critical Care Medicine, June 2026.

Corresponding author: Amy H. J. Wolfe - ajones3@childrensnational.org

Explaining death: is it knowledge or trust that matters most?

Perhaps we should not be surprised that death using neurological criteria is poorly understood by the public. Even among healthcare professionals, direct experience may be limited. For families encountering it for the first time, the diagnosis can seem to conflict with what they see: a body that is warm, a chest that rises and falls, and a heart that continues to beat.

Wolfe and colleagues asked members of Patient and Family Advisory Councils at four US children's hospitals what families might need to help them understand death using neurological criteria. Thirty completed a survey and 55 participated in focus groups.

Baseline knowledge was limited, but the findings need careful interpretation. Half of the survey participants were familiar with the term "brain death", while only 8 of 30 recognised the newer term "death by neurologic criteria". Only 3 knew how the diagnosis was made, and only 8 understood the distinction between death using neurological criteria, coma and persistent vegetative state.

But does unfamiliarity with the term death by neurologic criteria necessarily mean unfamiliarity with the concept? Or does it partly tell us that the public still knows it by its older and more familiar name, brain death?

The participants proposed many sensible ways to help: clear and consistent explanations, empathetic communication, attention to cultural and religious needs, multidisciplinary support, credible information, infographics, videos of testing and peer support from others with lived experience. Trust ran throughout their responses. There is a danger, which the paper does not fully address, of starting from the familiar premise that poor knowledge explains difficulty with DNC and that the answer is therefore better information. But clinical experience points to something more subtle.

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Most families do not need a sophisticated understanding of brain physiology. Many seem able to grasp the core idea quite readily: when the brain is gone, the person has gone. And despite decades of literature demonstrating limited public understanding, actual objection to a diagnosis of death using neurological criteria remains remarkably uncommon.

So perhaps the key question is not: How do we transfer enough knowledge for families to understand DNC? but: How do we establish enough trust for families to accept that the person they love has died, despite appearances that seem to contradict death?

The transaction between clinicians and families may be less a transfer of knowledge than a transfer of trust.

This may also explain why allowing families to observe neurological testing can be so powerful. They are unlikely to leave understanding every technical detail of the examination. That is not really the point. They have seen the care, thoroughness and seriousness with which death was determined. They have witnessed the process they are being asked to trust.

Seen this way, many of the paper's findings take on a different significance. Different doctors saying different things erodes trust. Clinicians who appear uncomfortable or unpractised erode trust. Feeling rushed erodes trust. The close timing of conversations about death and organ donation may erode trust. Clear language, consistency, time and visible professional confidence help to build it.

None of this means information does not matter. Families need clear explanations and reliable resources they can return to. But information alone is unlikely to resolve the apparent contradiction of someone who does not look like our familiar image of death.

Perhaps that is why, despite widespread confusion in surveys, most families do accept a diagnosis of death using neurological criteria. They do not become experts in the diagnosis of death. They come to trust that the clinicians caring for the person they love know what death is, know how to determine it, and have done so properly.

The paper calls for better family toolkits. Those will help. But perhaps the most important tool is still the clinician who knows the words, uses them consistently, and has practised how to explain death.