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PLEASE INTRODUCE YOURSELF AND DESCRIBE YOUR JOURNEY TO BECOMING A PHYSICIAN AND MEDICAL DIRECTOR FOR ORGAN DONATION AND TRANSPLANTATION IN ONTARIO.

My name is Andrew Healey. I'm an organ and tissue donation physician, critical care physician, and university professor. I'm also the provincial medical director for organ and tissue donation at the Trillium Gift of Life Network (TGLN) and the chief of emergency medicine and ICU at St. Joseph's Healthcare in Hamilton. I've always known I wanted to be a physician, and I was lucky enough to get into medical school in Newfoundland, where I grew up. Initially, I was drawn to emergency medicine, and while practicing in Hamilton, I became interested in critical care. In 2007, during one of my rotations, I made a donation mistake: after a discussion with a patient's family about withdrawing life support, we did so, and he died. However, I never referred him for consideration for organ donation. I realized that I missed an opportunity for another patient and their family, and that people on the waiting list would die as a result of my mistake. This was unacceptable to me, so I became interested in learning how to improve the donation and transplantation system. Additionally, in 2008, my son was born with biliary atresia. He underwent a living-donor liver transplant from my wife, so I became determined to ensure the opportunity to donate is available for every family.

IN ONTARIO, HOW ARE ORGANS DISTRIBUTED TO PATIENTS, AND HOW IS PRIORITY DETERMINED?

For deceased-donor organ donation, the process begins with an individual who's unwell due to a specific disease, condition, or injury. They first go through a period of active care, then prognostication. If someone receives a negative prognosis, this means that they're not going to survive, or they've made a decision to proceed with medical assistance in dying, or to withdraw from life support. These patients are then approached by TGLN Specialists in Organ and Tissue Donation as potential donors. Once the process begins, the safety of the organ is assessed. Is the organ suitable for transplantation? Is there a risk of transmitting disease or cancer? If the organ in its current status is safe to transplant, then organ allocation to patients on the waiting list and recovery are organized. There's also an overarching, high-status system where people who have a sensitized immune system or who are very sick have access to organs in any province. One's position on the list depends on a variety of publicly available factors, mostly around acuity and how long they've been on the list.

WE SAW FROM RECENT STATISTICS THAT 90% OF ONTARIANS SUPPORT ORGAN DONATION; HOWEVER, ONLY 35% ARE REGISTERED DONORS. FROM YOUR PERSPECTIVE, WHAT ARE THE MOST SIGNIFICANT BARRIERS PREVENTING HIGHER DONATION RATES, AND WHAT STRATEGIES DO YOU BELIEVE CAN BE IMPLEMENTED TO OVERCOME THOSE BARRIERS?

There's a variety of things that relate to that statistic. For example, people don't want to think about their own death, so they don't proceed with registering their consent. It's also not a front-of-mind issue—even if they are willing to consider it; most assume they're not going to die tomorrow. There are also a lot of myths about registering as an organ donor. Some people think that they're less likely to have their life saved. This was explored by a large study in Ontario, which actually found that if you're a registered organ donor, you're more likely to survive a trauma than if you're not, though they are likely not causally related. We are always working very carefully to improve the eligible approach rate. This is important because some families are never approached. It's crucial to consider that in these moments of crisis, families are being asked to make a very difficult decision.

We can set people up to make an informed decision as health care providers by ensuring that they've built trust in the healthcare system, that they're well-rested, and that the conversation is taking place in a comfortable environment. We also have coordinator

communicate with families to decouple that conversation from the physician. We want to ensure that families are able to make the decision the patient would have made for themself—and that's the hardest thing we ask anybody to do in healthcare. Making a decision based on what you know of somebody else, especially if you haven't had that specific conversation, is very difficult. This is why it's so important to register your consent and to talk to your family about organ donation, as they are always going to be asked.

WHAT EXPERIENCES AS A PHYSICIAN INSPIRED YOU TO BECOME A CLINICAL PROFESSOR AT MCMASTER, AND WHAT CORE VALUES DO YOU BELIEVE ARE MOST IMPORTANT TO CULTIVATE IN STUDENTS INTERESTED IN EMERGENCY MEDICINE OR ORGAN DONATION AND TRANSPLANTATION?

My primary goal is to give people a new lens to examine complex adaptive problems within a complex system. I hope that people take away genuine curiosity from the fascinating opportunity that presents itself through donation and transplantation. It's an amazing thing that demonstrates the human spirit—this is a moment of absolute tragedy and profound loss, and somehow, at that moment in time, a family is able to say, "I'm going to be generous to another human being." What's remarkable is that from this goodness, others' lives are saved and touched forever. The most important skill that I could encourage people to cultivate is critical thinking. In the classroom, I'm attempting to create an environment where we hold each other through difficult conversations. This holding environment is like a cooking pot where students, teachers, and education come together. As we start to turn up the heat and ask difficult questions, we enter a zone where we're feeling a bit uncomfortable. From here, we have an opportunity to further explore the meaning of the cases we're talking about. That's my goal. As for emergency medicine, it's a crazy environment. However, this type of medicine is not defined by a disease or condition—it's defined by four walls. If you come into those four walls, I will help you. I went into emergency medicine because I wanted to be able to tell people who have a lump in their neck, "This is not cancer. This is going to get better with penicillin." I get to be there at that moment of relief. I also get to be there when it is cancer, and I can treat that person in their most terrible moments and be present for them. This is such a privilege: to be able to help people. It really drives everything I'm doing—in emergency medicine, critical care, organ and tissue donation, teaching, and leadership.

AS THE PROVINCIAL MEDICAL DIRECTOR FOR ORGAN DONATION IN ONTARIO, WHAT ARE YOU AND YOUR TEAM CURRENTLY WORKING ON? WHAT EXCITES YOU MOST ABOUT WHERE THIS FIELD IS HEADED IN THE NEXT 5-10 YEARS?

What's most exciting from a transplant standpoint is the care of the organ after recovery. I think that eventually, we will be able to take an organ out of the body, resuscitate it, and support it until it reaches the recipient in a way that's not necessarily time-dependent. This will likely have a huge impact on the logistics of organ donation by allowing transplants to be performed on a more predictable schedule. Normothermic regional perfusion is one of the things which we're collaboratively working towards to enhance donor safety while also providing blood flow to the organs in the abdomen. There's also a new type of heart donation that just came through, where we can offer heart donation after death by circulatory criteria. Another really exciting thing that has been implemented in the last year is something called, "The Donor Family Listening Post". This is where we give donor families the opportunity to answer questions that we have for them to help us identify and prioritize the most important things we can do to improve their experience. What most excites me about donation is the privilege I have of witnessing—or talking to those who bear witness to—the ultimate act of love and generosity at a time when families and