So far there has not been a complete definition of death that is acceptable to all, and there likely will not be. However, the discussion can be advanced by precision in thinking and acknowledgement of all the available data.

Declaration of interest
None declared.

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Reply from the authors
Editor—I thank Drs Hill, Evans, and Stadlan for their comments on our recent article.1

Sometimes it is necessary, as Dr Stadlan suggests, to seek to improve and strengthen the criteria and definitions clinicians use to diagnose human death. Likewise, it is sometimes necessary to question the current practices of organ donation, so that greater legal and ethical clarity can be found.2 The objections Drs Hill and Evans, both retired UK medical practitioners, have raised consistently over many decades, against neurological criteria for diagnosing death, appear to arise from a total rejection of organ donation, in any of its forms, living and deceased. In Dr Evans recent correspondence in the Journal of Medical Ethics, he concludes, ‘And it may be time to question the whole edifice of human organ transplantation—which depends upon abuse of the dying or harming the healthy’.3 While Drs Hill and Evans are entitled to their personal view, it is important we never forget the ethical, legal, and societal framework organ donation now operates in within the UK, which has been outlined throughout this BJA supplement on the Diagnosis of Death and Organ Donation.

In the UK, there is clear guidance on criteria to diagnose death by the Academy of Medical Royal Colleges,4 Department of Health guidance establishing the legality of donation after circulatory death (DCD),5 an independent national Donation Ethics Committee which has published best practice ethical guidance for DCD,6 National Institute for Health and Clinical Excellence (NICE) guidance on organ donation,7 professional guidance,8 and a duty placed on UK doctors, by the General Medical Council, to identify potential organ donors and be prepared to explore the option of deceased donation when a patient is close to death.9 Society itself, time and time again in surveys, tells us that it supports organ donation and the government has responded with considerable investment, in organ donation, over the last 4 yr.

It is possible we are all wrong, and Drs Hill and Evans are correct in their objections to organ donation. But every time I witness the altruism and sacrifice of a donor family, or see the transformed life that this gift brings to another, I am reminded that organ donation represents humanity, at its most noble. Supporting a patient and their family’s wish to donate at the end of life is very much in keeping with the commitments I made, when I first became a medical practitioner.

Declaration of interest
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Goal-directed fluid therapy in patients undergoing colorectal surgery
Editor—We read with interest the study of intraoperative goal-directed fluid therapy (GDT) in aerobically fit and unfit patients undergoing colorectal surgery. The study by Elger et al.1 demonstrates that GDT significantly reduced red blood cell (RBC) transfusion requirements after colorectal surgery in patients undergoing laparoscopic colorectal surgery. This finding is consistent with previous studies2–4 that have shown GDT to be effective in reducing blood loss and transfusion requirements during major surgery. However, the study by Elger et al.1 has some limitations, including the use of a perioperative fluid protocol that may not be applicable in all surgical settings and the lack of data on the impact of GDT on clinical outcomes such as length of hospital stay and mortality.

In conclusion, GDT is an effective strategy to minimize blood loss and transfusion requirements during colorectal surgery. However, further research is needed to evaluate the impact of GDT on clinical outcomes and to develop evidence-based fluid management protocols for colorectal surgery.