OPTN/UNOS Ethics Committee Meeting
Report to the Board of Directors
November 14-15, 2011
Atlanta, GA

Summary

I. Action Items for Board Consideration

- The Board is asked to consider endorsing a paper entitled, " Ethical Considerations for Uncontrolled Donation after Circulatory Death (UDCD) Organ Recovery" to be used to guide further development by the policy making committees of policies and bylaws for the ethical and effective recovery of organs through UDCD. (Item 1, Page 3)

II. Other Significant Items

- The Committee has co-sponsored significant proposed modifications to Policy 6.0 (Transplantation of Non-resident Aliens) in conjunction with the Ad Hoc International Relations Committee. The proposal was distributed for public comment on September 16, 2011. (Item 2, Page 5)

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Alexandra Glazier, MPH, JD, Chair
Peter Reese, MD, Vice-Chair

The following represents the deliberations of the OPTN/UNOS Ethics Committee at its meeting by conference call on August 4, 2011, and its meeting in Chicago, Illinois on September 11-12, 2011:

1. Ethical Guidelines for Uncontrolled Donation after Circulatory Death (UDCD) Organ Recovery.

At its September 2011 meeting, the Committee reviewed and proposed revisions to a draft paper entitled, "Ethical Considerations for development of Policies on Uncontrolled Donation after Circulatory Death (UDCD)." At its April 2011, meeting, the Committee began discussions of preparing ethical guidelines for the development of UDCD protocols.

The Committee discussed how death is declared in uncontrolled or rapid DCD cases. It was noted that if the care team cannot correctly pronounce death and then start extracorporeal membrane oxygenation (ECMO) and chest compressions in order to maintain the viability of the organs for donation, then the care team should not implement those measures. In that case, it may be preferable to allow warm ischemic time until death is appropriately declared when the patient gets to the OR. It was noted that this is not an ideal way to procure organs.

In every donation including UDCD recovery, it is essential to have an appropriate document of gift.

With respect to the ethical questions of applying measures to a patient solely to facilitate donation, it was asked whether there is an ethical legitimacy to this practice when there are no other conflicts of interest? In these cases, the challenges are when ECMO is not used versus when it is used, and the attendant circumstances.

It was asked whether local hospitals are prepared for success through increases in the potential number of donors recovered through UDCD protocols, i.e. is there sufficient equipment, OR space, staff, etc.

It was noted that the Institute of Medicine (IOM) recommends against proceeding with organ preservation even in the presence of a signed donor card and will look for family consent as well. There is a level of uncertainty about whether an individual can be declared dead by circulatory criteria if circulation is being restored. The Committee considered balloon occlusion, and was concerned by protocols where a balloon is inserted to make sure that the brain is not perfused where the patient had already been declared dead. With a controlled DCD recovery, there is mutual agreement with family and the care team that patient is dead.

The Committee began a draft of a document; however there was not sufficient time to finalize a draft. Members were asked to review and share comments to the document via the Ethics Committee SharePoint site, and the Committee scheduled a follow up call to refine the draft further. A follow-up call was scheduled for May 26, 2011, and the document was discussed at length. Those attending the call supported the document in general; however a quorum was not present and no vote was taken on the document.

At its September 11-12, 2011, meeting, the Committee discussed the topic at length. The Committee invited Dr. James L. Bernat, Professor of Neurology and Medicine, Dartmouth Medical School, to give a presentation to the Committee via LiveMeeting on UDCD and end of life issues. Dr. Bernat discussed the analysis of a HRSA-recruited panel for the circulatory determination of death. The panel considered the language of the Uniform Declaration of Death Act (UDDA); the relationship of the brain and circulatory functions; auto-resuscitation data. Dr. Bernat and the Committee had a lengthy discussion on the distinction between the "permanent" versus the "irreversible" cessation of circulation.

Under the UDDA, individuals may be declared dead if they have sustained either: 1. irreversible cessation of circulatory functions, or 2. Irreversible cessation of all functions of the entire brain, including the brain stem. The Committee focused on the death by circulatory criteria. It was noted that the UDDA did not define the term "irreversible," and that the term is sometimes erroneously used interchangeably with "permanent." Dr. Bernat suggested the following distinction:

- *Irreversible*: cannot reverse using current technology
- *Permanent*: will not be restored spontaneously or through intervention
- Set of permanently lost functions encompasses those that are lost irreversibly; permanence rapidly yields irreversibility

Dr. Bernat suggested that the UDDA requires absence of circulatory not cardiac function and that once circulation has ceased permanently, the donor patient is dead when brain is infarcted. In that case, removal of the donor's heart and restarting it elsewhere has no impact on donor death status. Therefore, such a procedure does not affect death determination and is ethically acceptable.

The Committee discussed at length this distinction, and there were significant concerns raised about whether the restoration of circulation through artificial means such as ECMO have the effect of negating a previously declared death based on circulatory criteria. In such case, the donor is not dead.

With this background, the Committee further revised the draft of ethical considerations to be considered in UDCD organ recovery. After extensive discussion, by a vote of 16 for, 0 against, and 1 abstention, the Committee recommends the following proposal for consideration by the Executive Committee and/or Board of Directors:

> ****RESOLVED, that the following "Ethical Considerations for Uncontrolled Donation after Circulatory Death (UDCD) Organ Recovery" are hereby approved for use by OPTN/UNOS Committees in developing policies and bylaws for UDCD Organ Recovery, effective November 15, 2011:**

Ethical Considerations for
Uncontrolled Donation after Circulatory Death (UDCD) Organ Recovery

Uncontrolled donation after a circulatory determination of death (UDCD) or rapid organ recovery involves the recovery of organs following an unexpected circulatory arrest. Various UDCD protocols have been implemented in the Netherlands, Spain, and more recently in the U.S. The Institute of Medicine and other groups have observed that the practice of UDCD has the potential to greatly expand the pool of deceased organ donors.

UDCD, in principle, is ethically acceptable and appropriate. The following elements provide guidance for the development of ethically acceptable UDCD protocols:

a. Education and engagement of the community in which the UDCD protocol is applicable should precede development and implementation of a rapid organ recovery protocol.
b. Resuscitation measures must meet or exceed current accepted medical standards and legal requirements.

c. Protocols should address compliance with the patient's known wishes and surrogate decision making as to end of life care decisions.
d. Acceptable authorization for donation may include a first person document such as designation in a donor registry; a proxy/surrogate decision; or by statute. Authorization for organ donation also authorizes post mortem organ preservation.
e. Death must be appropriately declared in accordance with accepted medical and legal standards. Protocols need to carefully consider whether death by circulatory criteria can be appropriately declared if artificial circulatory support will be implemented after such a declaration of death.
    a. The Ethics Committee expresses concern that protocols that restore artificial circulatory support to the potential donor undermine the legal basis of a prior death declaration based on circulatory criteria.

2. Proposed Modifications to Policy 6.0 Proposal Co-sponsored with the Ad Hoc International Relations Committee.

The Committee met by conference call on August 4, 2011, to discuss proposed revisions to Policy 6.0 and the document supporting those proposed revisions, which is intended to be distributed for public comment. It was noted that the definitions for non-resident and non-citizen were essential in order to capture appropriate data regarding the potential burden on the U.S. transplant system of transplanting non-citizens. Until the definitions are updated, the potential problem cannot be adequately measured. Under the definitions of the Declaration of Istanbul, the updated data collection will begin to permit the OPTN to examine the number of transplant patients who "travel for transplantation" in the United States.

It was noted that the data collection categories included resident and non-resident but that there was no definition of "resident." It was suggested that "resident" could be self-described similar to other data elements such as "race." The intent of this data collection and any definitions should be to capture where the person actually lives and not to capture a person's legal immigration status.

It was noted that the OPTN cannot prohibit advertising by transplant hospitals targeting non-resident non-citizen patients.

The Committee did not comment on the proposed revisions to Policy 6.4 (Importation of Deceased Donors from Foreign Sources) because the modifications were within the expertise of the Ad Hoc International Relations Committee and did not have specific ethical implications.

The Committee reviewed the pre-public comment proposal from the Ad Hoc International Relations and Ethics Committees, as well as draft slides for presentation at Regional Meetings, which were prepared by leadership of both committees. By a vote of 9 for, 1 against, and 0 abstentions, the Committee supported distributing the document for public comment.

3. Review of Proposals Released for Public Comment.

At its September 2011 meeting, the Committee reviewed proposals that were scheduled to be distributed for public comment on September 16, 2011, and provide the following ethics-related feedback to the sponsoring committees:

1. **Proposal to Clarify Requirements for Waiting Time Modification Requests (Kidney Transplantation Committee)** Current policies for submitting waiting time modification requests are not clear, leading to wasted time for the transplant centers that submit requests, for OPTN Contractor staff who process requests, and for the Committees that review requests. Required documentation is often missing and results in delays for transplant candidates to receive the waiting time that they may be entitled to receive

under OPTN policy. With these proposed clarifications, the Committee expects to see fewer submissions of incomplete requests and faster time to implementation of approved requests.

Response: The Committee reviewed this proposal and determined that there were no ethical issues requiring comment.

2. **Proposal to Extend the "Share 15" Regional Distribution Policy (Liver and Intestinal Organ Transplantation Committee (Liver Committee))** The Liver Committee is proposing an extension of the current "Share 15 Regional" policy so that deceased donor livers (age 18 and higher) would be offered to all candidates with MELD/PELD scores of 15 or higher locally, regionally, and nationally before being offered to candidates with lower MELD/PELD scores.

   Response: It was noted that data suggest that liver transplant candidates should not be transplanted at a MELD <15. The Committee believes that this is an ethically appropriate, efficient, and fair proposal. The Committee reviewed this proposal and determined that there were no specific ethical issues requiring comment.

3. **Proposal For a New Category of Status 1 Liver Candidates (Liver Committee)** The Liver Committee is proposing to expand the Status 1 category in order to include additional candidates who have waiting list mortality rates similar to candidates in Status 1A and 1B. This proposal would create a new category of Status 1, „Status 1MELD35' (or Status1M), that would include candidates with MELD/PELD scores of 35 and higher. Following all combined local and regional Status 1A and 1B candidates, deceased donor livers age 18 and higher would be offered to candidates listed in Status 1M ranked by their MELD/PELD score, with local candidates given priority over regional candidates at each level of MELD/PELD score.

   Response: The Committee reviewed this proposal and determined that there were no ethical issues requiring comment.

4. **Proposed Plain Language Modifications to the Adult and Pediatric Heart Allocation Policies, Including the Requirement of Transplant Programs to Report in UNet℠ a Change in Criterion or Status within Twenty-Four Hours of that Change (Thoracic Organ Transplantation Committee)** The OPTN Contractor's policy evaluation plan requires that heart transplant programs record in UNet℠ changes to a heart transplant candidate's status or criterion within 24 hours, but this requirement is not written in Policies 3.7.3 (Adult Candidate Status) and 3.7.4 (Pediatric Candidate Status). The two policies state that the OPTN Contractor will notify "a responsible member of the transplant team" prior to downgrading a candidate's status, but the OPTN Contractor does not notify such personnel in addition to displaying the candidate's status in UNet℠. The proposed policy change includes the 24-hour requirement, removes the notification clause, and includes edits for plain language.

   Response: The Committee reviewed this proposal and determined that there were no ethical issues requiring comment.

5. **Proposed Revisions to and Reorganization of Policy 6.0 (Transplantation of Non-Resident Aliens) (Ad Hoc International Relations Committee and Ethics Committee)** This proposal clarifies the data collected about the citizenship and residency of donors and recipients. The proposal also amends the audit policy, allowing the Ad

Hoc International Relations Committee to review the circumstances of any transplant and make a public report. The proposal also contains technical amendments and removal of requirements that are not enforceable.

Response: The Committee is a co-sponsor of this proposal and continues to support its adoption.

6. **Proposed Update to the Calculated PRA (CPRA) (Histocompatibility Committee)** The purpose of this proposal is to update CPRA so it can better reflect current lab practices as well as the current donor pool. These revisions include updating the HLA frequencies used to calculate CPRA, the addition of the antigen C to the calculation and the removal of zero (0) as a default value.

   Response: The Committee reviewed this proposal and determined that there were no ethical issues requiring comment.

7. **Revision of the UNOS bylaws, the OPTN Bylaws and the OPTN Policies that govern HLA laboratories (Histocompatibility Committee)** This proposal revises the UNOS Bylaws and Policies that apply to histocompatibility laboratories to more closely align OPTN/UNOS requirements for member laboratories with current laboratory practices.

   Response: The Committee reviewed this proposal and determined that there were no ethical issues requiring comment.

8. **Proposal to Establish Requirements for the Informed Consent of Living Kidney Donors (Living Donor Committee)** This proposal would establish policy requirements for the informed consent of living kidney donors.

   It was noted that this is a lengthy policy and that transplant program staff are asked to review a lot of information in great detail with potential living donors. It was suggested that the requirements may be too prescriptive and may infringe on the doctor/patient relationship. The proposal places a lot of responsibilities on the independent donor advocate (IDA) whose primary role should be to advocate for the living donor. From an ethical perspective, the primary concern is the appropriate level of respect for the autonomy of patients. Professionally, it appears that the standard for informed consent has shifted from a professional standard to a reasonable person standard. It was asked how these requirements compare to CMS request for informed consent. It was suggested that the proposed language creates and overly complex and detailed consent procedure that risks confusing patients and also losing clarity in the consent process. The Committee agrees that informed consent is very important and particularly for living donors and favors the best informed consent achievable.

   By a vote of 16 for, 0 against, and 1 abstention, the Committee believes that the proposal is ethically acceptable supported the proposed modifications.

9. **Proposal To Establish Minimum Requirements for Living Kidney Donor Follow-Up (Living Donor Committee)** This proposal would require transplant programs to report required fields on the Living Donor Follow-up (LDF) form at required post-operative reporting periods (6, 12, and 24 months).

Response: The Committee reviewed this proposal and determined that there were no ethical issues requiring comment.

10. **Proposal to Establish Requirements for the Medical Evaluation of Living Kidney Donors (Living Donor Committee)** This proposal would establish policy requirements for the medical evaluation of living kidney donors. This proposal is in response to a directive from the Health Resources and Services Administration (HRSA), and based on recommendations from a Joint Societies Steering Committee composed of representatives of the American Society of Transplantation (AST); the American Society of Transplant Surgeons (ASTS) and the North American Transplant Coordinators Organization (NATCO) to the Living Donor Committee.

    Response: The Committee reviewed the proposal, and concerns were expressed about the exclusionary criteria. It was asked why is the medical evaluation process being included in policies and prescribing who must be eliminated from consideration? Specifically the absolute exclusion for living donors under age 18 was discussed. It was noted that this would be an extraordinary and rare event however; emancipated minors were noted as one example that would be affected by this absolute exclusion. The Committee recognized that some of the exclusionary criteria are included for the protection of the donor and some are for the safety of the recipient. It was noted that many of the guidelines could benefit from the use of more precise language. For example, a toenail fungus could be a persistent infection and per the policy, would be an absolute exclusionary criterion for the infected donor. It was asked why there was not more clinical discretion included as a component of the guidelines since the OPTN has never provided this level of detail to clinical practices in OPTN policies. From an ethical perspective, some of the guidelines and exclusionary criteria infringe on patient autonomy and to some degree on the doctor/patient relationship. It infringes patient autonomy and the policy excludes wiling and rational donors. It was suggested that the justification to invade donor autonomy is to ensure the public trust.

    By a vote of 17 for, 0 against, and 0 abstentions, the Committee approved the proposed modifications as written **except** for the EXCLUSION CRITERA in proposed Policy 12.3.2 (Medical Evaluation of the Living Donor).

    With respect to the exclusion criteria, the criteria are generally good but the policy could benefit greatly from more precise language. By a vote of 17 for, 0 against, and 0 abstentions, the Committee **opposed** the EXCLUSION CRITERA in proposed Policy 12.3.2 (Medical Evaluation of the Living Donor).

11. **Proposal to Require Use of a Standardized Label for Perfusion Machines (Organ Procurement Organization (OPO) Committee)** This proposal would make labeling of these machines consistent for all deceased and living donor organs that are transported outside of donor hospitals. Current policy allows the use of an "alternate" label, or a label other than the OPTN standardized label, when transporting organs on a mechanical preservation machine. OPOs create their own alternate labels resulting in inconsistent labeling. The proposed policy changes eliminate the use of alternate shipping labels on mechanical preservation machines and require OPOs to use a new standardized label that is part of the current color-coded labeling system distributed by the OPTN contractor.

    Response: The Committee reviewed this proposal and determined that there were no ethical issues requiring comment.

12. **Proposal to Change the Term "Consent" to "Authorization" Throughout Policy When Used in Reference Deceased to Organ Donation (Organ Procurement Organization (OPO) Committee)** The proposed modifications will change the term "consent" to "authorization" throughout policy when used in reference to deceased organ donation. Currently, OPTN policy uses the term "consent" to describe the act of making an anatomical gift. However, the public associates "consent" with the medico-legal concept of "informed consent" through which physicians must give patients all the information they need to understand the risks, benefits, and costs of a particular medical treatment.

    Response: It was noted that it may be inadvisable to cite to the American Medical Association Code of Medical Ethics in the supporting documentation of the proposal however, the commenter supported the actual proposed policy modifications as written. After brief additional discussion supported the proposal by a vote of 16 for, 0 against, and 0 abstentions.

13. **Proposal to Clarify Imminent and Eligible Death Data Collection (Organ Procurement Organization (OPO) Committee)** The proposed policy changes clarify the definitions for determining whether a death can be classified as "imminent" or "eligible."

    Response: The Committee reviewed this proposal and determined that there were no ethical issues requiring comment.

14. **Proposal to Clarify and Improve Variance Policies (Policy Oversight Committee (POC))** This proposal streamlines and clarifies requirements for review and approval of variances, including gathering all requirements into one policy category for the variance application, review, approval, modification, dissolution, and appeal processes; detailing the process for appealing a variance decision of the Committee or Board of Directors; eliminating redundancy in existing variance policies; and rewriting the variance policies using plain language.

    Response: The Committee reviewed this proposal and after brief discussion supported the proposal by a vote of 16 for, 0 against, and 0 abstentions.

4. Draft Paper from American Academy of Pediatrics (AAP).

The Committee received a request to provide feedback on a proposed paper entitled: "Donation after Cardiac Death: Declaring Death and Managing Conflicts of Interest," addressing Donation after Circulatory Determination of Death (DCDD). The Committee reviewed the paper and will provide suggested comments on the proposed paper, which do not represent official comments approved by the Board of Directors or its Executive Committee.

5. Vascular Composite Allografts (VCA).

It is expected that Vascular Composite Allografts (VCA) will be deemed to be organs and within the purview of the OPTN. If this determination is made, the OPTN will need to develop policies for the equitable allocation and distribution of VCAs as well as policies for VCA transplant program requirements, physician and surgeon requirements, data collection and follow-up, monitoring, as well as assessments of how to finance the oversight required for a new area of responsibility. Consistent with its annual goal assigned by the Executive Committee, the Committee intends to assist the policy writing

committees at early states in VCA policy development to identify and discuss potential ethical issues related to the policy topics.

Ms. Glazier gave the Committee a presentation on the present regulatory framework for organs, tissues, and VCAs. Organ Procurement Organizations (OPO) should be involved in the recovery of VCAs because the donor will likely be a heart beating/organ donor; donor screening will be required; donor authorization will need to be obtained consistent with current practices; there will need to be matching of potential donors with potential recipients; and there will need to be coordination of recovery logistics, all of which are presently performed by OPOs for the recovery of deceased donor organs. Unique to VCAs, the donor screening would need to include an evaluation of visual compatibility including skin color/tone, age, and gender. Obtaining Donor Authorization for VCA donation is governed by the Uniform Anatomical Gift Act. It was noted that there are unique issues of confidentiality because the recipient identity often public and some of these transplants, especially face transplants, attract significant media attention.

From a legal perspective, it is essential to obtain legally effective authorization for donation of VCAs. As with solid organ transplantation, it is also essential to perform appropriate medical screening of donor; provide for fair and appropriate allocation to recipients; confirm medical compatibility with identified recipient; and to arrange for the surgical recovery. Since OPOs are presently positioned to provide these services, it is appropriate to treat VCAs as solid organs recovered from deceased donors.

Dr. Simon Talbot, of Brigham and Women's Hospital, Division of Plastic Surgery was invited to give a presentation to the Committee via LiveMeeting regarding some of the successes and challenges available through VCA transplantation. Dr. Talbot gave an overview of some of the current treatment options for patients who would benefit from face, hand, and limb transplantation. In addition to the technical and immunological challenges, some of the ethical challenges to VCA transplantation include: Immune suppression for non-lifesaving organ; allocation of finite resources; selection of patients; and informed consent for an experimental procedure. Worldwide, approximately 16 partial/total face transplantations and 72 hand transplantations have been performed in 10 countries worldwide since 1998. United States centers include Brigham and Women’s Hospital (hand/face), Cleveland Clinic (face), UTSW (hand), Louisville (hand), Pittsburgh (hand), San Antonio (hand), Emory (hand) and UCLA (hand).

Dr. Talbot relayed the BWH criteria for inclusion and exclusion of VCA transplantation. To be considered a candidate to receive face/hand transplant at BWH, a patient must:

- Severe facial injury or dominant/bilateral hand amputee
- Age 18-60
- Strong motivation to proceed with transplant
- Accepts dedicating >2 years to postoperative rehabilitation
- Elapsed injury to transplant time >6 months, <15 years
- Reports suboptimal outcome with myoelectric prosthesis for >6 months, verified by occupational therapist

Exclusionary criteria for the BWH program are:

- Single, non-dominant hand amputee
- Record of poor compliance
- Inability to receive adequate follow up care and/or immunosuppression
- Inability to follow strict postoperative rehabilitation regimen
- Documented psychiatric disorder(s)
- Impaired renal and/or hepatic function
- Severe cardiopulmonary dysfunction
- Active cancer with or without metastases or within past 5 years

The criteria for potential face/hand donors has similarities and stark differences from criteria for potential organ donors:
Inclusion:

- Acceptable standard NEOB compatibility screen (ABO typing, HLA typing, panel reactive antibody, final crossmatch)
- Brain dead donors only
- Approximate forearm bone size matching via plain radiographs
- Same gender and approximate skin tone
- Approximate age match (within 20 years of recipient)

Exclusion:

- Unresolved sepsis
- CDC high risk criteria
- HIV/AIDS
- Active CMV, EBV, tuberculosis
- Viral hepatitis or encephalitis
- Systemic or limb-related neuropathies
- Rheumatoid arthritis or osteoarthritis

Dr. Talbot also shared the lessons learned by the BWH transplant program, which include:

- Patient compliance with rehabilitation and immunotherapy are critical to long-term transplant success;
- Patient satisfaction is highly dependent upon preoperative motivation and expectations;
- Objective functional outcomes are higher the more distal the level of transplantation;
- Maximal functional recovery requires at least 3-5 years; and
- Immunologic requirements are generally less than initially anticipated.

In summary, traditional approaches for managing severe facial injuries and upper extremity amputations are limited in their capacity to meet functional and aesthetic reconstructive goals. Face and hand transplantation offers a promising alternative to these traditional options and initial outcomes from the small but growing number face and hand transplants performed to date are encouraging. These transplant procedures offer the potential for true anatomic and psychological restoration for select patients

The Committee thanked Dr. Talbot for generously sharing his time and experiences with face and hand transplantation.

6. Committee Orientation and Planning.

At its September 2011 meeting, members of the Committee were introduced and the UNOS staff liaison gave an orientation regarding the OPTN and the role and responsibilities of the Committee and its regional representatives. The presentation included an overview of the OPTN, committee service, the function of the UNOS Research Department, and a brief overview of the role of the SRTR and the Minnesota Medical Research Foundation (MMRF).

During the June 2011 meeting of the Executive Committee, the following activity for the Ethics Committee was approved for 2011-2012:

- Work with policy writing committee at early states in policy development to identify and discuss potential ethical issues related to the policy topics.

The Committee also briefly discussed the Committee Project Evaluation tools and the process to obtain Executive Committee approval for specific projects.

Ethics Committee			
Name	**Position**	**August 4, 2011 Conference Call**	**Sept. 11-12, 2011 Chicago, Illinois**
Alexandra K. Glazier	Chair	X	X
Peter Reese, MD	Vice-Chair	X	X
Manuel Rodriguez-Davalos, MD	Region 1	X	
Peter Reese, MD	Region 2	X	X
Carlos F Zayas, MD	Region 3	X	X
Mark Fox, MD, PHD, MPH	Region 4	X	X
Daniel Bruggemeyer, MS	Region 5	X	X
Lisa S Florence, MD	Region 6		
Bhargav M Mistry, MD	Region 7		X
Scott Biggins	Region 8		X
Keren Ledin, PhD	Region 9	X	X (by phone)
Amy Pope-Harman, MD	Region 10	X	X (by phone)
Robert Sade, MD	Region 11	X	
Michael E. Shapiro, MD	Immediate Past Chair		X
Jack Berry	At Large		X
Kay Kendall, MSW, LISW	At Large		X
Robert Veatch, MD	At Large		X
Liz Lehr, BSN, MHA	At Large	X	X
Robert Truog, MD	At Large	X	X
Richard Demme, MD	At Large		X
Isabel Stenzel-Byrnes, MSW	At Large	X	
Deborah Adey, MD	At Large		X
Teresa Beigay, DrPH	Ex Officio – HRSA	X	
Bernie Kozlovsky, MD	Ex Officio – HRSA	X	X
James Bowman	Ex Officio – HRSA	X	
James L. Bernat, MD	Guest		X (by phone)
Simon Talbot, MD	Guest		X (by phone)
Tabitha Leighton	SRTR	X	X (by phone)
Maryam Valapour, MD	SRTR	X	X
Jason Livingston	UNOS Staff – Liaison	X	X
Gloria Taylor	UNOS Staff	X	X
Doug Heiney	UNOS Staff	X	
James Alcorn	UNOS Staff	X	X
Vipra Ghimire	UNOS Staff	X	
Cheryl Hall	UNOS Staff	X	
Sarah Taranto	UNOS Staff	X	