

**Kidney Transplantation Committee
Meeting Summary
October 26, 2015
Chicago, IL**

**Dr. Mark Aeder, Chair
Dr. Nicole Turgeon, Vice Chair**

Discussions of the full committee on October 26, 2015 are summarized below and will be reflected in the committee's next report to the OPTN/UNOS Board of Directors. Meeting summaries and reports to the Board are available at <http://optn.transplant.hrsa.gov/> .

Committee Projects

1. Simultaneous Liver Kidney (SLK) Project

The SLK allocation proposal was distributed for public comment August 14-October 14, 2015. Overall, public comment was favorable, but there are several major changes being discussed as a result of public comment. Because the changes are so substantial, the Committee expects the proposal will be released for a second and final round of public comment during the January-March 2016 period.

Below is a summary of the discussion by public comment theme.

SLK Allocation

Local SLK Priority

In the fall 2015 public comment proposal, the policy language tied both local and regional SLK eligibility to the MELD score. This was an unintended error in the policy draft. The proposal should require *local* SLK candidates to meet the kidney medical eligibility criteria only. The SLK working group and the Committee have both endorsed fixing this language in the next round of public comment.

Regional SLK Priority

One of the key elements of this project was to develop medical eligibility criteria for SLK allocation. The Liver Committee representatives have not been opposed to developing this criteria but only if it is accompanied by a "safety net". The Liver Committee representatives have also requested that any new SLK policy "fix" the inconsistencies that currently exist between multi-organ and deceased liver allocation policy regarding regional sharing for liver candidates who receive high priority due to higher MELD scores.

As the working group discussed it, the inconsistency deals with a 2012 change in liver policy (the "Liver Share 35" policy), which assigns broader sharing priority for liver candidates with a MELD score at or above 35. The current *multi-organ* policy (Policy 5.8) does not *require* an OPO to offer a kidney with the liver if the liver-kidney candidate that appears on the liver match is outside of the DSA. In other words, a candidate can be highly prioritized regionally for the liver offer because of their MELD score, but there is no requirement that the OPO offer the kidney with the liver if it is a regional or national candidate. According to several Liver Committee representatives on the group, these candidates are more likely to need an SLK transplant. The working group members agreed that there should be regional SLK priority for

Share 35 candidates. This was echoed by several members of the OPTN/UNOS Board of Directors at their meeting in June 2015.

However, some liver-kidney candidates who don't fall under the "Share 35" policy change are prioritized higher than "Share 35" candidates for regional sharing (ex. Status 1A adult liver candidates). These candidates are considered to be medically urgent but not tied to the MELD score classification known as "Share 35" priority. The SLK working group and the Committee have agreed that Status 1A and 1B liver candidates who meet the medical eligibility criteria should also receive regional SLK priority.

OPO Directive for Regional Liver-Kidney Allocation

The Fall 2015 public comment language was silent on whether OPOs are required to make SLK offers to eligible regional candidates when choosing to allocate as a liver-kidney combination. The SLK working group and the Committee have agreed that this should be changed in the next round of public comment. To be clear, the change will require that the OPO make liver/kidney offers to regional SLK candidates before offering to the kidney alone waiting list. The OPO will still have the discretion (as they do currently) to offer to other multi-organ candidates before offering as a liver-kidney combination.

National SLK Priority

The SLK working group and Committee previously discussed but could not come to consensus on whether eligible candidates beyond the OPO's region should receive priority for SLK allocation before the kidney is offered to the kidney alone waiting list.

Currently, there are situations where liver-kidney offers are made beyond the regional level (although the situation appears to be rare according to recent data). However, the fall 2015 public comment proposal as written would preclude national SLK allocation going forward. The Liver Committee leadership expressed concern about this and requested that the proposal be amended to include national SLK allocation as an option.

The Kidney Committee has indicated they would support a change consistent with kidney-pancreas allocation policy that provides the OPO with the option to either allocate the kidney to the kidney alone waiting list or to eligible national SLK candidates. The OPO would have this option only if there were no other local multi-organ candidates available and the national SLK candidate meets the medical eligibility criteria and has a high MELD score or is a Status 1A or 1B liver candidate.

Pediatric SLK Priority

The fall 2015 public comment proposal applied SLK eligibility criteria to all liver-kidney candidates, including pediatric liver-kidney candidates. This was something that the working group had discussed in passing (by adding a diagnosis to the metabolic disease category at the request of the Pediatric Committee), but not directly. The Liver Committee leadership expressed concern about the application of medical eligibility criteria for pediatric SLK candidates.

The Committee agreed with the SLK working group that medical eligibility should not apply to pediatric SLK candidates. They also agreed that pediatric candidates should be assigned SLK allocation priority at the local, regional, and national levels regardless of medical eligibility criteria.

SLK Medical Eligibility Criteria

Computer system programming v. documentation monitoring

As the working group developed the medical eligibility criteria it was anticipated that the diagnosis confirmation would be a new field added to the liver waiting list and UNOS would monitor the documentation required through on-site audits or retroactive requests made by the allocation analysis team. However, the working group and Committee recently discussed whether it may be more appropriate (for monitoring and for data collection that can be analyzed later) to program fields for the more detailed information that program's must report.

Both the working group and the Committee agreed that this will mean an additional data reporting burden on liver transplant programs. However, there was unanimous agreement that the benefit outweighs the burden. The Committee will need the data to determine whether the medical eligibility criteria were appropriate or too strict/too loose. This change will be made and discussed in the next round of public comment.

Documenting GFR values for acute kidney injury

In the Fall 2015 public comment period, transplant program representatives raised compliance related questions around documentation for the acute kidney injury category. Some programs have offered that it will be extremely difficult to obtain and document a GFR measurement every seven days for six weeks because many liver-kidney candidates are not hospitalized.

The intent of this requirement was that the liver program show the candidate has consistent kidney dysfunction over the period of six weeks. At the time it was developed, some of the Liver Committee representatives offered that this shouldn't be burdensome to liver programs because they are required to update MELD status every 7 days. However, this requirement only applies to liver candidates with higher MELD scores (at or above 25) and Status 1A or 1B. The transplant program is only required to update MELD status for patients with lower MELD scores every month (MELD 19-24) or every 3 months (MELD 11-18).

The working group and Committee discussed whether to change the requirement so that GFR/CrCl measurements would have to be updated on the same schedule as MELD data. However, the groups came to the conclusion that it would be rare when a liver candidate with sustained acute kidney injury and a MELD < 25 will be a liver-kidney candidate because the CrCl is a part of the MELD criteria. In those rare cases where a candidate does exist, the Committee representatives felt the liver transplant program needed to bear the burden to report kidney transplant eligibility for the candidate. The Committee is recommending a slight change to the wording to make it clear that the GFR/CrCl must be reported once a week for six consecutive weeks, not on the 7th day of each of those weeks.

Applicability of new rules to candidates waiting for liver-kidney on the date of implementation

The SLK working group and Committee have discussed how existing liver-kidney candidates will be treated on the day of implementation. Both groups agreed that all liver-kidney candidates should have to meet the medical eligibility criteria once the new rules are in place, but UNOS will need to program the new data fields and make them optional for a period of time before implementation to allow liver transplant programs to prepare and report the new data. This will be incorporated into the education and implementation plan for the project.

Safety Net

Eligibility requirements for the safety net

In general, there are fewer issues to address with the safety net component of the proposal. Several commenters were concerned with the precedent it sets for the future (re: will there eventually be a safety net created for heart and lung recipients as well?). There are also a couple of recurring comments that the Committee has heard before but needs to revisit again before finalizing the components.

The Fall 2015 public comment proposal would require that liver recipients meet one of the following criteria in the period that is 60-365 days after liver transplant in order to be eligible for the safety net:

- 1) The candidate is on dialysis for ESRD; or
- 2) The candidate has a GFR at or below 20 ml/min

The working group originally chose the 60-365 day timeframe in order to ensure some period of waiting after liver transplant to determine if the kidney function will return and capped within a period of time that it is reasonable to assume relation to the candidate's liver disease. The Liver Committee has requested that the timeframe be reconsidered and possibly adjusted so that eligibility would begin if the liver recipient meets one of these two criteria starting at 30 days after the liver transplant. The Liver Committee leadership also offered that the 365 day standard could be shortened if the beginning date is adjusted. The Committee discussed whether to shorten the safety net timeframe but was not in favor of this change, stating that 60 days had been a compromise to begin with.

One of the common themes in the feedback received from the regions was that the safety net should only apply to liver recipients who had some degree of kidney dysfunction prior to the liver transplant. The working group discussed this at length and decided not to create such a standard for several reasons:

- Such a standard would be incredibly complex to monitor and implement through IT programming.
- The main intent of the safety net is to provide a remedy for liver recipients who did not meet the new SLK medical eligibility criteria but continued to have kidney dysfunction in the 60-365 day period. In order to develop a new standard, the working group would need to decide which criteria are appropriate to show some level of kidney dysfunction and that would need to be different and less stringent than the SLK medical eligibility criteria (because if the candidate met that eligibility, he/she would be eligible for a liver-kidney offer).
- The working group previously agreed (after looking at outcomes data for kidney after liver transplants) that part of the reason for the safety net is to protect the outcome of the liver transplant, whether the candidate has ESRD before or after the liver transplant was performed.

Finally, it has been suggested that liver recipients should have to show continual kidney dysfunction in the year after their liver transplant in order to receive safety net priority. Some have suggested that the GFR should have to be measured and updated monthly to show it is consistently at or under 20 mL/min. The Committee reviewed this feedback and did not reach consensus during the meeting.

2. Revising KPD Priority Points

The Committee reviewed public comment feedback and discussed recommendations for revisions from the KPD Work Group. Public comment was favorable for this proposal overall and was on the non-discussion agenda at the regional meetings. The proposal did not receive any comments on the revisions to the priority points or on the remedy for a failed exchange. The KPD Work Group made recommendations to clarify the proposed public comment language:

- In two-way and three-way matches, AST suggested modifying the policy language so that donor recoveries must be “*scheduled to begin* within 24 hours of the previous recovery” rather than requiring them to *begin*. AST commented that policy should allow for the reality of issues that may arise unexpectedly prior to surgery and surgery start should not be rushed.
- In reviewing AST’s comment, the KPD Work Group also discussed whether the transplant programs needed to agree to proceed before beginning the donor surgeries in two-way and three-way exchanges. Previously, the donor surgeons involved in the exchange had to agree to proceed, but the public comment proposal removed this language. The KPD Work Group asked that this requirement be included in the final policy language, but it was acceptable for the transplant programs to agree to proceed rather than the donor surgeons specifically to allow for flexibility but also communicate before beginning the surgeries.
- The KPD Work Group also clarified *Policy 13.9.C: Ending Chains*. This policy explains how chains end when a transplant hospital that entered the non-directed donor initially chooses to allow the chain to continue through bridge donation. In the public comment proposal, one way to end a chain was if the “bridge donor decides to donate to the deceased donor waitlist at the transplant hospital that entered the non-directed donor that began the chain.” The KPD Work Group simplified this language to “the bridge donor donates to the deceased donor waitlist.”

The Committee agreed to the KPD Work Group recommendations and voted to submit the final policy to the OPTN/UNOS Board of Directors for approval in December.

3. Defining Biologically Incompatible

The Committee reviewed the status of the Defining Biologically Incompatible project. The subgroup assigned to work on this project distributed a memo asking for pre-public comment feedback on the initial definition of “biologically incompatible.” Based on the feedback received, the KPD Work Group believed that policy may not be the appropriate solution at this time. KPD Work Group members were concerned that trying to define this term and applying it to all KPD programs could negatively impact paired donation and stifle innovation. The initial definition allowed a transplant physician or surgeon to determine that a pair were biologically incompatible based on clinical characteristics such as age, anatomy, blood type, body size, gender, histology, immunology, microbiology, physiology, and serology. Feedback suggested that the definition should allow for altruism and compatible pairs. However, the KPD Work Group was concerned about adding these categories as they do not seem to imply incompatibility.

Therefore, the KPD Work Group requested to add different language to the definition of the KPD Program to put into the OPTN Kidney Paired Donation Pilot Program Operational

Guidelines and asked the Committee to approve it. The proposed addition to the operational guidelines was “The KPD Program accepts all pairs except those that would not require immunosuppression drugs as a result of transplantation.”

The Committee discussed this addition and agreed that this broad language captures all but the truly identical twins. One committee member noted that candidates in tolerance programs may not require immunosuppression drugs, but other committee members noted that this language does not limit a candidate from receiving a transplant from a donor that they are compatible with, only that the pair could not enroll in the OPTN KPD pair if they could otherwise donate to one another and not require immunosuppression drugs. Another member asked if putting in this language would make it more difficult for centers to participate in the OPTN KPD and drive them to use other programs. The addition still allows the physicians or surgeons to decide if they want to enter a pair into the OPTN KPD, but would not require centers to report or certify that a pair would not require immunosuppression drugs.

The Committee ultimately approved the proposed addition for inclusion in the operational guidelines. The OPTN Board of Directors will be notified via the Committee’s December 2015 Board Report and this project will be considered implemented.

4. Kidney Allocation System (KAS) Clarifications & Clean-Up

The KAS post-implementation subcommittee has representatives from the Kidney, OPO, Histocompatibility, and Minority Affairs committees. The subcommittee finalized its recommendations for KAS policy clarifications and asked the Committee for review and approval.

The Committee agreed with the subcommittee’s recommendations on the following clarifications:

- Maintain Consistency with *Policy 5.9: Released Organs*:
 - Deceased Donor Kidneys with Discrepant HLA Typings: Clarifies that if a discrepancy in HLA typing between the donor and recipient HLA lab cannot be resolved and the intended recipient cannot be transplanted, then the kidney must be reallocated according to *Policy 5.9*. Once the organ is released, the OPO can decide whether to allocate based on the original donor lab typing or the recipient lab typing.
 - National Kidney Offers: Clarifies that *Policy 5.9* is the prevailing policy if the intended candidate cannot be transplanted after accepting a national offer
 - Kidney-Non-Renal Organs Allocated and Not Transplanted: Clarifies that if a multi-organ combination involving a kidney cannot be transplanted, that the kidney must be reallocated according to *Policy 5.9*
- Correct Redundant Match Classification Titles in *Table 8-5*
- Clerical changes

The Committee decided it needed further discussion on two remaining clarifications: *Policy 8.5.C Informed Consent for Kidneys Based on KDPI Greater than 85%* and *Policy 8.7.A Mandatory Sharing*.

Committee Projects Pending Implementation

5. KPD Histocompatibility

KPD histocompatibility requirements will be implemented in early 2016.

6. Other KPD Projects Pending Implementation

The Committee was reminded that KPD informed consent requirements will be implemented on December 1, 2015. The KPD match deadlines are pending programming and the implementation date for OPTN policy has not been determined.

Implemented Committee Projects

7. Kidney Allocation System

The Committee reviewed the in-depth data from the first six months of KAS. Topics for discussion:

- Based on recent discussions with the Ethics Committee and Living Donor Committee, the Committee also reviewed and discussed living donor prioritization under KAS
- Logistics of placing kidneys for high CPRA patients
- Acceptance rates
- Transplant rates by age, CPRA, race/ethnicity, duration on dialysis, primary diagnosis, gender, blood type, HLA mismatch level, and patient population (i.e. prior living donors, pediatrics)
- Transplant rates for single, dual, and en bloc kidneys and multi-organ combinations
- Longevity Matching
- Geographic distribution of kidney transplants

The Committee discussed the following issues:

Registrations

- Since a candidate can get waiting time back dated to start of dialysis, a candidate may not be added to the list if they would immediately be set to inactive (ex. high BMI or cancer diagnosis). It may be better not to list someone than have listed in inactive status since patients will not lose waiting time accumulation. The program specific reports (PSRs) do not exclude the inactive numbers in calculating the center transplant rate and waitlist mortality.
- Hospitals may be evaluating whether transplant would even be the best therapeutic option for the patient. (Ex. Patient in 60s or 70s with a lot of co-morbidities when there is a long wait time for transplant in the region.)
- Is overall plateauing of list being impacted by the number of de-listings for reasons other than death or transplant? The UNOS Research Department is studying this further.

Pediatrics

- Transplant rates for pediatric candidates initially dropped slightly after KAS implementation, but the data presented during the meeting show that the numbers have rebounded and the difference pre- and post-KAS implementation are not statistically significant. The Committee will continue to monitor the data.
- Pediatric candidates are receiving better quality kidneys from the KDPI 0-34% range.
- Pediatric candidates are receiving transplants at five times the rate of adults.

0-ABDR mismatches

- 0-ABDR mismatch acceptance rate has declined 42%. Members discussed the possibility that the increase in KDPI of the kidney offers made to the 0-ABDR mismatches was causing the decline in the acceptance rate. More data is needed to further evaluate the cause of this decline.

Highly sensitized candidates

- 60% of candidates are re-listings (had a prior kidney transplant) and 40% are first-time listings

Average wait times

- The Committee asked if there were any updates to the average time a patient could be expected to wait for transplant. Multiple factors contribute to wait time and there does not seem to be any drastic change in average wait times although it may have changed for individual candidates (i.e. high CPRA). The number of donors available is about the same pre- and post-KAS. The SRTR noted that average wait time statistics among transplant patients can be misleading because waiting time assumes that you will receive a transplant, but not all candidates become recipients.

Subtype A₂ and A₂B transplants to blood type B recipients

- Transplants have increased four-fold, but numbers are still small (post-KAS: 47) and only 3% of blood type B candidates are listed as eligible to receive these subtype-compatible offers. The Minority Affairs Committee (MAC) is forming a work group to do some initial brainstorming and a survey. Based on these results, the MAC is going to ask the Policy Oversight Committee to approve a project that provides education or guidance to increase the number of these types of transplants. Committee members were asked to volunteer to participate in this work group.
- Members noted that the logistics of creating the written policy on the program's titer threshold and confirming/reconfirming candidate eligibility are challenging and labor intensive. Education will be very important to making this KAS component successful.
- Members believed that there may be confusion between the OPTN Policy which references A₂ but the system notes it as non-A₁. As part of an HLA project that will be implemented in early 2016, the system will note that A₂ and non-A₁ are the same.

Prior Living Donors

- The Committee discussed prior living donor prioritization under KAS. Committee leadership had presented early KAS data on prior living donors to the Ethics Committee and Living Donor Committee. This data does not show that prior living donors are being disadvantaged under KAS, but Committee leadership wanted to discuss this topic with these other committees to determine if there was a philosophical reason for prioritizing prior living donors before all other groups.
- The Committee reviewed the data and the feedback from the Ethics and Living Donor Committees and do not feel action is needed at this point.

Deceased donor kidney recovery and utilization

- The Committee discussed the donor recovery rate and discard rates. Although there was initial concern about the discard rate increasing during summer 2015, the data shows that discards have declined since that time. Donor recovery rates have increased and

the overall number of transplants has increased. UNOS Research and the Committee will continue to monitor these data points to see if the system will stabilize.

- Many members have been concerned as to what is causing the discards. Post-KAS implementation, about 36% of the kidneys were discarded due to biopsy findings and about 26% were because a recipient could not be located.
- The Committee continues to be concerned about regional sharing for high KDPI kidneys. Committee members noted that they need to find a way to expedite placement of high KDPI kidneys for better utility.

Other Significant Items

8. Update on OPTN KPD

The Committee reviewed the implementation dates for the upcoming KPD policy and data on the OPTN KPD. On a national level, paired donations in 2015 are on track to match the 2013-2014 level at approximately 600 transplants per year which represents about 10% of living donor kidney transplants. Although the OPTN KPD is identifying more matches, not as many are resulting in transplant. The following summarizes the data presented:

- 65% (150 of 231) of active kidney programs have signed on to participate in the OPTN KPD and 50% (115) have entered pairs participate in match runs.
- Over 250 pairs are included in each match run and the size of the pair pool continues to grow. However, non-directed donor numbers have declined.
- The average number of matches found each month continues to increase.
- As of September 2015, 155 transplants have been facilitated through the OPTN KPD since the program's inception.
- Highly sensitized candidates (CPRA 80%+) account for 34% of the transplants and 17% of transplant recipients had a CPRA of 95%+.
- The match success rate is about 7% (i.e. matches that result in transplant).
- Match offer refusal reasons are largely centered around three themes (crossmatch-related, donor-related, or candidate-related). The top 5 reasons were positive virtual crossmatch, candidate in other KPD program pending match, positive physical crossmatch, matched donor age, and matched donor medical history.

Committee members noted that a great deal of staff time at transplant centers is spent on trying to organize the exchanges only to have them fall through and that centers may be more inclined to ask that their candidates find a compatible living donor rather than pursue KPD. Committee members discussed whether other paired donation programs are facing similar issues (i.e. low match success rate, difficult to match pair pools, etc) and believed that all paired donation programs are experiencing similar challenges. A committee member also noted that adding DQA and DPB will help with unexpected positive crossmatches, but that there is no restriction on the MFI cut offs that each lab uses to determine whether an unacceptable must be reported. Until there is a more standardization over the MFI cut offs, this problem will be difficult to solve and all programs will struggle with this issue.

The Chair of the KPD Work Group also noted that work group members and committee leadership have been brainstorming different ideas to improve the OPTN KPD. The KPD Work Group would like to develop a plan with short term and long term goals for the OPTN KPD. Some of these ideas may require policy changes, but others only require operational guideline changes.

9. SRTR Presentation on Geographic Disparities in Kidney Allocation

In 2013, the OPTN Board of Directors directed the committees to evaluate whether the donor services areas for organ allocation should be reorganized. The Committee developed a work group to focus on this issue, but the project was put on hold until statistical modeling resources are available. The new SRTR contract requires the SRTR to further analyze geographic disparities in kidney transplants. The SRTR submitted a plan to HRSA on October 20, 2015 to examine metrics of disparity including measures of kidney supply, kidney demand, transplantation and a novel methodology to isolate the impact of kidney allocation service areas. The novel methodology would try to take into account all the ways that regions differ from each other and confounding factors. The intent of the project is not to solve the disparities, but to describe the state of geographic disparities so that the Committee can develop future proposals. The SRTR has one year to complete this analysis.

The SRTR did not request the Committee form a work group at this time but asked for permission to query the committee members on an informal basis for expert opinion. SRTR will prepare quarterly status reports for HRSA and will coordinate a similar update schedule for the Committee during its regularly scheduled meetings.

Discussion included:

- The analysis should account for the current disparities in order to assess how to equalize areas across the country.
- Resolving geographic disparities may unintentionally increase other types of inequities (ex. racial) and the analysis should have granular data to assess potential inequities.
- Is the Kidney Allocation System (KAS) sufficiently stable to support this analysis? The SRTR may need to use pre- and post-KAS data.
- Several committee members commented that they would like the SRTR to include the Committee early and often so that the analysis can be useful and problems can be identified early. If the Committee will need to rely on this data to make changes, the Committee wants to ensure that the analysis is useful.
- A committee member noted that transplant referral practices vary widely across the country.
- Demand should not be measured by only those patients on dialysis. Polycystic kidney disease patients often undergo pre-emptive transplants.
- The Committee is following the liver redistricting project to assess lessons learned.

10. Update from the Policy Oversight Committee

The Vice Chair provided an overview of the functions of the Policy Oversight Committee (POC) and notified the Committee that the POC approved the Committee's project on Improving Allocation of Double and En Bloc Kidneys. The Committee still needs the Executive Committee's approval to formally begin working on the project.

11. Brainstorming Session

Committee members presented ideas for new projects aimed at increasing the number of transplants. A summary of the ideas presented is provided below:

- *Matching donor typing results to resolution of "Unacceptable" equivalency table:* Highly informative donor typings, performed by molecular methods, are reported as less informative 'serologic' equivalents. Consequently, organs are offered and

shipped, especially for 99 and 100% CPRA patients when, if the more informative type were reported, the organ would be declined. This would increase the number of organs transplanted into the intended recipient, avoiding unexpected positive crossmatches and reducing discards.

- *Improvement in matching of high KDPI kidneys to appropriate recipients:* KDPI > 85% kidneys may be underutilized in the new KAS. We have observed excellent outcomes with utilization of these kidneys in some cases, but optimal outcomes may relate to recipient factors such as age and body size. Alternatively, certain characteristics, such as obesity and large body size, may be associated with impaired renal function in kidneys with KDPI > 85%. The goal would be to analyze which patients may have the best death-censored graft survival based on recipient factors. This might include younger recipients who do very well with high KDPI kidneys which could improve the rate of utilization of these kidneys.
- *Reducing discards through deregulation:* While there is a shortage of transplantable organs, 20% of procured kidneys are being discarded. Kidneys about to be discarded may have unmeasurable factors that place them at higher risk for failure, therefore transplant centers are reluctant to use them. Removing regulatory oversight for these kidneys can promote their use.
- *Surgeon Procurement Fees:* Some OPOs have stopped paying surgeon procurement fees. The OPO either directs the surgeon to contact the transplant center for payment or will only pay the surgeon if the organ gets used. The less likely a surgeon is to get paid, the less likely the organs will be procured. A nationwide uniform policy on payment would ensure that organs continue to be procured and transplanted.

Upcoming Meetings

- November 16, 2015
- December 21, 2015