PUBLIC HEARING

before

ASSEMBLY CORRECTIONS, HEALTH AND HUMAN SERVICES COMMITTEE

on

ASSEMBLY BILL 1360

(Prohibits the Sale of Certain Human Organs)

Held:
March 29, 1984
Woodrow Wilson School
Princeton University
Princeton, New Jersey

MEMBER OF COMMITTEE PRESENT:

Assemblyman Paul Cuprowski (Acting Chairman)

ALSO PRESENT:

David Price, Research Assistant
Office of Legislative Services
Aide, Assembly Corrections, Health and Human Services Committee

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ASSEMBLYMAN PAUL CUPROWSKI (Acting Chairman): Good morning ladies and gentlemen. First of all, I want to thank each and every one of you for being here this morning. The weather is obviously very bad today, and we certainly appreciate those that did make the effort to be here.

I am pleased to welcome all of you to this public hearing conducted by the Assembly Corrections, Health and Human Services Committee. My name is Assemblyman Paul Cuprowski. I represent the 32nd Legislative District, and I have been requested by the Chairman of this Committee, Mr. George Otlowski, to chair the proceedings here today.

Before we start, I would like to take this opportunity to introduce those members on the staff and on the Committee who are in attendance this morning. To my far left is Chris Simon, a member of the Democratic Majority Staff in the State Legislature. Chris, I appreciate you being here this morning. To my left is David Price, the liaison who put this hearing together, representing the Office of Legislative Services. Thank you David. And to my right is my Chief of Staff in the 32nd Legislative District, Mrs. Joan Quigley. Thank you Joan. The minutes will be transcribed by representatives of the Office of Legislative Services. I appreciate those girls making the effort also.

The purpose of this hearing is to consider Assembly Bill 1360, which I am sponsoring. This is an act to prohibit the sale of human organs or tissues from both living and dead bodies. This bill would make it a crime of the second degree to engage in this kind of activity. We know that this is a national concern; similar bills have been introduced in other states and have been recently enacted into law in at least two states -- Virginia and Oklahoma.

We know also that this is part of a broader set of concerns affecting the whole country as some members of Congress have focused on it in terms of legislative proposals. These concerns include such questions as how we can improve the effectiveness of our system of voluntary organ donations; how we can strengthen the organ procurement networks; and how we can ensure fair access to organ transplant procedures.

We want to examine all aspects of this problem as they relate to the legislation which we are considering today. We particularly want to consider the impact of this problem on our State, the State of New Jersey, and to look at possible solutions.

The Committee welcomes different points of view on this particular issue and looks forward to hearing from all the parties who are involved in this situation -- from government, from the medical community, from concerned organizations, and from others who know what is best for the issues that are involved. The Committee hopes that the testimony presented today -- if we have some additional testimony hopefully -- will provide a better perspective on the problems involved in this important policy area and will help us to better see all the dimensions of the subject. We look forward to hearing from everyone who has come here to speak today or who will supply written testimony. Anyone wishing to present testimony for the record may do so.

Before introducing our first witness, I would like, at this time, to ask my Chief of Staff, Mrs. Joan Quigley, to read a statement into the record on my behalf. Mrs. Quigley, as well Chris Simon and David Price, have been instrumental in helping to research the need for this particular piece of legislation and have done a lot of behind-the-scenes work by reading various medical journals and so forth.

JOAN QUIGLEY: This is a statement of Assemblyman Paul Cuprowski:

"Several months ago I read with shock and disgust a news report that a physician in Virginia has established an agency to buy and sell human kidneys for a profit. Not long afterwards I learned of a businessman who set up a similar brokerage in Maine. I discovered that in California, Michigan, and Wisconsin men were offering organs for sale to the highest bidder.

"With the aid of the Office of Legislative Services I researched the New Jersey statutes. There was no law on our books to prevent that kind of "flesh-peddling" here. There was nothing to prohibit unscrupulous dealers from preying on the poor and the desperate and nothing to safeguard the health of potential organ recipients.

"People have asked me why I have introduced legislation now when we have heard of no one trafficking in livers, kidneys, bones, and eyes in this State. But, I believe it is better to prevent the problem than to try and solve one after it occurs. Body parts are being bought and sold elsewhere, and I don't want to see this ghoulish trade begin in New Jersey.

"In my opinion, if we allow human body parts to become marketable commodities, that will be the end of the voluntary donor system. Although donations are not yet plentiful enough to meet the need, they are our best source of clean, healthy organs which are made available to recipients with the greatest medical needs and the greatest chances for transplant success. I believe people should be encouraged to donate their organs. I believe far fewer people would sign voluntary donor cards if they thought their organs could be sold, resulting in a larger estate for their heirs. I fear that some people would be tempted to lie about family medical history or to conceal problems in order to get the highest possible price for organs on the open market, thus endangering their own lives and the lives of the recipients.

"I am sure we will hear today many other reasons why this bill should become law. Perhaps we will hear some arguments why it should not. I welcome any suggestions that will make Assembly Bill 1360 a better bill and help us enact a better law. Those of us who are here today will listen carefully, and the members of the Assembly Corrections, Health and Human Services Committee unable to be present will read the testimony thoroughly."

There will be a hearing on this bill on April 10 before the Health Committee; is that correct?

ASSEMBLYMAN CUPROWSKI: At the present time that is not confirmed.

MS. SIMON: It is confirmed; it hasn't been publicly announced yet, but it has been okayed.

ASSEMBLYMAN CUPROWSKI: With the approval of the Chairman of the Assembly Corrections, Health and Human Services Committee, Mr. George Otlowski, we will continue and hopefully have that item on the agenda, and anyone who wants to make written testimony may do so.

Those who want to make verbal testimony may also appear at that particular hearing. But, we will definitely be in touch with all those who were unable to be here, who indicated their wishes to express themselves here this morning.

Thank you very much Joan.

At this time I would like to introduce David Price from the Office of Legislative Services who will indicate to us, for the record, those individuals -- and their titles -- who wished to be heard and to give testimony here this morning. However, obviously because of the weather, many of them are unable to be here. But, for the record, I am asking David to read those names at this time.

DAVID PRICE: The following is the Witness List prepared by the Assembly Corrections, Health and Human Services Committee for today's hearing:

J. Richard Goldstein, M.D., Commissioner, New Jersey Department of Health;

Hossein Eslami, M.D., Director of Organ Transplantation, Newark Beth Israel Medical Center;

John M. Kiernan, Administrator and Coordinator, Organ Recovery Program, Presbyterian Hospital of New York City;

Maxine Turon, President and Founder, Children's Liver Foundation;

Marshall Klein, Executive Director, Eye Bank Foundation of New Jersey;

Martin Jacobs, M.D., Director of Transplantation Center, St. Barnabas Medical Center, Livingston, New Jersey;

Dennis Filippone, M.D., Director of Surgical Transplantation, St. Barnabas Medical Center, Livingston, New Jersey and Director of Northern New Jersey Transplant Foundation;

Ira Greiffer, M.D., President of the National Kidney Foundation of New York and New Jersey.

In addition to these individuals, written testimony has been submitted to the Committee by Gary Friedlaender, M.D., of Yale University, who is President of the Executive Committee of the American Council on Transplantation.

In addition, the Committee anticipates receiving written testimony subsequent to the date of today's hearing from John Capelli, M.D., who is Director of the Renal Unit at Our Lady of Lourdes Hospital in Camden, New Jersey and from The New Jersey Medical Society.

ASSEMBLYMAN CUPROWSKI: Thank you very much David.

I think you can see by the names, the titles, and the representation of those names that David just read, that we certainly expect professional input into this particular piece of legislation, and we are looking forward to that. Hopefully, the net result will be a good piece of legislation -- a good law for the State of New Jersey.

At this time, I would ask Mrs. Quigley, if she would, to recap the written testimony that was received from Dr. Friedlaender.

MRS. QUIGLEY: Dr. Friedlaender is writing on the letterhead of Yale University. These are editorial comments that he had prepared for an earlier hearing on the national bill, which is similar to this one:

"Our medical and surgical expertise have caused a problem -- one that both society and health care professionals will have to address for many years to come. It is now possible to transplant numerous tissues and organs with such satisfactory and predictable success that for many individuals this approach must be considered a therapeutic option and, in some cases, the treatment of choice. The problem, or at least a major part of it, is assuring an adequate supply of organs and tissues satisfactory for human transplantation. Furthermore, until the availability of transplantable resources is improved, we must be most vigilant in providing the most equitable distribution of scarce organs and tissues.

"There are programs currently in place to enhance public awareness, to identify potential donors, to recover desired organs and tissues, to match these to waiting recipients and to accomplish transplant procedures. In fact, these efforts have provided for the transplantation of approximately 25,000 kidneys over the past 5 years, 500 livers and scores of hearts since these approaches were initiated, 15,000 corneas last year alone and an increasing percentage of the 100,000 to 200,000 bone grafts accomplished annually in the United States, as well as numerous skin grafts required for burn victims.

"This represents a commendable effort, but it has not been sufficient. Individuals in need of transplants still face many obstacles before being given the opportunity to benefit from the current state of medical expertise. There are clearly financial considerations preventing some patients from access to this technology, or at least making it more difficult to enter the system. Even when financing and suitable organs or tissues are available, there are a limited number of physicians and medical centers able to effectively pursue required surgical approaches. The remainder of my remarks, however, will focus only on the availability of organs and tissues, but keep in mind that other unresolved issues are equally as important to an effective national transplant program.

"Despite the attention of many devoted and effective educational and charitable foundations, public advocate groups, organ procurement agencies, medical centers, a vast array of health care professionals, insurance providers, and concerned citizens, our current approach to organ and tissue donation suffers in several ways. These include some degree of fragmentation, orientation to single organ or tissue interest, persistent unawareness of the public and many health care professionals as to the magnitude of the dilemna and, consequently, their lack of involvement of pursuing solutions, and ultimately, to constraints in the size of the potential donor pool. In theory, all of these problems except the latter can be successfully resolved; and in the case of the donor pool, we can certainly increase the percentage of individuals agreeing to provide organs and tissues.

"Improved coordinated attention to these issues alone would greatly enhance the availability of transplantable organs and tissues. In this regard, it has been comforting to see the recent formation of the American Council on Transplantation, a national federation of organizations and individuals concerned and expert in this area, and whose common goals address the need to increase and equitably distribute organs and tissues for transplantation. The impact of these honorable groups working together will be significant. It has been equally gratifying to see many segments of the public and private sector responding financially, by donating services -- for instance, the Oil Industry Lifesaving Flights Program -- and by contributing

their valuable time. Furthermore, members of both the executive and legislative branches of government have recognized the scope and magnitude of our transplantation needs and have come forward with a variety of constructive suggestions.

"As physicians and health care professionals we must overcome our individual reluctance to discuss organ and tissue donation knowledgeably and openly with our patients. This should occur during times of good health so that when a crisis arises for which donation is an alternative, the decision making process will have already been addressed and will not represent an added burden at a moment of grief. We must also be willing to take the initiative at the time of death to overcome any feelings of failure and not ignore the needs of society, and indeed, of our patients and their relatives to provide an opportunity for this precious gift to occur.

"It is through these types of voluntary and cooperative approaches, along with improvements of our regional and national recovery facilities and with additional trained personnel, that organ and tissue availability will increase.

"Other methods to increase the supply of transplantable resources have also been suggested, including the sale of organs either at the time of death, or in the case of kidneys, during life from unrelated donors. For the sake of this discussion let's give the individuals suggesting this approach the benefit of any doubt and assume their intent is solely in the public interest and that no financial awards would accure to the 'broker'. Let us also omit from this discussion the situation in which a patient may choose to directly reward or compensate a family member that otherwise altruistically provides an organ for a living-related transplant. Even put aside for a moment, if you will, the moral and ethical considerations, as hard as that might be for all of us. There are still serious ramifications for the donor, the recipient and for society that solidly defeat the notion that the 'sale' of organs would benefit the public.

"It is difficult to envision an individual selling one of his or her kidneys unless subjected to some form of life crisis, presumably with financial concerns involved. All those who have contacted me directly or have come to my attention fall into this pattern. It is

appropriate for us, as compassionate individuals, to be sensitive to these needs and to strive to find solutions for these desperate and disadvantaged people, but we cannot ignore reason in our attempts to help. The threat to life from kidney donation is small, but real, and the morbidity is apparent. Long-term concerns for optimum health with a single kidney unavoidably raise certain risk factors. Thus, the financially motivated donor must be under intense emotional pressure that may interfere with his ability to provide truly informed and rational consent.

"Risks to the recipient are also real and significant. A parallel experience occurs with blood donation, and despite attempts and available facilities to screen individuals, a small but unpredictable segment of the donor pool provides blood of dubious, if not dangerous qualities. Financial gain removes the altruistic desire of the donor or avoids contaminating the resource pool. The consequence would be an increased risk of unacceptable organs finding their way into the system.

"My final concern is for the system itself. Nothing would be more disruptive to the voluntary donation of organs and tissues than the pressure and confusion instilled by compensation. It would be difficult for the two approaches to exist simultaneously and effectively, and in this particular case competition would not improve the quality of the end product. It is not difficult to envision families whose next-of-kin are not totally suitable for donation, exerting undue influence on the system to be accepted, or who might find the 'system' culpable if the donation is not appropriately suggested or carried out. Confusion might also arise if the donated organ fails to perform properly. Equitable access to transplantable resources would clearly be corrupted by the sale and purchase of organs and the added costs -- financial, moral, ethical and emotional -- of this maldistribution would inevitably find their way back to all of us.

"My thoughts have not encompassed the moral and ethical issues, an exercise in self-control, but in the end these concerns are at least as significant. There are many ways to help our fellow human beings, and we must continually strive to do so, even when we cannot

fully succeed. Organ donation is an example. It will be impossible, for instance, to provide sufficient numbers of youthful, healthy hearts for replacement in the 'end stage heart disease' that occurs hundreds of thousands of times annually in this country, and it will be torture to establish priorities for equitable access to the insufficient supply of transplantable organs and tissues. However, to be human only requires that we try our best, and that we are willing to do."

In regard to this particular bill, in the letter that Dr. Friedlaender wrote to David Price, he said, "If I were to just briefly summarize, it is my understanding this bill is primarily offered to prohibit the sale of human organs and tissues within the State of New Jersey, a concept that I, in its general sense, support as an individual and that numerous professional organizations to which I belong have vigorously concurred -- American Council on Transplantation, American Association of Tissue Banks, and American Society of Transplant Surgeons.

"I would only offer a word of caution, and that is that there are potential costs incurred by relatives otherwise motivated by altruism to provide the gift of a required organ or tissue. Provision for reimbursement of these costs and for those expenses clearly associated with recovery, processing and distribution of donated organs and tissues must be considered. I would hope also that those private citizens and health care professionals who act in good faith would be protected by the language of your proposed legislation.

"If you have any further questions, I would be glad to respond," signed Gary E. Friedlaender, M.D.

ASSEMBLYMAN CUPROWSKI: Thank you very much Mrs. Quigley.

There was a concern in the written testimony of the doctor regarding the normal costs involved in a given transplant. This concern was given consideration in the drafting of this particular bill. I would ask that Mrs. Quigley read that particular statement for the record.

MRS. QUIGLEY: This is one point that you stressed you wanted included in here because it would differ significantly from the bill that is now pending before the House of Representatives. In A-1360 the term "valuable consideration" is defined as the payment of money or

something convertible into money or having a value in money as an inducement to a contract and any other type of consideration, except the reimbursement for reasonable costs incurred by voluntary donors in connection with travel, shelter, medical expenses for testing or removal, storage or transportation of human organs and the reimbursement of voluntary donors for all losses incurred as the result of time lost thereby from work or daily duties.

ASSEMBLYMAN CUPROWSKI: I think that provision within the bill certainly should alleviate the concern of the doctor.

At this particular time, I would like to call on a representative from the New Jersey Hospital Association headquartered here in Princeton, who requested to speak today -- Mr. Craig Becker.

CRAIG BECKER: I am Craig Becker, Vice President for Government Affairs with the New Jersey Hospital Association. I want to thank the Assemblyman today for allowing me to speak on this issue.

While this specific bill has not had the official support of the New Jersey Hospital Association, it is this type of legislation that the Association welcomes. I have spoken with several of our members, many of whom would have been here today had it not been for the inclement weather, and they have all spoken their vigorous support of this bill. Once a formal position has been taken by the Association, we will forward that input and comments to the Committee and to you, Assemblyman, hopefully by that April 10th date. Thank you.

ASSEMBLYMAN CUPROWSKI: Very good, Mr. Becker. We appreciate that your comimg here and giving that statement. Thank you very much.

At this time, is there anyone else in the audience who would like to be heard on this particular bill at this public hearing?

Anyone else? If not, I'm going to ask Mr. David Price to give us a quick recap of laws, either pending or passed, in other states within the United States.

MR. PRICE: Legislation has been introduced in the past two years to prohibit the sale, or solicitation for sale, of organs from both living bodies and cadavers in a number of states, including Maryland, Pennsylvania, and Virginia. These bills would prohibit the

sale of human organs either from a living or dead body, unless the sale is under the supervision of the state anatomy board or other state agency which oversees the sale of dead bodies to educational or research institutions. The sale of "self-replicating fluids" such as blood, sperm, or saliva are excepted from this prohibition.

The proposed penalties for violations vary widely in these bills. The two bills in Maryland -- House Bill 160 and Senate Bill 34 -- do not provide for penalities. However, pending legislation in the State of Pennsylvania -- House Bill 1661 of 1983 -- would impose a civil penalty of $50 thousand, the same as that provided in Assembly Bill 1360. The new Virginia law -- House Bill 731 of 1983 -- imposes a class three felony, which carries a 5 to 20 year prison sentence. And, a new law in the State of Oklahoma -- House Bill 1879 -- provides a $50 thousand fine and a prison sentence not to exceed five years.

Other states are investigating the application of other statutes in order to prohibit the sale of human organs and tissues. The State of New York may attempt to prohibit the for-profit brokering of organs by applying Article 45 of the New York State Public Health Act, which would prohibit a person from engaging on a for-profit basis in any business or service that includes the referral of persons to a physician or hospital for medical care. This also prohibits any physician or hospital from accepting such a referral. Although designed to eliminate the cooperation of for-profit abortion referral centers with for-profit abortion clinics, this act might be effectively applied to forbid for-profit brokering of organs. It would not, however, specifically address the actual sale of human organs.

ASSEMBLYMAN CUPROWSKI: Thank you very much David.

At this time I would like to ask Chris is she would like to make a statement.

MS. SIMON: No.

ASSEMBLYMAN CUPROWSKI: Okay.

David, do you have any additional statements or comments that you would like to make?

MR. PRICE: No. I would say that we have been notified by Marshall Klein, who is the Executive Director of the Eye Bank Foundation of New Jersey, that he is unable to be here because of the weather. However, he plans to submit comments on the bill, A-1360.

ASSEMBLYMAN CUPROWSKI: I believe I have a letter from the Eye Bank Foundation. At least I hope I do. Please bear with me a second while I try to find it. I apologize; I was expecting Mr. Klein to be here today and, therefore, I didn't think I would need it. At the moment I just cannot locate that particular letter, but the Eye Bank Foundation had indicated to me that they would be here today, that they were certainly supportive of the bill, and they would have representation to detail their support here this morning.

But again, we will welcome any written or verbal testimony. And just as a reminder, those who could not make it here this morning and want to give testimony, will be able to do so in writing to Mr. David Price. And those who want to give oral testimony, may be able to do so with the approval of the Chairman, assuming that this particular bill is on the agenda in Committee on April 10. And, that should be in Room 317 at the State House Annex in Trenton.

Is there anyone else at this point in time who would like to speak on this particular bill? (no response)

Again, I can't overemphasize my appreciation to all of you for coming down and giving your time under the very bad weather conditions.

Again, I want to give special thanks to David, who put this hearing together, and to Chris, as part of the Majority Staff, and also to Joan Quigley, who, as I said before, did a lot of research on this. I have another aide, Louis Artisicio, in attendance and my unpaid photographer, my son, Paul over there. I appreciate every one of you for coming down. Thank you very much.

(Hearing Concluded)

Presidential Address - American Council on Transplantation
January 23, 1984
Gary E. Friedlaender, M.D.

I have approximately 20 minutes to summarize the genesis, present state and future directions of the American Council on Transplantation. This requires a bit of background information, definition of goals and early organizational efforts, some indication of what ACT is - and what it is not and, finally, some personal thoughts on the future. The entire story is lengthy, despite the short 4-month history of the Council, but I will spare you many of the details and hope the essence of my extreme joy and gratitude as well as some frustration will not be lost from my summary. After all - "all beginnings are hard." Dr. Benjamin Baker, the Interim Executive Director of the American Council on Transplantation, provided the title "Act One" for this address - perhaps "Round One" would have been more accurate. As far as I can tell, however, this is the only miscalculation Ben has made since joining ACT in December; and I will get back to thanking him more properly in a moment.

Onward. First, the good news. Our scientific, surgical and medical expertise has made it possible to transplant numerous tissues and organs with such satisfactory and predictable success that for many individuals this approach must be considered a therapeutic option and, in some cases, the treatment of choice. We will be treated to a brief review of these accomplishments later this morning by outstanding purveyors of the art! [Heart/Lung, Phillip Oyer, M.D.; Kidney, Oscar Salvatierra, Jr., M.D.; Liver, Thomas Starzl, M.D.; Pancreas, David Sutherland, M.D.; Blood, William Miller, M.D.; Bone, Henry Mankin, M.D.; Bone Marrow, Partick Beatty, M.D.; Cornea, Peter Laibson, M.D.; Skin, Irving Feller, M.D.] Perhaps even more exciting than what has already been accomplished by transplantation is the obvious scientific and technological momentum that will undoubtedly expand our medical horizons even further in the future.

But now the dilemma, - efforts at acquiring, financing and equitably distributing precious transplantable resources - in other words realizing our full potential - are not, at the present time, providing everyone in need with the opportunity to benefit by this approach. As you know, our ability to sustain life, alleviate suffering and address disease by transplantation will get even better in the future, and it is our collective conscience, wit and wisdom that must minimize, if not eliminate, the tragic circumstances of current and projected unmet needs. The cornerstone of clinical transplantation is medical science and the building blocks are an adequate supply of satisfactory organs and tissues, appropriate medical facilities, proper numbers and types of trained professional personnel, an ongoing program of research and education and mechanisms to pay for all of this. The mortar is a strong recognition, desire and mandate from the public to put this type of program together and support it.

The proverbial glass is, in my estimation, half full - not half empty. There are many programs currently in place to enhance public and professional

awareness, identify potential donors, recover desired organs and tissues, match these to waiting recipients and accomplish transplant procedures. In fact, these efforts have provided approximately 5,500 kidneys for transplantation in the United States in 1983, more than 70,000 since this program began; over 800 heart, 500 liver and 300 pancreas transplants have been carried out since these approaches were initiated and between 15,000 and 18,000 corneas were donated and transplanted last year alone. A growing percentage of the 100,000 to 200,000 bone grafts accomplished annually in the United States represent donated, banked tissues and thousands of skin grafts required for burn victims were made available. A more advanced version of this "system" has provided us with millions of units of the highest quality blood the Nation has ever had available, and done so through a totally non-profit and almost completely voluntary system of donation without financial compensation to the donor.

This clearly represents a commendable effort, and the praise belongs to many of the individuals and organizations represented here today; but these accomplishments have not been sufficient. It remains an uncontested fact that many individuals in need of transplants still face obstacles before being given the opportunity to benefit from the current state of medical expertise. Some of these issues will be more fully explored this afternoon and are represented by title in your program. The list is not meant to be inclusive or prioritized, merely a start. [Committee on Patient and Family Issues, Amy Peele, R.N.; Committee on National Networks, William Braun, M.D.; Sale of Organs - State Legislative Activities, Richard Merritt, M.A.; Multi-Organ Transplants - Report of An N.I.H. Conference, Nicholas Feduska, M.D.; Public Education for Transplantation, Ira Greifer, M.D. and Jeffrey Prottas, Ph.D.; Professional Education for Transplantation, H. Arnold Muller, M.D.] Parenthetically, I believe the discussions of "Patient and Family Issues" and "National Networks" represent tangible progress by ACT toward clarifying issues and exploring solutions.

Despite the attention of many devoted and effective professional societies, educational and charitable foundations, public advocate groups, organ procurement agencies, medical centers, a vast array of health care professionals, insurance providers and concerned citizens, our current approach to organ and tissue donation suffers in several ways. These include some degree of fragmentation and duplication in efforts, orientation towards single organ and tissue interests, persistent unawareness by the public and many health care professionals as to the magnitude of the dilemma or knowledge of existing resources (which leads to their lack of involvement in pursuing solutions) and, finally, constraints must be recognized in the size of the potential donor pool. In theory, all these problems except the latter can be successfully resolved; and in the case of the donor pool, we can certainly increase the percentage of individuals agreeing to provide organs and tissues.

Co-ordinated communication and attention to these issues alone will greatly enhance the availability of transplantable organs and tissues. This, I believe, is the core about which the American Council on Transplantation is being built. The issues I have raised with respect to transplantation are no secret today, nor have they gone unrecognized by many other organizations and individuals in the past. Indeed, initiatives directed towards improving these circumstances have come forward from many directions, and as a public we must recognize and be appreciative of these efforts.

With specific reference to the American Council on Transplantation, we must recognize the concern and action demonstrated by Dr. C. Everett Koop, Surgeon General of the U.S. Public Health Service. His personal involvement in this area lead to a meeting at Project Hope of the Steering Committee that was to initiate the American Council on Transplantation. This conference was attended by over 40 individuals representing a vast array of interests and expertise in the field of transplantation, including representatives of the American Association of Tissue Banks, the American Society of Transplant Surgeons, the American Academy of Pediatrics, the American and National Medical Associations, the American College of Emergency Physicians, the American Hospital Association, the North American Transplant Co-ordinators Organization, the American Association of Critical Care Nursing, the American Nurses Association, the National Kidney Foundation, the American Liver Foundation and Children's Liver Foundation, bioethics groups, organ procurement agencies, eye banks, blood services, insurance carriers, the federal government and many others.

The gathering was catalyzed by the Surgeon General, following which the group reached a consensus on the need to establish an independent federation of professional peer groups with expertise in tissue and organ transplantation. Here I wish to stress the concept of an independent federation, a point I will return to again before concluding. The group was well aware of the need for speedy action, given the urgency and gravity of many issues before them (and now "us"). Accordingly, general goals were established, a name for the federation was chosen, interim officers were nominated and elected and dates for the first Annual meeting were determined.

Let me recite for you the general goals adopted at that meeting: 1. to motivate the public to donate organs and tissues for transplantation; 2. to encourage health care professionals to identify and refer potential donors to organ recovery programs and tissue banks; 3. promote equitable access and effective use of multiple organs and tissues and 4. address the technical, ethical and financial issues involved in organ recovery and transplantation. These goals are broad and noble, and it was not at all difficult for those people attending the conference to embrace them enthusiastically.

It was my personal perception as well as that of many I have spoken with that ACT would represent the sum total of our best efforts by creating a cohesive national framework in which established and independent groups could collaborate with direction, flexibility, co-operation and innovation. In concept, ACT will take a good system and make it better. Advantages of this federated approach include the fact much of the system already exists and is in place. A careful analysis of the present transplant effort will permit an organization such as ACT to encourage, promote and expand the effective elements of the current system as well as identify and address inadequacies in ways deemed appropriate by its membership. As a federation, the Council will combine the currently fragmented resources in such a fashion as to provide a more effective impact in areas of education, training, organ and tissue recovery, banking and most equitable distribution, as well as suggest mechanisms compatible with appropriate funding for transplantation. A similar approach proved highly successful for the American Blood Commission over 10 years ago.

Since late September, the interim officers have applied themselves to the charge provided them by the Steering Committee. That was to establish the

Council as a real and visible organization, with an internal structure capable of generating a national framework in which members could identify issues pertinent to successful organ and tissue transplantation programs, address these in meaningful ways and, finally, to organize the first annual meeting of the Council that was to occur on this particular date.

Now comes my favorite part of this address, the opportunity to recount what we have done and to thank the many people who have assisted our independent efforts. In November 1983, ACT established an office at 1825 I Street in Washington with a full-time administrative staff. The first three months rent has been donated by our landlord, Business Resources Corporation. Legal counsel has been provided by the firm of Beveridge and Diamond (particularly J. Marshall Coleman and Virginia Albrecht), accounting services by Coopers and Lybrand (particularly A. Michael Quint) and assistance with public relations by the firm Hill and Knowlton (particularly Mark Grayson and Nancy Glick). All these services have been received on an pro bono basis during our organizational phase so that no loss of momentum would be incurred. Subsequently, articles of incorporation were filed, our tax-exempt status application submitted and by-laws established that will permit the Council to move ahead with the same enthusiasm that characterized our other initial steps. The American Hospital Association donated sufficient funds to temporarily support an interim executive director, Dr. Benjamin Baker, who has approached his short-term committment (ending in March, 1984) with the zeal and brillance that marked his career as a former Deputy Assistant Secretary for Defense and Deputy Surgeon General for the Air Force. Giving directions to a former two-star general fulfills one of my life's fantasies, but I have gotten more in return than I expected. As is often typical of Executive Directors, the full impact of their wisdom is rarely appreciated in full, but let me publicly assure you that he has been an indispensible element in our efforts to date and will be sorely missed in the near future.

Indeed, there have been many other contributors to our effort far to numerous to mention in detail here, but I must point out that the Department of Health and Human Services has provided the Council with seed funds totaling $100,000 in a co-operative agreement, the only string attached being that we address the noble goals I stated previously. The private sector has also donated generously to ACT and numerous individuals and organizations have spontaneously contacted us with the desire to provide funds, services or personnel to help address our important and demanding mission. I would also like to thank all the members of the Council's Steering Committee, especially those actively serving as interim officers and committee chairpersons.

This brings me to a more sensitive portion of my address, that is explaining what ACT is not. Firstly, ACT is not a substitute for any of the individual organizations that participate in our independent, federated efforts. Each organization has a strong tradition of their own excellence, independence, direction and agendas, and I expect them to continue vigorously with their own points of view. It is my hope that the federation will achieve an overwhelming consensus on a wide range of issues coming before the Council. Nonetheless, individual identity should not be lost, for this would weaken the basic concept of a federation. Please keep in mind that differences of opinion, perceived or real, can be healthy, especially when expressed and worked through with honesty and dedication to common goals.

I would submit we saw the potential merits of a federated approach demonstrated over the two days preceding this meeting. Again catalyzed by Dr. Koop, a symposium entitled "Maintenance of a Cadaver Donor for Multiple Organ Procurement" was organized under the auspicies of the National Institutes of Health and co-chaired by Dr. Kenneth Sell, Scientific Director of the National Institute of Allergy and Infectious Disease and by Kenneth Goodman, Medical Services Liaison for the Upjohn Company. This very exciting initiative was not the sole focus or agenda of any specific group, but rather a successful amalgumation of multi-disciplinary expertise. As pointed out at the meeting, initiating directions are only a beginning, maintaining the dialogue and co-operation is the key to successfully and expediciously resolving issues. I would submit that the American Council on Transplantation should provide for this type of ongoing relationship between very knowledgeable, competent and dedicated groups as exemplified by the NIH Symposium, those brought together in September at Project Hope and again here today.

Next on my list of what ACT is not, and contrary to some peoples perception, the American Council on Transplantation does not offer itself as an alternative to anything except the void created by the absence of an independent, altruistic national forum. To be blunt and specific, in the hopes of avoiding confusion and misconceptions in the future, ACT does not consider itself in competition with other initiatives that may have impact on transplantation, including pending legislation. By the same token, the issue of specific legislation has not been addressed within the framework of ACT to date, so the organization cannot be perceived as either supporting or rejecting legislative initiatives or any other agendas developed outside the Council. Since ACT is a federation, individual participating organizations may certainly be identified with their own points of view in these matters, and I can assure you honest differences of opinion exist.

To continue, ACT has not convened itself for political purposes. This misconception by some has caused me a great deal of difficulty and anguish, and I have felt considerable personal concern, with the only comfort being that the slings and arrows have come at me and the Council from both sides of the "political" fence. Perhaps that is the ultimate compliment, but it interferes and I wish it would stop. I am not, and ACT is not to be construed as a spokesperson for Congress, for the Administration or for any specific individual organization or interest group. Allegations to the contrary are difficult for me to accept. Not being totally naive, however, I do understand the background for some of these misconceptions, although they do not alter the reality of the situation. Let me also state that I do not feel that I or the Council become a vehicle for or representative of an individual or organization just because they express pleasure with what ACT is or intends to accomplish. If judged by our actions, we may have been politicized by others but remain independent by deed. In fact, our only official posture as a Council (beyond our stated goals) has been to express concern over the proposed sale of organs, a statement adopted by the full Steering Committee in September. Consequently, I will continue to be grateful for credible support for ACT wherever it arises, but be assured it does not reflect negatively upon the independence or the governance of our organization. Perpetuating misconceptions in the future, unsubstantiated by deed, flagrantly interferes with ACT's efforts to raise and address issues important to further development and refinement of a fair, comprehensive and accessible national transplant program designed to serve the public.

Let me now turn specifically to what I see required for the future. ACT will gain its strength from broad-based and appropriate input provided by both organizations and individuals. I personally feel, and the Interim Executive Committee members present at our most recent meeting on January 9th unanimously concurred in the form of a motion, that the governance of the American Council on Transplantation must reside with professional organizations, but that both organizational and individual membership should be continued and encouraged.

The highly complex nature of transplant-related issues facing us demands the full weight and wisdom of knowledgeable professional groups, as partially represented by the original steering committee. The impact of these issues on society and on individuals, and the fact that many solutions and all the benefits will accrue to the public, demands that public input be recognized. I must hasten to add that ultimately we are all going to relate as individuals and those of us representing organization are proudly and inescapably also individual members of the public. Consequently, it is the decision of the current ACT Executive Committee to ask the officers and members of the Board to be elected tomorrow to address as a priority issue the restructuring of the Council and its by-laws to reflect this needed direction. It is my great hope, that the wisdom of individuals voting tomorrow will be to vigorously support and, indeed, mandate the formation of an organization of organizations, but one clearly responsive to individual needs.

So there you have it, the good news and the bad, the challenges met and the challenges that persist. I believe it is time to identify and support, in unison, comprehensive and feasible approaches that have as their goals increased numbers of tissues and organs suitable for transplantation; appropriate facilities and personnel for implementing recovery, transplantation and equitable distribution of these precious resources; continuing support for basic research to insure an even brighter future and a system of financial support that the public as a whole, and as individuals, can afford - and not afford to be without. The direction I envision for the American Council on Transplantation places its faith firmly in professional organizations, with the collective wisdom and input of the public, to address and resolve many of our transplantation needs effectively, efficiently, quickly and with fiscal responsibility. As sensitive and concerned people, we are all saddened when our current approach to transplantation cannot provide all individuals and their families with the necessary resources, be they the organ itself, financing, scientific expertise or surgical facilities. We must, however, constantly know that we are putting forth our best effort and strive to do even better in the future. From that perspective, we can all feel proud and move ahead, with tangible progress serving as the yardstick for measuring our efforts. Remember, you can't transplant rhetoric! Thank you.

MEDICAL
SOCIETY
OF NEW JERSEY

EXECUTIVE OFFICES ☐ TWO PRINCESS ROAD, LAWRENCEVILLE, NEW JERSEY 08648 ☐ TELEPHONE 609-896-1766

April 10, 1984

Mr. David Price
Office of Legislative Services
Assembly Corrections, Health and
Human Services Committee
CN-042
State House
Trenton, N.J. 08625

Dear Mr. Price:

This in reference to our March 27, 1984 letter concerning A-1360.

The Medical Society's Council on Legislation took a position of **APPROVAL** on A-1360 at its April 5, 1984 meeting.

I hope this is of assistance, if I can be of any further help to you, please do not hesitate to call upon me.

Sincerely yours,

June A. O'Hare
Legislative Liaison

j

MEDICAL SOCIETY OF NEW JERSEY

EXECUTIVE OFFICES ☐ TWO PRINCESS ROAD, LAWRENCEVILLE, NEW JERSEY 08648 ☐ TELEPHONE 609-896-1766

March 27, 1984

Mr. David Price
Office of Legislative Services
Assembly Corrections, Health and
Human Services Committee
CN-042
State House
Trenton, N.J. 08625

Dear Mr. Price:

At this writing, the Council on Legislation of the Medical Society of New Jersey has not yet taken a position on A-1360. We have been unable to secure a copy for review.

A Federal bill, H.R.4080, pending in Congress, has created a great deal of controversy. Enclosed are comments of the AMA and the American College of Surgeons related to H.R.4080.

As soon as we have reviewed A-1360, we will transmit our comments to you and Assemblyman Cuprowski.

Sincerely yours,

Vincent A. Maressa
Executive Director

VAM:joh
Enclosure
cc: Assemblyman Paul Cuprowski

LEGISLATIVE ROUNDUP

A Report on National Medical Legislation

ORGAN TRANSPLANT BILL REPORTED

The Health Subcommittee of the House Ways and Means Committee has reported out the Organ Transplantation Act. A number of amendments to the bill were offered, including a package of amendments by Representative Thomas W. Moore (R-VA) which would have created an organ transplant task force, established a list of organ recipients, banned the sale of organs, and deleted objectionable Medicare amendments contained in the bill. Representative Moore's package of amendments was defeated. Moore was successful, however, in amending the bill to delete the authority for Medicare to pay for outpatient immunosuppressive drugs, such as cyclosporine. Under existing law, Medicare does not pay for outpatient drugs of any kind. Moore also successfully offered an amendment to address AMA concerns over the language in the bill which would ban the sale of organs. New language will allow a physician to proceed with a transplant if the recipient is in a life-threatening situation even if the physician has reason to believe the procurement of the organ violated the ban. Finally, Representative Charles B. Rangel (D-NY) offered an amendment that would eliminate language in the Medicare amendment requiring the HHS Secretary to designate criteria for practitioners seeking to be reimbursed for specific technologies or procedures. The Rangel amendment, which left most of the objectionable Medicare amendments intact, was accepted by the Subcommittee.

The Subcommittee action came one day after a letter was sent to all members of the Ways and Means Committee from the AMA and 24 other medical and hospital groups. The letter objected to the Medicare amendments of HR 4080 and pointed out to Committee members that hearings on this bill have focused on transplantation matters and have failed to weigh the significance of the Medicare amendments.

American College of Surgeons

FOUNDED BY SURGEONS OF THE UNITED STATES AND CANADA 1913

55 EAST ERIE STREET CHICAGO, ILLINOIS 60611 AREA CODE 312 · 664-4050

C. ROLLINS HANLON, M. D., F. A. C. S.
DIRECTOR

March 6, 1984

The Honorable Dan Rostenkowski
Chairman, House Committee on Ways
and Means
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Chairman:

The American College of Surgeons wishes to comment on H.R. 4080, the National Organ Transplant Act. The College is a voluntary educational and scientific organization devoted to the ethical and competent practice of surgery and to the provision of high quality care for the surgical patient. The College provides educational programs for its more than 46,000 Fellows and others in this country and abroad, establishes standards of practice, disseminates medical knowledge, and provides information to the general public.

As the survival rates of many transplantation procedures have improved, public attention has focused on the increasing need for organs and for funds to pay for the complex medical and technological partnership that accomplishes transplantation innovations. The College approves the intent of H.R. 4080 to augment and improve the already significant private sector achievements in organ transplantation. Title II of H.R. 4080 provides financial support for certain immunosuppressive drugs favored by many specialists in transplantation. However, the College believes that Title II of H.R. 4080 expands the authority of the Secretary of Health and Human Services far beyond the sphere of organ transplantation. Title II would authorize the Secretary to determine whether a specific health care technology or procedure is reasonable and necessary.

Title II of H.R. 4080, as reported by the Energy and Commerce Committee, authorizes the Secretary of Health and Human Services to determine the eligibility of Medicare beneficiaries for health services, the qualifications of physicians to furnish services, the location of facilities or centers where services could be provided, and the conditions required for provision of services. Such criteria established by the Secretary of Health and Human Services for services covered under Medicare could take precedence over medical decisions regarding the patient's treatment.

The broad powers granted the Secretary under Title II are not limited to transplant technology or transplant procedures. These amendments would authorize the Secretary to control the practice of medicine by prescribing conditions and standards according to criteria not based on medical science and medical practice. The language of the Energy and Commerce Committee report clearly cites applications of the Secretary's authority that go beyond transplantation, for example: "a new imaging device, a new therapeutic agent, or a new type of surgery or surgical implant." It is in these broad areas rather than in the transplantation of organs that the greatest effects may be felt. For these reasons, the College opposes adoption of the current version of Title II of the National Organ Transplant Act.

The College believes that the adoption of Title II would result in a major policy shift for Medicare. Therefore, this provision should not be adopted in its present form.

Thank you for your consideration of these concerns.

Sincerely,

C. Rollins Hanlon, M.D., F.A.C.S.

CRH:bc

Individual letter sent to each member of the House Ways and Means Committee.

State of New Jersey

DEPARTMENT OF HUMAN SERVICES
COMMISSION FOR THE BLIND AND VISUALLY IMPAIRED
1100 RAYMOND BOULEVARD
NEWARK, NEW JERSEY 07102
TELEPHONE 648-3333

MRS. NORMA F. KRAJCZAR
Executive Director

March 26, 1984

Mr. David Price, Committee Aide
Assembly Corrections, Health
and Services
Human Services Committee
CN-042
State House Annex
Room 229-E
Trenton, New Jersey 08625

Dear Mr. Price:

At their meeting on March 21, 1984, the Board of Trustees of the New Jersey Commission for the Blind and Visually Impaired, considered Assembly Bill No. 1360. In view of the fact that this agency is frequently involved in serving clients who are in need of corneal transplants, as well as promoting public education in the area of prevention of blindness the substance of this bill is most relevant. We obviously wish to see that the conduct of programs promoting or providing organ transplants are maintained at the highest level of legal and ethical integrity.

The Board by formal motion requested that I share their support for Assembly Bill No. 1360, with you, and if there is anything further we can do to assist in the promoting of this bill, please do not hesitate to contact us.

Sincerely,

Norma F. Krajczar

(Mrs.) Norma F. Krajczar
Executive Director

l/nk/84

cc: Larry J. Lockhart, Deputy Commission
Sondra R. Clark
Arthur J. McGrath
Gilbert L. Dick

RE: Assembly, No. 1360 March 29, 1984

John M. Kiernan

Administrator/Coordinator
Organ Recovery Program
The Presbyterian Hospital in the City of New York

University Seminar: Death
Columbia University

Associate Member
The Hastings Center

While preparing my comments for this hearing, I received a call from a man who asked if he had reached the "medical department for organ transplants." I informed him that he had and asked him if he wanted a donor card and brochure. He did not want a card per se, but did want to know the procedures pertaining to organ donation. I told him that organs and tissues were commonly recovered from donors after death. He asked about living donors. I stated that kidneys -- and sometimes bone marrow -- were obtained from suitable living donors who are usually close relatives. This man then stated that he thought he could be compensated for the donation of an organ -- presumably a kidney -- while alive, or compensated while alive for a donation(s) to take place upon his death. He was informed that this was not possible and that this was simply not done. He declined my offer to mail him a donor card and explanatory brochure. The call ended.

I was relieved that he didn't bring up the subject of suicide. One unfortunate young man -- a resident of New Jersey -- once called and informed me that his father was dying of widely disseminated cancer of the liver. He wanted to know if any of his father's organs and tis-

sues could be sold. He contended that the father was leaving his mother and himself destitute. I told him that his father could not be an organ donor because of metastatic cancer -- with the one exception of eye donation. When told that there could be no payment of any kind for any donation, this man informed me that he was contemplating suicide because of the family's financial plight. I must have spent an hour on the phone discussing his alternatives and suggesting steps he might take to straighten out his life. I trust that he has sought those alternatives.

I have received a number of interesting letters from people hoping to sell a paired organ such as a kidney or a lung. One young man, admitting his desire to escape poverty, offered to sell one kidney and one lung for the combined price of $500,000. He wrote that he was sure that somewhere there would be takers. I chose not to answer his letter. He wrote again. The asking price was lowered to $250,000. I did not answer the second letter, nor did I hear from him again.

It is noteworthy that I have received many more calls and notes offering a heart or a liver gratis both from individuals realizing that this would be a terminal event if effected and individuals who didn't seem to understand such donations would end their lives.

I have coordinated organ recoveries for five years. The most crucial and emotionally demanding aspect of my work is the encounter with the family of a potential organ donor. I consider it standard practice to inform the family of a potential organ donor that they will <u>not</u> incur any expense as a result of the donation, and that they cannot be reimbursed for the donation or assisted with the cost

of burial. Families rarely ask me if there are any costs. Hence, I have made a point of informing them. I cannot recall a case in these five years of a family refusing to donate because of financial considerations. The mother of a 20-year old shooting victim asked only that her son's kidneys be given to poor people.

I have been singularly humbled by the generosity-in-grief of the donor families I have had the sad privilege to work with during this time.

The costs of organ recovery and organ transplantation have become an issue of public knowledge and concern. When I speak on these subjects, professional and public audiences are very interested in how organ recovery is paid for and what the recipient is charged. I inform them that at the present time the Medicare Program finances 100% of the costs of kidney recovery from living and cadaveric donors for Medicare-eligible kidney recipients. The recipient does not see the bill for the kidney. The transplant center bills Medicare. The direct costs of kidney recovery, preservation and sharing can be staggeringly high. They can easily exceed $ 10,000 per cadaveric kidney exclusive of tissue typing and personnel costs. Very few people could afford to pay such costs out of pocket. Commercial insurance carriers in growing numbers are recognizing heart and liver recovery costs as reimbursable components of such transplantation procedures.

I would maintain that no amount of money can cause a suitable organ to materialize for a particular transplantation candidate. The issue is not money. The issue is insufficient supply to meet demand.

Barry Jacobs created quite a stir last year with his proposed International Kidney Exchange. I have attached a copy of letter received at my hospital and apparently sent by Dr. Jacobs. The implicit assumption is that a number of hospitals would be interested in performing unilateral living donor nephrectomies and sending the kidney to the transplant center caring for the pre-selected recipient. The costs of recovering these kidneys would be billed to the transplantation centers in the cases of Medicare-eligible recipients. If the ultimate recipient were not Medicare-eligible, other payment mechanisms would apply. No mention is made in this letter of payment to the living, unrelated "donor."

No mention is made of any potential risks to the donor such as those of general anesthesia, post-surgical infection and other complications.

Is it possible to impute a dollar value to an organ, to a human life? I think not!

The sale of human organs is a matter of concern to the Congress as evidenced by HR 4080, the National Organ Transplant Act, introduced by Rep. Albert Gore. It is of concern to the Senate and General Assembly of the State of New Jersey as evidenced by Assembly, No. 1360.

Both proposals contain the same punishments, and, at the maximum, they are severe: a fine of $ 50,000 or five years in prison or both.

Assembly, No. 1360 is broader in scope than the Gore bill. It adds solicitation, brokerage and advertisement for sale to the list of punishable offenses.

George Annas article in the February, 1984 issue of "The Hastings Center Report" is most relevant to today's hearing. [1] It includes, for those of you who haven't seen it or read Annas' article, a facsimile of an ad from the Christmas 1983 edition of the Burlington County (NJ) Times. A 32-year old woman in excellent health advertised a kidney -- presumably her own -- for sale, no price mentioned. Annas concludes that the strongest argument against the sale of organs is an instinctive one. The instinct is that a person shouldn't be allowed to "sacrifice" himself or his health for monetary gain.

I agree with this. I do not believe that a human being -- body, mind, heart and soul -- can be reduced to a collection of parts. I do not believe that a human being should be treated as an object, a material thing with a dollar value. The placing of a price on an organ is a dangerous reduction. Organs are not commodities -- whether they are obtained from the living or the dead. I can only reiterate my previous comment on the remarkable generosity and altruism of the donor families with whom I have worked.

Voluntarism can work. The task at hand is the education and motivating of physicians, nurses and allied health professionals to identify potential donors and give their families the opportunities they need to consent to organ donation. They will consent more often than not when approached in the appropriate manner at the appropriate time.

It seems most unlikely to me that sale of organs and tissues would increase the supply. It could add greatly to concerns about the quality of organs, the safety of our recipients and the growing costs of organ recovery and transplantation.

I believe that organ transplantation is good for certain patients. You must remember that not all end-stage organ failure victims are suitable cadidates for transplantation.

I believe that the difficult work of organ recovery is worthwhile and worth doing well. The satisfaction of seeing a donation result in successful transplantations that save life or restore life to normal is impossible to describe.

It must also be remembered that not all transplantations are successful. The transplantation community is working toward that goal. The "life" of a transplanted organ can sometimes be measured, unfortunately, in minutes, hours or a few days. The fate of the organ cannot be ignored in any discussion of organ sales, risks to the donor and risks to the recipient.

Annas cautions that statutory prohibition of organ sales may be premature, unnecessary or inconsequential. [2] I believe that such statutes do serve a useful purpose. They may protect those who could suffer harm by selling an organ and those who could suffer harm from an ill-gotten organ.

In closing, I wish to make clear again that I support a statute such as Assembly, No. 1360. It might be difficult to enforce. I certainly hope that the young woman from Burlington County would not be penalized for placing the ad, nor the paper's publisher for running it. It would be wise to carefully define the scope of this act and to distinguish criminal intent and action from harmless gesture.

I would trust that professional and institutional codes of ethics and the sensibilities and generosity of the people of New Jersey and the United States would make enforcement of this statute unnecessary.

Thank you.

Notes:

1. G.J. Annas, "Life, Liberty, and the Pursuit of Organ Sales," The Hastings Center Report, v. 14, no. 1, February 1984, pp. 22-3.

2. Ibid.

H. BARRY JACOBS, M.D.
Diplomate of the American Board of Surgery
Diplomate of the National Board of Medical Examiners
Medical Director

TOLL FREE 800-336-0332
DC and VA. (703) 435-9400

International Kidney Exchange, Ltd.

11345 Sunset Hills Road
Reston, Virginia 22090 U.S.A.

Dear Hospital Administrator:

We are involved in national and international kidney transplantation programs.

We would like to utilize the services of your hospital for these programs. The donor patients will require elective uni-lateral nephrectomies. The recipient patients will require the transplantation operation.

For either or both of these services, please give us a firm price, which should include all hospitalization services, operating room costs, and anesthesia costs. Furthermore, we need to know the fee which will be charged by the operating surgeon as well as by any treating consultants. If you cannot quote the doctors' professional fees, please have them contact us directly or supply us with their names and addresses so that we may obtain that information from them.

The nephrectomy operation can be performed at any hospital with major operating room facilities. The removed kidney is irrigated free of all blood, placed in a sterile container, packed in ice, and immediately shipped to the recipient's hospital for transplantation.

Any Medicare approved hospital can perform the nephrectomy operation and be reimbursed by Medicare for the surgery and hospitalization. Your hospital invoices those services to the transplantation hospital which, in turn, submits the unified bill to Medicare. However, advance payment will be made for privately funded operations.

Medicare has approved payment to approximately 25 hospitals to do transplantation operations. If your hospital is also interested in performing transplantation operations which will be paid for on a cash basis, please let us know. All fees will be held in escrow prior to the operation and immediately disbursed subsequent to the operation, independent of the success of the procedure.

Unlike the nephrectomy surgery, transplantation surgery will need a fully equipped hospital, including arteriography x-ray facilities, radiation therapy (to treat acute rejection), and the services of a urologist, vascular surgeon, and internist with chemotherapy experience. Since the availability of Cyclosporin, the success of transplantation surgery has significantly improved, while complications from chemotherapy have substantially diminished.

You may limit your participation to only the nephrectomy operation. The patients will arrive from various locations (both from the United States and worldwide), may require additional out-patient studies, and then will be admitted for additional tests and for the nephrectomy operation. If the recipient will have the transplantation operation done at a different institution, a coordinating supervisor will work with you to arrange for the transportation of the kidney.

Please advise me as soon as possible of your interest as we shall limit participating hospitals to only one per geographic area.

Sincerely yours,

H. Barry Jacobs, M.D.

H. Barry Jacobs, M.D.
Medical Director

HBJ/plg

Eye Bank Foundation of New Jersey

(New Jersey Eye Bank)

EYE BANK ASSOCIATION of AMERICA

15 South 9th Street
Newark, New Jersey 07107

24 hr. phone: (201) 456-4620

March 29, 1984

Thank you very much for allowing me to speak at this hearing. I am here today as the Executive Director of the Eye Bank Foundation of New Jersey (formally the New Jersey Eye Bank), but I also represent the New Jersey Academy of Ophthalmology and Otolaryngology as their Executive Director and am Administrator of the Eye Institute of New Jersey.

The New Jersey Academy of Ophthalmology and Otolaryngology has sent a letter to Assemblyman Cuprowski supporting Assembly Bill #1360.

I have been involved in Eye Banking for over 25 years and have seen the tremendous growth in eye transplantation. In the early 60's, cornea transplants were guesswork. Surgeons felt that if they had younger donor tissue, the greater the success. Therefore, thousands of eyes were not used due to age. Now 25 years later, microsurgery has allowed physicians to be more proficient in their profession. They are using suturing 1/3 the size of human hair, which has dramatically increased the success rate of cornea transplantation. Another innovation is the specular microscope, which allows us to measure the endothelial cells of the cornea. We are now able to determine in advance whether donor tissue is suitable for transplant. Today, 95% of all corneal transplants are successful.

In this month's issue of the New England Journal of Medicine, an article entitled, "Free Market Approach to Organ Donations", stated that, "today, the supply of cadaveric organs is clearly inadequate

to meet the demands of a rapidly improving transplantation technology. In an effort to meet the need, a number of new plans and ideas have been put forward, including a recent proposal to allow unrelated persons to donate their organs, in this case one of their kidneys for a price determined by the "free market".

However, in the view of most physicians engaged in transplantation, this "free market" sale of one's organs is morally offensive and ethically indefensible. It is immoral to offer someone an incentive to undergo permanent physical damage. The opportunities that would be offered for coercion of the poor to yield a "perfectly matched" organ present a picture that is at once heartrending and frightening. Many centers have grappled with the ethical considerations implicit in donation by living related persons and have come to accept it only because of the high motivation of the donor and the improved success of the recipient. Neither of these is the case with a purchased kidney from a living unrelated donor. There are no data to suggest that kidneys taken from living unrelated donors will function better, more quickly, or longer than cadaveric grafts.

In eye banking, we are very fortunate that we are able to receive eyes 4 to 6 hours after death. Unfortunately, the other donor programs do not have the flexibility of receiving good donor tissue many hours after death. Even with this flexibility, we still need another 200-300 additional corneas a year. The Eye Bank Association of America has a code of ethics, which prohibits their member eye banks from receiving eyes from live donors. We will refuse any request from a live donor who might want to donate their eye to a loved one.

These type of requests are never for money, but only for love of someone close to them. In my 25 years of eye banking, I have never sold nor have I ever been approached by anyone to buy their eye for organ transplantation.

We all need more donor tissue, but we are all willing to wait for cadaveric organs. However, we feel that hearings such as this one is very important, as it gives us the opportunity to express our concerns regarding the organ donor. This can also serve as a vehicle to make more people aware of becoming an organ donor.

In closing, I would also like to mention that Doctor Stanley Bergen, President of the UMDNJ has called me and asked to send his regrets that he is unable to attend this hearing, but he has informed me to convey to you his support of this bill and urges the committee to release it to the entire assembly.

Thank you.

Marshall S. Klein

Marshall S. Klein
Exec. Director - Eye Bank Foundation
Exec. Director - N.J. Academy of O. & O.
Director - Eye Institute

RENAL PHYSICIANS ASSOCIATION
OF
NEW JERSEY

35 Kings Highway E.
Haddonfield, N.J. 08033

April 6, 1984

Mr. David Price
Office of Legislative Services
State House Annex
CN-042
Room 229E
Trenton, New Jersey 08625

Attention: Assemblyman Cuprowski

Reference: Assembly Bill 1360

Dear Mr. Cuprowski:

The Renal Physicians Association of New Jersey wishes to endorse Assembly Bill 1360.

The overwhelming consensus among professionals engaged in the care of patients with end-stage renal disease is complete opposition to the concept of selling human organs for transplantation. Such a concept raises a significant number of serious and complex legal, medical, ethical, and social issues, an analysis of which brings one to the conclusion that the sale of human organs is to be rejected under any circumstances.

The field of transplantation has progressed significantly since 1965, principally because organ procurement has steadily improved through the efforts of the medical community in appropriately educating the public on cadaveric organ donation. An enormous amount of work has gone into the development of careful criteria in the selection and determination of an acceptable cadaveric donor. The process has been slow and painstaking as it should have been. The result, however, has been gratifying, i.e., only patients truly brain dead with organs in optimum condition and expertly retrieved are taken for transplant. Had patients not properly selected been used for organ donation, surely at some point in time this would have emerged before the public's eye and the destructive aspect of such a debacle would set organ donation back for years. The Quinlan Case in New Jersey is an example of how adverse publicity could harm the procurement of organs. It took two years to recover from the notoriety of this case.

The sale of human organs leaves open the potential for frightening abuses. Families in need of money, or unscrupulous persons could bring pressure or even coercion upon an individual to donate an organ who would otherwise not wish to donate.

Now that organs are transported internationally, third world countries where $5,000 to $20,000 could represent a life-time of comfortable living, one could anticipate coercion to the point of perhaps even causing the demise of someone merely to gain this economic benefit. In this context, I am not referring merely to kidneys, where one can live with one such organ, but to hearts, livers, pancreases, or eyes, where death, or such severe co-morbidity, would ensue that the patient's quality of life may be no better than death.

Such acts of exploitation are not only morally, legally, and socially, repugnant but their impact on the entire transplantation procurement program would be devastating. What has taken years of work to gain public acceptance, could be snuffed out in the flick of just one such situation.

The American Society of Transplant Surgeons, and the International Society of Transplant Surgeons, has taken a strong public stand against any efforts to permit the sale of organs. Any transplant surgeon who would transplant an organ procured through organ sale will be expelled from these societies.

Finally, while someone may be motivated by greed or by overwhelming economic distress to donate an organ, he/she may not be as intellectually sound as a person making a donation for truly charitable reasons. Thus, one must be concerned about the validity of the reasons given for the donation, as well as the quality of the organs being sold. This is of particular concern for potential organs received from foreign countries.

In further consideration of the issue of motivation, it must be viewed as an indictment of our society and our government which can spend billions of dollars on weapons of destruction, and yet has members of its citizenry so desperate for survival that they must turn to a living-threatening solution, i.e., the removal of a healthy precious part of their body.

While there are other thoughts that can be expressed on this matter, I feel that those which have been expressed, sufficiently point out the justification for the position we have taken in support of this legislation.

Respectfully submitted,

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JPC/pf

cc: Medical Society of New Jersey
Legislative Committee