



**Statement for the Record**  
**American College of Physicians**  
**To the United States Senate Committee on Health, Education, Labor and Pensions**  
**On**  
**Examining the Future of the U.S. Organ Procurement and Transplantation Network**  
**December 11, 2025**

The American College of Physicians (ACP) is pleased to submit this statement and offer our views from a physician perspective. We emphasize the fundamental ethical principles and patient rights and welfare and how they relate to the objective of increasing viable organs for transplantation. We greatly appreciate that Chairman Cassidy, Ranking Member Sanders, and the Committee on Health, Education, Labor and Pensions (HELP) have convened this hearing held on December 11, 2025, to hopefully bring forward for consideration bipartisan legislation about reforming the organ procurement and transplant process.

ACP members include 162,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge, clinical expertise, and compassion to the preventive, diagnostic, and therapeutic care of adults across the spectrum from health to complex illness. Additionally, internal medicine is the specialty with the largest number of active physicians specializing in primary care, with more than 120,000 internal medicine physicians being identified as specializing in primary care in 2021.

Recently, there have been issues and controversies surrounding the current practices of the organ procurement process. The College determined that further examination in the context of long-standing ethical principles was necessary as outlined in, "[Ethical Issues in Organ Transplantation: A Position Paper From the American College of Physicians](#)" published in October 2025 (1). The United Network for Organ Sharing and the system it manages have been criticized as unfair, ineffective, and opaque (2). The Organ Procurement and Transplantation Network (OPTN) Modernization Initiative, an overhaul "to improve transparency, performance, governance, and efficiency of the organ donation and transplantation system," is underway (3). Other controversies, including ill-advised proposals to revise the Uniform Determination of Death Act and the emergence of thoracoabdominal normothermic regional perfusion (TA-NRP, commonly called NRP), have raised ethical concerns (4, 5). Even transplantation's bedrock ethical requirement, the dead donor rule (DDR), which ACP supports, has been questioned. (1)

Foundational ethical norms prohibit using one person solely to serve the ends of another. Although deaths due to unfulfilled needs for organs are tragic and increasing viable organs for transplant is laudable, this does not justify overriding physician duties and societal responsibilities to patients. ACP’s position paper provides ethical guidance for physicians, organ donor-patients and recipient-patients and their families, the public, policymakers, and others. While there are five overall recommendations, this statement will focus on two of them that can offer the HELP Committee the most policy guidance for reform as it examines this issue. (1)

***Metrics, financial or other incentives, or reputational concerns of health care institutions or the organ transplantation system must not override the physician’s primary duty to put the patient first (1).***

The U.S. organ transplantation system’s structure does influence a patient’s care. Fifty-six Organ Procurement Organizations (OPOs) distributed geographically, administered by the Centers for Medicare & Medicaid Services (CMS), assess donor potential, collect clinical information, discuss donation with potential donor-patients and surrogates, and coordinate organ recovery. Responding to concerns that some OPOs are consistently low performers (6), CMS quality reporting measures have created strong incentives to “encourage OPOs to pursue all potential donors” (7). (1)

Increasing the number of donor-patients as a percentage of total eligible inpatient deaths and maintaining donation and transplant rates within the top 25 percent (7) may unfortunately create strong pressures for OPOs to overstep ethical boundaries. While objective data (rather than self-report), actual transplant rates (not donation rates), and transparent reporting data can be important for patient safety and high-quality care, the risk for unintended consequences of these metrics are well known (8, 9). The pressure to increase organ donation might also contribute to the allure of new organ procurement technologies, such as TA-NRP, which violate ethical norms, including the DDR (10, 11). (1)

System-wide pressures can also adversely affect the care of transplant recipient-patients. CMS has judged the success of and certified transplant programs primarily on the basis of 1-year posttransplant patient survival and graft survival metrics (12). These metrics may have unintended effects that can undermine care. Under these outcome measures, “success means being alive—no matter what that life looks like—at 1 year” (13). Studies show that recipient-patients receive inadequate palliative care, driven in part by concerns about 1-year survival metrics and the mistaken belief that palliative care and curative therapies cannot be offered concurrently or have contradictory aims (14, 15,16). One study that interviewed 38 transplant pulmonologists at nine high-volume centers found that 37 percent would hesitate to engage palliative care within the first year after transplant for fear of damaging their programs’ mortality metrics (14). (1)

In addition to putting the patient first, physicians have a collective obligation to advocate for metrics that fully reflect high-quality, patient-centered care and avoid harm. This

includes partnering with patients to develop metrics and outcomes that matter to patients (17). System-level factors create the potential for unintended consequences or blurred ethical boundaries, but when created in alignment with ethical principles, factors like appropriate metrics and rigorous consent protections could reduce burden and make it easier to donate and do the right thing. (1)

***Achieving equity in organ donation and transplantation should be prioritized. This requires trust and trustworthy policies and practices (1).***

The principle of justice requires that transplant patients receive equitable treatment. The National Academies of Sciences, Engineering, and Medicine notes that the success of organ transplantation relies on patient and public trust that the system is ethical, equitable, and efficient (2 1).

Unfortunately, disparities remain at every stage of the process, from patient referrals to transplant centers to post-transplant outcomes (2). Disparities are based on race, ethnicity, gender, age, socioeconomic status, educational status, disability status, geographic location, language, health literacy, insurance coverage and payment, and the intersection of these characteristics (18, 19). For instance, evidence suggests centers may be less likely to accept an offer for a heart for a Black transplant candidate, even after other clinical factors are controlled for (20). (1)

Reducing transplantation disparities requires a comprehensive approach based on trust. Patients, families, and communities who already mistrust the health system and the organ transplantation system may be particularly attuned to utilitarian conversations that place increasing organ donation above respecting preferences and values of individual patients. Mistrust, lack of information, and inadequate access to care are key barriers to Black people becoming organ donors (21). Culturally appropriate educational resources that support informed donation conversations are needed, along with ensuring equity and transparency in transplantation practices. Metrics of quality should include patient-centered outcomes and metrics of equity, such as the Access to Transplant Score (22). (1)

Advancing equity also requires greater diversity and inclusivity in transplant policymaking, including Organ Procurement and Transplantation Network (OPTN) decision processes, with community engagement in decision making (2). Problematic practices should be addressed, such as wait-listing and using race as a biological category in clinical assessments that appear to give certain populations a head start on the transplant list (23, 24). Mandating vaccination for transplant recipients is clinically questionable and potentially discriminatory, particularly when vaccination status becomes a proxy for likelihood that the patient will adhere to posttransplant regimens (25, 26). (1)

Efforts to increase the organ supply can undermine trust if they negatively affect members of minoritized, marginalized, or stigmatized communities. Drug overdose victims are becoming “the fastest growing cohort and the most likely utilized” brain-dead donors (27),

raising concerns about consent and equitable distribution of benefits and burdens in society when those with undertreated substance use disorder are disproportionately donors (5). (1)

Recent proposals to overturn the National Organ Transplant Act's long-standing prohibition on payment for organ donation may or may not increase the number of organs available for transplantation, but they do risk exploiting socioeconomically disadvantaged donors (28). Increasing the supply of organs is a commendable goal, but direct financial incentives are ethically problematic as they treat humans as commodities, put pressure on donors and their families, and potentially lead to exploitation of vulnerable people (29). Although there should not be financial gain from donation, reimbursing a living donor for travel expenses or missed work incurred by donating can be ethically acceptable. (1)

### **Conclusion**

ACP sincerely thanks Chairman Cassidy and Ranking Member Sanders for their ongoing leadership to address the issues plaguing the organ procurement and transplant process. As transplantation medicine evolves, it must be guided by foundational and enduring ethical principles and medical professionalism. Trust in organ donation, transplantation, clinicians, and the medical profession require nothing less. We stand ready to continue to serve as a resource and welcome the opportunity to continue to work with you in developing policy to address these issues during the remainder of the 119th Congress. Please contact Jared Frost, Manager, Legislative Affairs, by phone at (202) 261-4526 or via email at [jfrost@acponline.org](mailto:jfrost@acponline.org) with any further questions or if you need additional information.

Thank you for your consideration.