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^AM-After She Died, Bjt-2 Takes,1236<
^Awash in grief, family confronts organ donation<
^With AP Photos WX106-112 of May 20<
^By LAURA MECKLER=
^Associated Press Writer=

PHILADELPHIA (AP) _ Natalie Woods is too tired, too empty to listen. She's been at the hospital since last night, when her husband died. Now her daughter is dead too.

But kneeling before her on the cold hospital floor is Janie Hibbler. She's asking for her daughter's 13-year-old heart. She also wants her kidneys, her pancreas and her liver.

"She could possibly help other people," Hibbler says over the roar of machines that are keeping this young heart pumping and lungs breathing.

"I would be with her the whole time," she says. "We would treat her with all the respect and love that she needs and that she deserves."

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It is a moment replayed two dozen times a day across the country. Half the people who are asked say yes, enabling 17,000 organ transplants each year. The other half say no.

Much of the discussion surrounding organ transplants concerns how to divvy up the scarce organs available, with economic, political and geographic fights overlaying the 4,000 people who die each year waiting for a transplant.

But the heart of any transplant begins in hospitals rooms like this one, where a 13-year-old girl has died, and a devastated family is forced to make a choice.

___

It's an ugly car crash. The Ford Taurus speeds off the long exit ramp of Interstate 95 and merges into traffic at 75 mph. The driver loses control and bounces off two cars before crossing the concrete divider, smashing into oncoming traffic and flipping into a ditch.

It's 6:55 p.m. Wednesday, and the driver is pronounced dead.

Critically injured, his young passenger still is breathing as an ambulance speeds her to Frankford-Torresdale Hospital. But hope fades fast in the emergency room as an X-ray shows a crushed brain.

The trauma surgeon calls the Delaware Valley Transplant Program.

"Jane Doe" is now a potential organ donor, although it will be two hours before her family gets first word of the accident. A transplant coordinator, Chris Carroll, makes his way to the hospital.

The intensive care unit is quiet except for room No. 4, where nearly a dozen doctors and nurses are working on Jane Doe as Carroll arrives.

Blood is filling her skull and sputtering out of her eyes, nose and swollen lips. Small pools collect on her light brown skin. Gauze is wrapped around her skull, as her long, black hair flows off the pillow.

A tiny braid still hangs along her face.

But nothing else is right. Her blood pressure is extraordinarily low, and there's little oxygen enriching her blood. Suddenly, her heart stops, and doctors must shock it back.

Quickly assessing the situation, Carroll figures Jane Doe will not be an organ donor. Her family hasn't even been found. The best candidates are brain dead but stable long enough to allow a family to consider donation and for coordinators to make dozens of complex arrangements.

Meanwhile, the patient's lungs are filling with blood, and doctors attach tubes to her chest to drain them. Before long, plastic containers on either side of the bed will be filled red.

Natalie Woods is pacing, checking the window, watching for her husband's Ford Taurus to pull up. Anthony should have been home hours ago, and her back pains sharpen each time she sees it's not him. He and FaLon, her daughter from a previous relationship, were just going to the grocery store.

There is already enough stress in their lives. Yesterday, the family moved out of a homeless shelter and into a Days Inn. Mrs. Woods is hoping the new car will help her husband find and keep a job.

Then she looks out and sees a police car:

There was a crash. Her husband is dead. Her daughter is in critical condition.

In intensive care, word comes that state troopers have found the girl's family. Jane Doe is now FaLon Willis, three days short of her 14th birthday. With the family on the way to the hospital, donation is suddenly a real possibility. Carroll calls his office to report her blood type, height and weight. The numbers are entered into a computer, and minutes later, hundreds of names awaiting transplants scroll across a screen.

Mrs. Woods doesn't change out of house slippers before rushing to the hospital. Doctors give her the bottom line: FaLon isn't going to make it. She doesn't believe them.

"No," she says to herself. "My baby's going to make it."

She keeps hoping as she makes her way to room No. 4 and sees FaLon's swollen, bloody face, so different from the young woman who dreamed of being a model, whose sparkling eyes dance through the family photo album.

Mrs. Woods clutches her hands over her mouth as she approaches.

"Oh my God. Oh! Oh!" she cries. "Mommy's here for you honey. Oh, please. Oh, God. Please."

Dr. Charlie Goldstein explains that doctors haven't yet performed tests to determine whether FaLon is brain dead, although they are virtually certain she is.

Mrs. Woods rocks side to side as she tries to absorb so much information.

Suddenly, she doubles over, leaning on a nearby nurse who guides her to a wheelchair. She's wheeled away from her baby, back to the waiting room, to wait.

Two tests _ performed six hours apart by different doctors _ are required to pronounce someone brain dead. Brain death occurs when there is no activity in the life-sustaining centers of the brain. It's a tough concept to grasp because victims often don't look dead, and families may think they are simply in a coma. But brain death is death, and there's no chance for recovery.

It's now 1:20 a.m. Thursday, eight hours after the car crash, but the first brain death test is still hours away. First nurses must warm FaLon up; she's so cold, it's possible that's what is keeping blood from her brain. Nurses cover her with a warming blanket.

The young girl under the blanket is but a shell of the vibrant child who loved to play with little kids and didn't mind kisses from her mom and younger brother.

FaLon Caprice Willis dreamed of being a singer, or an artist or a model. Or maybe a teacher. Her parents never went to college but she was headed for honors English in 9th grade this fall.

Her family was less than stable, bouncing from shelters to motels to public housing. She made friends easily, and it hurt when she changed schools.

Her mother would later find herself reading FaLon's poetry over and over. "I've got too much to think about," FaLon wrote, "and so little time."

A 20-page fax of names waiting for transplants is delivered to Chris Carroll. It's too early to approach Mrs. Woods _ that won't come until FaLon is pronounced dead. But Carroll needs to set the wheels turning.

He asks a nurse to collect a few vials of blood to test for HIV, hepatitis and other infections.

A nurse himself, he works alongside the medical staff all night, and as morning breaks, he's surprised FaLon is still hanging on _ he figured her heart would give out. But her blood pressure is strong, and her body warm.

At 7:43 a.m., Goldstein signs the form certifying that FaLon meets the criteria for brain death: Her eyes don't respond to light; she shows no reaction to intense pain. Pouring ice water into each ear brings no response.

Janie Hibbler drives to Frankford-Torresdale Hospital with her heart in her throat. It's her second 13-year-old in a week; the last time it was a boy who killed himself, and Hibbler is still hurting.

She's been sent in to relieve Carroll. First, she has nurses inject drugs to help preserve FaLon's organs. She orders an X-ray of FaLon's heart to see how it's functioning. She alerts the

operating room they may need a spot on the schedule. She checks lab results to help match organs with recipients.

But her frantic pace slows as she approaches FaLon's grandparents.

She takes the grandmother's hand and holds on longer than she has to. She wants the family to hear the facts about donation. She's worried FaLon's mother may say no without talking with her first.

But she only briefly mentions donation, helping the family sort through FaLon's death.

"She's in no pain. Know that, know that," Hibbler says.

"(God) gives us trials and tribulations," the grandfather says.

"But never more than you can handle," Hibbler says, tears in her eyes.

It's noon Thursday and Hibbler begins calling surgeons, careful to tell them the potential donor is not yet officially dead and her parents have not yet officially consented. But Hibbler needs to be ready.

She calls Dr. Harry Yang of Hershey Medical Center to offer the liver, the organ in highest demand because there's no way to keep patients alive while waiting for a donor.

Livers are offered to patients in the area, sickest first, and Yang's patient is at the top of the list. Hibbler tells him the liver is torn. Yang, consulting with a colleague, gives a quick answer: "No."

The second call goes to the University of Pennsylvania, where surgeon Abraham Shaked has the opposite reaction: "I'll take it," he says. Hearing about the tear does nothing to change his mind.

It's time for the second brain death exam. Mrs. Woods and Jesse Willis, FaLon's natural father, sit silently in room No. 4 as a neurologist they've never met rushes in, performs the tests and, two minutes later, rushes out, looking for the papers to sign.

FaLon's parents have no idea who this man is or why he was shaking their daughter's head so hard. He has already signed the chart pronouncing her dead; it will be a half-hour before another doctor tells them.

Then Hibbler enters the cramped hospital room. There is nowhere left to sit, so she kneels before them to ask.

She explains the donation procedure (like a normal operation) and the cost (none to the family). She answers a few questions.

The parents sign the consent form. It was an easy decision, Mrs. Woods says. When FaLon's grandmother died a few years ago, FaLon volunteered that she would like to be a donor if anything happened to her.

"She wanted to help other people," her mother says.

"She'll be helping a whole lot of people," Hibbler responds. "All the tears you cry here today, other people will be crying the opposite, the tears of joy, when they hear they have a heart for their loved one."

It's now 4:30 p.m. Thursday, and FaLon's heart, liver, pancreas and kidneys have been placed with local hospitals. Surgeons are on their way to Frankford-Torresdale to remove them.

But before FaLon is wheeled to the operating room, Mrs. Woods spends a few minutes alone with her.

She takes her hands, touches her body, brushes her hair. She pulls off the blankets, "just to see her body one more time."

And she tries to figure out why.

"I felt like I was being punished," she says later. "I couldn't understand. Why my baby?"

At 6 p.m. FaLon is wheeled to the OR; portable machines keep her heart and lungs moving. They'll continue to function until surgeons have opened her chest and cut her organs away from all but the vital connections needed to circulate blood.

The room is bright, cold and sterile _ just like a normal operation.

At 7:46 p.m. surgeons fix clamps on the arteries supplying blood to the heart. Cold preservation solution is flushed into FaLon's abdomen and ice is poured over her organs. Blood is suctioned out. And the clock starts ticking: Four hours to get the heart into its new owner, 24 hours for the liver, 48 hours for the kidneys.

The heart comes out first, and a surgeon holds it in one hand as he repairs a small hole. Soon it will be powering the body of a 56-year-old carpenter.

Twenty-five minutes after the clock began ticking, the heart is off in a red Playmate cooler to Temple University.

Surgeons move to the other organs. The pancreas _ along with one of the kidneys _ will be put into a 31-year-old woman who has gone blind from diabetes.

Meanwhile, the liver is "perfect," says University of Pennsylvania surgeon Kim Olthoff. What about the cut? "It's just a bruise," she says. A 13-year-old liver is so healthy it doesn't really matter, she says.

But it takes longer than usual to remove the liver and pancreas. Dr. Abraham Shaked, usually friendly and cool-headed, is on the phone yelling at Hibbler that his patient, a 40-year-old man with six children, is on an operating table, waiting for his liver.

Hibbler must juggle the egos and tempers of the surgeon on the phone and the surgeon at the table.

A sheet shields FaLon's head from the activity around her. Her body is empty. Still, the lone braid lies atop her hair, flowing off the back of the table.

Midnight, and the surgeons have all gone back to their hospitals, carrying their cargo in boxes marked "handle with care." FaLon's chest has been stitched shut, and soon she'll be in the care of the medical examiner.

Aides clean up the OR, filling bag after bag with bloody towels.

But Hibbler's job isn't done.

She takes a basin of warm, soapy water and begins to wash FaLon's body. In slow, circular motions, she removes the blood and grime from her face, her shoulders, her chest _ all the way

down to her feet.

When she's done, she folds FaLon's arms on her chest and crosses her ankles. With the body bag ready to receive its cargo, Hibbler touches FaLon's forehead, shakes her head and smiles a sad smile.

"It's closure for me too," Hibbler says. "It's my way of thanking her and saying goodbye."

EDITOR'S NOTE: FaLon's heart, liver, pancreas and two kidneys were successfully transplanted into three patients. All three are doing well, living in the Philadelphia area.

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^AM-After She Died-Issues,503<
^Donation decisions depend on complex set of issues<
^By LAURA MECKLER=
^Associated Press Writer=

WASHINGTON (AP) _ Two families at two hospitals confront the death of a child. Asked about organ donation, one says yes, the other no.

As the waiting list for organ transplants grows but donation rates remaining the same, the transplant community is trying to determine what makes the difference.

Much of it, they've concluded, depends on what happens at the hospital in the hours before death.

In-depth interviews with families who agreed to donation and those who said no, contained in a recent study, found donor families significantly more likely to believe that their loved ones received the best possible care and that everything was done to try to save them.

Conversely, many families who didn't donate showed "a great deal of anger ... as to how they were treated," said William DeJong of the Harvard School of Public Health, who co-authored the study.

The study also confirmed how important it is for a family to know the deceased's wishes.

Polling indicates many Americans are likely to donate organs if they believe that's what the deceased wanted. But many people who say they would like to be donors have not told their families.

That concept is at the center of a national campaign to promote organ donation: "Share your life, share your decision."

But the federal government and the private groups that run the transplant program are also focusing on what happens at hospitals. Among concerns:

_A family is asked about donation too soon.

Sometimes well-meaning doctors and nurses mention donation before a family has been told the loved one has died, often because the medical staff knows death is virtually certain. This plays into the fear that doctors won't really try to save someone if they can get their organs instead.

The family survey found only 46 percent of non-donor families said donation was brought up at the right time.

_Families do not understand brain death.

Most donors have died because their brains are no longer functioning, not because their hearts stop beating.

But that's tough to understand because the person often looks as if he's sleeping or in a

coma.

The survey found 45 percent of non-donors believed a brain dead person was "in a coma" rather than dead, vs. 28 percent of donor families who held that inaccurate view.

And only 60 percent of non-donors knew that "someone who is brain dead is dead even though his or her heart is still beating." Eighty percent of donor families knew that.

_A hospital never notifies the local organ procurement group that a potential donor has died.

About one-third of the families of people who are medically suitable to donate are never even asked.

Some states have laws requiring hospitals to notify procurement officials after every death. And the federal government plans to adopt a similar, nationwide rule _ over the objections of hospitals.

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^AM-OutFront-Organ Bankers, Bjt,1026<
^OUT FRONT: Big difference between best and worst in organ banks<
^With AP Photos WX101-108; AP Graphic Organ Bankers<
^By LAURA MECKLER=
^Associated Press Writer=

WASHINGTON (AP) _ More than 4,000 people die each year waiting for new hearts, livers, lungs and kidneys, but thousands more transplants could occur if not for wide disparities among the organ banks that find donors and match them with patients.

The nation's best organ banks move four times as many organs from the dead to the living as the worst, according to an Associated Press computer analysis.

As the government struggles to find the fairest way to allocate scarce replacement organs, that discrepancy helps explain why patients in certain parts of the United States stand a much better chance at getting the transplants they need.

Interviews with organ banks across the country suggest a program's ability to work with local hospitals accounts for much of the difference. Others appear to be hampered by ethnic minorities who are more reluctant to donate or a preponderance of illness that precludes donation, such as AIDS.

But no one is certain why some programs do so much better.

"You'd like to take the top 10 and clone them," said Coralyn Colliday at the Department of Health and Human Services.

Sixty-three organ banks cover the country, handling the intense, behind-the-scenes work essential for transplants to succeed.

They talk with grieving families, often moments after death. When families say yes, they match those donors with recipients and make the needed dozens of arrangements.

Some do it much better: In upper Wisconsin, there were 146 organ transplants for every 1,000 deaths in a year; in Mississippi, only 18.

The AP analysis of 1996 and 1997 data also suggested:

_Two thousand more transplants could be done each year if each below-average organ bank brought its performance up to the median. Half the programs perform above the median, half below.

_If every organ bank performed like the top 10, there would be 14,600 more transplants each year _ a huge increase over the 17,000 now done each year.

Over the last two decades, transplant techniques have improved and more hospitals have created programs.

But donation has not kept pace. Ten years ago, the list of people waiting for transplants was four times as long as the list of donors. By 1996, it was nine times as long.

Today, 57,839 people are waiting.

Waits are much longer in some parts of the country, often because a strong program attracts patients from elsewhere. Lists also get longer when there are fewer local donors.

That has prompted a debate over the best way to allocate the organs available. The Department of Health and Human Services wants an overhaul of the geographic-based system that now offers organs to local patients first, even if someone farther away is sicker.

HHS now requires hospitals to report all deaths to organ banks in hopes of finding more donors. And the government also is trying to increase donation, sponsoring a conference to share information about what works.

But federal officials do little to highlight the differences among organ banks, beyond assuring that they meet minimum criteria. And they have rarely suggested that communities that fail to donate organs _ or the organ banks that serve them _ are partly to blame for long waits.

The best organ banks work well with hospitals and have clear procedures for identifying donors and talking with families.

But in places where transplant rates hover near the bottom _ Mississippi, the upper Northwest, Buffalo, N.Y., and New York City _ organ banks say they miss many potential donors because hospitals do not notify them.

The Buffalo bank estimates 25 percent of potential donors are never referred, and another 25 percent are referred too late _ the patient has been taken off a ventilator, for instance, allowing organs to deteriorate. New York City officials think they miss half.

"Sometimes they report (potential donors) early but they won't let us come on site," said Denise Payne, who heads the New York Organ Donor Network, which serves New York City and ranked No. 58. "They feel it's too early and don't want us there."

In contrast, most high-performing organ banks say it's critical to get to the hospital early and put logistics in place, in case a family consents.

Most stress the importance of waiting to talk with families about donation until they understand their loved one is dead. By contrast, low performers have trouble getting doctors to deliver the bad news about death and ask about donation in separate conversations.

"The family needs time to accept the grief," said John Wingate of Minneapolis' LifeSource, the No. 2 organ bank.

And excellent programs usually have top-notch ways to communicate with donor families after transplants.

In Wisconsin, counselors call families on the anniversaries of donors' death and on birthdays, just to see how they're doing.

But organ banks have less control over other factors.

In New York City, a higher proportion of AIDS deaths means fewer people are medically eligible to donate organs.

And low-performing banks almost uniformly point to an ethnic group wary of donation: blacks in Georgia and New York City, Mexican-Americans in south Texas, Filipinos in Hawaii,

Native Americans in the Northwest.

"The Asian community still has some strong cultural ties to the ancestral belief that the body needs to be fully intact in order for the soul to rest peacefully," said Jill Steinhaus of LifeCenter Northwest in Washington state.

But demographics cannot explain all differences. In Los Angeles, one bank ranked No. 4 while another performed so poorly the government is shutting it down.

Still, three of the top five banks serve the neighboring states of Wisconsin, Minnesota and the Dakotas.

Lori Shinstine, of the University of Wisconsin, which runs the No. 1 organ bank, gave some of the credit to what she called a spirit of generosity that helps recruit donors.

"We live in a community where people are willing to help each other."

<AP> ORGAN BANKERS
090798: Comparision of two of the best and worst organ banks in the U.S.; with AM-Organ Bankers; for Tues. Sept.8; 1c x 7"; 52mm x 178mm; JAx; ETA 6 p.m. </AP>

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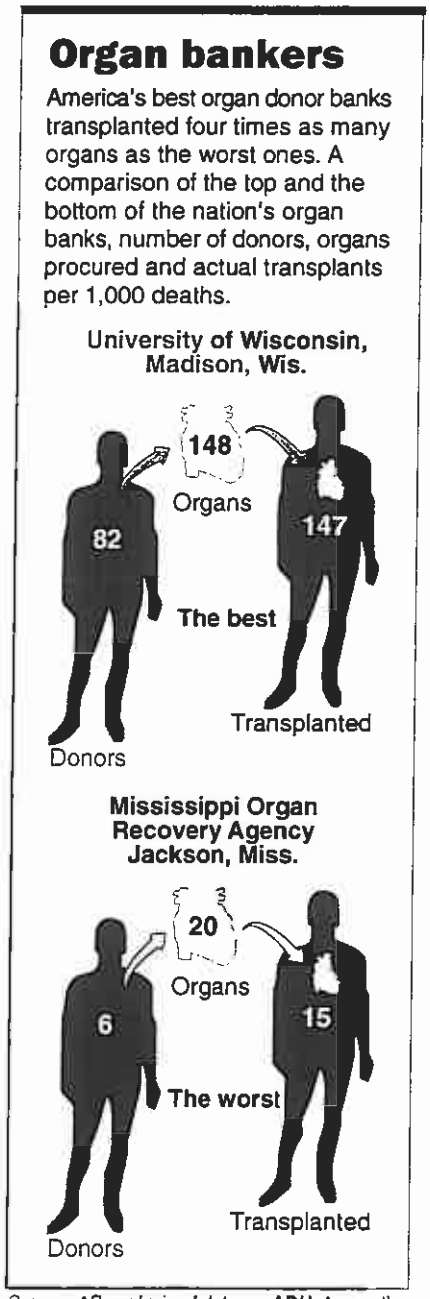
GRAPHICS



Source: AP analysis of data from Dept. of Health and Human Services

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^By The Associated Press=

The Associated Press analysis compared the number of deaths in 1994 to the number of transplants facilitated by each organ bank during 1996 and 1997, averaging the two years.

The transplant data comes from the Department of Health and Human Services' Health Care Financing Administration.

The death data, which only includes deaths of people under age 65, is from 1994, as reported by states to the Centers for Disease Control and Prevention. This is the most specific and recent death data available. Deaths in each organ bank's territory were calculated by the United Network for Organ Sharing. Network researchers say 1994 data can reasonably be substituted for data from 1996-1997.

Note that these data only include transplants of hearts, lungs, livers, kidneys and pancreases, from donors who have died. The numbers do not include kidney donors who are still living.

In judging organ banks, HHS considers the number of donors, procurements and transplants per million people living in the area. But officials throughout the transplant community _ along with the General Accounting Office _ say the number of deaths is a more precise measure because donors are recruited from among those who have died.

Still, researchers are working to develop an even more accurate measure that would take into account how a person died, since some types of deaths lend themselves to donation more readily than others.

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A list of organ procurement organizations and the number of transplants enabled per 1,000 deaths. The figure is an average of two years, 1996 and 1997. The list also includes the location of each group's headquarters and a description of its territory.

Institutions with higher numbers enabled more transplants, potentially saving more lives:

1. University of Wisconsin, 146.01
Madison, Wis.; Wisconsin except area surrounding Milwaukee
2. LifeSource, 99.94
St. Paul., Minn.; Minnesota, North Dakota, South Dakota, two counties in Wisconsin
3. Intermountain Organ Recovery Systems, 97.60
Salt Lake City; Utah, southern Idaho, southwest Wyoming
4. Southern California Organ Procurement Center, 95.15
Los Angeles; part of the Los Angeles area
5. Wisconsin Donor Network, 93.43
Milwaukee; 11 counties in eastern Wisconsin
6. Organ and Tissue Center of Southern California, 85.26
San Diego; Imperial and San Diego counties
7. Washington Regional Transplant Consortium, 82.59
Washington, D.C.; Washington plus Maryland and Virginia suburbs
8. Lifeline of Ohio, 78.79
Columbus, Ohio; Columbus, Mansfield, southeast Ohio, part of West Virginia
9. LifeLink of Florida, 75.48
Tampa, Fla.; Tampa area
10. Donor Alliance, 74.74
Denver; Colorado, most of Wyoming
11. TransLife, 71.88
Orlando, Fla.; Orlando area
12. NorthEast OPO, 71.23
Hartford, Conn.; most of Connecticut, western Massachusetts
13. Pacific Northwest Transplant Bank, 70.76
Portland, Ore.; Oregon, parts of Washington and Idaho
14. Golden State Donor Services, 65.84
Sacramento, Calif.; nine California counties
15. Iowa Statewide OPO, 65.66
Iowa City, Iowa; most of Iowa, one Nebraska county
16. LifeLink of Georgia, 64.90
Atlanta; most of Georgia, two counties in South Carolina
17. Delaware Valley Transplant Program, 63.57
Philadelphia; Delaware, eastern Pennsylvania and part of New Jersey
18. Kentucky Organ Donor Affiliates, 62.13
Louisville, Ky.; most of Kentucky, small parts of Indiana, Ohio and West Virginia
19. Nebraska Organ Retrieval System, 61.94
Omaha, Neb.; most of Nebraska, one Iowa county

20. California Transplant Donor Network, 60.25
San Francisco; 40 counties in California
21. Center for Organ Recovery and Education, 59.60
Pittsburgh; western Pennsylvania, part of West Virginia
22. Southwest Transplant Alliance, 57.02
Dallas; 90 Texas counties mostly in northeast
23. Mid-America Transplant Services, 55.82
St. Louis; eastern Missouri, southern Illinois, small part of Arkansas
24. University of Florida, 55.58
Gainesville, Fla.; northern Florida
25. Tennessee Donor Services, 54.28
Nashville; most of Tennessee, small parts of Georgia and Kentucky
26. Life Gift Organ Donation Center, 51.72
Houston; 108 Texas counties mostly in northwest
27. Midwest Organ Bank, 51.27
Westwood, Kan.; Kansas, western Missouri
28. Fingerlakes Donor Recovery Network, 50.27
Rochester, N.Y.; 19 New York counties
29. Ohio Valley LifeCenter, 50.09
Cincinnati; southwest Ohio, small parts of Indiana and Kentucky
30. LifeShare of the Carolinas, 49.89
Charlotte, N.C.; part of North Carolina, one county in South Carolina
31. LifeNet, 49.88
Virginia Beach, Va.; eastern Virginia
32. Donor Network of Arizona, 49.58
Phoenix; most of Arizona
33. Regional Organ Bank of Illinois, 49.25
Chicago; most of Illinois, small parts of Indiana and Iowa
34. Indiana Organ Procurement Organization, 48.76
Indianapolis; most of Indiana, one county in Kentucky
35. Life Connection of Ohio, 48.33
Maumee, Ohio; western Ohio
36. South Texas Organ Bank, 47.93
San Antonio, Texas; 56 Texas counties in central, southern and eastern Texas
37. Life Resources, 47.08
Johnson City, Tenn.; southwest Virginia and northeast Tennessee
38. Center for Donation and Transplant, 46.97
Albany, N.Y.; 23 New York counties, one Vermont county
39. Alabama Organ Center, 46.86
Birmingham, Ala.; Alabama and three Georgia counties
40. Arkansas Regional Organ Recovery Agency, 46.29
Little Rock, Ark.; most of Arkansas
41. University of Miami Organ Procurement Agency, 45.32
Miami; southern Florida
42. LifeBanc, 43.69
Cleveland; northeast Ohio
43. Mid-South Transplant Foundation, 43.39
Memphis, Tenn.; parts of Tennessee, Arkansas and Mississippi
44. LifeLink of Southwest Florida, 43.25
Tampa, Fla.; Fort Myers area
45. New England Organ Bank, 42.08

Newton, Mass.; Rhode Island, Maine, New Hamshire, most of Vermont, most of Massachusetts, New Haven c of Connecticut

46. Transplant Resource Center of Maryland, 41.83
Baltimore; Maryland except D.C. suburbs, one West Virginia country
47. Carolina Organ Procurement Agency, 41.61
Greenville, N.C.; eastern North Carolina, two counties in Virginia
48. Transplantation Society of Michigan, 41.55
Ann Arbor, Mich.; Michigan
49. Louisiana Organ Procurement Agency, 41.09
Metarie, La.; Louisiana
50. New Mexico Donor Program, 38.90
Albuquerque, N.M.; New Mexico
51. New Jersey Organ & Tissue Sharing Network, 38.59
Springfield, N.J.; most of New Jersey
52. Virginia's Organ Procurement Agency, 37.94
Midlothian, Va.; western Virginia
53. Nevada Donor Network, 37.80
Las Vegas, Nev.; Nevada, one Arizona county
54. Carolina LifeCare, 35.29
Winston-Salem, N.C.; western North Carolina
55. Organ Donor Center of Hawaii, 34.30
Honolulu; Hawaii
56. South Carolina Organ Procurement Agency, 34.27
Charleston, S.C.; most of South Carolina
57. Upstate New York Transplant Services, 33.10
Buffalo, N.Y.; seven New York counties
58. New York Organ Donor Network, 25.40
New York City; New York City area, Long Island
59. Regional Organ Procurement Agency of Southern California, 25.26
Los Angeles; part of the Los Angeles area
60. Mississippi Organ Recovery Agency, 17.80
Jackson, Miss.; most of Mississippi
61. LifeLink of Puerto Rico, 29.5
Guaynabo, P.R.; Puerto Rico and American Virgin islands

Note:

Two organ procurement agencies are not included in this ranking because data was unavailable on the number of deaths in the area, making a calculation of transplants per death impossible.

The Oklahoma Organ Sharing Network in Oklahoma City is not included because the state does not report death data to the Centers for Disease Control and Prevention.

LifeCenter Northwest, which covers Alaska, Montana and most of Washington, is not included because it is a product of two organ banks that recently merged. There is no reliable death data for the new entity.

It is, however, possible to calculate the number of transplants performed for every 1 million people living in these area. This is the standard that the government uses to judge organ banks.

Using the population standard, the Oklahoma Organ Sharing Network, which covers the state of Oklahoma, ranked No. 52 out of 63 organ banks. It performed an average of 54.46 transplants per year in 1996 and 1997 for every 1 million people.

LifeCenter ranked No. 56, performing 52.65 transplants for every 1 million people.

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^States challenging federal policy on donated organs<
^By LAURA MECKLER=
^Associated Press Writer=

WASHINGTON (AP) _ Louisiana doesn't want its citizens' livers going to Mississippi. Or Arkansas. Or anywhere else for that matter.

South Carolina wants to keep its citizens' livers, too. So do Wisconsin and Oklahoma.

In a direct challenge to a new federal policy, states are passing laws ordering that organs donated at home stay at home if there's a patient who could benefit.

It's the opposite approach from the federal Department of Health and Human Services, which has issued new rules meant to break down geographic barriers. HHS hopes to equalize waiting times across the country.

The new rules, now under congressional scrutiny, are not yet final. But in case that changes, states are laying the groundwork for a court challenge.

"Our work is based on the giving of South Carolinians," said Nancy A. Kay, executive director of the South Carolina Organ Procurement Agency. "We like to take care of our neighbors here."

It's a microcosm for the larger debate around organ allocation.

Supporters of the new policy say these state laws ignore the fact that many people leave their states to seek transplants. Opponents say they are just trying to protect the instate centers, ensuring care for patients who can't afford to leave.

The HHS plan would send organs to the sickest patients first, no matter where they live. It would overturn the current geographic system, which offers organs to patients at local transplant centers first.

Many fear the new policy would be a bonanza for a few transplant programs that serve the sickest patients _ but a loser for smaller centers everywhere else, who could get far fewer organs and might go out of business. They are lobbying Congress to overrule HHS.

But some states aren't waiting for Congress. Four states have passed laws erecting walls around their states, ready to challenge HHS in court. And at least four other states have considered similar laws. Others have approved resolutions urging the federal agency to reconsider.

"The federal government is trying to suck organs from small and middle-sized states and send them to large regional transplant centers," said Oklahoma Gov. Frank Keating when he signed

the state's law in April.

So far, these laws have been essentially symbolic. They allow the state's organ donation firms to continue with interstate agreements that are mutually beneficial. For instance, states may still send kidneys elsewhere when there is a perfect biological match.

But the state laws are in direct conflict with the new federal policy, which says geography cannot be a primary factor in organ allocation.

If it goes to court, the legal question would be whether HHS had the authority to write its rule in the first place. Opponents say the department overstepped its bounds.

Several states have considered laws but decided against them.

A Tennessee-first law was on a fast track until a local organ procurement group pointed out that the state's current system does not always follow state lines. Life Resources Regional Donor Center in Johnson City, Tenn., also serves part of Virginia and considered merging with a group that serves other states, as well.

"States are geographical accidents," said Lee McCartt, director of Life Resources. "In Bristol, Tenn., you can step across Main Street and you're in Virginia."

HHS Secretary Donna Shalala makes the same point. "We don't need to have patients dying because an organ was stopped at the border," she said.

The real winners, she and others say, are the transplant centers.

"I'm assuming there's a lot of lobbying going on," she said, "but it certainly is not lobbying on behalf of patients."

But lawmakers are also influenced by patients like Carla Jo Clark of Mulvane, Kan., who asked her state senator to write a law protecting Kansas organs. Mrs. Clark's kidneys are failing, and one day she'll need a transplant.

The legislature decided to study the issue and may revisit it next year.

"We felt we needed to do what we could," she said, "to keep the organs here in Kansas."

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^AM-Transplant Fight,818<
^Nasty fight over chance for life<
^By LAURA MECKLER=
^Associated Press Writer=

WASHINGTON (AP) _ The federal government and the surgeons and hospitals running the nation's transplant network are in a fierce fight over which patients should get the first chance at scarce organs.

Two months after the government ordered that lifesaving organs be given to the sickest first, the network is lobbying Congress and warning communities that their transplant centers could close, more people would die and the system would be thrown into chaos as organs are shipped cross-country.

Federal officials, meanwhile, are taking their case directly to surgeons.

The two sides haven't yet met, though they have a meeting scheduled in June.

The disagreement won't be resolved easily. Beyond the controversy over organ allocation, it involves questions about how much control the government should have over the private company running the transplant network.

Although the regulation issued by Health and Human Services Secretary Donna Shalala affects all organs, the sharpest controversy concerns livers.

Last year, 4,159 liver transplants were performed, but another 1,131 people died waiting for one. Under the current system, patients living closest to the donor get that liver, even if someone sicker lives elsewhere.

The government's order would change that. But with a limited supply of organs, any policy will give preference to one patient over another, meaning someone loses.

"Unless you've got God making the decisions, ultimately someone's going to think it's not fair," said Howard Nathan, executive director of Delaware Valley Transplant Program in Philadelphia.

People have staked out their positions, said Dr. Alan N. Langnas, a University of Nebraska liver surgeon who notes that transplants are prestigious and lucrative. "None of us can get past self-interest."

It was March when Shalala declared that people are dying simply because of where they live. She issued a broad regulation governing the United Network for Organ Sharing, known as UNOS, that included a mandate that UNOS devise a new allocation scheme for organs that gives priority to people in greatest medical need. It allowed for a period of public comment before it

took effect.

UNOS responded with a "legislative action kit" to help transplant officials lobby Congress and the media to oppose the regulation, which they see as a government grab for control.

That infuriated federal officials, who say the network is scaring people by sketching worst-case scenarios rather than finding a satisfactory solution.

"To have UNOS do such a blanket smear campaign just has been extremely frustrating," said Dr. Claude Earl Fox, who heads the HHS section that oversees the transplant program. To counteract the network's campaign, he has traveled the country to discuss the changes directly with transplant surgeons.

Network officials counter that they have no choice but to fight the rules before they become law. "It's speak now or forever hold your peace," said Walter Graham, UNOS' executive director.

UNOS has already scored one success: Congress delayed the regulation from taking effect until October _ giving lawmakers time to consider overturning it.

The current system offers a donated liver to local hospitals first, with the sickest patients getting first chance. If there are no local matches, it is offered regionally, then nationally.

That system assures organs for transplant centers nationwide that rely on local donations. The trouble, critics say, is that while donors are evenly spread around the country, needy patients are not, creating waiting lists five times longer in some areas where large transplant centers are operating.

The regulation's requirement that the transplant system rely primarily on medical urgency, not geography, says UNOS, would mean creating a national waiting list with organs flying across the country, creating logistical nightmares. The large transplant centers with the sickest patients would pull livers from smaller centers, threatening their existence, UNOS says.

Furthermore, UNOS says more people will die because survival rates are lower for very sick patients than for those who aren't yet on the brink of death.

Fox at HHS says the system could be made fairer without creating a national list. Ideas include broader sharing for the sickest patients only, or a formula that considers both distance and medical need.

The issue of control is also contentious. The network, which has no viable competitor, operates under a government contract.

"UNOS is not an agent of the government," Graham said.

However, Fox says UNOS gets the benefits of government involvement _ a monopoly, for one _ and must accept controls.

"We answer to Congress," he said, "and they answer to us."