Center for Practical Bioethics
Board of Directors Meeting
November 13, 2024
8:00 – 9:30 AM (Central) | 9:00 – 10:30 AM (Eastern) | 6:00 AM – 7:30 AM (Pacific)

Location: In-person or Zoom Conferencing
In-Person: 9th Floor, Shalton Conference Room, Polsinelli PC, 900 W. 48th Place, KC, MO 64112
By Computer: https://us02web.zoom.us/j/9528298699 *Preferred for document screen sharing.*
By Phone: +1 646 931 3860 US or +1 312 626 6799 US (Chicago)
Meeting ID: 952 829 8699

AGENDA

I. Call to Order — Steve Salanski, Chair

II. Audit Report — Matt Brickey, McBride Lock

2023 Draft Audit Report *(Attachments 1-4)*

- **VOTE:** Approve 2023 Audit Report

III. Committee Reports

Finance Report — Tresia Franklin, Chair

- **VOTE:** Approve 2025 budget, including special one-time Foley draw *(Attachments 5-8)*
- Review the "Biblo fund" *(Attachments 9; 23)*
- **VOTE:** Accept September 2024 financial statements *(Attachment 24-27)*

Governance Report — Maggie Neustadt and Mark Thompson, Co-Chairs

- **VOTE:** Approve updated PTO accrual method to allow for digital processing and tracking through Gusto Payroll software *(Attachment 10)*
- Board Member Demographics and Characteristics (~50% have completed)
  https://forms.office.com/r/z960tvd16c
  Then, email James that you have completed

Resource Development – Chair Introduction — Norberto (Rob) Ayala-Flores, Chair

Francis Chair Search Task Force — Eva Karp and Mark Thompson, Co-Chairs

1. Francis Chair search task force update
   a. Job description draft, scheduled meetings

IV. Consent Agenda (Administrative Matters)

Board Meeting Minutes
September 11, 2024 *(Attachment 11)*
Note: Flanigan Chair electronic vote, 10/10/2024 *(Attachment 12)*
Note: IRS Form 990 submission electronic vote, 10/17/2024 *(Attachment 13)*
Finance Committee Minutes
September 13, 2024, and November 7, 2024 *(Attachments 14-15)*
Executive Committee Minutes, October 9, 2024 *(Attachment 16)*
Governance Committee Minutes, October 11, 2024 *(Attachment 17)*
Audit Committee Minutes, October 8, 2024 *(Attachment 18)*

V. Diversity, Equity, and Inclusion Discussion Steve Salanski, Chair

VI. Chair and President Reports Steve Salanski, Chair & James Stowe

Chair's Report

1. Flanigan Chair announcement
2. CEO Performance Evaluation timeline

President's Report

1. Event Coordinator (contract) recruitment update
2. Ethical AI grants
    a. Meta and Future of Life Institute proposals submitted
    b. Robert Wood Johnson Evidence for Action: Innovative Research to Advance Racial Equity letter of intent submitted
    c. National Endowment for the Humanities (December)
        i. Ethical AI Research Center
    d. Sunderland (December or January; funder has new strategic focus)

VII. Program Update

Ethics Services Terry Rosell and Ryan Pferdehirt

Special Discussion: Normothermic regional perfusion in donation after circulatory death (NRP DCD), thoracoabdominal and abdominal approaches

(Attachments 19-22)

a. Board discussion

Next Board Meeting: January 8, 2025
8:00 – 9:30 AM (Central) | 9:00 – 10:30 AM (Eastern) | 6:00 – 8:30 AM (Pacific)

Upcoming Events:

1. Terry Rosell, Retirement Event
   Hosted by the Department of the History and Philosophy of Medicine, KU
   Save-the-date: Friday, December 6, 2-4 PM
   Details forthcoming

2. **Terry Rosell, Center Retirement Reception**
   Date:
   Thursday, December 12 at 5:30 – 7:00 PM CT

   Location:
   Nonprofit Village
   Event Space - 31w31, 31 W 31st St, KCMO

3. **2025 Board Retreat**

   Dates:
   Friday, April 11 at 11:30 am – 5 pm CT with Board and Staff Social to follow at 5:30 pm CT with KC Metro location TBD
   Saturday, April 12 at 8 am – Noon CT

   Location: In Person – Liberty Hospital Foundation Conference Rm, 2525 Glenn Hendren Dr,

Liberty, MO
or Zoom meeting -- https://us02web.zoom.us/j/9528298699

Strategic Initiative Focus: Ethical AI (January 2025)

Board Book & Materials Link

REPORT ON AUDIT
OF THE

CENTER FOR PRACTICAL BIOETHICS, INC.
KANSAS CITY, MISSOURI

AS OF AND FOR THE YEAR ENDED DECEMBER 31, 2023

McBRIDE, LOCK & ASSOCIATES, LLC

CERTIFIED PUBLIC ACCOUNTANTS
KANSAS CITY

TABLE OF CONTENTS

4151 N. Mulberry Drive, Suite 275
Kansas City, Missouri 64116
T: (816) 221.4559
F: (816) 221.4563
E: Admin@McBrideLock.com

McBRIDE, LOCK & ASSOCIATES, LLC
CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of the
Center for Practical Bioethics, Inc.

Opinion

We have audited the accompanying financial statements of the Center for Practical Bioethics, Inc. (a nonprofit organization), which comprise the statement of financial position as of December 31, 2023, and the related statements of activities, functional expenses, and cash flows for the year then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Center for Practical Bioethics, Inc. as of December 31, 2023, and the changes in its net assets and its cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Center for Practical Bioethics, Inc. and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Center for Practical Bioethics, Inc.'s ability to continue as a going concern within one year after the date that the financial statements are available to be issued.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting in error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with generally accepted auditing standards, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Center for Practical Bioethics, Inc.'s internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Center for Practical Bioethics, Inc.'s ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

Report on Summarized Comparative Information

We have previously audited the Center for Practical Bioethics, Inc.'s 2022 financial statements, and we expressed an unmodified audit opinion on those audited financial statements in our report dated June 8, 2023. In our opinion, the summarized comparative information presented herein as of and for the year ended December 31, 2022, is consistent, in all material respects, with the audited financial statements from which it has been derived.

McBride, Lock & Associates, LLC
Kansas City, Missouri
September 24, 2024

Exhibit A

Center For Practical Bioethics, Inc.
STATEMENT OF FINANCIAL POSITION
December 31, 2023

Assets	2023	2022
CURRENT ASSETS:		
Cash and Cash Equivalents	$ 172,129	$ 279,758
Investments (NOTE 4)	446,608	746,531
Accounts Receivable	113,989	130,435
Grants Receivable	-	94,173
Pledges Receivable (NOTE 3)	118,500	22,275
Prepaid Expenses	42,627	20,229
Inventory	1,980	15,500
Total Current Assets	$ 895,833	$ 1,308,901
PROPERTY AND EQUIPMENT:		
Furniture, Computers and Equipment	$ 50,431	$ 82,057
Accumulated Depreciation and Amortization	(29,000)	(60,533)
Total Property and Equipment	$ 21,431	$ 21,524
OTHER ASSETS:		
Investments - Endowment (NOTE 4)	$ 2,304,431	$ 2,119,509
Pledges Receivable (NOTE 3)	15,000	-
Deferred Compensation	150,677	233,384
Operating Lease Right-of-Use Asset	14,646	72,459
Beneficial Interest in Assets Held by Community Foundation (NOTE 7)	3,260,729	2,942,477
Total Other Assets	$ 5,745,483	$ 5,367,829
TOTAL ASSETS	$ 6,662,747	$ 6,698,254
Liabilities		
CURRENT LIABILITIES:		
Accounts Payable	$ 15,306	$ 52,819
Accrued Expenses	52,374	75,045
Deferred Revenue	50,000	48,487
Operating Lease Right-of-Use Liability	2,667	59,449
Line of Credit	50,000	-
Total Current Liabilities	$ 170,347	$ 235,800
LONG-TERM LIABILITIES:		
457(b) Deferred Compensation Liability	$ 150,677	$ 233,384
Operating Lease Right-of-Use Liability	7,370	10,038
Total Long-Term Liabilities	$ 158,047	$ 243,422
Total Liabilities	$ 328,394	$ 479,222
Net Assets		
NET ASSETS WITHOUT DONOR RESTRICTIONS:		
Undesignated	$ (76,373)	$ (108,190)
Board-Designated (NOTE 8)	87,838	87,838
Total Net Assets Without Donor Restrictions	$ 11,465	$ (20,352)
NET ASSETS WITH DONOR RESTRICTIONS (NOTE 7):		
Net assets with temporary restrictions	$ 1,035,282	$ 1,270,031
Net assets with perpetual restrictions	5,287,606	4,969,353
Total Net Assets With Donor Restrictions	$ 6,322,888	$ 6,239,384
Total Net Assets	$ 6,334,353	$ 6,219,032
TOTAL LIABILITIES & NET ASSETS	$ 6,662,747	$ 6,698,254

The accompanying notes to the financial statements are an integral part of this statement.

Center For Practical Bioethics, Inc.
STATEMENT OF ACTIVITIES
For the Year Ended December 31, 2023

	Net Assets Without Donor Restrictions	Net Assets With Donor Restrictions	Total 2023	Total 2022
Revenue				
Contributions, Grants, and Other Support	$ 262,334	$ 338,582	$ 600,916	$ 667,629
Fundraising	171,126	-	171,126	174,296
Earned Income	378,916	-	378,916	451,691
Membership Dues	-	-	-	15,260
Communications	8,737	-	8,737	11,419
Other Income	738	-	738	5,440
In-Kind Contributions	3,125	-	3,125	12,810
Net Assets Released From Restrictions	939,808	(939,808)	-	-
Total Revenue	$ 1,764,784	$ (601,226)	$ 1,163,558	$ 1,338,545
Expenses				
Program Expenses:				
Education and Consulting	$ 1,147,228	$ -	$ 1,147,228	$ 1,106,580
Support Services Expenses:				
Management and general	$ 312,364	$ -	$ 312,364	$ 274,747
Fundraising	273,383	-	273,383	198,330
Total Support Services Expenses	$ 585,747	$ -	$ 585,747	$ 473,077
Total Expenses	$ 1,732,975	$ -	$ 1,732,975	$ 1,579,657
Change in Net Assets from Operations	$ 31,809	$ (601,226)	$ (569,417)	$ (241,112)
Other Revenue (Expense):				
Investment Return, net	$ 8	$ 366,478	$ 366,486	$ (498,024)
Change in Value of Beneficial Interest	-	318,252	318,252	(724,042)
Total Other Revenue (Expenses)	$ 8	$ 684,730	$ 684,738	$ (1,222,066)
Change in Net Assets	$ 31,817	$ 83,504	$ 115,321	$ (1,463,178)
Net Assets, beginning of the year	(20,352)	6,239,384	6,219,032	7,682,210
Net Assets, end of year	$ 11,465	$ 6,322,888	$ 6,334,353	$ 6,219,032

The accompanying notes to the financial statements are an integral part of this statement.

Center For Practical Bioethics, Inc.
STATEMENT OF FUNCTIONAL EXPENSES
For the Year Ended December 31, 2023

	Program Services	Support Services		Total	
Personnel Expenses	Education and Consulting	Management and General	Fundraising	2023	2022
Salaries & Wages - Management	$ 84,452	$ 43,942	$ 81,020	$ 209,414	$ 119,345
Salaries & Wages - Other	637,675	90,976	55,910	784,561	754,842
Health Insurance	49,715	9,288	9,427	68,430	83,381
Payroll Taxes	60,070	11,223	11,391	82,684	70,487
Retirement Expense	19,519	3,647	3,701	26,867	23,222
Deferred Compensation Plan Expense	10,902	8,479	4,845	24,226	39,000
Health Reimbursement	1,635	305	310	2,250	1,763
Workers Compensation	4,357	814	826	5,997	4,028
Key-man Insurance	-	-	-	-	2,689
Life Insurance	2,652	495	503	3,650	-
Payroll Processing Fees	431	80	82	593	4,370
Search Expense	-	(3,789)	-	(3,789)	70,530
Other Employee Expense	-	3,212	-	3,212	10,000
Total Personnel Expenses	$ 871,408	$ 168,672	$ 168,015	$ 1,208,095	$ 1,183,657
Occupancy Expenses					
Rent	$ 34,661	$ 6,476	$ 6,572	$ 47,709	$ 60,428
Parking	235	44	45	324	63
Other Occupancy Expense	541	101	103	745	1,335
Insurance-Property & Casualty	4,300	803	815	5,918	5,659
Repairs & Maintenance	-	-	-	-	30
Total Occupancy Expenses	$ 39,737	$ 7,424	$ 7,535	$ 54,696	$ 67,515
Operating Expenses					
Consulting Fees	$ 84,002	$ 57,956	$ 67,002	$ 208,960	$ 170,002
Audit & Accounting Fees	47,566	8,887	9,019	65,472	16,302
Professional/Filing Fees	39,547	7,486	225	47,258	12,932
Community Relations	-	-	-	-	1,090
Bank/Credit Card Charges	64	196	-	260	1,668
Office Expense & Supplies	1,650	2,470	20	4,140	7,911
Printing Expense	25,755	1,850	13,970	41,575	37,811
Books & Subscriptions	544	21,678	-	22,222	16,606
Dues & Memberships	1,795	1,642	-	3,437	1,485
Postage & Shipping Expense	537	3,020	657	4,214	3,434
Telephone Expense	-	7,917	-	7,917	6,277
Equipment Lease Expense	2,822	527	535	3,884	7,918
Equipment Maintenance	265	49	50	364	1,056
Insurance - D&O Liability	1,794	335	341	2,470	1,173
Insurance - Professional Liability	2,506	468	475	3,449	3,808
Conference/Meeting Expense	21,634	3,759	4,447	29,840	20,487
Travel Expense	982	3,638	216	4,836	4,819
Depreciation Expense	-	13,326	-	13,326	12,906
Interest Expense	4,620	863	876	6,359	-
Other Operating Expense	-	201	-	201	800
Total Operating Expenses	$ 236,083	$ 136,268	$ 97,833	$ 470,184	$ 328,485
Total Program and Support Expenses	$ 1,147,228	$ 312,364	$ 273,383	$ 1,732,975	$ 1,579,657

The accompanying notes to the financial statements are an integral part of this statement.

Center For Practical Bioethics, Inc.
STATEMENT OF CASH FLOWS
For the Year Ended December 31, 2023

	2023	2022
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	$ 115,321	$ (1,463,178)
Adjustments to reconcile change in net assets to net cash provided by (used in) operating activities:		
Depreciation and Amortization	13,326	12,906
Net realized/unrealized (gains) losses on investments	(312,403)	543,344
Change in Value of Beneficial Interest	(318,252)	724,042
Lease Standard Cumulative Effect Adjustment	-	2,972
Changes in operating assets and liabilities:		
Accounts Receivable	89,125	(65,464)
Grants Receivable	21,494	(1,326)
Pledges Receivable	(111,225)	1,253
Prepaid Expenses	(22,398)	18,432
Inventory	13,520	(9,019)
Deferred Compensation	82,707	(5,841)
Operating Lease Right-of-Use Asset	57,813	(72,459)
Accounts Payable	(37,513)	10,075
Accrued Expenses	(22,671)	(35,699)
Deferred Revenue	1,513	(20,969)
Accrued Deferred Compensation	(82,707)	6,206
Operating Lease Right-of-Use Liability	(59,450)	69,487
NET CASH PROVIDED BY (USED IN) OPERATING ACTIVITIES	$ (571,800)	$ (285,238)
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchases of Computer Hardware and Software	$ (13,233)	$ -
Net (Purchases)/Maturities of Investments	427,404	160,818
NET CASH PROVIDED BY (USED IN) INVESTING ACTIVITIES	$ 414,171	$ 160,818
CASH FLOWS FROM FINANCING ACTIVITIES:		
Borrowings from/(Payments to) Line of Credit	$ 50,000	$ -
NET CASH PROVIDED BY (USED IN) FINANCING ACTIVITIES	$ 50,000	$ -
NET INCREASE (DECREASE) IN CASH	$ (107,629)	$ (124,420)
CASH AND CASH EQUIVALENTS, BEGINNING OF YEAR	279,758	404,178
CASH AND CASH EQUIVALENTS, END OF YEAR	$ 172,129	$ 279,758
SUPPLEMENTAL DISCLOSURES:		
Cash Paid For Interest	$ 5,611	$ -

The accompanying notes to the financial statements are an integral part of this statement.

CENTER FOR PRACTICAL BIOETHICS, INC.
NOTES TO THE FINANCIAL STATEMENTS
December 31, 2023

NOTE 1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Nature of Activities

The Center for Practical Bioethics, Inc., (the "Center") was incorporated in July 1984 as a Kansas not-for-profit corporation. The Center exists to raise and respond to ethical issues in health and healthcare to help patients, families, and health care providers find practical solutions to ethical problems. The guiding principles of the Center are as follows:

- To be unfettered by special interests
- To listen actively, think critically, and act wisely
- To lead and promote the leadership of others
- To collaborate with those who commit to civil discourse
- To work diligently toward our mission

Net Assets

The Center reports information regarding its financial position and activities according to two classes of net assets: net assets without donor restrictions and net assets with donor restrictions.

Net Assets Without Donor Restrictions – The portion of expendable funds that is available for support of the Center's operations. Additionally, the Center's Board has designated certain funds that have been donated in honor or memory of an individual.

Net Assets With Donor Restrictions – Funds that are subject to donor restrictions. These funds require either that the principal be invested in perpetuity or the income only be used by the Center or are temporarily restricted by the donor's intent as to usage.

Revenue Recognition

Contributions – Contributions, grants and other support are recognized when cash, securities or other assets are received, when an unconditional promise to give is made, or when a notification of a beneficial interest is received. Conditional contributions are those that include a barrier to entitlement and a right of return and are recognized as the conditions are met. Contributions are recorded as Net Assets Without Donor Restrictions or Net Assets With Donor Restrictions when recognized depending on the presence or absence of donor imposed restrictions. At December 31, 2022, there are no contributions that have not been recognized in the Statement of Activities because the condition(s) on which they depend have not yet been met.

Fundraising – Sponsorships and attendance fees received in connection with the Center's Annual Event are considered to be exchange transactions to the extent of the fair market value of benefits received by attendees and are recognized when the event is held. The amount received in excess of the value of the benefits received is treated as a contribution.

Earned Income – Revenues from the performance of professional educational and consulting services are recognized when the performance obligation of providing the services are met. These contracts are typically paid in advance or on a monthly basis.

Communications – Revenue from sales of Caring Conversations and Transportable Physician Orders for Patient Preferences (TPOPP/POLST) materials is recognized when the performance obligation of transferring the product to the customer is met. Payments are typically received prior to shipping the materials to the customer.

Accounts, Grants, and Pledges Receivable

The majority of the Center's receivables are due from revenues earned from consulting agreements and from contributions. Receivables are due at the donor's discretion. Accounts outstanding beyond the donor agreement are considered past due. The Center writes off receivables when they become uncollectible. There was no allowance for uncollectible pledges as of December 31, 2023.

Inventories

Inventories, representing booklets and forms, are stated at the lower of cost or market value determined by the first-in, first-out method.

Investments

Investments are stated at fair value based on quoted market prices, with unrealized gains and losses included in the accompanying statements of activities. Investment return is reported in the Statement of Activities and consists of interest and dividend income, and realized and unrealized gains and losses, net of external and direct internal investment expenses.

Property and Equipment

The Center capitalizes all acquisitions of property and equipment in excess of $1,000, which are recorded at cost, or fair value if donated. Property and equipment are depreciated using the straight-line method over the estimated useful life of the assets. Depreciation expense was $13,326 for the year ended December 31, 2023.

Income Taxes

The Center is exempt from income taxes under the provisions of Section 501(c)(3) of the Internal Revenue Code.

As required by FASB ASC No. 740, *Income Taxes,* the Center evaluated its tax positions and the certainty as to whether those positions will be sustained in the event of an audit by taxing authorities at the federal and state levels. The primary tax positions evaluated are related to the Center's continued qualification as a tax-exempt organization and whether there is unrelated business income activities conducted that would be taxable. Management has determined that all income tax positions are more likely than not of being sustained upon potential audit or examination; no disclosures of uncertain tax positions are required. The Center is no longer subject to United States federal or state examinations by tax authorities for the years before 2020. During 2023, the Center did not recognize any interest or penalties associated with any positions.

Cash Equivalents

The Center considers unrestricted cash, money market accounts, and highly liquid investments purchased with maturities of less than three months to be a cash equivalent.

Expense Allocation

The financial statements report certain categories of expenses that are attributed to more than one program or supporting function. The costs of supporting the various programs and other activities have been summarized on a functional basis in the Statement of Functional Expenses. Certain costs have been allocated among the program, management and general, and fundraising categories based on the percentage of salaries and wages expenses charged to each function.

The Center incurs costs related to the Annual Event and newsletters and other mailings that are considered to be both programmatic and fundraising in nature. Costs related to the Annual Event entertainment, including audio/visual costs, were split between program and fundraising because the talks are recorded and posted on the Center's website for educational purposes.

Advertising

Advertising costs are expensed as incurred.

Donated Services and In-Kind Contributions

The Center's policy is to recognize contributed professional services at the fair value of the services received if the services create or enhance nonfinancial assets or require specialized skills and are provided by individuals possessing those skills. Services provided by volunteers are not recognized in the financial statements because they do not meet the criteria for recognition under generally accepted accounting principles. Contributed goods are recorded at fair value on the date of donation. The Center received $3,150 of in-kind contributions during 2023 that were recognized in the financial statements.

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles in the United States of America requires management to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results could differ from those estimates.

Change in Net Assets from Operations

The Center's change in net assets from operations includes revenues and expenses directly related to carrying out the organization's mission. Income, gains, and losses from investments are considered non-operating.

NOTE 2 – LIQUIDITY AND AVAILABILITY

The Center for Practical Bioethics' permanent endowment fund consists of a donor-restricted endowment and funds appropriated subject to Center spending policy. Income from donor-restricted funds are restricted for specific purposes, and therefore, not immediately available for general expenditure. The Center appropriates for distribution each year for programs and administration from the endowment fund for which a spending policy has been adopted (Rosemary Flanigan Chair in Bioethics) in accordance with the Investment and Spending Policy a targeted amount of 5% with the option of up to 7% with Board approval. For other funds (i.e. Foley, Biblo and Memorial) spending levels are approved through the budgeting and Board review process. The organization considers contributions restricted for programs which are ongoing, major, and central to its operations to be available to meet cash needs for general expenditures.

As part of the Center's liquidity management, it structures its financial assets to be available as its general expenditures, liabilities, and other obligations come due. In addition, cash in excess of its daily needs over $35,000 is swept into an investment account. The Center has a committed line of credit up to $300,000, which could be drawn upon.

The following reflects the Center's financial assets as of the Statement of Financial Position date, reduced by amounts not available for general use because of contractual or donor-imposed restrictions within one year of the Statement of Financial Position date. Amounts not available include amounts set aside for board-designated reserves as needed for providing future programs and services.

Total Current Assets	$ 895,833
Less:	
Prepaid Expenses	(42,627)
Inventory	(1,980)
Current Financial Assets	$ 851,226
Less Those Unavailable for General Expenditures Within One Year:	
Board-designated funds	(87,838)
Financial assets available to meet cash needs for general expenditures within one year	$ 763,388

NOTE 3 – PLEDGES RECEIVABLE

Pledges receivable represent donors' promises to pay contributions to the Center and are measured at the present value of estimated future cash flows. Cash flows are discounted using the Treasury Bond yield rate on the date of the pledge that corresponds to the length of the pledge (i.e. rate on 3-year bond is used for a 3-year pledge). Collection of receivables at December 31, 2023 is expected as follows:

Due in less than one year	$ 82,000
Due in one to five years	51,500
Total Pledges Receivable	133,500
Less Discount to Present Value	-
Net Pledges Receivable	$ 133,500

NOTE 4 – INVESTMENTS

Investments consisted of the following as of December 31, 2023:

Money Market Funds	$ 75,439
Equities	1,770,348
Fixed Income Funds	905,252
Total Investments	$ 2,751,039
Investments	$ 446,608
Investments - Endowment	2,304,431
Total Investments	$ 2,751,039

NOTE 5 – FAIR VALUE MEASUREMENTS

Assets and liabilities measured at fair value are categorized into one of three different levels depending on the observability of the inputs employed in their measurement. Level 1 inputs are quoted prices in active markets for identical assets or liabilities. Level 2 inputs are market-observable inputs for measuring the asset or liability other than quoted prices included within Level 1. Level 3 inputs are unobservable inputs for measuring the asset or liability reflecting significant modifications to observable related market data or the Center's assumptions about pricing by market participants.

Equities and fixed income funds comprise mutual funds with readily determinable fair values based on daily redemption values. Money market funds are measured at cost, which approximates fair value. The beneficial interest is measured at fair value based on the fair value of fund investments reported by the community foundation.

The following table presents the assets and liabilities recognized in the accompanying statement of financial position that are measured at fair value on a recurring basis and the level within the fair value hierarchy in which those fair value measurements fall at December 31, 2023:

	Fair Value December 31	Level 1	Level 2	Level 3
Assets:				
Investments				
Money Market Funds	$ 75,439	$ -	$ 75,439	$ -
Equities	1,770,348	1,770,348	-	-
Fixed Income Funds	905,252	905,252	-	-
Total Investments	$ 2,751,039	$ 2,675,600	$ 75,439	$ -
Beneficial Interest	$ 3,260,729	$ -	$ -	$ 3,260,729
Deferred Compensation				
Money Market Funds	$ 1,960	$ -	$ 1,960	$ -
Equities	148,717	148,717	-	-
Total Deferred Compensation	$ 150,677	$ 148,717	$ 1,960	$ -
Liabilities:				
Deferred Compensation				
Money Market Funds	$ 1,960	$ -	$ 1,960	$ -
Equities	148,717	148,717	-	-
Total Deferred Compensation	$ 150,677	$ 148,717	$ 1,960	$ -

The following is a reconciliation of the beginning and ending balance of assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) for the year ended December 31, 2023:

	Beneficial Interest in Assets Held by Community Foundation
Balance at December 31, 2022	$ 2,942,477
Investment return, net	441,834
Distributions	(123,582)
Balance at December 31, 2023	$ 3,260,729

NOTE 6 – RETIREMENT PLANS

The Center sponsors a 403(b) defined contribution pension plan that covers all full-time employees. The Center matches 50% of employee contributions up to 6% of the employee's annual salary, for a total potential contribution from the Center of 3%. Employer contributions are vested over five years of service. In addition, management may authorize a discretionary matching contribution in the amount of 1.75% of gross salaries. Total expense under this plan for the year ended December 31, 2023 was $26,867.

During the year ended December 31, 2006, the Center adopted a 457(b) deferred compensation plan for a key employee. The employee and the employer can make discretionary contributions. Total deferred compensation expense for the year ended December 31, 2023 was $24,226.

NOTE 7 – NET ASSETS WITH DONOR RESTRICTIONS

Net assets were restricted for the following purposes as of December 31, 2023:

Subject to expenditure for specified purpose:		
Francis Family Foundation - Operating Reserve	$	50,000
Francis Endowed Chair		62,120
Latino Advanced Care Planning		25,000
Ethical AI		175,000
Endowments:		
Subject to appropriation and expenditure when a specified event occurs:		
Kathleen M. Foley Chair in Pain and Palliative Care		445,608
Perpetual in nature, earnings from which are subject to spending policy and appropriation:		
Rosemary Flanigan Chair in Clinical Ethics		2,304,431
Perpetual in nature, not subject to spending policy or appropriation:		
Beneficial Interest in John B. Francis Fund		3,260,729
Total Net Assets With Donor Restrictions	$	6,322,888

Net assets were released from donor restrictions by incurring expenses satisfying the restricted purpose or other events specified by donors as follows for the year ended December 31, 2023:

Satisfaction of purpose restrictions:		
Kathleen M. Foley Chair in Pain and Palliative Care	$	334,226
Latino Advanced Care Planning		98,482
Ethical.AI		195,000
Restricted-purpose spending rate distributions and appropriations:		
Rosemary Flanigan Chair in Clinical Ethics		147,252
John B. Francis Fund		164,848
Total Net Assets Released From Restrictions	$	939,808

Kathleen M. Foley Fund in Pain and Palliative Care

During the year ended December 31, 2008, the Center entered into an agreement with Purdue Pharma L.P. whereby $1,500,000 was awarded in a grant to provide funding for the Kathleen M. Foley Chair in Pain and Palliative Care. The grant was funded in the amount of $500,000 at the time of contractual signing by the Center, which occurred during the year ended December 31, 2008 and another payment was made in Fiscal Year 2009. The remaining balance of $500,000 was paid during

Fiscal Year 2011. The grant was provided to support the work of the Center in the area of Pain and Palliative Care. An investment account was established by the Center's Board of Directors, pursuant to a grant for the purposes of establishing the Chair. The funds remain under the management and control of the organization and its Board of Directors. During 2019, the Center decided to no longer consider this Fund as a quasi-endowment.

Rosemary Flanigan Chair in Clinical Ethics

In 2006, the Center for Practical Bioethics began fundraising to establish an endowed chair in honor of Sister Rosemary Flanigan, PhD., philosopher, teacher, bioethicist and Center staff member from 1992 until her retirement in 2010. Prior to becoming a staff member, Dr. Flanigan served on the Center Board of Directors and chaired the board in 1990/91. Between 2006 and 2013, more than $2 million was raised from over 200 donors with gifts ranging from $5 to $1.3 million. The annual proceeds of this endowed fund support a staff member of the Center with expertise in philosophy and clinical ethics who is named the holder of the Rosemary Flanigan Chair.

John B. Francis Chair in Bioethics

During the year ended December 31, 2005, the John B. Francis Chair in Bioethics Fund was established with the Greater Kansas City Community Foundation by the Francis Family Foundation for the benefit of the Center. The principal amount pledged to the Fund was $3,000,000, with the Center receiving annual distributions outlined by the terms of the agreement. The original agreement called for the Francis Family Foundation to have oversight responsibility of the fund for a period of 10 years after its inception. The transfer of authority took place in March 2023, giving the Center advisory privileges over the Fund.

A beneficial interest in the assets held by the Greater Kansas City Community Foundation has been recognized. The fund is held and invested by the Community Foundation for the benefit of the Center and is reported at fair value in the Statement of Financial Position, with distributions and changes in fair value recognized in the Statement of Activities. The Community Foundation has variance power which allows it to modify and condition or restriction on its distributions if such restriction becomes unnecessary or incapable of fulfillment, such as if the Center were to cease operations.

NOTE 8 – BOARD-DESIGNATED NET ASSETS WITHOUT DONOR RESTRICTIONS

Board-designated funds include the Robert L. Biblo Fund and Memorial Fund. Robert L. Biblo was on the Center's Board of Directors until his death in 1994, and this fund was established at the Center in his honor. The Memorial Fund is funded by undesignated donations made in honor or memory of someone. Net assets were voluntarily segregated by the Center's Board for the following purposes as of December 31, 2023:

Robert L. Biblo Fund	$ 80,000
Memorial Fund	7,838
Total Board-Designated Net Assets	$ 87,838

NOTE 9 – LINE OF CREDIT

On September 17, 2016, the Center renewed a one year promissory note with Country Club Bank for a line of credit up to $300,000. The note has a variable interest rate based on the Wall Street Journal U.S. Prime Rate, with a minimum rate of 5%. The Center must make interest payments on any outstanding principal balance on a monthly basis. At December 31, 2023, the Center had $50,000 of outstanding borrowings on this line of credit, which has a maturity date of September 17, 2024.

NOTE 10 – OPERATING LEASES

The Center leases its office space under an operating lease with a term of 36 months through January 31, 2024. The Center leased a copier with a 60 month term through June 2027. Any renewal options in the leases are included in the determination of the right-of-use asset and lease liabilities when the options are reasonably certain to be exercised.

The weighted-average discount rate is based on the discount rate implicit in the lease. The Center has elected the option to use the risk-free rate determined using a period comparable to the lease terms as the discount rate for leases where the implicit rate is not readily determinable. The risk-free rate option has been applied to the office and copier leases.

The Center has elected the practical expedient to not separate lease and non-lease components for the office lease. The office lease contains a variable non-lease component for common area maintenance, which is determined by the lessor on an annual basis.

The following provides information regarding total lease cost and cash flows from leasing transactions:

Operating lease cost	$ 58,295
Variable lease cost	745
Total lease cost	$ 59,040
Cash paid for amounts included in the measurement of lease liabilities:	
Operating cash flows from operating leases	$ 59,931
Right-of-use assets obtained in exchange for new operating lease liabilities	$ -
Weighted-average remaining lease term (years) - operating leases	3.50
Weighted-average discount rate - operating leases	3.75%

Future minimum lease payments under operating leases are as follows:

Year Ending December 31,	Amount
2024	$ 7,742
2025	2,998
2026	2,998
2027	1,499
Total lease payments	$ 15,237
Less interest	(5,200)
Present value of lease liabilities	$ 10,037

NOTE 11 – MAJOR CONCENTRATIONS

The Center maintains its cash balances within two accounts at a financial institution in Kansas City, Missouri. The balances are insured by the Federal Deposit Insurance Corporation up to $250,000. The Center has a repurchase agreement for balances in excess of insurance coverage. At December 31, 2023, the Center's cash balances were adequately secured.

The Center invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market, and credit risks. Due to the level of risk associated with certain investments securities, it is at least reasonably possible that changes could materially affect the amounts reported in the accompanying statements of financial position. The Board of Directors and management of the Center have established policies to provide prudent oversight of the investments.

NOTE 12 – ENDOWMENT

The Center's endowment consists of funds established for a variety of purposes. Its endowment includes donor-restricted endowment funds. As required by the accounting principles generally accepted in the United States of America (GAAP), net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions.

The Board has determined that, absent explicit donor stipulations to the contrary, the Uniform Prudent Management of Institutional Funds Act (2006) (UPMIFA) statutes as adopted in Kansas and Missouri allow the Center to appropriate for expenditure or to accumulate so much of an endowment fund as the Center determines is prudent for the uses, benefits, purposes and duration for which the endowment funds were established, and to make such determinations to appropriate or accumulate fund assets in good faith pursuant to investment and spending policies implemented in the context of the perpetual nature of an endowment which are designed to maintain the value of the fund over time and to permit annual expenditure amounts that are prudent, after considering the following factors: (1) the duration and preservation of the endowment fund; (2) the purposes of the Center and the fund; (3) general economic conditions; (4) the possible effect of inflation or deflation; (5) the expected total return from income and the appreciation of investments; (6) other resources of the Center; and (7) the investment and spending policy of the Center.

The Center considers a fund to be underwater if the fair value of the fund is less than the sum of (a) the original value of initial and subsequent gift amounts donated to the fund and (b) any accumulations to the fund that are required to be maintained in perpetuity in accordance with the direction of the applicable donor gift instrument. We have interpreted UPMIFA to permit spending from underwater endowments in accordance with prudent measures required under law.

Investment Return Objectives, Risk Parameters and Strategies

The Center has adopted investment and spending policies for the purpose of attempting to provide a reasonably predictable stream of funding to programs supported by endowment funds while also attempting to maintain the purchasing power of the Center's endowment assets over the long term. The Center shall seek an achievable return of 7% (net of investment fees) taking into account both capital appreciation (realized and unrealized) and current yield (interest and dividends) calculated as a moving three (3) year average of the fair market value of the funds.

Spending Policy

The Center has a policy of appropriating for distribution each year for programs and administration an amount up to but not to exceed 7% of a moving three (3) year average of the fair market value of the endowment funds determined quarterly. This is consistent with the Center's objectives to appropriate for expenditure or to accumulate so much of an endowment fund for the uses, benefits, purposes and duration for which the endowment funds were established.

Endowment net assets consist of $2,304,431 in Net Assets With Donor Restrictions, including $277,555 which is temporarily restricted and $2,026,876 which is perpetually restricted.

Changes in endowment net assets as of December 31, 2023 are as follows:

	Net Assets With Donor Restrictions		
	Temporary	Perpetual	Total
Endowment net assets, beginning of year	$ 92,633	$ 2,026,876	$ 2,119,509
Contributions	-	-	-
Investment Income	56,382	-	56,382
Net Appreciation	275,792	-	275,792
Amounts appropriated for expenditure	(147,252)	-	(147,252)
Endowment net assets, end of year	$ 277,555	$ 2,026,876	$ 2,304,431

NOTE 13 – REVENUE FROM CONTRACTS WITH CUSTOMERS

The following table reflects changes in receivables and deferred revenue (contract liabilities) arising from contracts with customers:

	Beginning Balance	Increases	Decreases	Ending Balance
Receivables	$ 40,760	$ 35,060	$ (34,510)	$ 41,310
Deferred Revenue	48,489	5,217	(3,706)	50,000

NOTE 14 – CONTRIBUTED NON-FINANCIAL ASSETS

The Center receives non-financial asset contributions. These assets are recognized at fair value based on the market value of the item(s) being donated and are presented in the financial statements as "In-Kind Contributions". Contributed non-financial assets consisted of professional legal services received related to the transfer of authority on the Francis funds held by the Greater Kansas City Community Foundation. No in-kind contributions were restricted.

NOTE 15 – PRIOR YEAR SUMMARIZED INFORMATION

The consolidated financial statements include certain prior-year summarized comparative information in total but not by net asset class. Such information does not include sufficient detail to constitute a presentation in conformity with generally accepted accounting principles. Accordingly, such information should be read in conjunction with the financial statements for the year ended December 31, 2022, from which the summarized information was derived.

NOTE 16 – SUBSEQUENT EVENTS

Management has evaluated and noted no subsequent events through September 24, 2024, the date which the financial statements were available for issue.

4151 N. Mulberry Drive, Suite 275
Kansas City, Missouri 64116
T: (816) 221.4559
F: (816) 221.4563
E: Admin@McBrideLock.com

McBRIDE, LOCK & ASSOCIATES, LLC
CERTIFIED PUBLIC ACCOUNTANTS

September 24, 2024

To the Board of Directors and management
Center for Practical Bioethics, Inc.

We have audited the financial statements of the Center for Practical Bioethics, Inc. for the year ended December 31, 2023, and we will issue our report thereon dated September 24, 2024. Professional standards require that we provide you with information about our responsibilities under generally accepted auditing standards, as well as certain information related to the planned scope and timing of our audit. Professional standards also require that we communicate to you the following information related to our audit.

Significant Audit Matters

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by the Center for Practical Bioethics, Inc. are described in Note 1 to the financial statements. No new accounting policies were adopted and the application of existing policies was not changed during the year. We noted no transactions entered into by the Organization during the year for which there is a lack of authoritative guidance or consensus. All significant transactions have been recognized in the financial statements in the proper period.

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimate affecting the financial statements was:

> Management's estimate of the value of the beneficial interest in the Francis Chair funds held by the Greater Kansas City Community Foundation which was based on the value of the investments in the fund. We evaluated the methods, assumptions, and data used to develop the estimate in determining that it is reasonable in relation to the financial statements taken as a whole.

The financial statement disclosures are neutral, consistent, and clear.

Difficulties Encountered in Performing the Audit

We encountered no significant difficulties in dealing with management in performing and completing our audit.

Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all misstatements identified during the audit, other than those that are clearly trivial, and communicate them to the appropriate level of management. Management has corrected all such misstatements. The following material misstatements detected as a result of audit procedures were corrected by management:

- The balance of the beneficial interest in the Francis fund was increased by $41,266 to agree to the fair value of the investments held by the Greater Kansas City Community Foundation at year end.
- Accounts Receivable and Donations revenues were increased by $20,000 to recognize an additional pledge that was received during the year but not recorded.

Disagreements with Management

For purposes of this letter, a disagreement with management is a disagreement on a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditor's report. We are pleased to report that no such disagreements arose during the course of our audit.

Management Representations

We have requested certain representations from management that are included in the management representation letter dated September 24, 2024.

Management Consultations with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the Organization's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Audit Findings or Issues

We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as the Organization's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

In planning and performing our audit of the statement of financial position of the organization as of December 31, 2023 and the related statements of activities, functional expenses, and cash flows, we considered the organization's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the organization's internal control. As part of obtaining reasonable assurance about whether the organization's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, noncompliance with which could have a

direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit. We issued a report on our consideration of internal control and compliance dated September 24, 2024.

However, during our audit we became aware of matters that are opportunities for strengthening internal controls. This letter does not affect our report dated September 24, 2024 on the statement of financial position and the related statements of activities, functional expenses, and cash flows of the organization.

Functional Expense Reporting

The organization uses the "Class" feature in the QuickBooks accounting system and has established separate classes for various programs, fundraising activities, and general administrative expenses. However, it was noted that the classes in the accounting system did not reflect all program expenditures. For example, QuickBooks reflected $162,984 of expenditures for the Ethical AI program, however, $195,000 of program expenses were reported on the temporarily restricted net asset detail and were released from restrictions. It was noted that certain items such as indirect costs were included in the amount released from restrictions but were not recorded as program costs in QuickBooks. We recommend that the organization ensure that the accounting system accurately reflects expenditures by program, fundraising, and administrative and that releases from restrictions for purpose restricted grants be based on the amount of expenditures recognized for those grants.

Other Matters

This information is intended solely for the use of the Board of Directors and management of the Center for Practical Bioethics, Inc. and is not intended to be, and should not be, used by anyone other than these specified parties.

Very truly yours,

McBride, Lock & Associates, LLC

4151 N. Mulberry Drive, Suite 275
Kansas City, Missouri 64116
T: (816) 221.4559
F: (816) 221.4563
E: Admin@McBrideLock.com

McBRIDE, LOCK & ASSOCIATES, LLC

CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT AUDITORS' REPORT ON INTERNAL CONTROLS

To the Board of Directors of
Center for Practical Bioethics, Inc.

In planning and performing our audit of the financial statements of the Center for Practical Bioethics, Inc. (the "Organization") as of and for the year ended December 31, 2023, in accordance with auditing standards generally accepted in the United States of America, we considered the Organization's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Organization's internal control. Accordingly, we do not express an opinion on the effectiveness of the Organization's internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A material weakness is a deficiency, or combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the Organization's financial statements will not be prevented, or detected and corrected, on a timely basis.

Our consideration of internal control was for the limited purpose described in the first paragraph and was not designed to identify all deficiencies in internal control that might be material weaknesses. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

This communication is intended solely for the information and use of management, the Board of Directors, and others within the Organization, and is not intended to be, and should not be, used by anyone other than these specified parties.

McBride, Lock & Associates, LLC
Kansas City, Missouri
September 24, 2024

September 24, 2024

McBride, Lock & Associates, LLC
4151 N Mulberry Dr, Suite 275
Kansas City, MO 64116

This representation letter is provided in connection with your audit of the financial statements of the Center for Practical Bioethics, Inc., which comprise the statement of financial position as of December 31, 2023, and the related statements of activities, functional expenses, and cash for the year then ended, and the disclosures (collectively, the "financial statements"), for the purpose of expressing an opinion as to whether the financial statements are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States (U.S. GAAP).

Certain representations in this letter are described as being limited to matters that are material. Items are considered to be material, regardless of size, if they involve an omission or misstatement of accounting information that, in light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would be changed or influenced by the omission or misstatement. An omission or misstatement that is monetarily small in amount could be considered material as a result of qualitative factors.

We confirm, to the best of our knowledge and belief, as of September 24, 2024, the following representations made to you during your audit.

Financial Statements

1) We have fulfilled our responsibilities, as set out in the terms of the audit engagement letter dated February 12, 2024, including our responsibility for the preparation and fair presentation of the financial statements in accordance with U.S. GAAP.
2) The financial statements referred to above are fairly presented in conformity with U.S. GAAP.
3) We acknowledge our responsibility for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.
4) We acknowledge our responsibility for the design, implementation, and maintenance of internal control to prevent and detect fraud.
5) The methods, significant assumptions, and data used in making accounting estimates and their related disclosures are appropriate to achieve recognition, measurement, or disclosure that is reasonable in accordance with U.S. GAAP.
6) There are no known related-party relationships or transactions which need to be accounted for or disclosed in accordance with U.S. GAAP.
7) All events subsequent to the date of the financial statements and for which U.S. GAAP requires adjustment or disclosure have been adjusted or disclosed.

8) The effects of uncorrected misstatements are immaterial, both individually and in the aggregate, to the financial statements as a whole. A list of the uncorrected misstatements is attached to the representation letter. In addition, you have proposed adjusting journal entries that have been posted to the Organization's accounts. We are in agreement with those adjustments.
9) There is no known actual or possible litigation, claims, and assessments are required to be accounted for and disclosed in accordance with U.S. GAAP.
10) Material concentrations have been appropriately disclosed in accordance with U.S. GAAP.

Information Provided

11) We have provided you with:
    a) Access to all information, of which we are aware, that is relevant to the preparation and fair presentation of the financial statements, such as records (including information obtained from outside of the general and subsidiary ledgers), documentation, and other matters.
    b) Additional information that you have requested from us for the purpose of the audit.
    c) Unrestricted access to persons within the Organization from whom you determined it necessary to obtain audit evidence.
    d) Minutes of the meetings of the governing board or summaries of actions of recent meetings for which minutes have not yet been prepared.
12) All material transactions have been recorded in the accounting records and are reflected in the financial statements.
13) We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.
14) We have no knowledge of any fraud or suspected fraud that affects the Organization and involves:
    a) Management,
    b) Employees who have significant roles in internal control, or
    c) Others where the fraud could have a material effect on the financial statements.
15) We have no knowledge of any allegations of fraud or suspected fraud affecting the Organization's financial statements communicated by employees, former employees, grantors, regulators, or others.
16) We have no knowledge of any instances of noncompliance or suspected noncompliance with laws and regulations whose effects should be considered when preparing financial statements.
17) We are not aware of any pending or threatened litigation, claims, or assessments or unasserted claims or assessments that are required to be accrued or disclosed in the financial statements in accordance with U.S. GAAP, and we have not consulted a lawyer concerning litigation, claims, or assessments.
18) The Organization has satisfactory title to all owned assets, and there are no liens or encumbrances on such assets nor has any asset been pledged as collateral.
19) We are responsible for compliance with the laws, regulations, and provisions of contracts and grant agreements applicable to us.
20) The Center for Practical Bioethics, Inc. is an exempt organization under Section 501(c)3 of the Internal Revenue Code. Any activities of which we are aware that would jeopardize the Organization's tax-exempt status, and all activities subject to tax on unrelated business income or excise or other tax, have been disclosed to you. All required filings with tax authorities are up-to-date.

Signature: _____

Title: _____

Center for Practical Bioethics
Budget Analysis
For Calendar Year 2025

	Proposed 2025 Budget	Approved 2024 Budget	9+3 Forecast 2024	Variance 25 Bud to 24 Act	
Income					
4110 Restricted Receipts			$ -		
4210 Funds Released from Restrictions	$ 425,000	$ 290,000	$ 282,815	$ 142,185	Grant. Sunderland and increase from Harmon ACP grant
4310 Endowment Receipts	$ 427,093	$ 410,492	$ 349,925	$ 77,168	
4510 Earned Income	$ 32,000	$ 143,188	$ 138,248	$ (106,248)	Decrease - Change in renewals. $75k KU + $30 CEIGR
4515 Provider Ethics Services	$ 290,375	$ 274,432	$ 259,604	$ 30,771	Increase for new affiliates
4520 Honoraria	$ 2,000	$ 4,000	$ 1,975	$ 25	
4530 Lecture-Workshop Income	$ 35,000	$ 2,500	$ -	$ 35,000	Increase for new activties
4660 Donations-unrestricted	$ 145,000	$ 350,000	$ 166,921	$ (21,921)	
4430 Event Income	$ 55,000	$ 72,000	$ 149,294	$ (94,294)	Decrease. Reduce event size. PY 40th Anniversary
4710 Membership - Institutional	$ 15,000	$ 15,000	$ 15,000	$ -	
4810 Communication Income	$ -	$ -	$ 1,980	$ (1,980)	
4820 Publications Income	$ -	$ -	$ 5	$ (5)	
5010 Other Revenue-Reimbursements	$ -	$ -	$ 511	$ (511)	
5050 Interest Income	$ -	$ -	$ 978	$ (978)	
Total Income	**$ 1,426,468**	**$ 1,561,612**	**$ 1,367,257**	**$ 59,210**	
Cost of Goods Sold					
7000 Cost of Goods Sold	$ -		$ 1,980	$ (1,980)	
Total Cost of Goods Sold	**$ -**	**$ -**	**$ 1,980**	**$ (1,980)**	
Gross Profit	**$ 1,426,468**	**$ 1,561,612**	**$ 1,365,277**	**$ 61,190**	
Expenses					
A) Salaries, Benefits & Other Employee Costs					
6010 Salaries and Wages	$ 782,715	$ 942,810	$ 890,331	$ (107,616)	Decrease. Staff reduction/mix. 2025 = 8 FTEs. PY 9 FTEs
6090 457(b) Deferred Compensation Exp	$ -	$ -	$ -	$ -	
6110 Employer FICA Taxes	$ 59,878	$ 72,127	$ 63,652	$ (3,774)	
6130 Unemployment Taxes	$ 60	$ 1,069	$ 825	$ (765)	
6210 Health Insurance Premiums	$ 57,998	$ 63,449	$ 54,803	$ 3,195	
6215 HSA/FSA Employer Matching Contribution			$ 1,233	$ (1,233)	
6220 Health Reimbursement Acct Exp	$ 2,100	$ 2,100	$ 1,950	$ 150	
6240 403(b) Matching Contributions	$ 19,120	$ 26,400	$ 23,080	$ (3,960)	
6270 Disability Insurance Expense	$ 3,420		$ 26	$ 3,394	
6350 Employee Development	$ 2,496	$ 500	$ 125	$ 2,371	
6380 Search Expense	$ 400		$ 135	$ 265	
6390 Other Employee Expense	$ 2,100	$ 2,000	$ 2,495	$ (395)	
Total A) Salaries, Benefits & Other Employee Costs	**$ 930,288**	**$ 1,110,455**	**$ 1,038,655**	**$ (108,368)**	
B) Occupancy					
6410 Office Lease	$ -	$ 4,744	$ 4,744	$ (4,744)	Decrease Lease Termination
6420 Parking	$ -	$ 31	$ 11	$ (11)	
6460 Repairs & Maintenance	$ -	$ -	$ -	$ -	
6490 Other Occupancy Expense	$ 1,320	$ 12,075	$ 831	$ 489	
Total B) Occupancy	**$ 1,320**	**$ 16,850**	**$ 5,587**	**$ (4,267)**	

C) Professional & Contract Services	$ -	$ -		$ -	
6510 Contract Services	$ 282,937	$ 147,500	$ 224,037	$ 58,900	Contractor mix changes. Incr - Harmon grant contractors & Event Coordinator. Decr - Trudi's Fnd/Mktg svc
6515 Stipends	$ -	$ 17,000	$ 4,000	$ (4,000)	Decrease - Remove stipends
Total 6510 Contract Services	**$ 282,937**	**$ 164,500**	**$ 228,037**	**$ 54,900**	
6520 Accounting & Audit Fees	$ 68,500	$ 65,704	$ 69,011	$ (511)	
6530 Legal Fees	$ 7,560	$ 1,200	$ 5,959	$ 1,602	
6550 Payroll Processing Fees	$ -		$ (0)	$ 0	
6570 Blackbaud & Other Fees	$ 480	$ 5,819	$ 3,863	$ (3,383)	
Total C) Professional & Contract Services	**$ 359,477**	**$ 237,223**	**$ 306,869**	**$ 52,608**	
D) Supplies					
6640 Office Supplies	$ 1,200	$ 1,832	$ 458	$ 742	
6650 Program-related Supplies	$ 25,900	$ 787	$ -	$ 25,900	Increase for Harmon grant expenses/ACP Session costs
Total D) Supplies	**$ 27,100**	**$ 2,619**	**$ 458**	**$ 26,642**	
E) Telephone			$ -		
6710 Telephone Expense	$ 1,200	$ 7,380	$ 1,756	$ (556)	
Total E) Telephone	**$ 1,200**	**$ 7,380**	**$ 1,756**	**$ (556)**	
F) Postage & Shipping					
6810 Postage	$ 1,700	$ 1,030	$ 691	$ 1,009	
6880 Mailing Services	$ 100	$ 375	$ 802	$ (702)	
Total F) Postage & Shipping	**$ 1,800**	**$ 1,405**	**$ 1,494**	**$ 307**	
G) Equipment & Maintenance					
6915 Equipment Rental Expense	$ 3,420	$ 2,738	$ 3,404	$ 16	
6950 NonCapital Equipment Costs	$ 4,300	$ 5,600	$ 1,436	$ 2,864	
Total G) Equipment & Maintenance	**$ 7,720**	**$ 8,338**	**$ 4,840**	**$ 2,880**	
H) Printing & Promotions					
7010 Printing & Collateral Materials	$ 2,280	$ 3,500	$ 3,289	$ (1,009)	
7040 Advertising Placement	$ 1,500	$ 1,000	$ 2,970	$ (1,470)	
7050 Audio & Visual Production	$ 3,500	$ 26,000	$ 23,696	$ (20,196)	Decrease PY includes 40th Anniv Event
Total H) Printing & Promotions	**$ 7,280**	**$ 30,500**	**$ 29,955**	**$ (22,675)**	
I) Travel & Transportation					
7110 Airfare	$ 18,740	$ 1,521	$ 3,083	$ 15,657	
7120 Hotel		$ 2,514	$ 1,675	$ (1,675)	
7130 Ground Transportation		$ 442	$ 1,062	$ (1,062)	
7140 Parking-travel		$ 14	$ 31	$ (31)	
7150 Meals, Beverages & Incidentals		$ 2,849	$ 1,037	$ (1,037)	
7160 Mileage & Tolls		$ 842	$ 436	$ (436)	
7190 Other Travel Expenses			$ 336	$ (336)	
Total I) Travel & Transportation	**$ 18,740**	**$ 8,182**	**$ 7,659**	**$ 11,081**	Increase for Harmon grant expenses
J) Conferences, Conventions & Meetings			$ -		
7220 Meeting Space	$ 2,400	$ 7,150	$ 4,973	$ (2,573)	
7240 Food & Beverage	$ 11,645	$ 25,500	$ 27,935	$ (16,290)	
7250 Speaker's Honoraria	$ 1,500	$ 22,000	$ -	$ 1,500	
7255 Speaker's Travel Expense	$ -	$ 3,000	$ -	$ -	
7270 Registration Fees	$ -	$ 300	$ 835	$ (835)	
7290 Other Conf/Meeting Expenses	$ 2,000	$ 12,500	$ 6,361	$ (4,361)	
7295 Board of Directors Expense	$ 7,200	$ 10,000	$ 7,756	$ (556)	
Total J) Conferences, Conventions & Meetings	**$ 24,745**	**$ 80,450**	**$ 47,861**	**$ (23,116)**	Reduction. PY 40th Anniversary Event

K) Memberships & Subscriptions					
7310 Individual Dues	$ 1,510	$ 1,000	$ 758	$ 752	
7320 Organization Dues	$ 1,690	$ 3,000	$ 1,550	$ 140	
7350 Subscriptions & Books	$ 320	$ 22,870	$ 16,843	$ (16,523)	Spread expense across new acct categories
NEW Website Subscriptions & Fees	$ 9,054		$ -	$ 9,054	
NEW Software Subscriptions & Fees	$ 6,440		$ -	$ 6,440	
Total K) Memberships & Subscriptions	**$ 19,014**	**$ 26,870**	**$ 19,151**	**$ (137)**	
L) Insurance					
6280 Life Insurance Expense	$ 3,600	$ 3,227	$ 3,589	$ 11	
7410 Business & Casualty Insurance	$ 4,360	$ 5,730	$ 3,981	$ 379	
7415 Business Umbrella	$ 3,720	$ 3,450	$ 4,364	$ (644)	
7420 Director's & Officer's Liability	$ 2,304	$ 2,602	$ 2,206	$ 98	
7450 Worker's Compensation	$ 6,000	$ 5,449	$ 4,506	$ 1,494	
Total L) Insurance	**$ 19,984**	**$ 20,458**	**$ 18,647**	**$ 1,337**	
M) Interest Exp					
7510 Interest Expense-Line of Credit	$ 4,200	$ -	$ 4,817	$ (617)	
Total M) Interest Exp	**$ 4,200**	**$ -**	**$ 4,817**	**$ (617)**	
N) Miscellaneous Operating Exp					
7660 Miscellaneous Expense			$ (318)	$ 318	
7770 Depreciation	$ 3,600	$ 10,882	$ 14,037	$ (10,437)	Reduction in fixed asset sch
Total N) Miscellaneous Operating Exp	**$ 3,600**	**$ 10,882**	**$ 13,719**	**$ (10,119)**	
Total Expenses	**$ 1,426,468**	**$ 1,561,612**	**$ 1,501,468**	**$ (75,000)**	
Net Operating Income	**$ -**	**$ -**	**$ (136,191)**	**$ 136,191**	
Other Income					
7820 Endowment Receipts Used for Operations	$ (427,093)	$ (410,492)	$ (349,925)	$ (77,168)	
7830 Investment Earnings			$ 112,735	$ (112,735)	
7840 Realized Investment Gains (Losses)			$ 158,058	$ (158,058)	
7845 UnRealized Investment Gains (Losses)			$ 469,348	$ (469,348)	
Total Other Income	**$ (427,093)**	**$ (410,492)**	**$ 390,217**	**$ (817,309)**	
Other Expenses					
7850 Investment Fees & Expenses	$ 28,800	$ 27,504	$ 29,388	$ (588)	
7910 Other Expense			$ -	$ -	
Total Other Expenses	**$ 28,800**	**$ 27,504**	**$ 29,388**	**$ (588)**	
Net Other Income	**$ (455,893)**	**$ (437,996)**	**$ 360,829**	**$ (816,721)**	
Net Income	**$ (455,893)**	**$ (437,996)**	**$ 224,638**	**$ (680,531)**	

Center for Practical Bioethics

BENEFITS OVERVIEW	2025 Rates 2025 Enrollments	2025 Rates 2025 Enrollments	2025 Rates 2025 Enrollments
Network	***Blue Select Plus***	***Blue Select Plus***	***Preferred-Care Blue***
DEDUCTIBLE	*Participant Pays*	*Participant Pays*	*Participant Pays*
· **Individual**	$5,000	$3,300	$6,500
· **Family**	$10,000	$6,600	$13,000
PHYSICIAN OFFICE VISITS & OTHER	*Participant Pays*	*Participant Pays*	*Participant Pays*
Primary Care Physician Office Visit	Deductible	Deductible	Deductible
Specialist Physician Office Visit	Deductible	Deductible	Deductible
Urgent Care Center Visit	Deductible	Deductible	Deductible
Emergency Room Visit *(Non Ntwk Emergency Paid as In Ntwk)*	Deductible	Deductible	Deductible
Lab Services	Deductible	Deductible	Deductible
X-Ray Services	Deductible	Deductible	Deductible
Hi-Tech Radiological Services *(CT, MRI, etc)*	Deductible	Deductible	Deductible
Chiropractor Visit/Spinal Manipulation *(Limits May Apply)*	Deductible	Deductible	Deductible
Inpatient/Outpatient Hospital Services *(General)*	Deductible	Deductible	Deductible
Other Covered Services *(General)*	Deductible	Deductible	Deductible
PLAN CO-INSURANCE *(General)*	90%	100%	100%
OUT-OF-POCKET MAXIMUM *(Includes The Deductible, Medical & RX Copays)*	*Participant Pays*	*Participant Pays*	*Participant Pays*
· **Individual**	**$6,450**	**$3,300**	**$6,500**
· **Family**	$12,900	**$6,600**	$13,000
RETAIL PRESCRIPTION DRUGS COPAY *Mail Order- Please See Carrier/Vendor Detailed Summary of Benefits*	**Tier 1** - Deductible **Tier 2** - Deductible **Tier 3** - Deductible **Tier 4** - Deductible **Tier 5** - Deductible	**Tier 1** - Deductible **Tier 2** - Deductible **Tier 3** - Deductible **Tier 4** - Deductible **Tier 5** - Deductible	**Tier 1** - Deductible **Tier 2** - Deductible **Tier 3** - Deductible **Tier 4** - Deductible **Tier 5** - Deductible
Employee Only	**$513.11**	**$536.81**	**$521.68**
Employee/Spouse	**$1,293.04**	**$1,352.76**	**$1,253.25**
Employee Children	**$1,039.20**	**$1,036.04**	**$959.83**
Family	**$1,539.33**	**$1,610.55**	**$1,492.14**

RENEWAL $6202.90 TOTAL

This is an Overview of Benefits only, where this summary the contract differ, the contract will prevail.

One-Time Special Distribution from the Foley Fund
2025 Budget
For November 2024 Board Meeting

The Center's Investment and Spending Policy governing use of the Foley funds permits spending in excess of the annual spending limit (7 percent) with the recommendation of the finance committee to the Board and two-thirds majority vote of the full Board.

If adopted, this resolution would authorize a one-time special distribution of $75,201 above the regular quarterly draws of 5% of the moving 3-year average of the fund (approximately $23,000 per year). The purpose of the draw is to balance the 2025 budget. Upon conclusion of the one-time distribution, the fund shall revert to the annual spending policy.

A similar resolution was adopted in 2024, including waiting until the end of FY 2024 to complete the special distribution, with the anticipation that not all the authorized funds would be needed, and therefore the corpus better preserved. Management will follow the same approach for the 2025 distribution(s).

Investment and Spending Policy
Temporarily Restricted Funds
Center for Practical Bioethics, Inc.

[Highlighted text = draft proposed revisions to existing policy]

Adopted by the Board of Directors: [insert date]

This policy supersedes and replaces any previous versions.

BACKGROUND

During the year ended December 31, 2008, the Center entered into an agreement with Purdue Pharma L.P. whereby $1,500,000 was awarded in a grant to provide funding for the Kathleen M. Foley Chair in Pain and Palliative Care. The annual proceeds of these funds support the work of the Center in the area of Pain and Palliative Care. The Investment Fund was established by the Center's Board of Directors, and in 2019, the Board of Directors voted that the fund shall no longer be considered a quasi-endowment. The funds remain under the management and control of the organization and its Board of Directors.

GOAL

The long-term investment goal for these funds will be, at a minimum, to achieve an investment return equal to the annual spending target plus inflation. To the extent it can be accomplished prudently, the management of the investment portfolio shall be oriented to maximize total return so that the funds would grow over time to generate sufficient income to support this work of the Center. This will allow for the preservation of the corpus' purchasing power and the long-term growth of these funds, in order of priority.

ANNUAL SPENDING POLICY

The annual spending policy will set the limit for the disbursement of funds as directed by the Board of Directors. Withdrawals from the Investment Funds in support of the Pain and Palliative Care work up to the annual spending level do not require any further approvals by the Board of Directors. Spending in excess of the annual spending limit will require the recommendation of the finance committee to the Board and two-thirds majority vote of the full Board.

The Center has a policy of appropriating for distribution each year an amount up to but not to exceed 6% of a moving three-year average of the fair market value of the funds at year end (December 31). The annual spending target is 5 percent, and with Board approval may be increased up to 7 percent. One fourth of this total annual spending amount will be distributed to the Center at the beginning of each quarter.

RESPONSIBILITY

The Board of Directors is responsible for fiduciary oversight of these long-term investments in all respects.

The Board will:

- Review this investment and spending policy at least annually.
- Direct the Finance Committee of the board to implement the policy.
- Vote on any changes recommended by the Finance Committee.
- Vote on investment manager contracts recommended by the Finance Committee.
- Review investment results at least annually.

The Finance Committee will:

- Implement the investment and spending policy.
- Recommend potential investment managers to the Board.
- Review the performance of outside investment managers, the investment's performance and the fund's assets allocation at least annually.
- Report to the Board annually on the investment performance of the endowment.
- Make recommendations to the board on any changes to the policy.

INVESTMENT GUIDELINES

The following are the target and optimal ranges for the Endowment's asset allocation. The Finance Committee may, after considering advice from its investment managers, but at its discretion, defensively increase the cash holding limit beyond 40 percent and may shift all assets to 100 percent cash (with the Board's approval) if necessary.

Asset Allocation Goals	Target	Optimal
Domestic Equity	50%	40-65%
International Equity	15%	5-25%
Domestic Fixed Income	25%	15-35%
Alternative Assets	5%	0-10%
Cash	5%	0-100%

All non-cash investments within the endowment will at all times be selected and managed by one or more reputable professional outside investment management firms that are recommended by the Finance Committee and approved by the Board. At no time will the Finance Committee or staff select any individual securities or investments. The investment managers will have discretion to manage the endowment's assets within the parameters of this policy and the agreement entered into with the investment manager. Investment managers will be selected and evaluated by the Finance Committee, and continued or replaced based on performance, service, and costs.

Investment managers will ensure that the portfolio is adequately diversified.

Time Horizon:
In general, investments will be managed with a long-term time horizon (5-10 years or more), with less of an emphasis on short term market performance. However, investments must also be managed to allow an orderly availability of cash to fund the Center's work in this area.

Investment Performance Measurement:

Investment managers will report on an annual basis to the Finance Committee. Investment managers' performance will be evaluated in part by comparing the fund's performance against the appropriate benchmarks.

THE COMMONWEALTH FUND

HARKNESS HOUSE
ONE EAST 75TH STREET, NEW YORK, NY 10021-2692
(212) 535-0400 FAX (212) 249-1276

ENHANCING THE COMMON GOOD FOR SEVENTY-FIVE YEARS 1918-1993

December 28, 1994
No. 95-78

MARGARET E. MAHONEY
PRESIDENT

Myra J. Christopher
Executive Director
Midwest Bioethics Center
1100 Pennsylvania Avenue, Suite 4041
Kansas City, MO 64105

Dear Myra Christopher:

It gives me great pleasure to inform you that the Board of Directors of The Commonwealth Fund has approved a grant of $30,000 to the Midwest Bioethics Center in support of the annual Robert L. Biblo Memorial Lecture.

The Fund's appropriation is to be placed in a restricted endowment fund account and maintained in perpetuity; up to 6 percent of this endowment is to be distributed each year towards the cost of the annual lecture. Should the Midwest Bioethics Center ever terminate operations, funds in this restricted endowment account should be repaid to The Commonwealth Fund. There is no commitment by the Fund to supply any further support to the Midwest Bioethics Center.

The appropriation is contingent upon agreement by the Midwest Bioethics Center to the terms and conditions for use of grant funds which will be specified in a letter of agreement that you will be receiving shortly from John Craig, Jr., Executive Vice President and Treasurer, and Adrienne A. Fisher, Grants Manager, of the Fund. Any questions pertaining to this project should be addressed to Mr. Craig, who has principal responsibility for the project here at the Fund.

If you plan to issue a press release about this grant once agreement on its terms has been reached, please let Mary Lou Russell, Director of Communications at the Fund, review the text of the release before it is distributed.

The Fund is pleased to be able to support this important work.

Sincerely,

Margaret E. Mahoney

MEM:af

cc: Joan Dolan Biblo, J.D.
Karen Davis
John E. Craig, Jr.
Adrienne A. Fisher
David M. Lawrence, M.D.
Mary Lou Russell

FAXED 11-9-96

THE
COMMONWEALTH
FUND

HARKNESS HOUSE
ONE EAST 75TH STREET, NEW YORK, NY 10021-2692
(212)535-0400 FAX (212)249-1276

ENHANCING
THE COMMON GOOD
SINCE 1918

April 27, 1995
Grant No. 95-78

Myra J. Christopher
Executive Director
Midwest Bioethics Center
1100 Pennsylvania Avenue, Suite 4041
Kansas City, MO 64105

Dear Ms. Christopher:

I am writing to follow up on Margaret Mahoney's letter of December 28, 1994, to you regarding The Commonwealth Fund's support for the Robert L. Biblo Memorial Lecture. The purpose of my letter is to be sure that you and the Fund's staff agree with regard to the purpose of the grant. I also wish to explain the general conditions for support from the Fund and ask you to agree to them. Please review these points and attachments carefully.

Here at the Fund, Adrienne A. Fisher, Grants Manager, will work directly with you on all programmatic, financial, and administrative matters. Please contact her if you have any questions about this letter or the grant.

1. Enclosed as Attachment 1 is a report approved by the Fund's Board describing this project. This report should represent an accurate and up-to-date summary of your project. Please advise us if this document is inaccurate in any way; otherwise, we will consider this to be your basic agreement with the Fund.

2. All Fund grants are subject to the terms and conditions specified in a form entitled "Request for Project Support" which is enclosed as Attachment 2. This form should be completed, signed by you and an authorized official of your institution, and returned to the Fund. On page one, the Amount of Support Requested should be $30,000.

Please include the IRS determination letters requested on page one of the form confirming that the Midwest Bioethics Center is exempt from Federal taxation under Section 501(c)(3) and not a private foundation under Section 509(a), along with a letter from an appropriate official of Midwest Bioethics Center stating that they are valid copies of the originals and remain in full force and effect.

Also, please note the three Special Conditions on page 3 of the form, which state that a) no more than 6% of the preceding 3-year average market value of this restricted endowment may be distributed annually; b) the first distribution from this restricted endowment shall not be earlier than June 1, 1996; and c) the fund balance in this restricted endowment must be returned to The Commonwealth Fund in the event that the

Midwest Bioethics Center ever terminates operations.

3. A timetable of grant payments and reporting requirements is provided as Attachment 3.

Three copies of all interim and final narrative reports should be sent to Ms. Fisher on the date due. In addition, three copies of any publications (e.g., books, journal articles) resulting from your project should be submitted to Ms. Fisher.

4. Any changes in key project personnel during the course of the grant should be brought to the attention of Ms. Fisher.

5. Mary Lou Russell, Director of Communications at the Fund, must review drafts of all announcements and press releases relating to this grant and/or its results prior to their release. Additionally, all communication media and dissemination vehicles (books, journal articles, videos, etc.) on this grant or its results must a) credit the support of The Commonwealth Fund, and b) include the following disclaimer: "The views presented here are those of the author and not those of The Commonwealth Fund, its directors, officers, or staff."

6. The grant number assigned by the Fund (Grant No. 95-78) should be used on all correspondence.

If you and the Midwest Bioethics Center are in agreement with the terms outlined in this letter and its attachments, please sign on page 3 and return this letter with the completed Request for Project Support Form and tax forms to Ms. Fisher. Upon receipt and approval of these documents, your grant payment will be remitted.

If we are not in agreement on any portion of this letter, please write to Ms. Fisher directly about the nature of your disagreement. Grant funds will not be released until we are in agreement with regard to the conditions of the grant.

Thank you and we look forward to hearing from you soon.

Sincerely,

John E. Craig, Jr.
Executive Vice President and
Treasurer

JC:af
cc: Joan Biblo
Adrienne A. Fisher

FAXED 11-9-06 EC

Tab 5

Attachments:
1. Board Report
2. Request for Project Support Form
3. Payment and Reporting Schedule

We hereby agree to the terms and conditions laid out in this letter of agreement dated April 27, 1995, and its attachments:

Myra A. Christopher 5/4/95
(signature of Project Director) Date

Institutional Approval:

R. C. P. 5/4/95
(signature of authorized official) Date

executed agreement
AF
5/8/95

Recommended Personnel Handbook language
November 2024

PTO Accrual:

PTO accrues on a bi-weekly basis, aligned with the pay period schedule. The annual PTO accrual amounts are distributed evenly across all pay periods in the year. The accrual schedule based on tenure is as follows:

Tenure	Hours/Pay Period	Days/Year	Maximum Carry Over
0-2 Years Service	5.33	16	80 hours
3-6 Years Service	7.00	21	105 hours
7-15 Years Service	8.67	26	130 hours
15+ Years Service	12.00	36	180 hours

New Employees:

PTO accrual begins on the first day of employment and is prorated based on the employee's start date. For example, if an employee starts mid-pay period, they will accrue a proportionate amount of PTO for that period.

Center for Practical Bioethics
Board of Directors Meeting
September 11, 2024
8:00 – 9:30 AM (Central) | 9:00 – 10:30 AM (Eastern) | 6:00 AM – 7:30 AM (Pacific)

Location: In-person or Zoom Conferencing
In-Person: 9th Floor, Shalton Conference Room, Polsinelli PC, 900 W. 48th Place, KC, MO 64112
By Computer: https://us02web.zoom.us/j/9528298699 *Preferred for document screen sharing.*
By Phone: +1 646 931 3860 US or +1 312 626 6799 US (Chicago)
Meeting ID: 952 829 8699

Minutes

Attendance: Raghu; Abiodun; Rob; Mitzi; Inmaculada; Alan; Tresia; Anita; Marvia; Eva; Vickie; Jane; Ed; Mike; Steve; Mark; James

I. Call to Order — Steve Salanski, Chair

Mission Reflection — James Stowe, President/CEO

James highlighted the recent push by the Ethical AI team to begin development of an Ethical AI "recognition program," which is a strong step into implementation of the group's work over the past several years. The program is modeled off of successful policy change initiatives in local and county governments innovated in many sectors, including livable communities (for aging) in the KC region. The recognition program will require participating organizations to meet a variety of standards to be able to claim various levels of "achievement" in Ethical AI competencies. Lindsey and her team will begin with a test among key regional healthcare organizations and systems who have expressed interest in ethical AI and who hold an active agreement with the Center – likely candidate organizations include Saint Luke's, University Health, and Advent Health. The longstanding Advisory Board is being transformed into an organizational membership approach. The work to make this pivot exemplifies the practical nature of the Center's focus and I'm pleased with the team's progress.

II. Approval of Board Meeting Minutes

July 10, 2024 *(Attachment 1)*

Alan moved to approve the minutes as submitted; Mark seconded; no questions nor discussion; motion carried.

III. Committee Reports

Finance Report — Tresia Franklin, Chair

- Financial statements, audit, and 990 all pending

We have experienced a slight delay in processing the audit and 990 this year, and Tresia discussed the suspected causes. Note: Following the meeting, James discussed the 990 with McBride Lock and determined that the extension deadline is for November 15, 2024. This adjusted timeline means that we remain on track for document preparation and review. The following resolution was adopted, but the granted authority is unlikely given this adjustment.

Tresia moved on behalf of the Finance Committee to delegate review and approval authority of the IRS Form 990 to James and Tresia so that the federal submission deadline could be met; Inmaculada seconded; no questions nor discussion; motion carried.

Tresia stated that financial statements/reports, the audit, and the 990 will be forwarded to the full board as soon as the Finance Committee has an opportunity to review them. A summary of the major elements of the 990 will be included in follow-up correspondence, and the Board is requested to review the various items as they are received.

Governance Report Maggie Neustadt and Mark Thompson, Co-Chairs

- **VOTE:** 2025 Board and Committee Meetings *(Attachment 2)*

Mark moved on behalf of the Governance Committee to adopt the 2025 Board and Committee Meetings schedule as submitted; Eva seconded; no questions nor discussion; motion carried.

Mark reported that the Committee is making progress on releasing the Board Self-Evaluation in December and following the DEIJB training on August 19, survey questions focused on these areas will be bolstered and adjusted. The Committee is also working to nominate a member who will fill the vacancy left by Jane's departure as well as the slate of officers who will begin service in January 2025. To-date, Tresia has agreed to serve another term as Treasurer, and Maggie is open to nomination to the Vice Chair role. Discussions are pending with individual(s) who may serve in the Secretary role.

Resource Development – Process Update Alan Edelman, Chair *(Attachment 3)*

Alan experienced a technical issue at the time of this report, so James provided a brief update that the Resource Development Committee has reviewed and commented on a Scope of Work that will be included in a Request for Qualifications process to secure a development and even coordinator contractor/consultant. The Scope was updated per comments by Committee members and Center staff who would be close to this work, and the ceiling on the contract amount was adjusted per feedback from Board members to $46,000 for 12 months of support.

Jane noted that the Scope suggests an expectation of at least $30k in revenue, but that this is below the maximum contract amount. James clarified that the revenue expectation will adjust according to the amount of the contract and we will maintain the need to earn margin on the engagement. Tresia wondered if there are enforceable consequences if the contractor fails to deliver on this expectation? One option may be for the consultant to continue services if the fundraising minimum is not met, so that cash would not have to be returned (difficult), but the Center would still continue to benefit.

Anita described experience with other organizations who encouraged legacy giving through matching mechanisms that were effective in attracting new commitments.

James replied that the Scope will be reviewed with these suggestions in mind, and that the final contract document will offer opportunity to clarify and outline our expectations.

IV. Consent Agenda (Administrative Matters)

Executive Committee Minutes, August 23, 2024 *(Attachment 4)*
Governance Committee Minutes, August 9, 2024 *(Attachment 5)*
DEIJB Training Minutes, August 19, 2024 *(Attachment 6)*

Mark moved to approve the consent agenda as submitted; Raghu seconded; no questions nor discussion; motion carried

V. Diversity, Equity, and Inclusion Discussion Steve Salanski, Chair

1. Next steps following August 19 training

Steve noted that for an off-time training, 12 members in attendance was an accomplishment. The first half of the training was a review and level set of what occurred at the April Board Retreat. The second half of the training focused on what we are doing well and what areas could be improved as well as how we hold ourselves and the Board/Center accountable for the needed changes. Despite the strong participation, by the end of the training, we were left with approximately 5-6 members, so more input is needed.

Steve suggested that because those who were not at the training could not respond using the software that the consultant made available, members send comments directly to James on what we are doing well and where we could improve as well as any ideas around accountability. In turn, this will assist with the Self-Evaluation Survey mentioned in the Governance report, as the Governance Committee will synthesize responses into survey questions. An action plan will be formulated as a result of the survey.

Steve noted that attendees appreciated the break-out time to know and hear more about colleague Board members, and recommended time at Board meetings to give a small presentation, or work in small groups/breakout rooms to get to know one another better.

Expect an email from James that will help to clarify next steps and provide the video link.

Marvia wondered if the Board had a strategic plan, and Steve responded that we have been using the CEO Goals and Objectives, which is more focused on the Center's programs. As the DEIJ action plan is formulated, Marvia encouraged the Board to answer how it folds into the overall plan and work of the Center. Placing it as a standalone or extra/auxiliary, including in our fundraising efforts, is less effective than looking at how every aspect of the Board is advancing the work.

Alan commented that he has been impressed by the note for applicants in job descriptions and contract opportunities as an example of how the organization is taking DEIJ seriously.

Rob stated that this effort should not be siloed but included in programs and maintained as an ongoing priority. He encouraged the Board that there are a number of things that can be done to attract diverse Board candidates and enhance representation on the Board. He also noted that members can go to events, places in the community in which people of color are represented and gather and be there as an entity – get outside of our bubble and use the opportunity to tell our story.

In response to Mike's question about what specific input is needed, James stated that he will re-send the video link. Mark affirmed that the video is accessible, and the areas for needed input by the Board will likely be clear after viewing the video.

VI. Chair and President Reports Steve Salanski, Chair & James Stowe

Chair's Report

1. Flanigan and Francis Chair search task force update *(Attachments 7-8)*
    a. Job description drafts, scheduled meetings

Steve noted that a combined task force will assist with both Chair searches. The task force will first prioritize Flanigan, and then move to Francis. Next week, the task force will meet to review the Flanigan job description and develop a strategy for moving forward, which may include a smaller-scale search. Then, a broader search for the Francis Chair is expected.

James mentioned that the Flanigan job description was straightforward due to Terry's assistance with creating the current draft.

Ed wondered if there was an expectation for the Flanigan Chair to publish? James responded that publication was a likely byproduct of the work and collaboration of the Chair, but would not be a requirement; however, the task force could review this point and emphasize peer-reviewed publication, if warranted. James noted that all senior Center staff were publishing to some extent. Ed also observed and encouraged the possibility of deeper collaboration in bioethics among the three medical schools.

Jane noted that the responsibilities list was broad, and that she perceived a likelihood of fluidity in ownership of roles between the Flanigan Chair and Ryan's current role, unless this were more clearly defined either in the job description, or in management of the Chair. James responded that this was an insightful comment and the current high degree of collaboration between the two roles could be disrupted by someone new to the culture.

Regarding the Francis Chair, Steve noted this search would be for the 5th holder of the Chair, and James described the positioning of the role to likely require a continued appointment at a research institution, and that the Chair has some equivalencies to a research fellowship. The candidate will be expected to hold extramural funding and that the Center opportunity is to accelerate translation and testing of their discoveries in real-world settings and programming.

Marvia appreciated the thoughtfulness of clarifying the role. In past offline interactions she noted a lack of clarity, so she is happy with where the job description landed.

Jane asked if the estimated $150,000 was all inclusive (of the Chair's salary, support staff, and all other expenses. James replied that it was, and that the actual amount will increase or decrease with market performance of the endowed funds. Moreover, this is one reason why an appointment to a research institution will be necessary (to provide a full salary to the Chair.) Jane then asked if the position was renewable. James replied that the idea is to secure the role, likely through a 1099 independent contractor relationship, with considered check points of satisfaction on both ends. This will occur annually, and the intention is communicated that each Chair will serve a 5-year term – if both parties are satisfied, and the Chair is performing at high levels, an additional term will be considered, with ongoing annual evaluations. Jane also stated that the job description should be clearer on the expectation of the Chair helping to raise funds as a part of generating sustainable programming. There was discussion around the wording, and "supporting funds," was suggested as a good term for communicating this need.

President's Report

1. Update on client relationship management database
2. Update on collaboration: Mid-America Regional Council, USAging Center of Excellence to Align Health and Social Care (funding from the Administration for Community Living)
3. City of Kansas City, MO Public Health Department Contract ($18k)
    a. Learning Management System (LMS) course and education consultant
4. Future of Life Institute – grant proposal

James provided an update on these areas of operations – all are progressing at a reasonable pace. The Future of Life Institute proposal will be submitted by September 15th, and there is a similar opportunity open through Meta because of the new data center in the region. The team will attempt to adapt the Future of Life Institute proposal to conform with the Meta call for proposals.

VII. Program Update

1. African American Care Goal Conversations/Advance Care Planning James Stowe *(Attachment 9)*
    a. Board discussion – evaluation of program goal and objectives

James shared a draft of the goal and objectives under the Harman Foundation supported African American ACP project. In discussions with the Board, other national experts, and Gloria, it has been determined that there is unlikely to be financial sustainability around ACP activities alone. The Center's experience with Caring Conversations and Gloria's experience with the Let's Talk About ACP (LTAACP) materials both support this conclusion. Therefore, the objectives speak to community and expert input through an advisory board as well as some of the immediate process and automation enhancements to LTAACP that will help open opportunity to think of an "and" that can be incorporated into the work to be more likely to unlock sustainability. James suggested this would be some type of work at the systems level that would drive change and outcomes, and therefore be of financial value to the health system or philanthropic interests. At present, the objectives focus on a training curriculum for healthcare professionals, but there is some hesitation about this being enough for sustainability and that it lacks distinction from other initiatives at the national level.

Vickie echoes the hesitation about whether a training curriculum is an open lane or not. ACP has not proved effective, so being able to answer why it has not and why do Black communities not sign

up for ACP would be important. It is not because training and curricula are unavailable. So, she suggests starting where the client is, for insight into what really matters and works for them. In general, patients/families are not interested in signing paperwork, although she perceives value in enhancing communication skills and structural competence in healthcare to raise difficult conversations. Moreover, there is a business case for ACP, as represented by Aging with Dignity's 5 Wishes, and they have had some success, but the Center is unlikely to instigate a competitive approach.

Steve noted value in having the conversation and that it could impact trajectories of care.

Inmaculada wondered about the metric of success – if it is signing paperwork, it may be harder to achieve, but if success is being able to discuss these issues because it is important, then a framing of how to be more prepared to discuss them may have opportunities.

Mark raised two issues regarding the business case of the work, including embedding Gloria's materials and training into medical education programs, and in turn, continuing education opportunities. He also stated that attorneys, especially those who do estate planning, may be an opportunity, albeit we would need to understand more about community needs and the frequency of estate planning in underserved groups.

Other issues:
In response to a question by Mark, James stated that parking and venue details for the upcoming Flanigan lecture will be shared to registrants in a future email.

Jane wondered about recognition for Terry's service sometime in December. James said he was going to have Terry endorse the idea but wanted to plan a small gathering. (Update: Terry was open to this idea, so please expect an invitation in the near future.)

Next Board Meeting: November 13, 2024
8:00 – 9:30 AM (Central) | 9:00 – 10:30 AM (Eastern) | 6:00 – 8:30 AM (Pacific)

Upcoming Events:

VIII. Flanigan Lecture
Guest Lecturer: Dr. Anita Ho
Monday, September 30, 2024

IX. 2025 Board Retreat
April 11-12, 2025
Liberty Hospital, 2525 Glenn Hendren Dr, Liberty, MO

Strategic Initiative Focus: Ethics Services – *special discussion normothermic regional perfusion in donation after circulatory death (NRP DCD), thoracoabdominal and abdominal approaches* (November 2024); Ethical AI (January 2025)

Board Book & Materials Link

10/9/2024

Board Electronic Vote on Flanigan Chair Recommendation to appoint Ryan Pferdehirt

Member	Vote		Comments
	Yea	Nay	
Adiga	X		I think this is actually wonderful news. I can't think of anyone better than Ryan to fill this position. I fully support it. Thanks.
Akinwuntan	X		I vote yes.
Ayala-Flores	X		I vote yes!
Cardenas	X		I support.
Melo-Martin	X		Sorry James, it was a busy day and I'm just now getting to my email. I support the recommendation. Thank you.
Edelman	X		I vote yes.
Franklin	X		I vote to approve Ryan. A well deserved opportunity for him!
Ho	X		I fully support Ryan's dual appointment for both the Flanigan Chair.
Johnson			
Jones	X		Yes! Thank you!
Karp	X		I vote yes.
Leff	X		I fully support Ryan receiving this position.
Lombard			
Neustadt	X		I also vote yes!
O'Connor	X		I vote yes!
Rode	X		Love this – yes!
Salanski			*Note: nonvoting*
Thompson	X		I vote yes!!

Communication Memo

To: Center for Practical Bioethics Board

Re: Rosemary Flanigan Chair in Bioethics Position Recommendation

The Flanigan Chair Job Description was edited by James Stowe and the Flanigan Chair Task Force following suggestions from the September 11 CPB Board of Directors Meeting. The Flanigan Chair Position/Job Description was then posted internally, following attorney input regarding compliance with Federal terms and conditions. Ryan Pferdehirt, PhD was the sole applicant for the Position. Ryan's Curriculum Vitae and Cover Letter are attached to this email.

Ryan spoke with the Flanigan Chair Task Force, sharing his vision for the role of the Flanigan Chair. He answered questions from Task Force Members regarding that vision. It was evident from that conversation, plus the known quality of his current work at the Center as Vice President of Ethics Services, that Ryan is extremely well-qualified for the Flanigan Chair Position. Ryan is also clearly passionate about his work in doing clinical ethics case consultations, as well as his Bioethics teaching with Medical Students and other learners. This resembles the passion for Bioethics embodied in Sister Rosemary Flanigan and Dr. Terry Rosell.

James has provided some context for the organizational implications of appointing Ryan to the Flanigan Chair. Ryan's day-to-day service to the Center's contracted healthcare partners, teaching at KCU, and assistance to the team in building and executing on marketing strategies are unlikely to change in the near term. To represent this continuity and ensure that any future hires recognize the Flanigan Chair as the key Ethics Services leader, Ryan will retain a dual title of Rosemary Flanigan Chair and VP of Ethics Services. Since Ryan is one person, new clinical bioethics capacity will be needed for additional Ethics Services contracts that may be secured in 2025, or if the relationship with KU is extended. James and Ryan have discussed an approach of using 1099 independent contractor bioethicists to secure this capacity while not taking the immediate step of onboarding a new full-time employee. In considering this approach, several well-experienced regional and national bioethicists were approached who tentatively endorsed the model and signaled potential interest should a contract opportunity arise.

The Flanigan Chair Task Force unanimously recommends Ryan Pferdehirt, PhD to be the second Rosemary Flanigan Chair in Bioethics at the Center for Practical Bioethics. **Please respond to this email with your vote on this recommendation.** If you have any questions before voting, feel free to reach out to James Stowe or Steve Salanski. Thanks to the Flanigan Chair Task Force Members: Mark Thompson, Eva Karp, Tresia Franklin, Karen Johnson, and Vickie Leff.

10/17/2024

Board Electronic Vote on submitting the IRS Form 990

With the approaching extension deadline of November 15, we are hoping for electronic review and approval to file our Form 990. The Audit Committee has reviewed and recommended the audit and 990 to the Finance Committee. In turn, the Finance Committee has reviewed and recommended the 990 to the full Board. We will follow our normal cadence of review and approval of the audit. The Center's auditor, Matt Brickey with McBride Lock, will provide a brief presentation at November's full Board meeting.

Regarding the 990, **please email me back with your vote to approve authorizing McBride Lock to file Form 990 with the IRS.** If you have questions or desire to raise any issues for discussion, please "reply all."

I apologize for the second electronic approval, but I appreciate your time and helping us move administrative matters forward in a timely fashion.

Finance Committee: 10/11/2024			
Member	**Vote**		**Comments**
	Yea	**Nay**	
Adiga	X		I approve as well. Thanks
Franklin	X		I approve.
Gould	X		Approve. Thank you
Hammer	X		Hi James, I approve the Form990. Thank you
Rode	X		Approve
Salanski	X		I approve the 990.

Full Board: 10/17/2024			
Member	**Vote**		**Comments**
	Yea	**Nay**	
Adiga	X		I approve. Thank you!
Akinwuntan	X		I approve.
Ayala-Flores	X		I approve authorizing McBride Lock to file the 990 with the IRS.
Cardenas	X		I approve.
Melo-Martin	X		I vote to approve. Thanks.
Edelman	X		I approve.
Franklin	X		I vote to approve and authorize the filing of the 990 with the IRS.
Ho	X		Thanks, James. I vote to approve authorizing McBride Lock to file Form 990 with the IRS.
Johnson	X		This is approved.
Jones	X		I vote to approve and authorize the filing of the 990 with the IRS.
Karp	X		I approve as well

Leff	X		I approve.
Lombard	X		I also approve this Form.
Neustadt	X		I also approve authorizing McBride Lock to file the 990 with the IRS.
O'Connor	X		I vote yes.
Rode	X		I vote yes
Salanski			*Note: Non-voting*
Thompson	X		I vote to approve 990 filing

Center for Practical Bioethics Finance Committee Meeting
September 13, 2024 4:00 PM

Location: Zoom Conferencing
By Computer: https://us02web.zoom.us/j/9528298699
By Phone:
646 931 3860 US
301 715 8592 US (Washington DC)
312 626 6799 US (Chicago)
646 558 8656 US (New York)
Meeting ID: 952 829 8699

Attendance:
Tresia, Steve, Kathleen, Raghu
James (staff)
Tom Ross (guest)

Minutes

I. Call to Order/Welcome Tresia Franklin, Chair

II. Update on Audit/990 Tresia Franklin, Chair

James stated the due date is 11/15/24, so we are on track to have these out soon and reviewed by the full Board at the November meeting.

Kathleen asked about the audit status and when the Audit Committee would convene to review the findings. Tom stated that we were expecting an audit draft as early as this week, so it is likely to arrive sometime next week. He stated the auditor has sent some informational requests to help complete the 990, and James is expected to produce responses early next week.

James stated that he will work with Kathleen and the other Audit Committee members on a convenient meeting date to review the audit.

III. Review of Financial Statements

A. Statement of Activities

Actual revenue of $802, over budget at 112% - primary drivers include endowment funds released ($64k), mainly due to timing.

Showing favorability in earned income, but behind in donations.

After the timing is removed, we're at about $20k favorable to budget.

$911k expenses versus $924k, favorability of about $13k; main favorability is under meeting expenses due to a refund on the speaker charger for the annual event.

Contract services is higher because of Gloria Anderson's compensation under the Harman grant, but there is offsetting revenue.

Actual loss of income at $110k versus budget loss of $210k.

$460k favorable on the endowment funds. Strong investment performance is helping the total bottom line.

Steve asked why the endowed funds show up in income at the top of the report – Tom stated this is confusing, but because there are planned distributions and a tradition in the organization of displaying it, it has been included. Then, to ensure that the revenue picture is not overly optimistic, it is removed at the bottom of the Statement of Activities, which is in accordance with the auditor's standard of GAAP accounting.

It is important to keep the fact of endowment receipts covering expenses, or the organization would quickly run into losses.

Will we track each fund directly? Yes, says Tom, by class in Quick Books, and as we recognize revenues that are tied to the individual in question. When it comes to indirect costs it becomes a little grayer, because you aren't sure how to allocate the non-direct types of expenses.

James described our current procedure of looking very closely at the various restricted pots of funds. For some that require scrutiny for funder accountability and smooth program operation (e.g., Harman), we are tracking close to every penny. For the indirects, we are applying the audited indirect rate to any qualifying expenses for a solid estimate of the actual. Those actuals have been regularly shared with Supporting so that they can maintain oversight of how monies are classified and represented within statements. We are not closely tracking the Flanigan distributions at this time because the Flanigan distributions do not fully cover Flanigan expenses. Therefore, we have confidence that those dollars are being used in the correct categories.

Perhaps in a future Finance Committee meeting take us into close detail on the buckets – due to a full schedule in November with budget preparation, review, and approvals, this is likely to be at the January 2025 meeting or later.

B. Statement of Position

As of the end of July, we had $342k cash on-hand.

Tom will need to investigate line 3500 ($998,544) – Tom believes this is due to us operating at a loss, which will give us a negative equity position. Will we already be at this much of a loss? Tom will need to think on that further. This will require follow-up.

Tresia and Tom discussed how the loss is displayed, but Tom will follow up after further exploration.

C. Statement of Cash Flows

The top portion shows cash flow as of July compared to December 2023, primarily from operating activities.
The lower portion shows investment cash, and the decrease means we are pulling cash from the investments.
After these balance sheet changes, there was a net positive.

D. Headlines

Motion to accept the financial statements as presented; Raghu motioned to accept with the addition of checking on line 3500 (-$998,544) on the Statement of Position; Steve seconded; motion carried.

IV. (Informational only) John B Francis Chair Search Distributions

A. On-hand, unallocated: $27,357

A. Up to two distributions (Oct. and Jan) "…for costs and expenses incurred to recruit qualified candidates for, select and hire the next succeeding holder of the Chair."

James stated that he has conferred with the Greater KC Community Foundation, who administers the Francis fund on resources for the Chair search. They conferred with their legal team and determined that because of the timing of Erika's resignation, we would still be eligible for an additional two regular distributions to cover expenses (i.e., the amount currently held as restricted is not "counted against" these future distributions for the purposes of the search). James expressed confidence in finding the Chair in an expedient manner and that the funds available will be more than adequate.

V. Adjourn

Next Finance Committee Meeting:
Thursday November 7, 2024, 7:45 AM Central | 5:45 AM Pacific | 8:45 AM Eastern

Center for Practical Bioethics Finance Committee Meeting
November 7, 2024 7:45 AM

Location: Zoom Conferencing
By Computer: https://us02web.zoom.us/j/9528298699
By Phone:
646 931 3860 US
301 715 8592 US (Washington DC)
312 626 6799 US (Chicago)
646 558 8656 US (New York)
Meeting ID: 952 829 8699

Minutes

Attendees:

James, Kathleen, Tresia, Marc, Steve, Raghu

Tom Ross (Supporting Strategies)

I. **Call to Order/Welcome** — Tresia Franklin, Chair

II. **Review draft audit report** — Kathleen Gould, Audit Comm. Chair

A. VOTE: Recommend approval of audit report

This is an unmodified, "clean" report. Walked through the balance sheet and saw the amount in the Board designated, referenced in a note, which we'll talk about later.
Kathleen walked through the various audit components.
Question on page 5 – Consulting Fees, Audit and Accounting Fees, Professional/Filing fees – what are in these categories and why was there a change?

Tom Ross and Supporting Strategies provided detail on these areas following the meeting.

Here is a written summary to explain the changes between 2022 and 2023. Please keep in mind that we have incomplete data from 2022 due to the change in accounting personnel and software system. I can provide any additional detail, if needed.

Consulting Fees
The major expenses here are Trudi Galblum's contract for marketing, IT vendor(s), some project related consultants, and some administrative consultants (e.g., social media marketing consultant). The increase from 2022 to 2023 of about $38,000 is primary due to bringing on a higher-cost, comprehensive IT support vendor (Results Technology), a 40th Anniversary development consultant (e.g., Patricia Kearns), the

marketing consultant, and program consultants (e.g., Puente Marketing). Many of the listed consultants were one-time and are no longer utilized.

Audit and Accounting Fees

The change here is almost entirely due to outsourcing accounting to Supporting Strategies.

Professional Filing/Fees

This category includes a variety of smaller fees for website and operations maintenance. The approximately $34,000 increase in 2023 is largely due to stipends to advisory council participants under program grants ($30,300; Ethical AI and one of Erika's grants), and booking in-kind legal fees ($3,150) donated to the Center to assist with transferring control of the Francis Chair endowment.

Raghu motioned to recommend approval of the audit report; Marc seconded; there was discussion about the audit report moving forward for approval by the Board, but that James is investigating the Biblo fund (see item B., below) and will bring forward any discovered information to the auditor. In turn, detail on that item would be included in the management response letter that will be returned to the auditor; motion carried

B. Review designation of the "Biblo fund."

There was an item in the audit that has carried over for many years regarding the "Biblo fund." The audit states this is a Board designated fund.

Normally for an endowed fund, you keep the corpus separate and track those funds and revenues accordingly.

The audit shows that this fund is at $80,000 (with a memorial fund at $7,838), so a total of $87,838.

If we do not need to use these funds, we should release them into general, but we need to comply with any endowment requirements.

James will speak with John Carney and also reference printed materials in our records in the storage unit, if applicable.

The classification of funds as restricted or permanently restricted – since the audit has not been issued, and if we discover something that may be important, we are obligated to reach out to the auditor to inform them. The auditor may have documentation on their end to inform this as Board designated.

Motion by the Board to remove a Board designation is all that is needed; however, to remove a permanent restriction from a donor, that is not an easy process. You need to go through the State Attorney General.

Tom thinks "designation" is a key term.

Do we need to clarify this item before finalizing the audit? Kathleen's suggestion on this is that there are numerous audit reports stating this is Board designated; we don't know if we have seen all of the documentation to-date; she recommends talking to Matt to disclose the old information and we are doing additional research; he may say just keep the report as-is.

This designation could be in the minutes of the Board meeting, or any number of places.

They need to bring the management letter up to the date of Board approval, so James should disclose this information to the auditor before that management letter is issued.

C. Note: Form 990 previously reviewed

III. Review 2023 Form 5500 (filed on 10/11/2024)

James briefly covered the submitted Form 5500, which was drafted by ERP Associates for the Center's 403(b) retirement plan.

Kathleen moved to approve the form; Raghu seconded; no questions nor discussion; motion carried

IV. Review of 2025 Budget Tom Ross and James Stowe

A. Draft 2025 Budget
B. Staff Benefits and Insurance
    1. Benefits – no changes
    2. Health Insurance – 4.9% premium increase
C. VOTE: Recommend approval of 2025 Budget, including staff benefits and insurance

Tom included a full 2024 forecast in the budget draft. We discussed the KU agreement and concluded that James should write a summary of the KU items and send that to Raghu, who may be able to operate within the KU system to learn more about possible 2025 commitments.

Regarding fundraising, there was a question about the categories: Donations-unrestricted versus Event Income. Tom described how these were calculated and forecasted. James added that Donations-unrestricted appears high because it includes unrestricted grants from philanthropic sources, such as the Sosland Foundation and the Victor Speas fund that is administered by Bank of America. The Event Income line item relates to one or more smaller fundraising events in 2025 and will be in proportion to the contract that is signed with an Event Coordinator.

The budget draft displayed a net operating income loss of approximately $75k. The plan is similar to last year: if we end 2025 at a loss, a special one-time draw from the Foley fund (above the annual draw of 5%) will be utilized to balance the budget. A resolution will be sought by the Board for this one-time draw, and the requested amount will be included in several areas of the budget document.

Kathleen noted that visibility of this type of distribution is healthy due to the desire to always maintain the corpus of funds and not overspend to the point of depletion.

James noted that it does not appear that we will need to fully utilize the budgeted 2024 one-time draw from Foley, and hopefully that will be the case in 2025. The current fund value is approximately $462k. James will prepare a resolution for the Foley Board Designated draw.

Marc moved to approve, noting that the updated budget document should reflect the additional $75,200.68 draw; Steve seconded; no questions nor discussion; motion carried.

V. Review August 2024 Financial Statements

James will soon receive the September statements – Tresia recommends we review those when received, since they are more current. If we need to convene or electronically review, we can proceed as needed. Tresia's largest concern is to see how we end the year.
Tom has the September statements available. From a bottom-line perspective, it is not significantly different than what has been previously reviewed. The Committee will review September electronically, and then an electronic vote to prepare for the Full Board.

VI. Adjourn

Next Finance Committee Meeting:
Tuesday January 7, 2024, 7:45 AM Central | 5:45 AM Pacific | 8:45 AM Eastern

Center for Practical Bioethics Executive Committee Meeting
October 9, 2024
8 AM Central | 9 AM Eastern | 6 AM Pacific

Location: Zoom Conferencing
By Computer: https://us02web.zoom.us/j/9528298699
By Phone:
646 931 3860 US
301 715 8592 US (Washington DC)
312 626 6799 US (Chicago)
646 558 8656 US (New York)
Meeting ID: 952 829 8699

Attendance: **Tresia, Mark, Steve, Maggie, Eva, and Alan James**

AGENDA

I.	**Call to Order/Welcome**	Steve Salanski, Chair
II.	**Strategic Opportunities and Operational Considerations**	Steve Salanski and James Stowe

A) Audit and 990
- Filing of the 990 is due on 11/15
    1. Audit Committee will convene to review draft 990 and audit

The Audit Committee met yesterday with the auditor, Matt Brickey. The audit was "clean" and the Committee voted to recommend the draft audit and 990 to the Finance Committee for approval. After Finance Committee review and approval, the audit and 990 will go to the full Board for final approval. James recommended to Tresia that the 990 be approved electronically by both the Finance Committee and full Board so that it can be reasonably file before the IRS deadline.

B) Administrative Team Update
- Development capacity (posted at NPConnect; next step is review of RFQ responses)

A refined version of a job description/scope of work was posted and is expected to attract qualification submissions from a variety of event coordinators and others qualified for development consulting and assistance. There are several individuals/firms who have been recommended to the Center, and James and other staff are forwarding the posting as appropriate. James stated that the consultant will work on at least an annual fundraising event and most likely, the Flanigan Lecture. James observed several coordination details absent or forgotten at that event, and if we are to offer a hybrid option again next year, we will want professional involvement and oversight to ensure the details come together reliably. We may negotiate another event if the budget and anticipated returns warrant additional engagement.

C) Ethics Services
- Ethical AI grants

1. Meta Data Center Communities grant (prepared for mid-October submission)
2. Future of Life (new due date of 10/31)
3. National Endowment for the Humanities – AI Research Center
    a. Collaboration discussions

The first two proposals will help to support the Ethical AI program, primarily to advance the Recognition Program that Lindsey envisions as the next major body of work for her portfolio. Current Sunderland Foundation funding ends near the beginning of December, so additional funding sources are needed to continue to support Lindsey's work. Progress has been made in incorporating Ethical AI into service agreements, but we are not yet near to being able to support full salaries and project expenses.

The NEH AI Research Center is more academic in nature and designed to imbue Humanities perspectives into AI Research. Humanities research expertise will be needed to make the proposal competitive, or some of our collaborators have suggested that Lindsey has the credentials and experience to function as a Humanities leader.

Lindsey approached collaborators at UMKC to be the primary applicant organization, and we briefly entertained the prospect of collaborating with the History Department there. However, a subsequent meeting revealed that the proposed History PI was unwilling to expand the scope of their proposal to include healthcare, so no clear path forward existed.

The Center will develop its own proposal as the primary applicant organization, and we will seek Humanities collaborators as the proposal comes into additional focus. The proposal will be submitted in December.

D) Flanigan and Francis Chair Recruitment

- One internal candidate applied and met with the Task Force at their 10/3 meeting

Steve recounted Ryan's conversation with the Task Force after his application was received. The Task Force was very pleased with his experience and leadership potential in the Flanigan role and hopes that he will be recommended to the full Board for appointment.

The Executive Committee discussed Ryan's merits and some of the challenges and opportunities on the horizon. James mentioned that Ryan will hold a dual title of Rosemary Flanigan Chair and VP of Ethics Services.

The Task Force will next convene to review the Francis Chair job description and then determine a recruitment strategy.

E) Other recommendations/ideas

Steve raised the CEO evaluation process. Last year's process proved cumbersome due to the number of goals and objectives. This year, Steve recommends that James submit a report now, which is effectively a 6-month review, and then a full evaluation closer to the Board Retreat. Make the standard time frame to be a year from when the goals and objectives are established.
Mark likes the idea of a full year to review; not everything an organization does must be tied to its fiscal and tax year; eases the admin burden for staff and the strategic thinking for the Board doesn't all have to be on a calendar year deadline (budgeting in the fall; strategy in the spring).

Completing the goals – by a set time and establishing the new goals is needed to observe progress and track performance. Tresia suggests setting a disciplined date. Steve thinks that the Board Retreat is a good time to review and get this set. The Governance Committee was mentioned as potentially helping to frame an evaluation model.

V. Adjourn

Next Executive Committee Meeting: December 11, 2024 (8:00 AM, Central)

Governance Committee Meeting
Friday, October 11, 2024
8 AM Central | 9 AM Eastern | 6 AM Pacific
Minutes

By Computer: https://us02web.zoom.us/j/9528298699
Meeting ID: 952 829 8699

Co-Chairs: **Maggie Neustadt and Mark Thompson**

Members: **Abiodun Akinwuntan**, Mary Beth Blake, **Mitzi Cardenas**, **Anita Ho**, Marvia Jones, **Eva Karp**, Jane Lombard, **Inmaculada de Melo-Martin**

Board Chair: Steve Salanski

Staff: **James Stowe**

Bold = in attendance

1. **Note: August 9, 2024 Minutes and August 19, 2024 special DEIJ training Minutes accepted at September Board meeting**

2. **VOTE: Update PTO accrual method to allow for digital processing and tracking through Gusto Payroll software**
    - **Recommended Personnel Handbook language**

PTO Accrual:

PTO accrues on a bi-weekly basis, aligned with the pay period schedule. The annual PTO accrual amounts are distributed evenly across all pay periods in the year. The accrual schedule based on tenure is as follows:

Tenure	Hours/Pay Period	Days/Year	Maximum Carry Over
0-2 Years Service	5.33	16	80 hours
3-6 Years Service	7.00	21	105 hours
7-15 Years Service	8.67	26	130 hours
15+ Years Service	12.00	36	180 hours

New Employees:

PTO accrual begins on the first day of employment and is prorated based on the employee's start date. For example, if an employee starts mid-pay period, they will accrue a proportionate amount of PTO for that period.

Motion to approve – Anita; Seconded by Mitzi; no questions nor discussion; motion carried.

3. Board Member Recruitment and Officer Selection

a. Review Updated Candidate Matrix

Board demographics – can people simply self-identify their race and ethnicity? In the survey, create a separate section for them to say they have responded to the survey and also ask about pronouns here; make sure they know that the data will be non-identified.

Less granularity and broader categories – option to self-identify, but careful not to lump as "other"

Change religion to self-identify and the LGBTQ – please identify gender and sexual orientation.

We need to have survey responses to the matrix to see which candidates to prioritize – extra session to review the matrix, the candidate names, and how we would prioritize them, then make the contacts. We only have one position to fill, so that makes it easier.

The Governance Committee needs to look at the survey one more time, and then send it out to the Board to return in one-week, telling them why we want it back.

4. Board Self-Evaluation

James will share the entire instrument before the next meeting with new questions related to DEIJ, including a short preamble to identify the direction of the feedback into the action plan.

Next Meeting Friday, December 13, 2024
8 AM Central | 9 AM Eastern | 6 AM Pacific

Center for Practical Bioethics Audit Committee Meeting
October 8, 2024 | 12:00 PM

Location: Zoom Conferencing
By Computer: https://us02web.zoom.us/j/9528298699
By Phone:
646 931 3860 US
301 715 8592 US (Washington DC)
312 626 6799 US (Chicago)
646 558 8656 US (New York)
Meeting ID: 952 829 8699

Attendance:
Tom Ross; Brandy Gray; James Stowe (CPB staff and contractors)

Marc Hammer; Tresia Franklin, Kathleen Gould

Matt Brickey (Auditor)

AGENDA

I. Call to Order/Welcome — Kathleen Gould, Chair

II. Presentation on draft Audit/990 — Matt Brickey, McBride Lock

A. **Committee Questions and Discussion**

Matt discussed the draft audit report; it is a "clean" audit.

Covered the balance sheet, primarily discussing endowment income

Undesignated is a negative value: Undesignated represents the portion of unrestricted net assets which are also not Board Designated for any purpose; total unrestricted (including both undesignated and Board Designated amounts) net asset – this finished in a positive position at the end of 2023; Board designated net assets (titled the Biblo fund) have been there for a long time, and nothing has changed with those.

Tresia asked where are these funds held? A Board action would be needed to release those from the Board-Designated category–

Matt recommends that if we no longer have a need for the Biblo fund or that purpose is no longer relevant, it would be good to bring forward a motion to remove the Board Designation, which will then release that amount to the general Unrestricted category.;

Regarding the Biblo fund – if it is not accounted for anywhere, how do we handle that? Tom and Matt suggested that that is simply removed as a separate reporting line. Kathleen offered a description: Board Designation is a process of separately tracking funds internally. it's similar to a situation if you have cash in your account, and you want to use a specific portion of it, for example, pay off a loan. Over time you may change your mind or have other priorities so you may want to use the portion that you earmarked for another purpose, so later, you drop the original idea and mark that cash as undesignated. The original purpose went away over time, and you no longer feel like you need to set that aside for another purpose.

Statement of Activities: total revenues for the year $1,163,000 – a 13% decrease compared to the previous year; primarily due to an expired ACP grant, and some 2022 contracts were not renewed (e.g., Hallmark). Total expenses, $1,732,000, an increase from the previous year. Other revenue: investments brought in a positive $684k to net assets, giving a positive net assets balance for the year.

Kathleen asked about a way of representing draws out of endowments for operational usage – how is that represented on these statements? Generally, this shows up on the cash flow, but because we are not putting out a classified income statement, it doesn't show that way because all earnings are in non-operating. Draws and releases are in net assets released from restrictions line.

***Statement of Functional Expenses**: This document provides more detail on the expenses; largest increases were consulting fees, audit and accounting, professional filing; fundraising and marketing consultants were the source of increase for the fees item; outsourcing accounting increased the audit and accounting item; and stipends for programs went to professional filing.*

They look at program, fundraising and management as a % of total – programs 62.2% of the total expenses, down from 72% last year; total management and general – 18% of total expenditures, consistent with 17.4 and 18% in years previous.

15.8% of total expenses for fundraising, a bit higher than the two previous years.

Statement of Cash Flows: Overall, a decrease in cash balance of $107k during the year; decrease in operations of $571k; most of the investment change is Foley and Flanigan draws, and the $50k line of credit draw.

Kathleen – are there any footnotes in particular that they should pay attention to? Matt didn't think there were really any changes, other than the amounts, so nothing in particular that he would highlight.

Internal Control Report: *They do not issue an opinion on internal controls, but if they noticed any issues, they would place these in this report. During the audit, they did not identify any issues with internal controls that they view as material weaknesses.*

Governance Letter: *Required communication at the end of an audit to those in charge of Governance. On page 3, they did have one recommendation – temporarily restricted net assets during the audit – when you have a grant or investment earnings that are restricted, the release should happen when the funds are used for that purpose. They looked at release of funds and timing of expenditures – For example, Ethical AI had release of $195k, but QuickBooks showed $162,984. Upon additional inquiry, there were other costs, such as indirects, that should have been attributed to Ethical AI, so the recommendation is that the releases, including those that are indirect in nature, be reconciled back to the general ledger to ensure those are captured and released from restriction appropriately.*

Tom said that when restricted amounts come in; James is now showing what he sees as restricted in an Excel spreadsheet, including indirect costs, and communicating that to the accounting team on a regular basis so that the accounting team can capture the indirectly related costs and properly release them from restriction throughout the year. Additionally, when reporting to funders, James and the accounting team will compare total costs per James' tracking to what is in QuickBooks to ensure those are in sync.

Management rep letter: *To be signed by James; no passed audit adjustments because they recorded everything that is noted.*

Kathleen – can Matt provide more information on the two corrections that were noted in the Governance letter related to the Francis Fund and a pledge? The first one is a recorded distribution in December, but it actually came in January, so it missed the recording timing cutoff. The second one was late retrieval of a pledge and they initially only recorded the first installment.

Form 990: *Nonprofit informational tax return. No changes to the form by the IRS this year, so it was simply updating numbers. Page 2, they report programmatic expenditures by three largest programs. For 990 purposes, they are split among 3 major categories: Ethics Edu and Consult; ACP; and Systems Change.*

Officers and directors and reportable compensation are listed on page 7; John Carney was still an active employee in 2023, and shows more earnings than expected because his retirement account (457b) distribution was reported on his 2023 W-2.

Employees who earned over $100k in reportable compensation also appear in this list.

Pages 9-11 are the financial statements.

Schedule A: Public support test; this shows we are publicly supported rather than a private foundation; we were at 58% publicly supported for the year; anything over 33.3% is considered publicly supported organization.

Schedule D: Supplemental Financial. Page 2 describes the endowments; more information on building and equipment; the next page, more details on assets and liabilities, and then a reconciliation of the revenues and expenses per the audit to pages 9-10 of the 990; differences are mostly due to unreported gains and losses, per IRS instructions.

Schedule G: Fundraising activities reporting; split gross amount between contributions and fair value of benefits received. Of $171k total received, $18,750 was benefits (exchange transaction) and anything above that is considered a contribution, which is why the total net seems low at $1,500.

***Part II:** additional information on anyone with more than $150k in compensation*

***Part IV:** additional information on a company owned by a Board member. (Rob's company provided work on the Latino ACP grant from Health Forward Foundation).*

Tresia moved to recommend acceptance of the audit and 990 to the Finance Committee; Kathleen seconded; no questions nor discussion; motion carried.

Kathleen described best practice for 990 is to give the full board the ability to review the 990 prior to filing. As an example, KCU has the audit committee review the 990, then they present it in the materials for the full Board, but then they say barring any feedback to the contrary, they will file on x date.

Tresia requested that Matt attend the November 13 full Board meeting to provide a 5-7 minute overview of the audit and be available to answer any questions.

III. Adjourn

ethics perspective on TA-NRP-cDCD

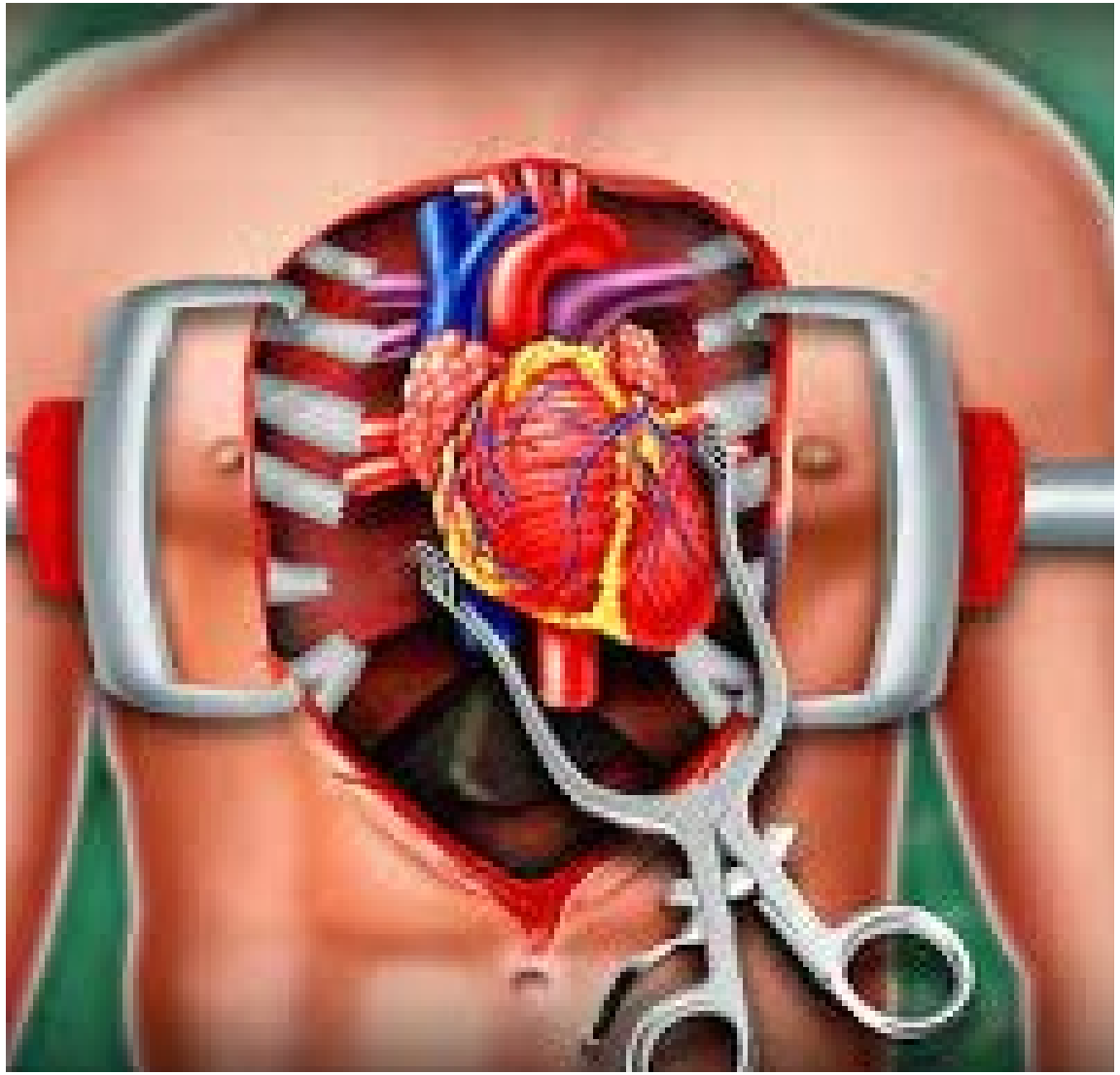
Tarris (Terry) Rosell, PhD, DMin
Flanigan Chair, Center for Practical Bioethics
Clinical Professor, KUMC-SOM
Professor of Pastoral Theology—Ethics, Central Seminary
Director, Ethics Consult Team; Co-Chair, Hospital Ethics -- UKHS

Disclosures

In regard to this presentation, Tarris Rosell has no relevant conflicts of interest to disclose, financial or otherwise.

Thorocoabdominal Normothermic Regional Perfusion with Controlled Donation after Circulatory Death (TA-NRP-cDCD)

An in-situ protocol aiming at optimal recovery of organs donated for transplantation following pronouncement of death on circulatory criteria ("irreversible cessation of respiratory and circulatory functions")



TA-NRP-cDCD

- Begins after 5-minute stand-off from flat-line to preclude spontaneous resuscitation
- After death pronouncement . . .
  - Chest opened and mechanical circulation (e.g., ECMO) begins, restarting heart
  - Perfusion only to thorocoabdominal regions, occluding vessels to brain (and perhaps legs)
  - In-situ observation and assessment of heart and other vital organs
  - Recovery of organs deemed useful for transplant
  - Warm ischemic injury minimized
  - Quality and quantity of transplantable organs optimized by approx. 15%-30%

Ethics Issues with TA-NRP-cDCD

1. Perceived to violate the UDDA and Dead Donor Rule
2. UDDA revisions are uncertain and may not resolve controversy
3. Bioethicists are not of one mind, with perhaps most objecting
4. Occluding blood flow to brain is perceived by some as inducing brain death and by others as obligatory so as to preclude resumption of consciousness
5. Potential violation of the public trust
6. Potential legal risk

Ethics Issues with TA-NRP-cDCD

1. **Perceived to violate the UDDA and Dead Donor Rule**
   - Uniform Determination of Death Act / "Determination of Death" statutes
     - Circulatory Death = "irreversible cessation of circulatory and respiratory functions"
   - Dead Donor Rule (DDR)
     - vital organs may be recovered only from dead donors
     - recovery process must not be the proximal cause of death
   - In TA-NRP-cDCD, mechanical reperfusion restarts heart and circulation . . .
     - Does this constitute resuscitation of the patient/person?
     - Is reperfusion of organs a reversal of circulatory cessation, therefore NOT "irreversible"?
     - Does this constitute annulment of previous death pronouncement?
     - Does organ recovery process then proceed on a patient no longer dead?

Ethics Issues with TA-NRP-cDCD

1. **Perceived to violate the UDDA and Dead Donor Rule**
   - **This is a valid concern.**
   - **It may be that the Rule gets in the way of the Good.**
   - **If so, given significant good for many with no harms to anyone, the Rule ought to be revised.**
   - **However, I am personally NOT persuaded that TA-NRP actually "resuscitates" a patient/person, especially if reperfusion is limited to abdominal-thoracic regions. So the donor remains dead.**

Ethics Issues with TA-NRP-cDCD

2. **UDDA revisions are uncertain and may not resolve controversy**
   - Uniform Law Commission drafting committee draft of revised UDDA
     - Perceived need to update definition of brain death, but circulatory also
   - Considered replacing "irreversible" cessation with "permanent". . .
     - Is "permanent" any different than "irreversible" relative to TA-NRP-cDCD?
     - "permanent" defined as: "a loss of function that will neither restart spontaneously *nor be restored as a result of medical intervention*"
     - Anyway, as of Feb 2023, no change made to definition
   - Currently no consensus on UDDA committee regarding proposed updates, and none under consideration would do anything to resolve NRP controversy

Ethics Issues with TA-NRP-cDCD

2. **UDDA revisions are uncertain and may not resolve controversy**

- Uniform Law Commission drafting committee draft of revised UDDA
  - Perceived need to update definition of cardiac death but unclear how also
- "permanent" replacing "irreversible" cessation . . .
  - Is "permanent" any different than "irreversible" relative to TA-NRP-cDCD?
- "permanent" defined as "a loss of function that will neither restart spontaneously *nor be restored as a result of medical intervention*"
- Currently no consensus on UDDA committee regarding proposed updates

- **It may be that the Rule gets in the way of the Good.**
- **Given significant good for many with no harms to anyone, the Rule ought to be revised.**

Ethics Issues with TA-NRP-cDCD

3. Bioethicists are not of one mind, with perhaps most objecting

- American College of Physicians (ACP) statement on April 17, 2021:
  - "*NRP-cDCD raises profound ethical questions regarding the dead donor rule, fundamental ethical obligations . . . , and the categorical imperative to never use one individual merely as a means to serve the ends of another, no matter how noble or good those ends may be.*"
- *American Journal of Bioethics* (AJOB, Jan 2023) . . .
  - Dr Lainie Ross (UC Chicago, U of Rochester Med Ctr):
    - *"(1) 'Patients must not be killed by organ retrieval . . . and (2) organs must not be taken from patients until they die'. . . . Reestablishment of circulation by ECMO is contrary to these requirements as it reverses the permanent cessation of circulation. Adding clamps to prevent blood flow to the brain may ensure the eventual death of the brain, but it leaves the patient on the table not yet dead by either of the standards (circulatory-respiratory or neurologic) by which death is determined according to the [UDDA]. . . . And since deceased donors must be dead, NRP is inconsistent with the DDR."*

Ethics Issues with TA-NRP-cDCD

3. Bioethicists are not of one mind, with perhaps most objecting

- **I am somewhat surprised by the level of controversy and so many bioethics colleagues focusing on a legalistic conclusion—the Rule outweighing the Good.**
- **With donor/family wanting maximal donation, and potential for one or several recipients benefiting, there seems to be much Good and no one harmed.**
- **The ACP interpretation of TA-NRP relative to DDR is not the only one to be considered, and their ethics case may not be strongest.**
- **AJT (2022, Vol 22:1311-15) article makes a strong ethics case for permissibility of TA-NRP-cDCD.**
- **With them (Wall et al.), I am personally NOT persuaded that TA-NRP actually "resuscitates" a patient/person, especially if reperfusion is limited to abdominal-thoracic regions. So the donor remains dead. DDR remains intact.**

Ethics Issues with TA-NRP-cDCD

4. **Occluding blood flow to brain is perceived by some as inducing brain death and by others as obligatory so as to preclude resumption of consciousness**
   - ACP Statement: "Brain death has been caused in order to prevent brain reperfusion when circulation is restored. The purpose seems to be to justify reversing *what was supposed to be irreversible*: circulatory death."
   - Dr Lainie Ross (AJOB, Jan 2023): "*Adding clamps to prevent blood flow to the brain may ensure the eventual death of the brain, but it leaves the patient on the table not yet dead by either of the standards (circulatory-respiratory or neurologic) . . . .*"

Ethics Issues with TA-NRP-cDCD

4. **Occluding blood flow to brain is perceived by some as inducing brain death and by others as obligatory so as to preclude resumption of consciousness**

- **I find more persuasive the arguments of Wall et al. in AJT (2022):**
  - **"…The exclusion of cerebral perfusion ensures that there is no artificial reanimation of brain function, which some could find ethically problematic."**
  - **"The action of excluding the cerebral circulation occurs after death, and so it cannot 'bring on death'."**
  - **"Rather, the purpose is to ensure that the organ procurement procedure does not contravene the wishes of the individual or their surrogate who has chosen to stop all life-sustaining treatments and has put a DNR order in place."**
  - **"Clamping the cerebral vessels eliminates any suggestion that artificial resuscitation of the brain is possible with TA-NRP DCD organ procurement and ensures unhindered progression to complete cessation of brain function, which is also what happens after cold perfusion in the standard DCD donor."**

Ethics Issues with TA-NRP-cDCD

5. Potential violation of the public trust

- Even ethically worthy innovations, if unable to be communicated adequately to the donor base, might be perceived negatively and result in a net loss of organ donors.
- Lack of transparency about a new and controversial organ recovery protocol would be ethically problematic, especially for donor authorization or family consent. Yet it may be challenging to convey to prospective donors the complexities of TA-NRP without confusion and diminished comprehension.

Ethics Issues with TA-NRP-cDCD

5. Potential violation of the public trust

- **TA-NRP proponents, skeptics, and opponents mostly agree that these are significant concerns that require resolution.**
- **The public trust might be violated also by failing to use optimal recovery processes that could prevent wasting donated life-saving hearts and other organs . . .**

Ethics Issues with TA-NRP-cDCD

6. Potential legal risk

- Kansas "Determination of Death" statute 77-205:
  - "An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead."
  - Organ procurement organizations (OPOs), recovery and transplant personnel and programs, and the healthcare facilities in which they practice are all engaging in risk-benefit analysis when deliberating whether or not to use TA-NRP for cDCD.

Ethics Issues with TA-NRP-cDCD

6. Potential legal risk

- **To date, we are unaware of anecdotal or published evidence that anyone using TA-NRP-cDCD protocols has been charged, prosecuted, or sued for violation of UDDA statutes or the DDR. Risk seems low.**
- **UDDA/statutes may also be inaccurate when describing brain death as "irreversible cessation of all functions of the entire brain, including the brain stem"—Yet current practices of pronouncing death on neurological criteria nonetheless proceed without perceived legal risk.**

Ethics Recommendations:

- **<u>TA-NRP-cDCD seems ethically permissible although not obligatory</u>, and if utilized the following recommendations apply:**

1. Deliberate TA-NRP-cDCD with awareness of ethical-legal controversy.
2. Advocate for ethically pragmatic revisions of UDDA/statutes.
3. Provide accommodations for individual conscientious objection.
4. Perfuse only the thoracic-abdominal regions, mitigating possibility of any continuation or restoration of consciousness during recovery.
5. Exercise transparency and mitigate potential for violation of public trust.
6. Conduct careful and ongoing risk-benefit analysis.

March 17, 2023

ETHICS PERSPECTIVE AND RECOMMENDATIONS re: THORACOABDOMINAL NORMOTHERMIC REGIONAL PERFUSION WITH CONTROLLED DONATION AFTER CIRCULATORY DEATH (TA-NRP-cDCD)

TA-NRP-cDCD seems ethically permissible although not obligatory, and if utilized, the following recommendations apply:

1. Deliberate TA-NRP-cDCD with awareness of ethical-legal controversy amongst bioethicists, nationally and internationally.

2. Provide accommodations for individual conscientious objection throughout the process.

3. Perfuse only the thoracoabdominal region, mitigating possibility of any continuation or restoration of brain activity during recovery of organs.

4. Exercise transparency and mitigate potential for violation of public trust.

5. Conduct careful and ongoing risk-benefit analysis.

By consensus agreement of the Hospital Ethics Committee following discussions and deliberation in meetings from November 2022 to March 2023.

UKHS Hospital Ethics Committee
Co-Chairs: Tarris Rosell, PhD, DMin and Terry Rusconi, Chief Culture Officer

DISCUSSION:

Normothermic Regional Perfusion for controlled Donation after Circulatory Death (NRP-cDCD) references various protocols aiming at optimal recovery of organs donated for transplantation following pronouncement of death on circulatory and respiratory criteria. While there are protocols for abdominal (A-NRP) reperfusion only and ex situ reanimation of the heart, we are concerned here with in situ thoracoabdominal NRP (TA-NRP). This is what is most discussed and debated in regard to ethical and legal permissibility of NRP-cDCD.

TA-NRP does not commence until pronouncement of death occurring after a typically five-minute stand-off period to preclude spontaneous resumption of circulatory or respiratory functions. Subsequently, the heart is restarted by artificial mechanical means while still in the thoracic cavity (in situ), often with extracorporeal membrane oxygenation (ECMO). Reperfusion enables observation and evaluation of vital organs prior to surgical excision. Organs deemed unsuitable for transplantation need not be removed. Ischemic injury is minimized by reperfusion in those organs that appear sufficiently healthy for use in a recipient, enhancing quality and long-term outcomes.

Reported outcomes of TA-NRP-cDCD thus far indicate potential for significant increases in quality and quantity of transplantable organs, especially hearts. Approximately 20 transplant programs in the U.S. and several internationally have implemented protocols using TA-NRP. Other programs and jurisdictions either have not done so yet, reportedly have done so but then paused, or have decided for now—presumably on ethical-legal grounds—not to use TA-NRP for organ recovery.

The primary ethics issue debated by bioethicists is that TA-NRP is perceived by some to violate the meaning of “irreversible” or “permanent” in statutory versions of the Uniform Determination of Death Act (UDDA). If so, this could be perceived also as a violation of the Dead Donor Rule (DDR) requiring that vital organs are recovered only from dead donors and that the recovery process must not be the proximal cause of death. The Kansas “Determination of Death” statute 77-205 states: “An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.” Missouri’s legal definition of circulatory death, 194.005, is similar: “When respiration and circulation are not artificially maintained, there is an irreversible cessation of spontaneous respiration and circulation.”

Bioethicists objecting to the use of TA-NRP-cDCD believe that reperfusion of the heart in situ constitutes resuscitation of the patient. They claim the prior death pronouncement on criteria of “irreversible cessation of circulatory and respiratory functions” is consequently annulled. If the patient is now alive, they are ineligible for organ recovery on grounds of the DDR. Occlusion of vessels to the brain in the TA-NRP protocol would lead to brain death, but as a causative factor, which would be impermissible also. There is also worry that TA-NRP would violate the public trust. A 2021 statement of the American College of Physicians (citation below) makes these arguments against TA-NRP-cDCD.

Other ethicists argue convincingly, we think, in favor of proceeding with this protocol. They interpret determination of death laws as technically compatible with TA-NRP. It is argued that mechanically perfusing an organ or organs while still in the thoracoabdominal region does *not* constitute resuscitation of a patient, hence there is *no* violation of either the UDDA or DDR. TA-NRP proponents argue that clamping vessels to the brain is permissible or even obligatory so as to ensure permanent absence of brain function while reperfusing the thoracic-abdominal regions and recovering organs. Ensuring brain death in this manner is not problematic for the DDR because the patient was already legally dead, and that pronouncement is not, or should not be, considered reversible/annullable by means of regional reperfusion.

Proponents point to the good outcomes experienced from TA-NRP protocols, while avoiding the fallacy of an "ends justifies means" argument or even reliance on the ethics principle of "double effect." They ask, "Who is harmed?" by TA-NRP—given that there was no intent by any stakeholder to continue life supports in violation of an agreed upon DNAR order and no prognosis for meaningful recovery due to a terminal condition. In addition, the decedent and/or their loved ones valued organ donation as something good that could happen in the midst of their tragedy. Instead of harms, it appears that only good can come from innovative and improved protocols optimizing both quality and quantity of organs for transplant. Harms might result instead by failing to utilize an available protocol with real potential for saving the lives of those awaiting transplant.

A 2022 article by Wall et al. in the *American Journal of Transplantation* (citation below) makes a strong case in favor of TA-NRP-cDCD. We find their ethics arguments to be valid and ultimately more persuasive than those in opposition to this protocol.

Avoiding real or potential violation of the public trust is a fundamental norm for organ recovery and transplantation. Even ethically worthy innovations, if unable to be communicated adequately to the donor base, might be perceived negatively and result in a net loss of organ donors. Lack of transparency about a new and controversial organ recovery protocol would be ethically problematic, especially for donor authorization or family consent. While it may be challenging to convey to prospective donors the complexities of TA-NRP without confusion and diminished comprehension, we think it is possible. Empirical evidence from peer institutions utilizing TA-NRP validates an optimistic perspective and provides guidance to organ procurement organizations and transplant programs for how to do it well.

REFERENCES:

Alamouti-fard, E. et al. Normothermic Regional Perfusion is an emerging cost-effective alternative iin Donation after Circulatory Death (DCD) in heart transplantation. *Cureus 14*(6): e26437, https://doi.org/10.7759/cureus.26437

Basmaji, J., Weijer, C., Skaro, A., Healey, A., Shemie, S. D., & Slessarev, M. (2021). Paving the road for the adoption of Normothermic regional perfusion in Canada. *Critical Care Explorations*, *3*(11). https://doi.org/10.1097/cce.0000000000000553

Batten, J. N., O'Meeghan, R., Catarino, P. A., Nurok, M., & Cotler, M. P. (2023). Changing the focus in the donation after circulatory death debates. *The American Journal of Bioethics*, *23*(2), 48–49. https://doi.org/10.1080/15265161.2022.2159094

Courtwright, A. M. (2023). Normothermic regional perfusion, causes, and the dead donor rule. *The American Journal of Bioethics*, *23*(2), 46–47. https://doi.org/10.1080/15265161.2022.2159571

DeCamp, M., Fins, J. J., & Snyder Sulmasy, L. (2022). Rebuttal from Dr DeCamp et al. *Chest*, *162*(2), 292–293. https://doi.org/10.1016/j.chest.2022.03.014

DeCamp, M., Snyder Sulmasy, L., & Fins, J. J. (2022). Point: Does normothermic regional perfusion violate the ethical principles underlying organ procurement? yes. *Chest*, *162*(2), 288–290. https://doi.org/10.1016/j.chest.2022.03.012

Dotinga, R. (2022, September 28). *No brain death? No problem. New Organ Transplant Protocol stirs debate.* Medical News. Retrieved January 26, 2023, from https://www.medpagetoday.com/special-reports/exclusives/100950

Entwistle, J. W., Drake, D. H., Fenton, K. N., Smith, M. A., & Sade, R. M. (2022). Normothermic regional perfusion: Ethical issues in thoracic organ donation. *The Journal of Thoracic and Cardiovascular Surgery*, *164*(1), 147–154. https://doi.org/10.1016/j.jtcvs.2022.01.018

*Ethics, Determination of Death, and Organ Transplantation in Normothermic Regional Perfusion (NRP) with Controlled Donation after Circulatory Determination of Death (cDCD): American College of Physicians Statement of Concern. (2021). *American College of Physicians*, 1–6.

Hanley, M. (2022, October 27). *Always hungry for more organs, transplant surgeons are exploiting -- and illuminating -- the different standards for determining death*. MercatorNet. Retrieved January 26, 2023, from https://mercatornet.com/always-hungry-for-more-organs-transplant-surgeons-have-created-a-new-standard-for-determining-death/81178/

James, L., Parent, B., Moazami, N., & Smith, D. E. (2022). Rebuttal from Dr James et al. *Chest*, *162*(2), 293–294. https://doi.org/10.1016/j.chest.2022.03.013

Johnson, L. S. (2023). DCD donors are dying, but not dead. *The American Journal of Bioethics*, *23*(2), 28–30. https://doi.org/10.1080/15265161.2022.2159584

Karches, K., Salter, E. K., Eberl, J. T., & McCruden, P. (2023). Dead enough? NRP-CDCD and remaining questions for the ethics of DCD protocols. *The American Journal of Bioethics*, *23*(2), 41–43. https://doi.org/10.1080/15265161.2022.2159578

Khan, A. N., & Klitzman, R. (2023). The needs to focus on process and precise language in ethical determination of CDCD. *The American Journal of Bioethics*, *23*(2), 50–52. https://doi.org/10.1080/15265161.2022.2159582

Markin, N. W., Chacon, M. M., Castleberry, A. W., Fristoe, L., Lowes, B. D., Um, J. Y., & Urban, M. (2022). Cardiac function unchanged following reanimation with normothermic regional perfusion in donation after circulatory death. *JTCVS Techniques*, *15*, 136–143. https://doi.org/10.1016/j.xjtc.2022.07.018

Miñambres, E., Royo-Villanova, M., & Domínguez-Gil, B. (2022). Normothermic regional perfusion provides a great opportunity to maximize organ procurement in donation after the circulatory determination of death. *Critical Care Medicine*, *50*(11), 1649–1653. https://doi.org/10.1097/ccm.0000000000005645

Padela, A., & Lizza, J. P. (2023). Donors and organs at the borders of vitality and public trust: Why DCD donors must be dead and not dying. *The American Journal of Bioethics*, *23*(2), 53–55. https://doi.org/10.1080/15265161.2022.2159579

Parent, B., Caplan, A., Moazami, N., & Montgomery, R. A. (2022). Response to American College of Physician's statement on the ethics of transplant after normothermic regional perfusion. *American Journal of Transplantation*, *22*(5), 1307–1310. https://doi.org/10.1111/ajt.16947

Peled, H., Mathews, S., Rhodes, D., & Bernat, J. L. (2022). Normothermic regional perfusion requires careful ethical analysis before adoption into donation after circulatory determination of death. *Critical Care Medicine*, *50*(11), 1644–1648. https://doi.org/10.1097/ccm.0000000000005632

Schiff, T., & Parent, B. (2023). Not dead, but close enough? you cannot have your cake and eat it too in satisfying the DDR in CDCD. *The American Journal of Bioethics*, *23*(2), 22–24. https://doi.org/10.1080/15265161.2022.2159093

Smith , W. J. (2022, October 21). *Don't let doctors kill sick patients for their organs*. Discovery Institute. Retrieved January 26, 2023, from https://www.discovery.org/a/dont-let-doctors-kill-sick-patients-for-their-organs/#

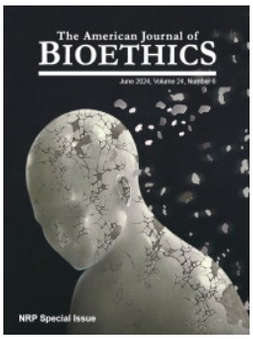
University of Nebraska Medical Center performs organ harvesting from living donors, resulting in their death. (n.d.).

UW Health. (n.d.). UW Organ and Tissue Donation NRP Playbook. Madison, WI.

*Wall, A. & Amy Fiedler, et al. (2022). Applying the ethical framework for donation after circulatory death to thoracic normothermic regional perfusion procedures. *Am J Transplant, 22:*1311-1315. https://doi.org/10.1111/ajt.16959.

Wall, A., & Testa, G. (2023). Defining the cause of death and vitality of organs in the ethical analysis of controlled donation after circulatory death procedures. *The American Journal of Bioethics*, *23*(2), 35–38. https://doi.org/10.1080/15265161.2022.2159575

Reference List compiled by Marissa Hernandez, Center for Practical Bioethics



Taylor & Francis
Taylor & Francis Group

The American Journal of Bioethics

ISSN: (Print) (Online) Journal homepage: www.tandfonline.com/journals/uajb20

Ethical and Equity Guidance for Transplant Programs Considering Thoracoabdominal Normothermic Regional Perfusion (TA-NRP) for Procurement of Hearts

Denise M. Dudzinski, Jay D. Pal & James N. Kirkpatrick

To cite this article: Denise M. Dudzinski, Jay D. Pal & James N. Kirkpatrick (2024) Ethical and Equity Guidance for Transplant Programs Considering Thoracoabdominal Normothermic Regional Perfusion (TA-NRP) for Procurement of Hearts, The American Journal of Bioethics, 24:6, 16-26, DOI: 10.1080/15265161.2024.2337393

To link to this article: https://doi.org/10.1080/15265161.2024.2337393

THE AMERICAN JOURNAL OF BIOETHICS
2024, VOL. 24, NO. 6, 16–26
https://doi.org/10.1080/15265161.2024.2337393

Taylor & Francis
Taylor & Francis Group

TARGET ARTICLE

Ethical and Equity Guidance for Transplant Programs Considering Thoracoabdominal Normothermic Regional Perfusion (TA-NRP) for Procurement of Hearts

Denise M. Dudzinski[a,b], Jay D. Pal[a] and James N. Kirkpatrick[a,b]

[a]University of Washington School of Medicine; [b]University of Washington School of Medicine Ethics Consultation Service

ABSTRACT

Donation after circulatory determination of death (DCDD) is an accepted practice in the United States, but heart procurement under these circumstances has been debated. Although the practice is experiencing a resurgence due to the recently completed trials using ex vivo perfusion systems, interest in thoracoabdominal normothermic regional perfusion (TA-NRP), wherein the organs are reanimated in situ prior to procurement, has raised many ethical questions. We outline practical, ethical, and equity considerations to ensure transplant programs make well-informed decisions about TA-NRP. We present a multidisciplinary analysis of the relevant ethical issues arising from DCDD-NRP heart procurement, including application of the Dead Donor Rule and the Uniform Definition of Death Act, and provide recommendations to facilitate ethical analysis and input from all interested parties. We also recommend informed consent, as distinct from typical "authorization," for cadaveric organ donation using TA-NRP.

KEYWORDS

Health policy; informed consent; organ transplantation; organizational ethics

INTRODUCTION

Donation after circulatory determination of death (DCDD) raises ethical issues, some of which have been discussed as DCDD gained international acceptance (Gries et al. 2013; Bernat et al. 2014; Bernat 2018; Boucek et al. 2008). In the current era, a potential DCDD donor is removed from life-support therapies, leading to hypoxemia resulting in cessation of circulation. Heart procurement following DCDD has become widely accepted with the recent development of ex vivo organ perfusion systems. The Transmedics (Andover, MA) Organ Care Systems (OCS) is the only commercially available ex vivo perfusion system for donor hearts. OCS potentially expands the donor pool by permitting the use of marginal donors, the transport of donor organs from distal procurement sites, and the inclusion of recipients with complex anatomy (Pinnelas and Kobashigawa 2022). In the setting of DCDD, ex vivo perfusion allows for reanimation of the donor heart and normalization of myocardial energetics prior to transplantation. Early clinical outcomes have been encouraging (Langmuur et al. 2022).

An alternative to ex vivo organ perfusion is in situ thoracoabdominal normothermic regional perfusion (TA-NRP), which raises additional ethical issues in the context of heart procurement (Fischkoff et al. 2021; Holm et al. 2022; Manara et al. 2020; Basmaji et al. 2021; American College of Physicians 2021; DeCamp, Sulmasy, and Fins 2022; Entwistle et al. 2022; James et al. 2022; Hoffman et al. 2021; Lazaridis 2022). When normothermic regional perfusion (NRP) is used to procure hearts, a potential donor is removed from life-support therapies, leading to hypoxemia resulting in cessation of circulation. Following declaration of death, a 5-min stand-off period begins during which critical care physicians observe to make certain neither breathing nor circulation resumes, arch vessels are ligated, and organ procurement commences. NRP heart procurement poses additional ethical questions because the heart is reanimated in situ, thereby resuming systemic circulation to the donor body.

Two advantages of TA-NRP are (1) the ability to assess left and right ventricular function in the donor circulation, during which time loading conditions may

CONTACT Denise M. Dudzinski dudzin@uw.edu Bioethics & Humanities and Pediatrics, Division of Bioethics & Palliative Care, University of Washington School of Medicine, Seattle, WA, USA.

be manipulated as desired, and (2) a reduction in normothermic/warm cardiac ischemic time. Diverse procurement practices speak to the ethical complexities of TA-NRP. For example, some European countries have adopted NRP (Jochmans et al. 2021), but Australian and New Zealand practice precludes postmortem whole-body perfusion, so in situ NRP is not permitted. "Manoeuvres that may inadvertently restore circulation in the body of the donor, such as cardiac compressions or repeated lung insufflation, should be avoided" (Australian and New Zealand Intensive Care Society [ANZICS]: Bernat et al. 2023). Because DCDD and TA-NRP are tied together, we provide (a) an overview of ethical issues in both procedures, and (b) the recommendation that TA-NRP is only ethically permissible with robust informed consent, as distinguished from *authorization* for cadaveric organ donation by the prospective donor or their surrogates. We conclude with guidance for programs considering TA-NRP.

CLINICAL OVERVIEW OF CONTROLLED TA-NRP

Typical TA-NRP heart donors have suffered a devastating neurological injury while retaining some level of brainstem activity, so circulatory criteria are used to determine death. Despite some regional variation, the general procedure for TA-NRP donation is as follows: The patient either remains in the intensive care unit (ICU) or is transported to the preoperative holding area. The patient receives analgesia and other palliative interventions. When the surrogate/family is ready, the patient is extubated and 30,000 units of heparin are administered. The patient is transported to the operating room. Once the patient's heart stops, an independent physician not associated with the transplant program or organ procurement organization (OPO) declares the patient dead, then observes a "hands-off" period of 5 min while watching for resumption of any respiratory or cardiac activity. Assuming no cardiac activity is noted on the ECG, procurement begins. A median sternotomy and a laparotomy are performed. Ligation of the arch vessels and venting of brachiocephalic vessels prevent cerebral perfusion. The patient is cannulated via the ascending aorta and right atrium. Extracorporeal circulation is initiated. The heart is manually massaged and defibrillated. Temporary pacing may be required. During this period of reperfusion and cardiac reanimation, the intrathoracic and intraabdominal dissection is completed. Organ function is assessed, the donor is weaned from cardiopulmonary bypass, and hemodynamic measurements are obtained. Once all of the transplant teams are ready, the aorta is cross-clamped and the remainder of procurement occurs as it would in a brain dead donor.

ETHICAL CONSIDERATIONS WITH CONTROLLED DCDD

The ethical issues raised by DCDD (without TA-NRP) were debated in the 1990s, when the Pittsburgh protocol for non-heart-beating cadaveric donors was introduced (Youngner and Arnold 1993; Childress 1993; Caplan 1993; Lynn 1993; Spielman and McCarthy 1995; DeVita and Snyder 1993). In that protocol, organ recovery began 2 min after declaration of death. The ethical issues debated included (a) whether a 2-min hands-off period was long enough; (b) interpretations of the Dead Donor Rule (DDR) and Uniform Determination of Death Act (UDDA), especially distinctions between irreversible and permanent cessation of circulation; (c) the importance of prioritizing patient comfort during terminal withdrawal and the dying process; (d) conflicts of interest that arise when both the prospective donor and potential transplant recipients are "patients," leading to strict firewalls between the dying patient's treating team and the transplant team; (e) conflicts of interests for organ procurement organizations (OPOs), transplant programs, and health systems, who benefit financially from expanding the donor pool; (f) impact on public trust; (g) ensuring no action is taken to hasten the death of the prospective donor, including risky antemortem procedures that serve only the interest of the transplant recipient; (h) informed consent; (i) ensuring concerns of all stakeholders are addressed prior to the initiation of a program; and (j) involvement of ethics committees. We review several of these issues.

The question we address is whether TA-NRP raises new ethical concerns. We believe TA-NRP revives and complicates several ethical questions raised by DCDD for two reasons. First, the heart is reanimated in situ, circulating blood throughout the body and bringing with it questions of resuscitation versus organ perfusion. DCDD without TA-NRP does not raise these concerns because upon declaration of death, the heart does not pump again until it is removed from the body. Second, ligating the arch vessels to prevent perfusion to the brain is only necessary once extracorporeal circulation restarts the heart. DCDD prior to TA-NRP never called for this safeguard.

Ensuring the Comfort of the Dying Patient

Ethically, donor comfort may not be compromised for the sake of prospective transplant recipients, even though anesthesia may impact the viability of donor grafts. There is broad agreement that the well-being of the dying patient takes precedence. After consent is obtained for terminal withdrawal of life-sustaining treatments, traditional comfort care measures are provided as dictated by the clinical team overseeing withdrawal. Antemortem procedures like cannulation and administration of heparin are permitted under the following strict conditions: "(1) the administration is not intended or likely to cause death; (2) [for heparin] active bleeding is not known to exist; … (3) the risk to the patient is deemed negligible or minimal by the patient's attending physician; (4) the decision to allow the administration [of antemortem drugs and procedures] is made by the family of the patient with the counsel of the patient's attending physician" (Motta 2005).

Similarly, antemortem testing that does not directly benefit the dying patient must present minimal risk to the potential donor, and the surrogate must provide consent. These criteria honor commitments to beneficence and nonmaleficence owed to the dying person. The prospective donor and the organ recipients are equal in dignity and moral worth, and the dying person may never be treated merely as a source of organs.

CONFLICTS OF INTEREST

Simultaneous consideration for prospective organ donors and transplant recipients leads to conflicts of commitment and conflicts of interest, necessitating a firewall between the team caring for the dying patient and the transplant team (Bernat et al. 2014, 668). The team caring for the potential donor safeguards their patient's goals of care and interests throughout the dying process. Their patient advocacy must be independent of the interests of the transplant teams and hospital/health system, such as favorable financial impact on transplant programs. Donor families do not engage with the transplant team, however they do speak with representatives from organ procurement organizations (OPOs), whose interests align squarely with transplant teams and recipients. The OPO is responsible for obtaining consent from the donor's surrogate for any testing or interventions related to organ placement or preservation. We argue that surrogates should also consent to postmortem TA-NRP procedures in light of potential equity, cultural, spiritual, and other ethical concerns. OPOs may disagree with our recommendation, however, opting to spare families the gruesome details of procurement so as not to deter surrogates from consenting to donation.

Dead Donor Rule as a Matter of Justice and Equity

The Dead Donor Rule (DDR) stipulates (a) that donors must be deceased prior to organ procurement and (b) that organ procurement may not cause death (Robertson 1999; Dalle Ave, Sulmasy, and Bernat 2020). Further, the DDR requires that withdrawal of life-sustaining treatment (LST) never occurs *for the sake of* organ donation (Dalle Ave, Sulmasy, and Bernat 2020). Rather, a decision should be made that LST is more burdensome than beneficial for a terminally ill patient. LST is removed to allow death from underlying terminal illness/es. Then, in light of the patient's death, organ donation proceeds according to the patient's previous wishes or a surrogate's judgment.

Because ethical requirements must be met for terminal withdrawal, the following are proscribed: organ procurement from inmates (as has been reported in China), from individuals against their will, and from anyone without imminently lethal pathophysiology (Robertson and Lavee 2022; Huang, Mao, and Millis 2008). Procurement from patients who die of drug overdoses, a population contributing to increasing DCDD donations, raises equity and justice issues, because stigmatized and disadvantaged populations are frequently donors but rarely transplant recipients (Robertson and Lavee 2022; Huang, Mao, and Millis 2008; Wanis et al. 2018; Lin et al. 2012). "Calls to expand DCDD following drug overdoses could disproportionately affect an underserved and/or stigmatized population already burdened by the nation's substance abuse epidemic" (American College of Physicians 2021). Our society has neglected these core equity commitments in the past. There was a period of time in the 1990s when procurement from anencephalic infants prior to death was endorsed by the American Medical Association, violating the DDR (Lagay 2004). Course correction quickly followed.

Faithful allegiance to the DDR protects historically marginalized populations (American College of Physicians 2021; DeCamp, Snyder Sulmasy, and Fins 2022). It also protects the integrity of death declarations that are made according to physiological *evidence* rather than altruistic concern for transplant candidates. Any other approach blurs the line between *scientific confirmation* that a human life has ended and the *cultural, religious, and personal significance* of dying and death. Both are crucial but only the former is under the purview of medicine.

As discussed below, even though patients and families do not dictate clinical determinations of death, some will favor an *irreversibility* standard for a variety of spiritual, cultural, and moral reasons. Potential donors come from diverse communities, including communities that have reason to distrust the health care system due to long histories of institutionalized racism, sexism, ableism, and classism. Procurement begun before the dying process has ended, especially if not disclosed, may be seen as yet another form of persecution and exploitation.

Uniform Determination of Death Act: Permanent or Irreversible?

In 1981 the Uniform Determination of Death Act (UDDA) was drafted by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical Research with the goal of establishing a model state statute. The UDDA has been accepted by most U.S. states and the District of Columbia, and the Uniform Law Commission recently decided not to revise the definition. The UDDA states that a person may be declared legally dead *when either of the following* occurs: (a) irreversible cessation of circulatory and respiratory functions, or (b) the irreversible cessation of all functions of the entire brain, including the brainstem. The UDDA does not require cessation of both circulatory and neurological functions. Either criterion is sufficient.

"A physiologic function that ceases *irreversibly* means that the function *cannot* be restored. A physiologic function that ceases *permanently* means that the function *will not* be restored" (Bernat et al. 2023; Bernat 2010). Some interpret the UDDA's *irreversible* stipulation strictly as meaning that circulatory and neurological functions *cannot physiologically* return (DeCamp, Sulmasy, and Fins 2022; Peled and Bernat 2022). On this view, DCDD/TA-NRP ignores both the DDR and the UDDA's irreversibility standards because the *whole person* is effectively resuscitated when extracorporeal circulation restores heart function in situ. The declaration of death is invalidated. The patient is alive. Portending TA-NRP dilemmas, neurologist and ethicist Dr. James Bernat noted, if "the utilization of extracorporeal membrane oxygenation (ECMO) adequately provided circulation and oxygenation to the donor's entire body, it would retroactively negate the death determination by preventing the loss of circulation and respiration from becoming permanent or irreversible, potentially 'reanimating' the heart and preventing the progression to brain destruction on which the circulatory criterion of death is predicated" (Bernat 2008).

In contrast, many clinicians and ethicists interpret "irreversible" to mean "permanent" (Entwistle et al. 2022; Dalle Ave, Sulmasy, and Bernat 2020; DeCamp et al. 2023; Parent et al. 2022b; Parent and Turi 2020. Permanence connotes a decision by the patient or surrogate to allow death from the underlying lethal pathophysiology. Parent et al. note that, despite the irreversibility wording of the UDDA, in practice we observe a permanence standard because clinicians do not routinely confirm irreversibility. "If irreversibility were interpreted as 'circulation has stopped and cannot be restarted', then almost no one would be dead, including donors involved in standard DCDD" (Parent et al. 2022a). Permanence connotes an informed choice by the patient or surrogate to allow death from the underlying lethal pathophysiology—a choice not to be resuscitated. If permanence is the standard, then even if circulation could be restored for resuscitative purposes, it should not be.

On this view, interventions such as ligating aortic arch vessels and venting brachiocephalic vessels during TA-NRP are permissible. Since the patient has been declared dead by circulatory criteria and autoresuscitation has not occurred, subsequent procurement is performed on a deceased prospective donor, thus abiding by the dead donor rule. The permanence standard reduces but does not eliminate the ethical conundrum of ligation of the aortic arch vessels, however (Manara et al. 2020).

The "unified brain-based concept of death" provides that when the cessation of brain function results from circulatory arrest, the relevant circulation which has ceased is that of the brain [such that] … in DCDD, the permanent cessation of systemic circulation leads to the permanent cessation of brain functions … For a unified brain-based circulatory determination of death to be valid in NRP, it is essential that all brain circulation has ceased completely and is not restored by NRP or any other means" (Bernat et al. 2023). This does not answer the question of whether restored circulation to the brain (via extracorporeal membrane oxygenation [ECMO]) might restore brain function, but rather purports that *regional* perfusion of the thoracic and abdominal region (TA-NRP) does not foil the declaration of death, while *systemic* circulation of the whole body would, hence the need to clamp the head vessels. The ethical conundrum persists.

AUTORESUSCITATION AND STAND-OFF PERIOD

Declaring death based on circulatory criteria requires a period of observation to ensure apnea and pulselessness (Hornby, Hornby, and Shemie 2010; Dhanani et al. 2021). One goal of the 5-min stand-off period is to ensure the spontaneous return of cardiac activity (autoresuscitation) has not occurred. This serves as a marker that the dying process has concluded.

The duration of the stand-off period is important when considering organ viability. Shorter observation periods (2 min) reduce warm ischemic time and render organs more suitable for transplantation, while longer periods (5–10 min) are more likely to permit completion of the dying process prior to organ recovery. If the clinical goal is successful transplantation, then the shorter the waiting period, the better. Shorter observation periods pose ethical issues, however.

Because the stand-off period is designed to ensure that autoresuscitation does not occur, evidence about the timing of autoresuscitation is pertinent to the irreversibility requirements of the UDDA. The 2013 consensus statement on DCDD written by the American Thoracic Society, the International Society for Heart and Lung Transplantation, the Society for Critical Care Medicine, the Association for Organ and Procurement Organizations, and the United Network for Organ Sharing recommends a 2-min observational period, based on the claim that "there is no literature to support 'auto-resuscitation' of the heart following two minutes of circulatory arrest" (Gries et al. 2013). Short observational periods are problematic ethically and may jeopardize public trust in organ donation, though. The procurement of organs from deceased infants 1.25 min after

cardiac arrest had a chilling effect on the practice of DCDD in 2008 (Boucek et al. 2008).

Today, a 5-min stand-off period to observe apnea and pulselessness is common practice and ethically appropriate, in keeping with a recent study indicating that 4 min 20 sec was the longest period of spontaneous return of cardiac activity (Dhanani et al. 2021). The authors conclude, "After this period, without attempts to restart circulation and without spontaneous resumption of circulation, loss of circulation is considered permanent and organ recovery may begin" (Dhanani et al. 2021). Of course with NRP, attempts are made to restart circulation.

Ethical complications arise related to the Dead Donor Rule (DDR). If reanimating the heart in situ is *resuscitation*, it is ethically impermissible to proceed with organ recovery because the patient is no longer deceased. If a 5-min waiting period effectively renders the patient brain dead, then procurement could only occur after death by neurological criteria is confirmed, but confirming brain death is not standard practice in DCDD. "At this point [5 min] permanent loss of the circulation also equates with permanent loss of brain functions, which will inevitably become irreversible if there is no restoration of brain perfusion" (Manara et al. 2020).

As discussed in the preceding, under the UDDA, physicians are not required to confirm both circulatory and brain death. TA-NRP donors are dead solely based on circulatory criteria. At the conclusion of the stand-off period, the patient is placed on extracorporeal circulatory support.

TA-NRP protocols call for ligation of the arch vessels for two reasons. The first is to allow the cessation of cardiac function to lead to the cessation of neurological function (Soltani-Nia 2022). The second is to protect against the possibility of awareness, suffering, or sensory experience that might follow cerebral perfusion. TA-NRP *without* ligation of arch vessels would restore brain perfusion, but the act of ligating the arch vessels in a patient who is not yet dead violates the second provision of the Dead Donor Rule by causing the patient's death. The act of intentionally ligating the arch vessels 5 min after declaration of death raises the question of moral responsibility. Are transplant surgeons intervening to ensure death by neurological criteria? Are they hastening death?

The Death Paradox

TA-NRP creates a death paradox. If the patient is dead, why ligate the arch vessels? Transplant professionals, experts in fine details of procurement, want to prevent perfusion to the brain, suggesting that the line between life and death during procurement is not crisp. Despite the brain undergoing 5 min of warm ischemic time, it is possible that the dying process has not finished, rendering TA-NRP a form of resuscitation of the whole person. The potential donor is not dead yet. "The present TA-NRP protocol calls for perfusing organs in situ except the brain as part of the preservation effort, which might appear to invalidate the previously satisfied permanent circulatory cessation standard" (Parent et al. 2022b). Transplant professionals seem to be protecting the deceased from harm, which is a paradox since the donor is dead.

In summary, with TA-NRP, when extracorporeal circulation is initiated and the heartbeat resumes, some will consider this tantamount to attempting CPR, while others will argue that it cannot be resuscitation because the patient is dead, and the intention is solely to perfuse organs. Some will see the distinction as morally significant; others will not. Therefore, robust informed consent is required. Otherwise, the values of the deceased and/or the surrogate do not dictate the moral permissibility of TA-NRP. The values of transplant medicine and OPOs do. It is paramount that transplant programs considering accepting TA-NRP organs or initiating TA-NRP programs should consider ethical arguments in favor and opposed to the practice (see Tables 1 and 2).

ETHICAL ARGUMENTS IN FAVOR OF LIGATION OF THE AORTIC ARCH VESSELS

First, even though brain death is not confirmed under TA-NRP protocols, 5 min of warm ischemic time following asystole is likely to cause profound neurological injury. The majority of prospective donors already have serious neurological injury before terminal withdrawal, suggesting (but not proving) that 5 min of ischemia on top of the underlying neurological injury leads to irreversible neurological devastation. Even though brain death is not confirmed, the donor is dead by circulatory criteria. Ligation of arch vessels is solely precautionary. Second, if DCDD is permissible, then an argument can be made that preventing cerebral perfusion is an ethical obligation according to the principle of nonmaleficence. Organ recovery will occur 5 min after declaration of circulatory determination of death even without TA-NRP. Without confirmation of neurological death, the prospective donor (dead by circulatory criteria) may still be harmed by any procurement measure.

Of course, discussion of even "sensory harm" is confusing. Ava et al. recommend separating nonmaleficence from discussions of DCDD, as dead people may not be harmed (Bernat et al. 2023). Still, the confusion seems unavoidable if postmortem interventions are intended to prevent painful or other sensory experiences. Third, procurement procedures respect the donor or surrogate's autonomy by fulfilling the altruistic desire to donate organs. This argument is strongest when the dying patient's wishes regarding NRP are unambiguous. Fourth, "perfusing the thoracic and abdominal organs after circulatory determination of death does not alter the fact that the heart will not restart on its own" (Parent et al. 2022b). This argument suggests that *autoresuscitation* would be an indication that the person was alive, but those in favor of NRP argue that extracorporeal circulation does not *resuscitate* the patient; it simply perfuses the organs. Finally, a decision by the patient or surrogate has been made not to attempt

Table 1. Ethical and equity arguments supporting and opposed to DCD/TA-NRP.

Ethical/equity issue	Arguments supporting DCD/TA-NRP	Arguments opposing DCD/TA-NRP
Utility	-Increasing the donor pool and maximizing viability of cadaveric organs produces the greatest good for society -Cadaveric organs can be lifesaving for transplant patients -Number of listed transplant patients exceeds available cadaveric organs	-Increasing the donor pool is often falsely equated with better transplant outcomes -Utility for transplant recipients does not trump other ethical considerations relevant to prospective donors, like equity and informed consent -Donors may not be used solely as a means to the end of successful transplant
In situ vs. ex vivo perfusion options	-NRP may improve the viability of thoracic organs	-Ex vivo perfusion systems offer similar advantages without introducing ethical and equity issues -Higher cost of ex vivo systems is not sufficient ethical argument to assume ethical/equity risk of NRP -Potential for in situ and ex vivo systems to be used together, thereby negating cost saving arguments
Informed consent and equity	-Legally, cadaveric organ donation requires *authorization*, not consent, justifying limited information to those joining organ registry -Consent from legal surrogates sought because TA-NRP involves premortem interventions (cannulation, blood thinners) -Most postmortem procurement details are not delineated for surrogates to spare them grief, and NRP is no different -Avoid exploitation of marginalized populations and widening of health disparities (e.g., targeting procurement from patients who die of drug overdoses)	-Insufficient information provided to prospective donors at the Department of Motor Vehicles (DMV); insufficient information about impact on families or ethical/equity issues in DCDD and TA-NRP is shared prior to authorization -Full informed consent should supplant first-person authorization because TA-NRP invites value judgments based on personal beliefs, cultures, religious traditions -Reasonable people will disagree about whether DCDD/TA-NRP is ethically permissible -Detailed TA-NRP informed consent is ethically required because without full disclosure, diverse prospective donor beliefs and values cannot be respected
Uniform Determination of Death	-Patient deceased based on circulatory criteria; therefore TA-NRP procedures, including ligation of arch vessels, are performed on cadavers	-in situ resuscitation of heart is effectively whole-body resuscitation; patient is no longer dead once heart reanimated -The intention of the donor/surrogate for postmortem donation is irrelevant if procurement begins while the dying process is still in process
Irreversible vs. permanent distinction	-Death is permanent based on DCDD -Honor surrogate's decision not to attempt resuscitation. -Permanence connotes a decision by patient/surrogate to allow death to occur; any resuscitation is regional organ reperfusion, not systemic whole-body resuscitation based on the patient's/surrogate's goals, interests, and intentions -*Both* circulatory and neurological criteria need not be met under the UDDA	-The declaration of death is negated when the heart is resuscitated in situ; death is neither irreversible nor permanent
Dead Donor Rule (DDR)	-Irrelevant if prospective donor does not meet neurological criteria for death because *either* circulatory *or* neuro criteria are required per DDR	-If TA-NRP resuscitates the whole person, the person cannot be dead, yet surgical procurement begins, violating the DDR -Ligation of arch vessels may be interpreted a moral act that causes brain death -See Ethical ligation of arch vessels
Respect for patient autonomy	-Highest priority is to respect the autonomy of prospective donors by abiding by their choice to donate organs (via the donor registry) -Goal of terminating life-sustaining treatment is to permit death; only organ resuscitation in keeping with patient's goals -Donation is a gift	-Without mandated choice, OPOs respect the autonomy of those who choose to donate but not those who decline or refrain from registering as organ donors; if donor not on the registry, consent is sought from surrogates but surrogates are not enlisted if it might reverse donor's prior authorization to donate -OPOs approach surrogates for consent when dying patients are not on the registry, violating the autonomy of patients who deliberately choose not to register as organ donors -Patient's goal of terminal withdrawal is irrelevant; if resuscitation occurs, whole patient is revived and they are not dead
Respect for persons	-Ligation of arch vessels/venting to air is a precautionary measure of preventing reperfusion of the brain, thereby protecting dying patient of sensory experience or suffering during procurement	-See Ethical ligation of arch vessels
Ethical significance of ligating arch vessels (LAV)	-Patient deceased based on circulatory criteria; therefore NRP procedures, including clamping head vessels, are performed on cadavers -Permits completion of the dying process -Preventing cerebral perfusion is an ethical obligation according to the principle of nonmaleficence	-LAV is intended to ensure completion of the dying process; if patient is alive when LAV occurs, the transplant surgeon has violated the DDR by causing/ensuring the neurological death of the patient -If the patient is dead, why ligate the arch vessels, as the prospective donor is beyond sensory or other experience? -Transplant professionals assume moral and professional responsibility for facilitating the dying process -In some cultural and religious traditions, this act might be seen as euthanasia

(*Continued*)

Table 1. Continued.

Ethical/equity issue	Arguments supporting DCD/TA-NRP	Arguments opposing DCD/TA-NRP
Hands-off/waiting period	-Autoresuscitation has not been demonstrated after 5 min -Goal of reanimating the heart is to preserve organs, not resuscitate the whole person	-Autoresuscitation data are moot after whole-body resuscitation
Conflicts of Interest	-Expansion of donor pool and innovation are core concerns of all transplant programs -Improved transplant outcomes save lives	-Utilizing NRP donor organs and initiating NRP programs will increase revenue for transplant programs, hospitals, and health systems -Failure to accept NRP organs or initiate NRP programs is likely to make transplant programs less competitive -Improved transplant outcomes improve statistics for transplant programs

Table 2. Guidance for programs considering and initiating TA-NRP programs.

Ethical/equity issue	Guidance for programs considering whether to participate in TA-NRP	Guidance for programs that initiate TA-NRP programs or accept NRP organs
Prioritize well-being of dying patient	-Consider whether/under what circumstances program will accept NRP organs vs. initiate its own NRP program -Comfort and dignity of dying patient takes precedence over organ recipient interests -Premortem interventions to improve viability of organs (cannulation, blood thinners) must be benign to dying patient -Firewall between team managing terminal withdrawal and transplant team	-Exclude dying patients with awareness at the time of terminal withdrawal to ensure no sensory or other experiences during procurement (e.g., ALS patients)
Ensure benefit to recipients and financial benefits do not trump ethical issues	-Weigh TA-NRP against DCD without TA-NRP -Rapid recovery and ex vivo recovery systems sidestep ethical issues discussed	-Explain why TA-NRP is preferred over ex vivo perfusion systems clinically, ethically, etc.; cost alone is insufficient rationale
Honor the liminal space between life and death	-Minimum 5-min hands-off period after declaration of circulatory death	
Respect the Dead Donor Rule	-Provide rationale under DDR for NRP position -Procurement may not cause death	-Provide rationale under DDR for endorsing NRP -Seek ethics consultation and legal counsel -Procurement may not cause death
Ensure robust informed consent	-Involvement of surrogates are critical to respect values, cultures, and religions of prospective donors -Simple authorization is ethically insufficient	-A robust consent process and involvement of surrogates is important to respect values, cultures, and religions of prospective donors -Transplant program works with OPO to require detailed disclosure of TA-NRP components, including ligation of arch vessels
Directly address shortcomings of first-person authorization (FPA) for TA-NRP	Work with OPOs to delineate a carve-out in FPA for TA-NRP	-Due to limited information provided while registering for organ donation (at DMV and elsewhere), *authorization* for NRP is not ethically sufficient. -Full informed consent must be obtained for TA-NRP, thereby requiring consent from surrogates
Ligation of arch vessels	- Describe mechanism and goals of ligating arch vessels -Seek input on ethical permissibility from stakeholders	-Describe mechanism and goals of ligating arch vessels in NRP family materials and in consents
Respect diversity	-Engage in multidisciplinary discussion at the institution/health system level among all potential stakeholders affected when considering implementation, enlisting hospital leadership and ethics early -Explicitly address equity and inclusion by enlisting community stakeholders and/or equity programs/professionals -Respect diverse cultural, religious, moral perspectives through robust informed consent for NRP/vessel ligation -Ensure education of impacted health care workers; permit conscientious objection opt-outs for NRP from clinical staff -See Ensure Robust informed consent	
Address conflicts of Interest	-Advantage to potential recipients does not override ethical and equity concerns related to donors -Financial advantage to OPOs, transplant programs, and hospitals/health systems in initiating NRP programs -Positive financial impact is not sufficient to initiate TA-NRP program	
Align with institutional values and transparency	-Consider the values of the hospital/health system: is TA-NRP consistent with those values? -Hospitals/health systems should draft document outlining rationale for adopting/not adopting TA-NRP organs/program	

resuscitation of the whole person, so procurement interventions are not designed to resuscitate. Further, a requirement to confirm both cardiac and neurological death before procurement could render all DCDD, not just TA-NRP, unethical, though the practice might still be legal under the UDDA.

Ethical Arguments Against Ligation of Aortic Arch Vessels

TA-NRP is practiced in Europe (Jochmans et al. 2021), but not in Canada or Australia, because these countries object to the resumption of cardiac activity in situ (Basmaji et al. 2021). The American College of Physicians (ACP), among others, object to TA-NRP for a variety of reasons (Entwistle et al. 2022; Peled and Bernat 2022; Sade et al. 2022). First, postmortem ECMO or bypass restores perfusion to the heart, thereby restarting it. Intentional ligation of the arch vessels then ensures death by neurological criteria. In addition, some programs also vent brachiocephalic vessels (Hoffman et al. 2021) to atmosphere to prevent all residual blood flow to the brain. "This protocol … is more accurately described as organ retrieval after cardiopulmonary arrest and the *induction of brain death*" [emphasis mine] (American College of Physicians 2021). The authors claim that ligation of the arch vessels *causes* brain death because the declaration of circulatory determination of death is invalidated when extracorporeal circulation is initiated.

Second, the declaration of death may be deemed invalid given the resumption of circulation. "A declaration of death is voided when the grounds for that declaration are negated by subsequent action. In interrupting circulation to the brain, nature is not taking its course, but rather medicine is intervening to ensure death" (DeCamp, Sulmasy, and Fins 2022). Critics of TA-NRP maintain that transplant surgeons hasten death when they ligate arch vessels to induce brain death. Professional oaths and ethical commitments forbid clinicians from directly causing a patient's death. Even aid-in-dying statutes do not permit euthanasia.

Third, TA-NRP prevents death from following its natural course—death of all organs and the whole person. "The purpose seems to be to justify reversing what was supposed to be irreversible: circulatory death" (American College of Physicians 2021). Fourth, "restarting circulation while preventing blood flow to the brain cannot be justified by saying the actions are not intended to resuscitate or benefit the donor. Intended or not, the actions do in fact resuscitate the patient" (DeCamp, Sulmasy, and Fins 2022). If TA-NRP resuscitates the whole person, the person cannot be dead, yet surgical procurement begins, violating the DDR. Fifth, the declaration of death itself is misleading. "Is declaring a patient dead by irreversible circulatory criteria, then rendering the patient brain dead before restoring circulation honest, transparent and respectful of patient autonomy and dignity?" (American College of Physicians 2021).

Sixth, as discussed in the following, in the absence of robust informed consent the practice raises justice and equity concerns. Seventh, even if all aspects of the procedure are disclosed to patients/surrogates, informed consent does not render other ethical commitments moot, since the practice violates ethical commitments of medicine itself, including beneficence and nonmaleficence (DeCamp, Sulmasy, and Fins 2022). Eighth, alternatives such as ex vivo perfusion also reduce warm ischemic time and preserve organs for successful transplantation. It is unclear why in situ perfusion is necessary if comparable alternatives exist that spare us the vexing ethical issues. Finally, if donor and recipient are not co-located, ex vivo organ procurement recovery might still be needed for transportation, begging the question: Why use TA-NRP in the first place, especially if costs increase by using both ex vivo procurement methods and TA-NRP (DeCamp, Sulmasy, and Fins 2022)?

The Critical Issue of Informed Consent

First-person authorization (FPA) for posthumous organ donation is legally protected. Adults may indicate their interest in being an organ donor at the department of motor vehicles (DMV) or through an organ donor registry, and surrogates may not override their decision. However, surrogates are responsible for consenting for terminal withdrawal of LST and DCDD antemortem preservation interventions. So even with FPA, DCDD donation hinges on the family's consent to antemortem procedures, as well as to the timing and location of terminal withdrawal (Gries et al. 2013).

In addition, *authorization* is so called because the standards of *informed consent* are deemed unnecessary because procurement occurs postmortem. Instead, a simple request for altruistic donation is made without explaining what authorization might entail to prospective donors and loved ones. Undoubtedly, some who authorize donation might be unconcerned with the impact on their family, while others put high value upon it.

Because detailed information is not provided at the point of authorization, surrogates should always be involved in TA-NRP decisions; however, if FPA extends to DCDD decisions, the patient's values, as expressed by the family, will not be heeded because OPOs rely on poorly informed authorization, not consent. At this time, OPOs have sole responsibility and discretion about whether and how to inform surrogates about the ethically controversial aspects of NRP, but FPA stipulates that they need not have these conversations with surrogates of registered donors. Full and detailed TA-NRP consent is essential so that surrogates can make informed choices about whether ligation of arch vessels, for example, comports with the dying patient's values. Therefore, changes in laws, policies, and practices are required to meet robust consent requirements, without which NRP is not ethically permissible. The International Society for Heart and Lung Transplantation concurs, writing, "Appropriate information about the procedure should

be given to the donor's family or guardian." Where relevant, this should include the fact that a member of the medical team confirms death has occurred, the use of a hands-off period, and whether interventions such as vessel ligation will be taken to transition from a DCDD to DBD donor (Holm et al. 2022).

A thorough consent process not only respects the authority of surrogates, it accommodates and respects diverse cultural, religious, and moral viewpoints. In controlled DCDD, organ recovery must be initiated quickly, so the consent process occurs after a decision has been made to withdraw life-sustaining treatments but prior to withdrawal.

A robust DCDD/TA-NRP consent will include descriptions of (1) antemortem preservation efforts, with their rationale and timing (American Society of Anesthesiologists 2017); (2) the separation of the team overseeing withdrawal and the transplant team; (3) the palliative measures taken to ensure the patient's comfort during withdrawal; (4) the timing and location of terminal withdrawal; (5) the time limit for cessation of circulatory function after withdrawal; (6) the duration of the hands-off period and its rationale; (7) initiation of extracorporeal circulation and its timing; (8) the process of circulatory reanimation; (9) additional procedures for procurement; (10) details of TA-NRP including arch vessel ligation and venting brachiocephalic vessels, its purpose, and rationale; (11) ex vivo alternatives to TA-NRP.

Some OPOs favor providing less information about TA-NRP since the interventions occur postmortem, feeling that family should be spared the morbid details. Parent et al. advocate for protecting the family from suffering by limiting detailed information about the organ recovery process; however, withholding TA-NRP information, including arch vessel ligation, risks disrespecting both cultural and religious beliefs as well as public trust in organ donation (Parent et al. 2022b). While OPOs retain oversight of procurement "authorizations," hospitals and health systems on which they depend can insist on explicit documentation and candor with surrogates. Candor and full informed consent never preclude the sympathy and kindness families of the deceased deserve.

In addition, more detail is better than less to address the equity considerations outlined above. Multidisciplinary input on consent and education documents ideally includes review by hospital/health system leadership, palliative care, transplant professionals, critical care, nursing, perfusionists, legal counsel, ethics, and equity teams. Informed consent documents must be simple and easy to understand, and all questions should be addressed during the consent process. Failure to make family/surrogates fully aware not only abrogates the principle of autonomy but can damage public trust (American College of Physicians 2021).

While the majority of patients will be neurologically devastated at the time of death, current practice does not preclude a decisional, alert patient from becoming eligible for DCDD/TA-NRP following discontinuation of life-sustaining treatments and DCDD. Special care must be taken in these circumstances, as there is a stronger possibility of sensory experience between circulatory and neurological death. Until research is conducted on the impact on deceased donors in these circumstances, reanimation of the heart with TA-NRP in this population is strongly discouraged.

We have outlined the ethical concerns every hospital, program, and health system should consider when deciding whether to accept TA-NRP organs or to procure organs using TA-NRP. Based on our analysis, we offer guidance for programs who participate in TA-NRP and those who decline.

CONCLUSION

At the time of this writing, 3,385 patients were awaiting heart transplantation (OPTN, HRSA database; see https://optn.transplant.hrsa.gov/data/), with approximately 100 additional recipients added each week. As more patients with end-stage heart failure are listed for transplant, the need for heart donors continues to exceed the number of viable grafts, despite recent increases that resulted from the opioid epidemic and relaxation of donor criteria. TA-NRP offers another mechanism to bridge the gap. It also introduces a number of ethical issues worthy of careful consideration by OPOs and transplant programs before accepting DCDD and TA-NRP organs or initiating programs. We provide an overview of those ethical issues and outline practical actions that address them.

DISCLOSURE STATEMENT

No potential conflict of interest was reported by the author(s).

FUNDING

The author(s) reported there is no funding associated with the work featured in this article.

REFERENCES

American College of Physicians. 2021. American College of Physicians. Ethics, determination of death, and organ transplantation in normothermic regional perfusion (NRP) with controlled donation after circulatory determination of death (cDCD): American College of Physicians Statement of Concern. extension://elhekieabhbkpmcefcoobjddigjcaadp/https://www.acponline.org/acp_policy/policies/ethics_determination_of_death_and_organ_transplantation_in_nrp_2021.pdf.

American Society of Anesthesiologists, Committee on Critical Care Medicine, Ethics, and Transplant Anesthesia. 2017. Statement on controlled organ donation after circulatory death. October 25, 2017. https://www.asahq.org/standards-and-guidelines/statement-on-controlled-organ-donation-after-circulatory-death.

Basmaji, J., C. Weijer, A. Skaro, A. Healey, S. D. Shemie, and M. Slessarev. 2021. Paving the road for the adoption of normothermic regional perfusion in Canada. *Critical Care Explorations* 3 (11):e0553. doi: 10.1097/CCE.0000000000000553.

Bernat, J. L. 2008. The boundaries of organ donation after circulatory death. *The New England Journal of Medicine* 359 (7):669–71. doi: 10.1056/NEJMp0804161.

Bernat, J. L. 2010. How the distinction between 'irreversible' and 'permanent' illuminates circulatory-respiratory death determination. *Journal of Medicine and Philosophy* 35 (3):242–55. doi: 10.1093/jmp/jhq018.

Bernat, J. L. 2018. Conceptual issues in DCDD donor death determination. *Hastings Center Report* 48 (S4):S26–S8. doi: 10.1002/hast.948.

Bernat, J. L., T. P. Bleck, S. A. Blosser, S. L. Bratton, A. M. Capron, D. Cornell, M. A. DeVita, G. J. Fulda, A. K. Glazier, C. J. Gries, et al. 2014. Circulatory death determination in uncontrolled organ donors: A panel viewpoint. *Annals of Emergency Medicine* 63 (4):384–90. doi: 10.1016/j.annemergmed.2013.05.018.

Bernat, J. L., B. Domínguez-Gil, A. K. Glazier, D. Gardiner, A. R. Manara, S. Shemie, R. J. Porte, D. E. Martin, H. Opdam, A. McGee, et al. 2023. Understanding the brain-based determination of death when organ recovery is performed with DCDD in situ normothermic regional perfusion. *Transplantation* 107 (8):1650–4. doi: 10.1097/TP.0000000000004642.

Boucek, M. M., C. Mashburn, S. M. Dunn, R. Frizell, L. Edwards, B. Pietra, and D. Campbell. 2008. Pediatric heart transplantation after declaration of cardiocirculatory death. *The New England Journal of Medicine* 359 (7):709–14. doi: 10.1056/NEJMoa0800660.

Caplan, A. L. 1993. The telltale heart: Public policy and the utilization of non-heart-beating donors. *Kennedy Institute of Ethics Journal* 3 (2):251–62. doi: 10.1353/ken.0.0125.

Childress, J. F. 1993. Non-heart-beating donors of organs: Are the distinctions between direct and indirect effects & between killing and letting die relevant and helpful? *Kennedy Institute of Ethics Journal* 3 (2):203–16. doi: 10.1353/ken.0.0014.

Dalle Ave, A. L., D. P. Sulmasy, and J. L. Bernat. 2020. The ethical obligation of the dead donor rule scientific contribution. *Medicine, Health Care, and Philosophy* 23 (1):43–50. https://heinonline.org/HOL/P?h=hein.journals/medhcph23&i=43. doi: 10.1007/s11019-019-09904-8.

DeCamp, M., K. Prager, American College of Physicians Ethics, Professionalism and Human Rights Committee. 2023. Standards and ethics issues in the determination of death: A position paper from the American College of Physicians. *Annals of Internal Medicine* 176 (9):1245–50. doi: 10.7326/M23-1361.

DeCamp, M., L. S. Sulmasy, and J. J. Fins. 2022. POINT: Does normothermic regional perfusion violate the ethical principles underlying organ procurement? Yes. *Chest* 162 (2):288–90. doi: 10.1016/j.chest.2022.03.012.

DeVita, M. A., and J. V. Snyder. 1993. Development of the University of Pittsburgh Medical Center Policy for the care of terminally ill patients who may become organ donors after death following the removal of life support. *Kennedy Institute of Ethics Journal* 3 (2):131–43. http://offcampus.lib.washington.edu/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=pif&AN=EP57527160&site=ehost-live. doi: 10.1353/ken.0.0175.

Dhanani, S., L. Hornby, A. van Beinum, N. B. Scales, M. Hogue, A. Baker, S. Beed, J. G. Boyd, J. A. Chandler, M. Chassé, et al. 2021. Resumption of cardiac activity after withdrawal of life-sustaining measures. *The New England Journal of Medicine* 384 (4):345–52. doi: 10.1056/NEJMoa2022713.

Entwistle, J. W., D. H. Drake, K. N. Fenton, M. A. Smith, and R. M. Sade. 2022. Normothermic regional perfusion: Ethical issues in thoracic organ donation. *The Journal of Thoracic and Cardiovascular Surgery* 164 (1):147–54. doi: 10.1016/j.jtcvs.2022.01.018.

Fischkoff, K., S. Derrington, C. Heith, D. Oxman, L. Shepherd, and M. F. Marshall. 2021. Donation after circultory death with normothermic regional perfusion: A brief ethical analysis. *Critical Connections*, no. Spring.

Gries, C. J., D. B. White, R. D. Truog, J. Dubois, C. C. Cosio, S. Dhanani, K. M. Chan, P. Corris, J. Dark, G. Fulda, et al. 2013. An Official American Thoracic Society/International Society for Heart and Lung Transplantation/Society of Critical Care Medicine/Association of Organ and Procurement Organizations/United Network of Organ Sharing Statement: Ethical and policy considerations in organ donation after circulatory determination of death. *American Journal of Respiratory and Critical Care Medicine* 188 (1):103–9. doi: 10.1164/rccm.201304-0714ST.

Hoffman, J. R. H., W. G. McMaster, A. S. Rali, Z. Rahaman, K. Balsara, T. Absi, M. Levack, M. Brinkley, J. Menachem, L. Punnoose, et al. 2021. Early US experience with cardiac donation after circulatory death (DCD) using normothermic regional perfusion. *The Journal of Heart and Lung Transplantation* 40 (11):1408–18. doi: 10.1016/j.healun.2021.06.022.

Holm, A. M., A. Courtwright, A. Olland, A. Zuckermann, and D. Van Raemdonck. 2022. ISHLT position paper on thoracic organ transplantation in controlled donation after circulatory determination of death (cDCD). *The Journal of Heart and Lung Transplantation* 41 (6):671–7. doi: 10.1016/j.healun.2022.03.005.

Hornby, K., L. Hornby, and S. D. Shemie. 2010. A systematic review of autoresuscitation after cardiac arrest. *Critical Care Medicine* 38 (5):1246–53. doi: 10.1097/CCM.0b013e3181d8caaa.

Huang, J., Y. Mao, and J. M. Millis. 2008. Government policy and organ transplantation in China. *The Lancet* 372 (9654):1937–8. doi: 10.1016/S0140-6736(08)61359-8.

James, L., B. Parent, N. Moazami, and D. E. Smith. 2022. COUNTERPOINT: Does normothermic regional perfusion violate the ethical principles underlying organ pro-

curement? No. *Chest* 162 (2):290–2. doi: 10.1016/j.chest.2022.03.011.

Jochmans, I., A. J. Hessheimer, A. P. Neyrinck, D. Paredes, M. I. Bellini, J. H. Dark, H. J. A. N. Kimenai, L. H. M. Pengel, and C. J. E. Watson. 2021. Consensus statement on normothermic regional perfusion in donation after circulatory death: Report from the European Society for Organ Transplantation's Transplant Learning Journey. *Transplant International* 34 (11):2019–30. doi: 10.1111/tri.13951.

Lagay, F. 2004. Considering organ donation by anencephalic neonates. *AMA Journal of Ethics* 6 (8):364–7. doi: 10.1001/virtualmentor.2004.6.8.code1-0408.

Langmuur, S. J. J., J. H. Amesz, K. M. Veen, A. J. J. C. Bogers, O. C. Manintveld, and Y. J. H. J. Taverne. 2022. Normothermic ex situ heart perfusion with the organ care system for cardiac transplantation: A meta-analysis. *Transplantation* 106 (9):1745–53. doi: 10.1097/TP.0000000000004167.

Lazaridis, C. 2022. Normothermic regional perfusion: Ethically not merely permissible but recommended. *American Journal of Transplantation* 22 (9):2285–6. doi: 10.1111/ajt.17066.

Lin, S. S., L. Rich, J. D. Pal, and R. M. Sade. 2012. Prisoners on death row should be accepted as organ donors. *The Annals of Thoracic Surgery* 93 (6):1773–9. doi: 10.1016/j.athoracsur.2012.03.003.

Lynn, J. 1993. Are the patients who become organ donors under the Pittsburgh protocol for 'non-heart-beating donors' really dead? *Kennedy Institute of Ethics Journal* 3 (2):167–78. doi: 10.1353/ken.0.0081.

Manara, A., S. D. Shemie, S. Large, A. Healey, A. Baker, M. Badiwala, M. Berman, A. J. Butler, P. Chaudhury, J. Dark, et al. 2020. Maintaining the permanence principle for death during in situ normothermic regional perfusion for donation after circulatory death organ recovery: A United Kingdom and Canadian proposal. *American Journal of Transplantation* 20 (8):2017–25. doi: 10.1111/ajt.15775.

Motta, E. D. 2005. The ethics of heparin administration to the potential non-heart-beating organ donor. *Journal of Professional Nursing* 21 (2):97–102. doi: 10.1016/j.profnurs.2005.01.005.

National Data—OPTN. n.d. Accessed April 11, 2023. https://optn.transplant.hrsa.gov/data/view-data-reports/national-data/#.

Parent, B., A. Caplan, N. Moazami, and R. A. Montgomery. 2022a. Regarding normothermic regional perfusion: Arguing by insistence is not a strong argument. *American Journal of Transplantation* 22 (6):1729–30. doi: 10.1111/ajt.17046.

Parent, B., A. Caplan, N. Moazami, and R. A. Montgomery. 2022b. Response to American College of Physician's statement on the ethics of transplant after normothermic regional perfusion. *American Journal of Transplantation* 22 (5):1307–10. doi: 10.1111/ajt.16947.

Parent, B., and A. Turi. 2020. Death's troubled relationship with the law. *AMA Journal of Ethics* 22 (12):E1055–61. doi: 10.1001/amajethics.2020.1055.

Peled, H., and J. L. Bernat. 2022. Why arch vessel ligation is unethical for thoracoabdominal normothermic regional perfusion. *The Journal of Thoracic and Cardiovascular Surgery* 164 (2):e93. doi: 10.1016/j.jtcvs.2022.04.029.

Pinnelas, R., and J. A. Kobashigawa. 2022. Ex vivo normothermic perfusion in heart transplantation: A review of the TransMedics® Organ Care System. *Future Cardiology* 18 (1):5–15. doi: 10.2217/fca-2021-0030.

Robertson, J. A. 1999. The dead donor rule. *The Hastings Center Report* 29 (6):6–14. doi: 10.2307/3527865.

Robertson, M. P., and J. Lavee. 2022. Execution by organ procurement: Breaching the dead donor rule in China. *American Journal of Transplantation* 22 (7):1804–12. doi: 10.1111/ajt.16969.

Sade, R. M., J. W. Entwistle, D. H. Drake, K. N. Fenton, and M. A. Smith. 2022. Reply from Authors: Tying off brain vessels: Can that be ok? *The Journal of Thoracic and Cardiovascular Surgery* 164 (2):e93–94. doi: 10.1016/j.jtcvs.2022.04.041.

Soltani-Nia, S. 2022. AOPO statement on normothermic regional perfusion. *AOPO* (blog). December 15, 2022. https://aopo.org/statement-on-normothermic-regional-perfusion/.

Spielman, B., and C. S. McCarthy. 1995. Beyond Pittsburgh: Protocols for controlled non-heart-beating cadaver organ recovery. *Kennedy Institute of Ethics Journal* 5 (4):323–33. http://offcampus.lib.washington.edu/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=pif&AN=PHL1636825&site=ehost-live. doi: 10.1353/ken.0.0183.

Wanis, K. N., A. Madenci, M. Katherine Dokus, K. Tomiyama, B. Al-Judaibi, M. Hernán, and R. Hernandez-Alejandro. 2018. The effect of the opioid epidemic on donation after cardiac death transplantation outcomes. *Transplantation* 103 (5):973–9. doi: 10.1097/TP.0000000000002467.

Youngner, S. J., and R. M. Arnold. 1993. Ethical, psychosocial, and public policy implications of procuring organs from non-heart-beating cadaver donors. *JAMA* 269 (21):2769–74. doi: 10.1001/jama.1993.03500210069034.

Neither Ethical nor Prudent

Why Not to Choose Normothermic Regional Perfusion

by ADAM OMELIANCHUK, ALEXANDER MORGAN CAPRON, LAINIE FRIEDMAN ROSS, ARTHUR R. DERSE, JAMES L. BERNAT, and DAVID MAGNUS

In transplant medicine, normothermic regional perfusion (NRP) can be used to increase the number of high-quality organs procured and to make organ allocation more efficient. Yet NRP faces ethical and legal challenges because it restores the donor's circulation, thus invalidating a death declaration based on the permanent cessation of circulation. Tortuous and inaccurate arguments are used to justify NRP. *Ethical parsimony* favors an alternative that yields comparable outcomes: normothermic machine perfusion.

The practice of obtaining organs from patients who die after life-sustaining treatment has been withdrawn generated ethical debate when it was initiated by the University of Pittsburgh Medical Center three decades ago.[1] The concern was that the "Pittsburgh protocol" violated the dead donor rule (DDR), which holds that vital organs may be procured only from patients who are dead and that physicians may not cause death while or for the purpose of procuring vital organs.[2] In time, a consensus emerged among transplant programs and health authorities around the world that the practice, now known as "donation after circulatory determination of death"[3] (or "DCDD"), is consistent with ethical norms and legal requirements because permanent cessation of the donor's circulation means that death has occurred.[4] Today, DCDD supplies a substantial percentage of deceased-donor organs in many countries including the United States, where it provided more than a third of all organs from deceased donors in 2023.[5]

Unfortunately, DCDD organs suffer warm ischemic damage after life-sustaining technologies are removed and the donor is allowed to die. The customary method for reducing such damage is rapid cooling of the body's core, removal of the organs that will be transplanted, and their placement in static cold storage to preserve them temporarily. Organs can be maintained for only a limited time because prolonged cold storage increases the risk of graft dysfunction and complications for the recipient.[6]

Adam Omelianchuk, Alexander Morgan Capron, Lainie Friedman Ross, Arthur R. Derse, James L. Bernat, and David Magnus, "Neither Ethical nor Prudent: Why Not to Choose Normothermic Regional Perfusion," *Hastings Center Report* 54 (2024): 1-10. DOI: 10.1002/hast.1584

One strategy to extend the preservation period, which has recently come to be used in DCDD, is to perfuse transplantable organs with warm oxygenated blood or perfusate.[7]

Normothermic regional perfusion (NRP) is one such strategy that reverses some of the effects of ischemic damage, something that static cold storage cannot do.[8] In NRP, an extracorporeal membrane oxygenation (ECMO) machine circulates oxygenated blood to the organs to be transplanted, and arteries that carry blood to the brain are occluded. When only the liver, kidneys, and pancreas are recovered, the procedure is known as "A-NRP" because circulation is clamped off above the abdominal region; when the heart or lungs are also obtained, the procedure is termed "TA-NRP" because blood flows into all organs in the thoracoabdominal space, which restores cardiac function, and is occluded at the aortic arch.

NRP was first used in 1997 and subsequently incorporated into the DCDD protocols of some medical centers in the United Kingdom and Spain.[9] As those programs reported improved results over conventional DCDD, some transplant programs in the United States started performing A-NRP and TA-NRP. In 2021, the American College of Physicians urged U.S. medical centers to pause before implementing such protocols to allow further study. This professional organization, which termed NRP with DCDD "a protocol more accurately described as organ retrieval after cardiopulmonary arrest and the induction of brain death,"[10] was not alone in concluding that NRP does not meet existing ethical or legal standards.[11] In response, proponents argue that NRP improves graft survival rates and surgical efficiency, increases the number of organs procured, and reduces overall costs.[12] Some proponents further argue that it is ethical and aligned with the current law,[13] while others recommend a change in the law to treat the permanent loss of circulation as a proxy for the permanent loss of brain function.[14] These claims have been cross-examined not only on ethical and policy grounds but also on scientific grounds that have, for example, led transplant programs in the United Kingdom to suspend the use of TA-NRP while important issues are investigated.[15] In short, NRP faces three major objections, one that alleges a failure of legal compliance, one that claims the dead donor rule is violated, and one from the failure to respect persons and their autonomous choices.

Recognizing the importance of these issues, the American Society of Transplant Surgeons (ASTS) communicated in a recent consensus statement that "[t]o preserve public trust in organ donation, ethical issues need to be investigated, navigated, and discussed but are not insurmountable. NRP must be conducted within the confines of the UDDA. Finally, communication with donor families is paramount to ensure transparency."[16] While the ASTS is optimistic that NRP will come to be accepted, it recognizes the need to establish a "wider national consensus on the ethical and legal acceptability of NRP."[17] Claiming to be "fully cognizant of ethical concerns raised regarding NRP," the ASTS nevertheless supports its "ongoing utilization" and is confident that it "does not violate essential moral, philosophical, and bioethical medical precepts."[18] In recommending that NRP be implemented now, based on the promise that an ethical and legal consensus will emerge in its favor in the future, the ASTS views critics as pessimists who hesitate to authorize a lifesaving therapy. To policy-makers and administrators, their statement communicates that proceeding with NRP is presumptively ethical because it appears to promote clinical utility, helps donors donate effectively, and will, like the Pittsburgh protocol, come to be accepted.

Yet the ethical and legal issues are harder to resolve than NRP proponents would have people believe. We argue that the restoration of circulation in NRP invalidates the declaration of death, and we explain why arguments to the contrary are unconvincing. The effort to wedge NRP into existing ethical frameworks poses significant risks to public trust in organ donation, which is further undermined by recommendations from the ASTS and other NRP proponents about the limited medical information that needs to be disclosed when obtaining consent.

We believe that there is no need to take such an unwise step and proceed with NRP on such a weak basis because an alternative means of oxygenated perfusion, normothermic mechanical perfusion (NMP), can be performed *ex situ* by connecting organs to a machine after they have been removed from the donor. As we discuss below, both NMP and NRP seek the same objectives: to salvage some deceased donor organs that might otherwise not be usable, to improve the quality of other organs, and to reduce waste and improve equity by providing more time for organ allocation. We conclude by showing that when choosing between alternative means of achieving these results, prudent U.S. policy-makers, physicians, and transplant centers should prefer the ethically simpler one rather than the one that depends on performing verbal gymnastics and misreading statutes or that generates ethical controversies that may undermine public trust in organ donation.

Irreversibility, Permanence, and the Restoration of Circulation

There is a strong case that NRP does not comply with the legal criteria for determining death. With minor variations, all U.S. jurisdictions recognize the two standards for determining death found in the Uniform Determination of Death Act (UDDA): "An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is

dead. A determination of death must be made in accordance with accepted medical standards."[19]

When DCDD was first proposed, critics argued that DCDD donors are not dead under the circulatory-respiratory standard because resuscitative measures could restore donors' circulation and respiration, meaning the cessation of these functions is not "irreversible" at the moment when they are declared dead. DCDD came to be accepted, however, on the understanding that what the statute—like the common-law standard based on "a total stoppage of the circulation"[20]—actually requires is that the cessation of functions remain unchanged in perpetuity. The UDDA expresses this requirement as "irreversible cessation" to remind physicians of the need to rule out confounding conditions that could be masking relevant signs of life in certain circumstances. In this context, "irreversible" was intended to be a checkpoint in the process of determining whether the loss of function is permanent. But in the ordinary practice of medicine, outside the context of organ donation, when hospitalized patients with a do-not-attempt-resuscitation (DNAR) order experience cardiorespiratory arrest, physicians routinely declare death even though the cessation of circulation and respiration might in some cases be reversed. The report that the medical consultants to the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research prepared on the diagnosis of death explained "irreversible" as follows: "*Irreversibility* is recognized by the persistent cessation of functions during an appropriate period of observation and/or trial of therapy. In clinical situations where death is expected, where the course has been gradual, and where irregular agonal respiration or heartbeat finally ceases, the period of observation following the cessation may be only the few minutes required to complete the examination. Similarly, if resuscitation is not undertaken and ventricular fibrillation and standstill develop in a monitored patient, the required period of observation thereafter may be as short as a few minutes."[21] Thus, the circulatory criterion of death is satisfied when a person's circulation has ceased permanently.[22]

Of course, were respiration and circulation to resume spontaneously, a prior determination of death would be invalidated. Therefore, the typical DCDD protocol allows death to be declared only when asystole continues during a "no touch" period of at least five minutes, which is long enough to rule out autoresuscitation. Since DCDD involves patients (or their surrogates) who have rejected all attempts to reverse the loss of circulation and respiration following the removal of life-sustaining treatment, the loss of these functions will be permanent.

With NRP, however, circulation is restored through a vascular circuit that supplies oxygen and nutrients to, and removes waste from, the donor's organs and tissues, thereby contradicting the premise on which death was declared, namely, that circulatory functions have permanently ceased. Indeed, in TA-NRP, both blood flow and cardiac function resume, which proponents of NRP argue has the additional benefit of making possible "functional assessment" of the heart, which is informative for transplant surgeons.[23] With the determination of death invalidated, however, procuring organs from donors through NRP violates the DDR, since such donors are not dead and the removal of vital organs would cause their death, thus risking a homicide charge. Notably, Australia does not permit the use of NRP.[24]

Unconvincing Defenses

In response to this straightforward conclusion, those in favor of NRP argue that its use is consistent with death-determination statutes because the circulation that NRP restores in DCDD donors should not be equated with the circulatory functions in the statutory definition of death. At the center of several interconnected arguments is the semantic claim that NRP does not "restore circulation" but merely "perfuses tissues *in situ*."[25] These arguments hold that "restoring circulation" mischaracterizes what this use of ECMO does because that language implies reviving the patient, which is not the objective of NRP; instead, the procedure merely aims at "[r]estoring the circulatory function of the heart"[26] or "[p]erfusing the thoracic and abdominal organs."[27] But this distinction misstates the relationship: circulation, whether generated naturally or artificially, exists for the purpose of perfusing organs and tissues, and the permanent loss of circulation brings about death because, without oxygen, organs lose the ability to function.

Under the law, what matters in making a circulatory determination of death is *whether* circulation is present in the individual's body, not *why* it is there, and whether circulation has *permanently* ceased.

NRP proponents raise two other, related objections. First, they argue that, since "resuscitation" involves a therapeutic intent that NRP lacks, NRP's use of ECMO must be interpreted as an act of "reperfusion," which "does not change the circumstances that lead the family, in collaboration with the care team, to conclude that the possibility of a meaningful life no longer exists for the patient."[28] The problems with these arguments go beyond the complex web of words the proponents

spin, as they try to separate perfusion from circulation or to distinguish restoration of circulation from resuscitation of the patient. The central weakness is that they read concepts into the death-determination statutes that aren't there. The UDDA and comparable laws say nothing about resuscitation. The statute describes a civil status—being dead—which occurs because of certain characteristics of an individual; in the case of DCDD, the relevant one is the permanent cessation of circulatory and respiratory functions. Likewise, the presence or absence of a therapeutic intent is irrelevant. Under the law, what matters in making a circulatory determination of death is *whether* circulation is present in the individual's body, not *why* it is there, and whether circulation has *permanently* ceased.[29]

NRP proponents try to rewrite the death-determination statutes in another way when they assert that "irreversible cessation of circulatory and respiratory functions" refers only to the loss of "spontaneous cardiorespiratory function."[30] This claim would extend the UDDA to patients who are placed on ECMO during surgery. Such patients lack spontaneous cardiac activity but, of course, are not regarded as dead on the basis that their circulation occurs artificially rather than spontaneously. Moreover, even were the spontaneity of circulation a criterion under the UDDA—which it is not—the TA-NRP protocol results in "reperfusion of the heart and coronary circulation, which enables resumption of spontaneous cardiac activity" and thereby "restores blood flow independent of the extracorporeal circuit."[31]

The proponents' second objection to the conclusion that the restoration of circulation invalidates a DCDD death determination is that "NRP cannot resuscitate the deceased because the capacity for spontaneous function remains absent and because interventions [to restore it] were determined medically ineffective in accordance with accepted medical standards."[32] The claim that the "capacity" for spontaneous function is absent in DCDD donors is false since many patients who have just been declared dead under the circulatory standard still possess the capacity for spontaneous circulation. As just noted, TA-NRP typically results in resumption of spontaneous cardiac activity, which is not surprising given what happens in other cases of cardiopulmonary arrest where cardiopulmonary resuscitation (CPR) produces a return of cardiac function. Likewise, if CPR delivers blood to the brain in sufficient quantity, normal functions can sometimes be restored even when resuscitation commences more than five minutes after a sudden cardiac arrest. Interventions that could achieve such results are withheld in DCDD not because they would be "medically ineffective" in restoring circulation but because the family and medical team have concluded that the patient does not want such an attempt to extend life or would not benefit from it.

Calling the interventions in the donor "medically ineffective" in achieving spontaneous cardiac function equivocates between "physiologically ineffective" and "medically inappropriate." The first reading must be rejected for several reasons. Most basically, ECMO *is* effective in producing the circulation needed to achieve regional perfusion. Further, if ECMO were physiologically ineffective in establishing circulation, NRP practitioners would not occlude vessels to the brain to prevent brain perfusion and the possible restoration of neurological functioning. Thus, the proponents apparently mean that one must conclude that ECMO is "perfusing" the body because it would be "medically inappropriate" to provide "circulation," as the patient or family rejected any attempts at resuscitation—the epitome of begging the question.

In short, the proponents' arguments are convoluted, factually inaccurate, and twisted by attempts to introduce concepts such as *therapeutic intent*, *spontaneous function*, and *medical ineffectiveness* into a statute where they neither appear nor belong. The arguments fail to refute the conclusion that the circulation restored by NRP in the body of a DCDD donor necessarily negates the premise—that circulation will not return—on which the legal determination of death was based.

The Risk of Unintended Consequences

Ultimately, proponents do not rest their case on a convincing rebuttal to the critiques. Instead, they contend that NRP will allow transplant programs to maximize the lifesaving impact of DCDD by improving the number and quality of transplantable organs through the efficient use of financial and medical resources.[33] Yet that is an incomplete description of the problem because the problem calls for a solution that safeguards public trust and is consistent with the DDR.

While the organ shortage is serious, and creative ways to meet it are needed, embracing NRP based on such weak arguments substantially risks undermining public trust.[34] The willingness to be a deceased donor rests on people's confidence that they will have died before organs are removed.[35] Americans' conceptions of death vary, ranging from the belief that death occurs as soon as someone ceases to be aware of the world to the view that life continues as long as there is breath, even when that is provided by a ventilator, to the belief that a person is in a transitional state but not dead for a time after they cease breathing. The neurological criteria for determining death are poorly understood, and doubts about whether they define "biological death" have led some to suggest that a revised UDDA should allow anyone who objects to "brain death" to reject the use of that standard to declare them dead.[36] This social trend speaks against one possible solution some NRP proponents favor: grounding the law on a brain-based standard for

determining death, under which only perfusion of the brain, rather than systemic circulation, would need to have ceased permanently for a death determination to be valid.[37] But even if such a change were made, a serious diagnostic problem needs to be resolved, namely, that insufficient evidence exists that brain circulation has completely ceased when TA-NRP is used.[38] More significantly, given the public's greater skepticism about "brain death," shifting the basis for declaring death in DCDD from circulatory to neurological functions without public endorsement risks reducing the number of people willing to become donors after the withdrawal of life support.

However these issues are to be resolved, the public expects physicians to put patients' interests above the interests of others and to treat every person as an end and never solely as a means. Since physicians would violate these ethical imperatives if they were to declare the death of potential donors while also caring for patients who might receive organs from these donors, U.S. law forbids physicians from playing both roles.[39] Yet if the physicians who determine death in DCDD and organ procurement organizations that verify such deaths know that these donors' circulatory functions will be restored by NRP in order to benefit organ recipients, these physicians represent the sort of conflict of interest that the law and medical ethics prohibit, particularly regarding the procurement team's efforts to cut off blood flow to the donor's brain so as to ensure an unverified form of brain death. This could lead members of the public to conclude that donor hospitals, organ procurement organizations, and transplant programs value organ recipients' welfare over donors'. The resulting loss of public confidence could reduce the number of organs available for transplantation. At the very least, candor is needed regarding what is happening and why since the public has an interest in knowing that there is a controversy about whether NRP protocols are consistent with the DDR.

The Ethical Unacceptability of Obfuscation and Withholding Information

Given the interest that anyone would have in being correctly diagnosed as dead before their vital organs are procured, one would expect NRP proponents to strongly recommend full disclosure about NRP to potential donors and their families. Instead, proponents' writings reveal hesitancy to disclose facts about NRP. For example, they have warned against "dumping all details on grieving traumatized families," and they advise further study about whether families "want to know, or need to know, specific NRP techniques" since withholding "technique details" is standard practice in obtaining valid authorization under DCDD protocols.[40] But this reasoning targets a strawman. It is never good practice to ignore grief and trauma when choosing how to communicate, much less to "dump all details" on patients and their families. More importantly, the term "technique details" fails to accurately describe the morally relevant facts about NRP, which include that it restores circulation in the donor's body, requires active steps to prevent blood flow to the brain, and fails to employ tests to determine whether blood reaches the brain or whether its functions, including perception of pain or minimal consciousness, have been permanently lost.[41]

Hesitation to disclose relevant information is apparent in the euphemistic—and, indeed, obfuscatory—recommendations of the ASTS: "Terminology such as 'reanimation,' 'resuscitation,' and 'ECMO' should be avoided when discussing NRP as these terms do not clearly reflect the process of organ recovery from a donor who has already been declared deceased due to hemodynamic arrest. In lieu, more specific and less emotionally laden terms such as 'in situ tissue perfusion' or 'dynamic in situ organ assessment' should be used."[42] This recommendation presents three problems. First, the meaning of "hemodynamic arrest" does not align with the statutory requirement of permanent cessation of circulatory functions. Second, while a desire to avoid terms such as "reanimation" and "resuscitation" is understandable, avoiding them is problematic precisely because the activities they name are recognizably linked to restoring circulation. Third, clarity is supplanted by Latinate jargon when "ECMO" is omitted in describing the means used and "in situ tissue perfusion" or "dynamic in situ organ assessment" is presented as the end being sought. The ASTS recommendations thus disregard the basic ethical principle of respect for persons, which requires clear and comprehensible communication of the information that would matter to a decision-maker. The information might upset families because they had been told that interventions to restore circulation will be forgone since they would not benefit the patient, yet the families can see that ECMO restores circulation, in violation of the DNAR order that was supposed to allow their loved one a peaceful passing. Withholding the information—and replacing it with

Physicians who recommend not disclosing information about NRP that might alarm or confuse donor families want to avoid choices that fail to maximize benefits to the transplant enterprise.

medical mumbo jumbo—is deceptive. Indeed, the use of euphemisms and jargon to steer families' thinking and to keep them from making what the physician thinks would be the wrong decision resembles medical paternalism, which was an early target of bioethics, except that paternalists hoped to keep patients from making choices that they thought were not in the patients' best interests, while physicians who recommend not disclosing information about NRP that might alarm or confuse donor families want to avoid choices that fail to maximize benefits to the transplant enterprise.

Evaluating Alternatives to NRP

Must such concerns about the legality, ethics, and public acceptance of NRP be swept aside because of the benefits that postmortem perfusion of organs offers for treating more patients awaiting a transplant? Not necessarily, since normothermic machine perfusion (NMP) offers an alternative means of achieving comparable benefits.[43] This machine perfusion is performed on organs removed from deceased donors and thus leaves undisturbed the permanent cessation of circulation in the donor's body.

The technology and techniques of NMP are still evolving but show promise.[44] For example, one multiinstitutional randomized controlled trial had positive outcomes when NMP was used in transplanted hearts. Eighty-nine percent of the DCDD hearts that underwent machine perfusion were transplanted and produced six- and twelve-month patient and graft survival rates that were not inferior to those of the control group, who received hearts from donors declared dead based on neurological criteria,[45] the source that has long been considered the "gold standard" for heart transplants.[46] Another recent study directly compared NRP to NMP in liver transplantation. It found that NMP succeeded 85 percent of the time (34/40), which was 15 percent higher than the 70 percent rate when NRP was used (157/224).[47] TA-NRP facilitates procuring more organs from a donor (specifically, both liver and heart); NMP usually allows for only one or the other, although it may benefit combined heart-liver transplants.[48]

Nonetheless, TA-NRP provides a superior opportunity for functional assessment of hearts in situ and permits the circulation of the body's metabolic substrates, which does not occur with NMP. In sum, while NMP allows for prolonged perfusion after extraction, which can buy extra time for liver graft assessment and repair,[49] its medical benefits may not yet quite equal those of NRP, although they may increase as a result of further research on perfusates and biomarkers.[50]

Proponents of in situ perfusion, particularly those focused on obtaining hearts, argue that, since TA-NRP is less expensive and resource intensive than NMP, it can be adopted faster and more equitably than NMP. The estimated costs of NMP appear to be higher than those of NRP because NMP requires the purchase and maintenance of a purpose-built machine, whereas NRP uses already purchased ECMO machines and NMP relies more on disposable supplies.[51] The argument from material costs is not very compelling, however, since transplant specialists view NMP not as a competing technology but, rather, as a complementary means of oxygenated perfusion that can support and rehabilitate organs regardless of whether procurement involved TA-NRP, A-NRP, or the standard protocol after brain death.[52] Moreover, the added expenses of NMP are only a small fraction of the total cost of a transplant (the average charge for a heart transplant in 2020 was $1,664,800[53]), which is still a cost-effective alternative to paying for ongoing care of patients with organ failure and which also produces substantial social and economic benefits by restoring recipients to productive work and family life, among other benefits.[54]

Nor can one be certain that NRP will bring an overall benefit to DCDD more quickly or extensively than NMP could. TA-NRP may not be widely implemented while research about the extent and effects of brain perfusion under current NRP protocols is being completed,[55] the applicability of homicide laws is being resolved,[56] and the public is being honestly informed about what NRP entails and reaching conclusions about the ethics of the procedure. Although the Organ Procurement and Transplantation Network (OPTN) Ethics Committee "shares the enthusiasm of the transplant community in developing and implementing solutions to improve the transplant system and reduce wait times and deaths for patients awaiting organ transplantation,"[57] it found that NRP raises "serious ethical concerns"[58] and concluded that, "[a]s with all new technologies, consideration for how the technology can be implemented ethically is critical to its widespread adoption and acceptance by the public."[59]

Applying Ethical Parsimony to NRP

The decision to implement an NRP protocol turns on more than whether it is cheaper or more efficient than NMP at improving the quality of deceased-donor organs and even salvaging some that would otherwise be discarded and at extending preservation times, which can facilitate more just and well-ordered allocation of organs. These laudable goals are incomplete unless another is included: acting in a way that is clearly consistent with the law and accepted medical ethics. Those who speak for the ASTS believe that NRP probably meets these goals and recommend that the procedure be incorporated into DCDD, even while its ethicality and legality continue to be explored. They concede, however, that a broad-

er consensus is needed to implement NRP more widely.

Among other things, the OPTN has advised its members that they need to resolve questions about whether NRP adheres to the DDR and whether the risks of nonmaleficence (harm to public trust, distress to clinicians) are adequately minimized.[60] For transplant professionals and programs that are undecided—including those that believe that NRP might be ethically justifiable—a good reason exists *not* to implement NRP, based on a prudential rule, which we term "ethical parsimony," that is derived from Occam's razor. That ancient philosophical precept favors theories that postulate "fewer entities, processes, changes, or explanatory principles"[61] that complicate proving (or disproving) the theory and introduce both potential sources of error and barriers to comprehension. Similarly, ethical parsimony holds that, in the choice between competing means of achieving a result, the ethically simpler one is to be preferred. Ethical parsimony favors policies and actions that depend upon fewer (controversial) justifications, procedural requirements, semantic changes, or subjective judgments about which good outweighs another. The more complex an ethical analysis is, the more vulnerable it is to objection, misinterpretation, and miscommunication. By contrast, the simpler the analysis, the less there is to dispute, distort, or misunderstand. If option A requires a simpler analysis than option B to fit within a widely accepted ethical framework, then A is the better choice.

This kind of prudential reasoning is not without precedent. In 1998, scientists opened up new but controversial avenues for biomedical research and potential therapies when they succeeded in creating embryonic stem cell (ESC) lines from human blastocysts donated from in vitro fertilization clinics.[62] Although the Clinton administration set up a program in 2000 to fund research using human ESCs, the following year, President Bush sparked a heated public debate when he suspended that program. Six years later, the debate cooled when research in somatic cell differentiation produced induced pluripotent stem cells (iPSCs),[63] which could be used in place of ESCs. Although the equivalence of iPSCs to ESCs was initially disputed,[64] researchers largely agreed that the ethical concerns surrounding ESC could be circumvented because iPSCs offered comparable benefits without destruction of human embryos. Therefore, special legislation was not required to authorize federal funding for the creation of iPSCs, nor did researchers need to obtain parental consent for embryo use and gamete donation to create new cell lines.[65] None of this is to say that the use of human embryos could not be justified. The point is that the ability to conduct studies with iPSCs obviated the need for ESCs and thereby avoided the ethical controversies and complex arguments that were invoked to justify using ESCs. The human stem cell research saga thus confirms the value of ethical parsimony: if goals can reasonably be achieved by an option that is simple and uncontroversial, then, as a matter of prudence, one should choose it over other options that require complex or convoluted justifications and generate strong disagreement.

Applying this prudential approach to the procurement of DCDD organs clearly means implementing NMP over NRP. No linguistic hoops need to be jumped through to align NMP with the DDR or the statutory standards for determining death. No ad hoc process of tendentiously rewriting the statutory requirements for determining death need occur. No investigation need be undertaken into whether patients and their family members want euphemisms and evasions rather than clear explanations about what procedures will be performed after death is declared and what effects they will produce.

Indeed, some NRP proponents understand this and have recommended the following: "[NMP] is less ethically complex than NRP, so its use is encouraged as the primary method for heart procurement in [DCDD]."[66] We concur with this recommendation and hope that its implication—that prudence favors the simpler, less contentious course—is recognized by every institution deciding whether to employ NRP.

No linguistic hoops need to be jumped through to align NMP with the dead donor rule or the statutory standards for determining death.

Ethical parsimony may even favor continuing with static cold storage, the current method of preserving organs for transplantation, if an institution cannot yet provide NMP for DCDD organs. While static cold storage may not increase the number of organs for transplant as efficiently as NRP does, it does not risk decreasing donations should NRP create public mistrust as a departure from the DDR and a risk to donor safety. In contrast, static cold storage clearly complies with the legal standard for circulatory determination of death and the ethical standards regarding disclosure and permission for deceased organ donation. Nonetheless, when NMP is available, it should be favored over static cold storage because it improves the number of transplantable organs, reduces waste, and extends the period available for orderly allocation and distribution of organs while also being fully consistent with existing law and generally accepted medical ethics.

The Wise Choice: NMP, not NRP

There are good reasons to reject NRP, as it fails to satisfy legal standards, comply with the dead donor rule, and inspire confidence in the disclosure process with donors and their decision-makers. Even those who hold the opposing view recognize that the use of NRP does not enjoy anything close to a consensus in the medical profession. Unless the law changes, informed consent processes are implemented, and the public comes to accept NRP, DCDD programs seeking to increase the benefits of postmortem organ perfusion should adopt NMP and forgo NRP.

Programs using NMP have demonstrated that it increases the number and quality of organs procured from DCDD donors while also respecting core ethical principles of clinical care, including physicians' obligation to fully inform patients and their authorized decision-makers about what they propose to do, and honoring the letter and spirit of the law, as encapsulated in the DDR. Ethics committees at hospitals and transplant programs that view NRP through the lens of ethical parsimony will see how imprudent it would be to approve an ethically contested method of organ procurement when NMP can produce comparable results without the logical and linguistic complexity entailed in arguments for NRP and the ethical and legal controversies that it raises, all of which endanger public trust in organ donation.

Disclosure

Lainie Friedman Ross participated in writing the statement from the OPTN Ethics Committee.

Acknowledgment

We are grateful for the feedback given on an earlier draft of this paper by the faculty of the Center for Medical Ethics and Health Policy at Baylor College of Medicine.

Notes

1. M. A. DeVita and J. V. Snyder, "Development of the University of Pittsburgh Medical Center Policy for the Care of Terminally Ill Patients Who May Become Organ Donors after Death following the Removal of Life Support," *Kennedy Institute of Ethics Journal* 3, no. 2 (1993): 131-43.

2. J. Lynn, "Are the Patients Who Become Organ Donors under the Pittsburgh Protocol for 'Non-Heart-Beating Donors' Really Dead?," *Kennedy Institute of Ethics Journal* 3, no. 2 (1993): 167-78; A. L. Dalle Ave, D. P. Sulmasy, and J. L. Bernat, "The Ethical Obligation of the Dead Donor Rule," *Medicine, Health Care, and Philosophy* 23, no. 1 (2020): 43-50.

3. "Donation after circulatory determination of death" is sometimes abbreviated as "DCD," which is confusing because "DCD" was previously used for "donation after cardiac death" and "donation after circulatory death" and because those phrases suggest that the absence of cardiac activity or circulatory and respiratory functions is "death" rather than the means by which death is determined. When the withdrawal of life-sustaining treatment is planned, the procedure is called "controlled DCDD"; the "uncontrolled" version, which is practiced in about half of the countries in Europe but not in the United States, involves donors who experienced a sudden cardiopulmonary arrest in or outside a hospital when either they could not be resuscitated or no attempt to resuscitate them was made.

4. J. L. Bernat et al., "The Circulatory-Respiratory Determination of Death in Organ Donation," *Critical Care Medicine* 38, no. 3 (2010): 963-70.

5. "Deceased Donors Recovered in the U.S. by Circumstance of Death, National Data: January 1, 1988-December 31, 2023," U.S. Department of Health and Human Services, Health Resources and Service Administration, Organ Procurement and Transplantation Network, at https://optn.transplant.hrsa.gov/data/view-data-reports/national-data/#. To reach the results reported in our text, first, choose the category "Donor" and choose "All Organs." Then, choose this report: *All Donors by Donor Type*. After the screen changes, select "Add field to report: Donation after Circulatory Death (DCD)." The results displayed for 2023 were 10,442 in what the OPTN terms the "Brain Death Donor" category and 5894 in the "DCD Donor" category.

6. L. Jing et al., "Organ Preservation: From the Past to the Future," *Acta Pharmacologica Sinica* 39, no. 5 (2018): 845-57.

7. B. Domínguez-Gil et al., "Expanding Controlled Donation after the Circulatory Determination of Death: Statement from an International Collaborative," *Intensive Care Medicine* 47, no. 3 (2021): 265-81.

8. A. S. Shah, "Normothermic Regional Perfusion in Donor Heart Recovery: Establishing a New Normal," *Journal of Thoracic and Cardiovascular Surgery* 164, no. 1 (2022): 142-46; J. Couzin-Frankel, "Giving Heart," *Science* 380 (2023): 572-76.

9. L. B. Johnson et al., "Successful Emergency Transplantation of a Liver Allograft from a Donor Maintained on Extracorporeal Membrane Oxygenation," *Transplantation* 63, no. 6 (1997): 910-11; G. C. Oniscu et al., "In Situ Normothermic Regional Perfusion for Controlled Donation after Circulatory Death—the United Kingdom Experience," *American Journal of Transplantation* 14 (2014): 2846-54; C. Fondevila et al., "Liver Transplant Using Donors after Unexpected Cardiac Death: Novel Preservation Protocol and Acceptance Criteria," *American Journal of Transplantation* 9, no. 7 (2007): 1849-55.

10. American College of Physicians, "Ethics, Determination of Death, and Organ Transplantation in Normothermic Regional Perfusion (NRP) with Controlled Donation after Circulatory Determination of Death (cDCD): American College of Physicians Statement of Concern," April 17, 2021, https://www.acponline.org/sites/default/files/documents/clinical_information/resources/end_of_life_care/ethics_determination_of_death_and_organ_transplantation_in_nrp_2021.pdf, p. 4.

11. M. DeCamp, L. S. Sulmasy, and J. J. Fins, "POINT: Does Normothermic Regional Perfusion Violate the Ethical Principles Underlying Organ Procurement? Yes," *Chest* 162, no. 2 (2022): 288-90; A. K. Glazier and A. M. Capron, "Normothermic Regional Perfusion and US Legal Standards for Determining Death Are Not Aligned," *American Journal of Transplantation* 22 (2022): 1289-90; H. Peled et al., "Normothermic Regional Perfusion Requires Careful Ethical Analysis before Adoption into Donation after Circulatory Determination of Death," *Critical Care Medicine* 50 (2022): 1644-48.

12. E. Alamouti-fard et al., "Normothermic Regional Perfusion Is an Emerging Cost-Effective Alternative in Donation after Circulatory Death (DCD) in Heart Transplantation," *Cureus* 14, no. 6 (2022) doi:10.7759/cureus.26437; B. Parent et al., "Ethical and Logistical Concerns for Establishing NRP-cDCD Heart Transplantation in the United States," *American Journal of Transplantation* 20, no. 6 (2020): 1508-12; J. Basmaji et al., "Paving the Road for the Adoption of Normothermic Regional Perfusion in Canada," *Critical Care Explorations* 3, no. 11 (2021): doi:10.1097/CCE.0000000000000553.

13. B. L. Adams et al., "cDCDD-NRP Is Consistent with US Legal Standards for Determining Death," *American Journal of Transplantation* 22, no. 10 (2022): 2302-5; A. E. Wall et al., "Applying the Ethical Framework for Donation after Circulatory Death to Thoracic Normothermic Regional Perfusion Procedures," *American Journal of Transplantation* 22, no. 5 (2022): 1311-15; B. Parent et al., "Response to American College of Physician's Statement on the Ethics of Transplant after Normothermic Regional Perfusion," *American Journal of Transplantation* 22, no. 5 (2022): 1307-10.

14. A. Manara et al., "Maintaining the Permanence Principle for Death during In Situ Normothermic Regional Perfusion for Donation after Circulatory Death Organ Recovery: A United Kingdom and Canadian Proposal," *American Journal of Transplantation* 20, no. 8 (2020): 2017-25.

15. R. Choi, M. Tuppeny, and A. Reynolds, "The Ethical Conundrums of Normothermic Regional Perfusion," *Currents*, June 14, 2023, https://currents.neurocriticalcare.org/Leading-Insights/Article/the-ethical-conundrums-of-normothermic-regional-perfusion; S. Hughes, "Does New Heart Transplant Method Challenge Definition of Death?," *Medscape*, March 23, 2023, https://www.medscape.com/viewarticle/989937; J. L. Bernat et al., "Understanding the Brain-Based Determination of Death When Organ Recovery Is Performed with DCDD In Situ Normothermic Regional Perfusion," *Transplantation* 107, no. 8 (2023): 1650-54.

16. A. E. Wall et al., "The American Society of Transplant Surgeons Consensus Statement on Normothermic Regional Perfusion," *Transplantation* 108, no. 2 (2024): 312-18, at 316.

17. Ibid., 317.

18. Ibid., 317.

19. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Defining Death: Medical, Legal and Ethical Issues in the Determination of Death* (Washington, D.C.: U.S. Government Printing Office, 1981), 2.

20. H. C. M. A. Black, ed., *Black's Law Dictionary*, 4th ed. (St. Paul, MN: West Publishing Company, 1968), 488.

21. "Guidelines for the Determination of Death: Report of the Medical Consultants on the Diagnosis of Death to the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research," *Journal of the American Medical Association* 246 (1981): 2184-86, at 2185. The report was also included as appendix F, "Guidelines for the Determination of Death" (pp. 159-66), in the President's Commission's *Defining Death*.

22. Bernat et al., "The Circulatory-Respiratory Determination of Death in Organ Donation"; J. L. Bernat, "How the Distinction between 'Irreversible' and 'Permanent' Illuminates Circulatory-Respiratory Death Determination," *Journal of Medicine and Philosophy* 35, no. 3 (2010): 242-55.

23. Basmaji et al., "Paving the Road for the Adoption of Normothermic Regional Perfusion in Canada."

24. Ibid.; Y. Joshi et al., "Donation after Circulatory Death: A New Frontier," *Current Cardiology Reports* 24, no. 12 (2022): 1973-81; DeCamp, Sulmasy, and Fins, "POINT," 288-89.

25. Adams et al., "cDCDD-NRP Is Consistent with US Legal Standards for Determining Death," 2303.

26. Wall et al., "Applying the Ethical Framework for Donation after Circulatory Death to Thoracic Normothermic Regional Perfusion Procedures," 1314.

27. Parent et al., "Response to American College of Physician's Statement," 1308.

28. Ibid., 1308.

29. Glazier and Capron, "Normothermic Regional Perfusion and US Legal Standards for Determining Death Are Not Aligned."

30. Adams et al., "cDCDD-NRP Is Consistent with US Legal Standards for Determining Death," 2303.

31. Basmaji et al., "Paving the Road for the Adoption of Normothermic Regional Perfusion in Canada," 2.

32. Adams et al., "cDCDD-NRP Is Consistent with US Legal Standards for Determining Death."

33. Ibid.

34. R. D. Truog, A. Flescher, and K. Ladin, "Normothermic Regional Perfusion—the Next Frontier in Organ Transplants?," *Journal of the American Medical Association* 329 (2023): 2123-24.

35. J. DuBois and E. Anderson, "Attitudes toward Death Criteria and Organ Donation among Healthcare Personnel and the General Public," *Progress in Transplantation* 16, no. 1 (2006): 65-73; I. Neiders and V. Dranseika, "Minds, Brains, and Hearts: An Empirical Study on Pluralism Concerning Death Determination," *Monash Bioethics Review* 38, no. 1 (2020): 35-48.

36. K. Zheng et al., "Public Understandings of the Definition and Determination of Death: A Scoping Review," *Transplantation Direct* 8, no. 5 (2022): doi:10.1097/TXD.0000000000001300; D. A. Shewmon, "Statement in Support of Revising the Uniform Determination of Death Act and in Opposition to a Proposed Revision," *Journal of Medicine and Philosophy* 48, no. 5 (2023), 453-77.

37. N. B. Murphy et al., "Rationale for Revisions to the Definition of Death and Criteria for Its Determination in Canada," *Canadian Journal of Anaesthesia* 70, no. 4 (2023): 558-69.

38. Bernat et al., "Understanding the Brain-Based Determination of Death When Organ Recovery Is Performed with DCDD In Situ Normothermic Regional Perfusion."

39. National Conference of Commissioners on Uniform State Laws, *Revised Uniform Anatomical Gift Act (2006) (Last Revised or Amended in 2009)* (Chicago: National Conference of Commissioners on Uniform State Laws, 2009).

40. B. Parent et al., "Regarding Normothermic Regional Perfusion: Arguing by Insistence Is Not a Strong Argument," *American Journal of Transplantation* 22, no. 6 (2022): 1729-30, at 1729.

41. Some proponents of not sharing information with surrogates about NRP surgical techniques claim that postmortem authorization for transplantation carries a less demanding standard for information sharing than that required for informed consent in cases involving a living patient. Assuming arguendo that a lower postmortem standard exists, since questions remain about whether donors whose circulation has been reestablished are dead, it would be prudent not to rely on a postmortem standard for information disclosure.

42. K. P. Croome et al., "American Society of Transplant Surgeons Recommendations on Best Practices in Donation after Circulatory Death Organ Procurement," *American Journal of Transplantation* 23, no. 2 (2023): 171-79, at 173.

43. This is sometimes referred to as "direct procurement and perfusion."

44. S. López-Martínez, C. Simón, and X. Santamaria, "Normothermic Machine Perfusion Systems: Where Do We Go From Here?," *Transplantation* 108, no. 1 (2024): 22-44.

45. J. N. Schroder et al., "Expanding Heart Transplants from Donors after Circulatory Death (DCD)—Results of the First Randomized Controlled Trial Using the Organ Care System (OCS™) Heart—(OCS DCD Heart Trial)," *Journal of Heart and Lung Transplantation* 41, no. 4 (2022): S72; J. N. Schroder et al., "Transplantation Outcomes with Donor Hearts after Circulatory Death," *New England Journal of Medicine* 388, no. 23 (2023): 2121-31; N. K. Sweitzer, "Safely Increasing Heart Transplantation with Donation after Cardiac Death," *New England Journal of Medicine* 388, no. 23 (2023): 2191-92.

46. A. Page, S. Messer, and S. R. Large, "Heart Transplantation from Donation after Circulatory Determined Death," *Annals of Cardiothoracic Surgery* 7, no. 1 (2018): 75-81, at 75.

47. K. Mohkam et al., "In Situ Normothermic Regional Perfusion versus Ex Situ Normothermic Machine Perfusion in Liver Transplantation from

Donation after Circulatory Death," *Liver Transplantation* 28, no. 11 (2022): 1716-25.

48. S. P. Alexopoulos et al., "Adult Combined Heart-Liver Transplantation: The United States Experience," *Transplant International* 35 (2022): doi:10.3389/ti.2021.10036.

49. P. C. Groen, J. de Jonge, and R. J. Porte, "Prolonged Normothermic Machine Perfusion: Buying More Time for Liver Graft Assessment and Repair," *Transplantation* 107, no. 6 (2023): 1221-22.

50. D. Andrijevic et al., "Cellular Recovery after Prolonged Warm Ischaemia of the Whole Body," *Nature* 608 (2022): 405-12; M. Bona et al., "Cardiac Graft Assessment in the Era of Machine Perfusion: Current and Future Biomarkers," *Journal of the American Heart Association* 10, no. 4 (2021): doi:10.1161/JAHA.120.018966.

51. A. F. Sunjaya and A. P. Sunjaya, "Combating Donor Organ Shortage: Organ Care System Prolonging Organ Storage Time and Improving the Outcome of Heart Transplantations," *Cardiovascular Therapeutics* (2019): doi:10.1155/2019/9482797.

52. A. Page, S. Messer, and S. R. Large, "Heart Transplantation from Donation after Circulatory Determined Death," *Annals of Cardiothoracic Surgery* 7, no. 1 (2018): 75-81; D. Ghinolfi et al., "Sequential Use of Normothermic Regional and Ex Situ Machine Perfusion in Donation after Circulatory Death Liver Transplant," *Liver Transplantation* 27, no. 3 (2021): 385-402; J. E. Villanueva et al., "Expanding Donor Heart Utilization through Machine Perfusion Technologies," *Current Transplantation Reports* 9, no. 4 (2022): 219-26; J. Stehlik et al., "(620) First Report of the Transmedics Organ Care System Heart Perfusion Registry. A Multi-Institutional Outcomes Analysis," *Journal of Heart and Lung Transplantation* 42, no. 4 (2023): S277-78. We thank the anonymous reviewer who drew our attention to the point about NMP being a complementary, rather than solely a competing, technology.

53. D. O'Carroll, "What to Know about Heart Transplants," *Medical News Today*, August 31, 2022, https://www.medicalnewstoday.com/articles/heart-transplant-cost.

54. P. N. Martins and W. W. Williams, "To Cool or Not to Cool—Organ-Preservation Strategies in Transplantation," *New England Journal of Medicine* 388, no. 5 (2023): 468-69.

55. Bernat et al., "Understanding the Brain-Based Determination of Death When Organ Recovery Is Performed with DCDD In Situ Normothermic Regional Perfusion."

56. It seems unlikely that physicians' potential criminal or civil liability for performing NRP will be eliminated through a modification of the UDDA, since the committee appointed in 2021 by the Uniform Law Commission to revise that act was unable to reach a consensus on any points and suspended its work in September 2023. R. D. Truog and D. C. Magnus, "The Unsuccessful Effort to Revise the Uniform Determination of Death Act," *Journal of the American Medical Association* 330, no. 24 (2023): 2335-36.

57. OPTN Ethics Committee, "Ethical Analysis of Normothermic Regional Perfusion," UNOS Policy Department, 2023, https://optn.transplant.hrsa.gov/media/mq2m43uf/20240123-ethics_nrp_wp_final.pdf, p. 25.

58. Ibid., 25.

59. Ibid., 25.

60. Ibid., 25.

61. E. Sober, "Simplicity," in *A Companion to Epistemology*, ed. J. Dancy and E. Sosa (Malden, MA: Blackwell Publishers, 1992), 477-78, at 477.

62. J. A. Thomson et al., "Embryonic Stem Cell Lines Derived from Human Blastocysts," *Science* 282 (1998): 1145-47.

63. K. Takahashi et al., "Induction of Pluripotent Stem Cells from Adult Human Fibroblasts by Defined Factors," *Cell* 131, no. 5 (2007): 861-72.

64. D. A. Robinton and G. Q. Daley, "The Promise of Induced Pluripotent Stem Cells in Research and Therapy," *Nature* 481 (2012): 295-305.

65. H. M. Blau and G. Q. Daley, "Stem Cells in the Treatment of Disease," *New England Journal of Medicine* 380 (2019): 1748-60; D. Goldenberg et al., "Regenerative Engineering: Current Applications and Future Perspectives," *Frontiers in Surgery* 8 (2021): doi:10.3389/fsurg.2021.731031.

66. J. W. Entwistle et al., "Normothermic Regional Perfusion: Ethical Issues in Thoracic Organ Donation," *Journal of Thoracic and Cardiovascular Surgery* 164, no. 1 (2022): 147-54, at 153.

REPORT ON EXAMINATION
OF THE

CENTER FOR PRACTICAL BIOETHICS, INC.
KANSAS CITY, MISSOURI

AS OF AND FOR THE YEAR ENDED DECEMBER 31, 2012

TABLE OF CONTENTS

SUITE 900
1111 MAIN STREET
KANSAS CITY, MO 64105
TELEPHONE: (816) 221-4569
FACSIMILE: (816) 221-4563
EMAIL: ADMIN@MCBRIDELOCK.COM
CERTIFIED PUBLIC ACCOUNTANTS

McBRIDE, LOCK & ASSOCIATES

INDEPENDENT AUDITORS' REPORT

To the Board of Directors of the
Center for Practical Bioethics, Inc.

We have audited the accompanying financial statements of the Center for Practical Bioethics, Inc. (a nonprofit organization), which comprise the statement of financial position as of December 31, 2012, and the related statements of activities, functional expenses, and cash flows for the year then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Center for Practical Bioethics, Inc. as of December 31, 2012, and the changes in its net assets and its cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Summarized Comparative Information

We have previously audited the Center for Practical Bioethics, Inc. 2011 financial statements, and our report dated July 11, 2012, expressed an unmodified opinion on those audited financial statements. In our opinion, the summarized comparative information presented herein as of and for the year ended December 31, 2011, is consistent, in all material respects, with the audited financial statements from which it has been derived.

McBride, Lock & Associates
Kansas City, Missouri
May 21, 2013

Center For Practical Bioethics, Inc.
STATEMENT OF FINANCIAL POSITION
December 31, 2012

Assets	Unrestricted	Temporarily Restricted	Permanently Restricted	Total 2012	Total 2011 (Restated)
CURRENT ASSETS					
Cash and Cash Equivalents	$ (38,765)	$ 295,342	$ -	$ 256,577	$ 576,391
Accounts Receivable	12,927	-	-	12,927	3,376
Grants Receivable	-	25,000	-	25,000	1,000
Pledge Receivable (NOTE 2)	6,000	60,187	6,500	72,687	36,000
Prepaid Expenses	19,875	-	-	19,875	19,072
Total Current Assets	$ 37	$ 380,529	$ 6,500	$ 387,066	$ 635,839
PROPERTY AND EQUIPMENT					
Furniture and Equipment	$ 16,176	$ -	$ -	$ 16,176	$ 16,176
Computer Hardware and Software	14,420	-	-	14,420	14,420
Leasehold Improvements	1,965	-	-	1,965	1,965
Accumulated Depreciation and Amortization	(32,561)	-	-	(32,561)	(32,340)
Total Property and Equipment	$ -	$ -	$ -	$ -	$ 221
OTHER ASSETS					
Investments - Restricted (NOTE 3)	$ -	$ -	$ 3,595,669	$ 3,595,669	$ 3,382,837
Interfund Receivable (NOTE 10)	-	-	293,000	293,000	293,000
Pledges Receivable (NOTE 2)	9,000	-	3,132	12,132	7,633
Deferred Compensation	114,309	-	-	114,309	94,117
Total Other Assets	$ 123,309	$ -	$ 3,891,801	$ 4,015,110	$ 3,777,587
TOTAL ASSETS	$ 123,346	$ 380,529	$ 3,898,301	$ 4,402,176	$ 4,413,647
Liabilities					
CURRENT LIABILITIES					
Accounts Payable	$ 27,152	$ -	$ -	$ 27,152	$ 14,905
Accrued Expenses	51,810	-	-	51,810	33,740
Interfund Payable (NOTE 10)	293,000	-	-	293,000	293,000
Line of Credit (NOTE 11)	55,000	-	-	55,000	-
Deferred Revenue	50,762	-	-	50,762	24,050
Total Current Liabilities	$ 477,724	$ -	$ -	$ 477,724	$ 365,695
LONG-TERM LIABILITIES					
457(b) Deferred Compensation Liability	$ 113,251	$ -	$ -	$ 113,251	$ 90,282
Total Liabilities	$ 590,975	$ -	$ -	$ 590,975	$ 455,977
Net Assets					
Unrestricted					
Operating	$ (554,867)	$ -	$ -	$ (554,867)	$ (314,014)
Board Designated (NOTE 9)	87,238	-	-	87,238	87,238
Total Unrestricted	$ (467,629)	$ -	$ -	$ (467,629)	$ (226,776)
Temporarily Restricted (NOTE 8)	$ -	$ 380,529	$ -	$ 380,529	$ 459,324
Permanently Restricted (NOTE 6)	-	-	3,898,301	3,898,301	3,725,122
Total Net Assets	$ (467,629)	$ 380,529	$ 3,898,301	$ 3,811,201	$ 3,957,670
TOTAL LIABILITIES & NET ASSETS	$ 123,346	$ 380,529	$ 3,898,301	$ 4,402,176	$ 4,413,647

The accompanying notes to the financial statements are an integral part of this statement.

Exhibit B

Center For Practical Bioethics, Inc.
STATEMENT OF ACTIVITIES
For the Year Ended December 31, 2012

Revenue	Unrestricted	Temporarily Restricted	Permanently Restricted	Total 2012	Total 2011
Contributions, grants, and other support	$ 435,588	$ 187,517	$ 2,074	$ 625,179	$ 1,164,332
Fundraising	281,423	85,187	-	366,610	314,804
Membership Dues	120,390	-	-	120,390	119,743
Communications	6,041	-	-	6,041	4,071
Investment Income	2,375	-	114,538	116,913	99,234
Other Income	7,084	-	-	7,084	1,292
Net assets released from restrictions	539,829	(351,499)	(188,330)	-	-
Total Revenue	$ 1,392,730	$ (78,795)	$ (71,718)	$ 1,242,217	$ 1,703,476
Expenses					
Program expenses					
Education and Consulting	$ 1,216,764	$ -	$ -	$ 1,216,764	$ 1,416,365
Support services expenses					
Management and general	$ 235,595	$ -	$ -	$ 235,595	$ 221,356
Fundraising	177,175	-	-	177,175	195,999
Total support services expenses	$ 412,770	$ -	$ -	$ 412,770	$ 417,355
Total Expenses	$ 1,629,534	$ -	$ -	$ 1,629,534	$ 1,833,720
Change in Net Assets from Operations	$ (236,804)	$ (78,795)	$ (71,718)	$ (387,317)	$ (130,244)
Other Revenue (Expense):					
Realized Investment Gains (Losses)	$ 238	$ -	$ 78,704	$ 78,942	$ 108,292
Unrealized Investment Gains (Losses)	5,414	-	189,688	195,102	(176,908)
Interest Expense	(9,681)	-	-	(9,681)	(9,954)
Investment Expense	(20)	-	(23,495)	(23,515)	(23,311)
Total Other Revenue (Expenses)	$ (4,049)	$ -	$ 244,897	$ 240,848	$ (101,881)
Change in Net Assets	$ (240,853)	$ (78,795)	$ 173,179	$ (146,469)	$ (232,125)
Net Assets, beginning of the year (NOTE 9)	(226,776)	459,324	3,725,122	3,957,670	4,189,795
Net Assets, end of year	$ (467,629)	$ 380,529	$ 3,898,301	$ 3,811,201	$ 3,957,670

The accompanying notes to the financial statements are an integral part of this statement.

Center For Practical Bioethics, Inc.
STATEMENT OF FUNCTIONAL EXPENSES
For the Year Ended December 31, 2012

	Program Services	Support Services		Total	
	Education and Consulting	Management and General	Fundraising	2012	2011
Personnel Expenses					
Salaries & Wages - Management	$ 272,659	$ 52,631	$ 92,274	$ 417,564	$ 335,318
Salaries & Wages - Other	272,685	98,132	15,554	386,371	593,412
Health Insurance	76,650	21,190	15,156	112,996	106,791
Payroll Taxes	39,684	10,971	7,846	58,501	63,870
Retirement Expense	12,862	3,556	2,543	18,961	16,997
Deferred Comp Plan Expense	15,581	4,308	3,081	22,970	14,943
Health Reimbursement Acct	1,581	437	312	2,330	-
Disability Expense	(220)	(61)	(44)	(325)	1,559
Paid Time Off Liability Expense	7,095	1,982	1,357	10,434	-
Workers Compensation	1,932	534	382	2,848	3,750
Key-man Insurance	3,353	-	838	4,191	4,191
Payroll Processing Fees	1,137	314	225	1,676	2,041
Employment Development	271	75	54	400	196
Search Expense	9,768	2,700	1,931	14,399	18,026
Other Employee Expense	-	-	-	-	296
Total Personnel Expenses	$ 715,038	$ 196,769	$ 141,509	$ 1,053,316	$ 1,161,390
Occupancy Expenses					
Rent	$ 52,995	$ 6,624	$ 6,624	$ 66,243	$ 64,342
Parking	1,228	153	153	1,534	1,817
Insurance-Property & Casualty	2,635	728	521	3,884	3,705
Other Occupancy Expense	1,298	162	162	1,622	2,486
Total Occupancy Expenses	$ 58,156	$ 7,667	$ 7,460	$ 73,283	$ 72,350
Operating Expenses					
Consulting Fees	$ 153,547	$ -	$ -	$ 153,547	$ 284,954
Audit Fees	6,241	1,725	1,234	9,200	9,000
Professional/Filing Fees	21,908	2,739	2,739	27,386	6,279
Community Relations	2,293	634	453	3,380	349
Bank/Credit Card Charges	2,668	334	334	3,336	6,505
Finance/Late Charges	-	-	-	-	25
Office Expense & Supplies	5,368	1,484	1,059	7,911	17,316
Printing Expense	97,900	3,940	6,938	108,778	50,972
Books & Subscriptions	11,588	-	-	11,588	162
Dues & Memberships	1,095	130	93	1,318	945
Postage & Shipping Exp	3,915	791	670	5,376	6,972
Telephone Expense	7,597	2,100	1,502	11,199	11,883
Equipment Lease Expense	12,902	717	717	14,336	14,125
Equipment Maintenance	2,011	112	112	2,235	3,497
Equipment-Computer Expense	3,790	211	211	4,212	6,268
Insurance - D&O Liability	1,560	432	309	2,301	2,244
Insurance - Professional Liability	3,621	1,002	717	5,340	5,340
Conference/Mtg Expense	76,066	12,329	8,936	97,331	113,880
Travel Expense	28,573	2,223	1,998	32,794	31,794
Depreciation Expense	150	41	30	221	710
Bad Debt Expense	-	-	-	-	9,750
Other Operating Expense	777	215	154	1,146	17,010
Total Operating Expenses	$ 443,570	$ 31,159	$ 28,206	$ 502,935	$ 599,980
Total Program and Support Expenses	$ 1,216,764	$ 235,595	$ 177,175	$ 1,629,534	$ 1,833,720

The accompanying notes to the financial statements are an integral part of this statement.

Center For Practical Bioethics, Inc.
STATEMENT OF CASH FLOWS
For the Year Ended December 31, 2012

	2012	2011 (Restated)
CASH FLOWS FROM OPERATING ACTIVITIES		
Change in net assets	$ (146,469)	$ (232,125)
Adjustments to reconcile change in net assets to net cash provided by (used in) operating activities:		
Bad Debt Expense	-	9,750
Depreciation and Amortization	221	710
Permanently restricted contributions	(2,311)	(1,525)
Changes in operating assets and liabilities:		
Accounts Receivable	(9,551)	38,207
Grants Receivable	(24,000)	176,548
Pledges Receivable	(41,186)	924,375
Prepaid Expenses	(803)	(13,430)
Deferred Compensation	(20,192)	(15,072)
Accounts Payable	12,247	(10,455)
Accrued Expenses	18,070	(17,893)
Deferred Revenue	26,712	6,050
Accrued Deferred Compensation	22,969	14,943
NET CASH PROVIDED BY (USED IN) OPERATING ACTIVITIES	$ (164,293)	$ 880,083
CASH FLOWS FROM INVESTING ACTIVITIES		
Net Purchases of Investments	$ (212,832)	$ (747,457)
CASH FLOWS FROM FINANCING ACTIVITIES		
Proceeds from Permanently Restricted Contributions	$ 2,311	$ 1,525
Line of Credit	55,000	-
NET CASH PROVIDED BY FINANCING ACTIVITIES	$ 57,311	$ 1,525
NET INCREASE (DECREASE) IN CASH	$ (319,814)	$ 134,151
CASH AND CASH EQUIVALENTS, BEGINNING OF YEAR	576,391	442,240
CASH AND CASH EQUIVALENTS, END OF YEAR	$ 256,577	$ 576,391
SUPPLEMENTAL DISCLOSURES		
Cash Paid For Interest	$ 9,681	$ 9,954

The accompanying notes to the financial statements are an integral part of this statement.

CENTER FOR PRACTICAL BIOETHICS, INC.
NOTES TO THE FINANCIAL STATEMENTS
December 31, 2012

NOTE 1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Nature of Activities

The Center for Practical Bioethics, Inc., (the "Center") was incorporated in July 1984 as a Kansas not-for-profit corporation. The Center exists to raise and respond to ethical issues in health and healthcare to help patients, families, and health care providers find practical solutions to ethical problems. The guiding principles of the Center are as follows:

- To be unfettered by special interests
- To listen actively, think critically, and act wisely
- To lead and promote the leadership of others
- To collaborate with those who commit to civil discourse
- To work diligently toward our mission

Net Assets

The Center reports information regarding its financial position and activities according to three classes of net assets: unrestricted net assets, temporarily restricted net assets, and permanently restricted net assets.

Unrestricted – The portion of expendable funds that is available for support of the Center's operations. Additionally, the Center's Board has designated certain funds that have been donated in honor or memory of an individual.

Temporarily restricted and permanently restricted – Funds that are subject to donor restrictions. These funds require either that the principal be invested in perpetuity or the income only be used by the Center or are temporarily restricted by the donor's intent as to usage.

Revenue Recognition

Contributions – Pledges are recorded as unrestricted, temporarily restricted, or permanently restricted support in the period in which they are pledged.

Fundraising – Sponsorships and attendance fees received are recorded in the period in which the event occurs.

Memberships revenue – Annual dues are assessed yearly based on the organizational or individual member's anniversary date and are considered earned when received.

Accounts, Grants, and Pledges Receivable

The majority of the Center's receivables are due from revenues earned from consulting agreements and from contributions. Receivables are due at the donor's discretion. Accounts outstanding beyond the donor agreement are considered past due. The Center writes off

receivables when they become uncollectible. No allowance for doubtful accounts was considered necessary at December 31, 2012.

Investments

Investments are stated at fair value based on quoted market prices, with unrealized gains and losses included in the accompanying statements of activities.

Property and Equipment

The Center capitalizes all acquisitions of property and equipment in excess of $1,000, which are recorded at cost, or fair value if donated. Property and equipment are depreciated using the straight-line method over the estimated useful life of the assets.

Income Taxes

The Center is exempt from income taxes under the provisions of Section 501(c)(3) of the Internal Revenue Code.

Cash Equivalents

The Center considers unrestricted cash, money market accounts, and highly liquid investments purchased with maturities of less than three months to be a cash equivalent.

Expense Allocation

The costs of providing various programs and other activities have been summarized on a functional basis. Accordingly, certain costs have been allocated among the programs and services benefited. The allocation rate corresponds to the functional allocation of salaries and wages.

Advertising

Advertising costs are expensed as incurred.

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles in the United States of America requires management to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results could differ from those estimates.

NOTE 2 – PLEDGES RECEIVABLE

Pledges receivable represent donors' promises to pay contributions to the Center and are measured at the present value of estimated future cash flows using a discount rate of 3.3 percent. Collection of receivables at December 31, 2012 is expected as follows:

Due in less than one year	$	72,687
Due in one to five years		12,500
Total Pledges Receivable		85,187
Less Discount to Present Value		(368)
Net Pledges Receivable	$	84,819

NOTE 3 – INVESTMENTS

Investments consisted of the following as of December 31, 2012:

Money Market Funds	$	171,489
Equities		2,237,179
Fixed Income		1,115,874
Exchange Traded Funds		71,127
Total Investments	$	3,595,669

NOTE 4 – FAIR VALUE MEASUREMENTS

Generally accepted accounting principles establish a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. This hierarchy consists of three broad levels: Level 1 inputs consist of unadjusted quoted prices in active markets for identical assets and have the highest priority, Level 2 inputs consist of observable inputs other than quoted prices for identical assets, and Level 3 inputs have the lowest priority. The Center chooses its valuation techniques based on the available inputs to measure the fair value of its investments. When available, the Center measures fair value using Level 1 inputs because they generally provide the most reliable evidence of fair value. Level 3 inputs are only used when Level 1 or Level 2 inputs are not available.

The following table presents the assets and liabilities recognized in the accompanying statement of financial position that are measured at fair value on a recurring basis and the level within the fair value hierarchy in which those fair value measurements fall at December 31, 2012:

	Fair Value December 31	Level 1	Level 2	Level 3
Assets:				
Investments				
Money Market Funds	$ 171,489	$ 171,489	$ -	$ -
Equities	2,237,179	2,237,179	-	-
Fixed Income	1,115,874	1,115,874	-	-
Exchange Traded Funds	71,127	71,127	-	-
Total Investments	$ 3,595,669	$ 3,595,669	$ -	$ -
Deferred Compensation				
Money Market Funds	$ 37,920	$ 37,920	$ -	$ -
Mutual Funds	75,331	75,331	-	-
Fixed Income	1,058	1,058	-	-
Total Deferred Compensation	$ 114,309	$ 114,309	$ -	$ -
Liabilities:				
Line of Credit	$ 55,000	$ 55,000	$ -	$ -
Deferred Compensation				
Money Market Funds	37,920	37,920	-	-
Mutual Funds	75,331	75,331	-	-
Total Deferred Compensation	$ 113,251	$ 113,251	$ -	$ -

NOTE 5 – RETIREMENT PLANS

The Center sponsors a 403(b) defined contribution pension plan that covers all employees. The Center matches 25% of employee contributions up to 5% of the employee's annual salary, for a total potential contribution from the Center of 1.25%. Employer contributions are vested over five years of service. In addition, management may authorize a discretionary matching contribution in the amount of 1.75% of gross salaries. Total expense under this plan for the year ended December 31, 2012 was $18,961.

During the year ended December 31, 2006, the Center adopted a 457(b) deferred compensation plan for a key employee. In 2012, the plan was expanded to include a second key employee. The employees and the employer can make discretionary contributions. Total deferred compensation expense for the year ended December 31, 2012 was $22,970.

NOTE 6 – PERMANENTLY RESTRICTED NET ASSETS

Net assets were permanently restricted for the following purposes as of December 31, 2012:

Rosemary Flanigan Chair in Clinical Ethics	$ 2,338,522
Kathleen M. Foley Chair in Pain and Palliative Care	1,559,779
Total Permanently Restricted Net Assets	$ 3,898,301

Rosemary Flanigan Chair in Clinical Ethics

In 2006, the Center for Practical Bioethics began fundraising to establish its second endowed chair in honor of Rosemary Flanigan, PhD., philosopher, teacher, bioethicist and Center staff member from 1992 until her retirement in 2010. Prior to becoming a staff member, Dr. Flanigan served on the Center Board of Directors and chaired the board in 1990/91. Between 2006 and 2012, more than $2.3 million was raised from over 200 donors with gifts ranging from $5 to $1.3 million. The annual proceeds of this endowed fund support a staff member of the Center with expertise in philosophy and clinical ethics who is named the holder of the Rosemary Flanigan Chair.

Kathleen M. Foley Chair in Pain and Palliative Care

During the year ended December 31, 2008, the Center entered into an agreement with Purdue Pharma L.P. whereby $1,500,000 was contributed to provide funding for the Kathleen M. Foley Chair in Pain and Palliative Care. The trust was funded in the amount of $500,000 at the time of contractual signing by the Center, which occurred during the year ended December 31, 2008 and another payment was made in Fiscal Year 2009. The remaining balance of $500,000 was paid during Fiscal Year 2011.

NOTE 7 – JOHN B. FRANCIS CHAIR IN BIOETHICS

During the year ended December 31, 2005, the John B. Francis Chair in Bioethics Fund was established with the Greater Kansas City Community Foundation by the Francis Family Foundation for the benefit of the Center. The principal amount pledged to the Fund was $3,000,000, with the Center receiving annual distributions outlined by the terms of the agreement. The Francis Family Foundation has oversight responsibility of the fund for a period of 10 years after its inception. On the tenth anniversary date of the Fund, the Francis Family Foundation will transfer oversight responsibility to the Center provided conditions in the agreement are met.

NOTE 8 – TEMPORARILY RESTRICTED NET ASSETS

Net assets were temporarily restricted for the following purposes as of December 31, 2012:

John B Francis Chair	$	195,938
Francis Family Foundation - Operating Reserve		50,000
TPOPP		19,754
PAINS		5,939
PAAINS Communication		23,711
2013 Annual Dinner		85,187
Total Temporarily Restricted Net Assets	$	380,529

NOTE 9 – BOARD DESIGNATED UNRESTRICTED NET ASSETS

Board designated endowments include the Robert L. Biblo Endowment and the General Endowment. Robert L. Biblo was on the Center's Board of Directors until his death in 1994, and this endowment was established at the Center in his honor. The General Endowment is funded by undesignated donations made in honor or memory of someone. Net assets were voluntarily segregated by the Center's Board for the following purposes as of December 31, 2012:

Robert L. Biblo Endowment	$	80,000
General Endowment		7,238
Total Board Designated Net Assets	$	87,238

NOTE 10 – INTERFUND RECEIVABLE/PAYABLE

The Center has a promissory note with the Flanigan Endowment, which was agreed to by the donor, with a face amount of $300,000. The agreement will be reviewed annually on or about March 17 by the Finance Committee and Board of Directors. The note has an interest rate of "Wall Street Prime." Accrued interest on the unpaid balance is due on or before the 15th day of the month following the last day of the month for which it is calculated. At December 31, 2012, the line of credit was drawn to $293,000.

NOTE 11 – LINE OF CREDIT

On September 17, 2012, the Center entered into a one year promissory note with Country Club Bank for a line of credit up to $300,000. The note has a variable interest rate based on the Wall Street Journal U.S. Prime Rate, with a minimum rate of 5%. On December 31, 2012, the Center borrowed $55,000 against this line of credit. The Center must make interest payments on any outstanding principal balance on a monthly basis. The Center paid the balance in February 2013.

NOTE 12 – OPERATING LEASES

The Center leases its office space under operating leases. The office lease will expire January 31, 2017. Rent expense related to this operating lease was $66,243 for the year ended December 31, 2012.

Future minimum lease payments under the office lease are as follows:

Year Ending December 31,	Amount
2013	$ 68,230
2014	70,266
2015	72,391
2016	74,567
2017	6,229

NOTE 13 – MAJOR CONCENTRATIONS

The Center maintains its cash balances within two accounts at a financial institution in Kansas City, Missouri. The balances are insured by the Federal Deposit Insurance Corporation up to $250,000. The Center has a repurchase agreement for balances in excess of insurance coverage. At December 31, 2012 the Center's cash balances were adequately secured.

The Center invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market, and credit risks. Due to the level of risk associated with certain investments securities, it is at least reasonably possible that changes could materially affect the amounts reported in the accompanying statements of financial position. The Board of Directors and management of the Center have established policies to provide prudent oversight of the investments.

NOTE 14 – ENDOWMENTS

The Center's endowment consists of funds established for a variety of purposes. Its endowment includes donor-restricted endowment funds. As required by the accounting principles generally accepted in the United States of America (GAAP), net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions.

The Board has determined that, absent explicit donor stipulations to the contrary, the Uniform Prudent Management of Institutional Funds Act (2006) (UPMIFA) statutes as adopted in Kansas and Missouri allow the Center to appropriate for expenditure or to accumulate so much of an endowment fund as the Center determines is prudent for the uses, benefits, purposes and duration for which the endowment funds were established, and to make such determinations to appropriate or accumulate fund assets in good faith pursuant to investment and spending policies implemented in the context of the perpetual nature of an endowment which are designed to maintain the value of the fund over time and to permit annual expenditure amounts that are prudent, after considering the following factors: (1) the duration and preservation of the

endowment fund; (2) the purposes of the Center and the fund; (3) general economic conditions; (4) the possible effect of inflation or deflation; (5) the expected total return from income and the appreciation of investments; (6) other resources of the Center; and (7) the investment and spending policy of the Center.

Investment Return Objectives, Risk Parameters and Strategies

The Center has adopted investment and spending policies for the purpose of attempting to provide a reasonably predictable stream of funding to programs supported by endowment funds while also attempting to maintain the purchasing power of the Corporation's endowment assets over the long term. The corporation shall seek an achievable return of 7% (net of investment fees) taking into account both capital appreciation (realized and unrealized) and current yield (interest and dividends) calculated as a moving three (3) year average of the fair market value of the funds.

Spending Policy

The Center has a policy of appropriating for distribution each year for programs and administration an amount up to but not to exceed 6% of a moving three (3) year average of the fair market value of the endowment funds determined quarterly. This is consistent with the Center's objectives to appropriate for expenditure or to accumulate so much of an endowment fund for the uses, benefits, purposes and duration for which the endowment funds were established.

The endowment net asset composition of $3,898,301 is included entirely in the Permanently Restricted Fund.

Changes in endowment net assets as of December 31, 2012 are as follows:

	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets, beginning of the year	$ -	$ 3,725,122	$ 3,725,122
Contributions	-	2,074	2,074
Investment Income	-	114,538	114,538
Net Appreciation	-	244,897	244,897
Amounts appropriated for expenditure	-	(188,330)	(188,330)
Endowment net assets, end of the year	$ -	$ 3,898,301	$ 3,898,301

NOTE 15 – PRIOR YEAR SUMMARIZED INFORMATION

The consolidated financial statements include certain prior-year summarized comparative information in total but not by net asset class. Such information does not include sufficient detail to constitute a presentation in conformity with generally accepted accounting principles. Accordingly, such information should be read in conjunction with the financial statements for the year ended December 31, 2011, from which the summarized information was derived.

NOTE 16 – RESTATEMENT OF BOARD DESIGNATED NET ASSETS

The Center has determined that the Robert L. Biblo and General endowments should be classified as board-designated unrestricted net assets, rather than permanently restricted net assets, due to the lack of donor imposed restrictions on the use of the funds. The summarized period information included in these financial statements has been restated to reflect this reclassification. These changes had the effect of increasing "Cash and Cash Equivalents" by $87,238 and decreasing "Cash – Restricted" by $87,238 at December 31, 2011 on the Statement of Financial Position. Unrestricted beginning net assets were increased by $81,586 and Permanently Restricted beginning net assets were decreased by $81,586 on the Statement of Financial Position and the Statement of Activities.

NOTE 17 – SUBSEQUENT EVENTS

Management has evaluated and noted no subsequent events through May 21, 2013, the date which the financial statements were available for issue.

SUITE 900
1111 MAIN STREET
KANSAS CITY, MO 64105
TELEPHONE: (816) 221-4569
FACSIMILE: (816) 221-4563
EMAIL: ADMIN@MCBRIDELOCK.COM
CERTIFIED PUBLIC ACCOUNTANTS

McBRIDE, LOCK & ASSOCIATES

INDEPENDENT AUDITORS' REPORT ON INTERNAL CONTROLS

To the Board of Directors of
Center for Practical Bioethics, Inc.

In planning and performing our audit of the financial statements of the Center for Practical Bioethics, Inc. (the "Organization") as of and for the year ended December 31, 2012, in accordance with auditing standards generally accepted in the United States of America, we considered the Organization's internal control over financial reporting (internal control) as a basis for designing our auditing procedures for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Organization's internal control. Accordingly, we do not express an opinion on the effectiveness of the Organization's internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A material weakness is a deficiency, or combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis.

Our consideration of internal control was for the limited purpose described in the first paragraph and was not designed to identify all deficiencies in internal control that might be deficiencies, significant deficiencies, or material weaknesses. We did not identify any deficiencies in internal control that we consider to be material weaknesses, as defined above.

This communication is intended solely for the information and use of management, the Board of Directors, and others within the organization, and is not intended to be and should not be used by anyone other than these specified parties.

McBride, Lock & Associates
Kansas City, Missouri
May 21, 2013

HEADLINES FOR SEPTEMBER 2024 FINANCIAL PERFORMANCE

REVENUE

Through the month of September, actual revenue is $986,396 and favorable to budget by $104K. The primary variances are in Endowment Receipts which is favorable to budget by $68K, due to the timing of the receipt compared to the budget. Funds released from restrictions is over budget by $46K, primarily due to funds from the Harman Foundation. Earned Income is $26K favorable to budget, primarily due to CEIGR income which was not budgeted for 2024.

EXPENSES

Total actual operating expenses are $1,146,560, which is favorable to budget by $14K. Salaries, Benefits, & Other Employee costs are favorable to budget by $26K due to open positions. Occupancy is under budget by $8K, the budget includes $500 a month for meeting expenses which have not been incurred. Conferences, Conventions & Meetings category is under budget by $22K due to the refund of speaker fees. Contract Services are over budget by $42K primarily due to payments for the Harman Foundation project lead.

OTHER INCOME

Other Income includes $260K in distributions from Flanigan, Foley, and Francis Funds. These funds cover 2024 expenditures but do not reflect 2024 income based on GAAP accounting. Other Income is favorable to budget by $672K primarily because endowment income was not budgeted.

OPERATIONS THROUGH SEPTEMBER 2024

Net unrestricted operating revenue over expenses is ($162,144). Combined with the other investment income and distributions related primarily to Francis and Flanigan Funds, net income is $295,142, approximately $788K favorable to budget.

Center for Practical Bioethics
Budget vs. Actuals: Budget_FY24_P&L - FY24 P&L Classes
January - September, 2024

	Actual	Budget	Total over Budget	% of Budget	Annual Budget
Income					
4210 Funds Released from Restrictions	192,355	146,250	46,105	131.52%	290,000
4310 Endowment Receipts	260,968	192,949	68,019	135.25%	410,492
4510 Earned Income	113,999	88,391	25,608	128.97%	143,188
4515 Provider Ethics Services	202,604	205,824	-3,220	98.44%	274,432
4520 Honoraria	1,975	0	1,975		4,000
4660 Donations-unrestricted	196,215	248,250	-52,035	79.04%	422,000
4710 Membership - Institutional	15,000	0	15,000		15,000
4810 Communication Income	1,980	0	1,980		0
4820 Publications Income	5		5		0
5010 Other Revenue-Reimbursements	511		511		0
5050 Interest Income	783		783		0
Total Income	**986,396**	**881,663**	**104,732**	**111.88%**	**1,561,612**
Cost of Goods Sold					0
7000 Cost of Goods Sold	1,980		1,980		0
Total Cost of Goods Sold	**1,980**	**0**	**1,980**		**0**
Gross Profit	**984,416**	**881,663**	**102,752**	**111.65%**	**1,561,612**
Expenses					0
A) Salaries, Benefits & Other Employee Costs	804,940	830,966	-26,026	96.87%	1,110,455
B) Occupancy	5,407	13,831	-8,424	39.09%	16,850
C) Professional & Contract Services	205,014	162,417	42,597	126.23%	237,223
D) Supplies	368	1,964	-1,596	18.76%	2,619
E) Telephone	1,756	5,535	-3,779	31.73%	7,380
F) Postage & Shipping	1,494	1,054	440	141.74%	1,405
G) Equipment & Maintenance	3,990	6,254	-2,263	63.81%	8,338
H) Printing & Promotions	29,955	29,250	705	102.41%	30,500
I) Travel & Transportation	6,659	900	5,759	739.85%	8,182
J) Conferences, Conventions & Meetings	43,011	64,875	-21,864	66.30%	80,450
K) Memberships & Subscriptions	15,251	19,984	-4,732	76.32%	26,870
L) Insurance	14,879	15,343	-465	96.97%	20,458
M) Interest Exp	3,617		3,617		0
N) Miscellaneous Operating Exp	10,219	8,162	2,057	125.21%	10,882
Total Expenses	**1,146,560**	**1,160,535**	**-13,975**	**98.80%**	**1,561,612**
Net Operating Income	**-162,144**	**-278,871**	**116,727**	**58.14%**	**0**
Other Income					0
7820 Endowment Receipts Used for Operations	-260,968	-192,949	-68,019	135.25%	-410,492
7830 Investment Earnings	112,735		112,735		0
7840 Realized Investment Gains (Losses)	158,058		158,058		0
7845 UnRealized Investment Gains (Losses)	469,348		469,348		0
Total Other Income	**479,174**	**-192,949**	**672,123**	**-248.34%**	**-410,492**
Other Expenses					0
7850 Investment Fees & Expenses	21,888	20,628	1,260	106.11%	27,504
Total Other Expenses	**21,888**	**20,628**	**1,260**	**106.11%**	**27,504**
Net Other Income	**457,286**	**-213,577**	**670,863**	**-214.11%**	**-437,996**
Net Income	**295,142**	**-492,448**	**787,590**	**-59.93%**	**-437,996**

Center for Practical Bioethics

Balance Sheet

As of September 30, 2024

	TOTAL
ASSETS	
Current Assets	
Bank Accounts	
1010 CENTER FOR PRACTICAL BIOETHICS INC (0266) - NEW	42,847
1070 MONEY MARKET ACCOUNT (8991) - NEW	140,065
Total Bank Accounts	**$182,912**
Accounts Receivable	
1240 Receivables	209,415
Total Accounts Receivable	**$209,415**
Other Current Assets	
1450 Prepaid Insurance	1,392
1460 Prepaid Exp-Other	2,817
Total Other Current Assets	**$4,208**
Total Current Assets	**$396,536**
Fixed Assets	
1640 Furniture, Computers & Equipment	50,431
1740 Accum Depreciation - Furniture, Computers, Equipmnt	-39,536
Total Fixed Assets	**$10,894**
Other Assets	
1805 Flanigan Endowed Chair Investment	2,445,117
1806 Foley Investment Account	479,414
1807 Francis Family Endowment	3,535,301
1840 Operating Lease	14,646
Total Other Assets	**$6,474,478**
TOTAL ASSETS	**$6,881,908**
LIABILITIES AND EQUITY	
Liabilities	
Current Liabilities	
Accounts Payable	
2040 Accounts Payable (Bill)	16,430
Total Accounts Payable	**$16,430**
Other Current Liabilities	
2130 Accrued PTO	32,458
2145 Operating Lease Liability	2,667
2150 Accrued Expenses - Other	660
2350 Line of Credit Loan	50,000
Deferred - Contract Services - Earned	35,251
Deferred - Contract Services - Provider Ethics	49,931
Total Other Current Liabilities	**$170,967**
Total Current Liabilities	**$187,398**

Center for Practical Bioethics

Balance Sheet

As of September 30, 2024

	TOTAL
Long-Term Liabilities	
2770 Operating Lease Liability LT	7,370
Total Long-Term Liabilities	**$7,370**
Total Liabilities	**$194,768**
Equity	
3100 Permanently Restricted Funds	5,287,606
3300 Temporarily Restricted Funds	1,092,927
3500 Unrestricted Funds	-103,856
5900 Retained Earnings	115,322
Net Income	295,142
Total Equity	**$6,687,140**
TOTAL LIABILITIES AND EQUITY	**$6,881,908**

Center for Practical Bioethics

Statement of Cash Flows

January - September, 2024

	TOTAL
OPERATING ACTIVITIES	
Net Income	295,142
Adjustments to reconcile Net Income to Net Cash provided by operations:	
1240 Receivables	38,073
1450 Prepaid Insurance	14,850
1460 Prepaid Exp-Other	23,569
2040 Accounts Payable (Bill)	1,124
2060 Other Accounts Payable:Accounts Payable -Pension	-8,858
2130 Accrued PTO	-8,461
2150 Accrued Expenses - Other	-1,936
Deferred - Contract Services - Earned	35,251
Deferred - Contract Services - Provider Ethics	49,931
Total Adjustments to reconcile Net Income to Net Cash provided by operations:	**143,543**
Net cash provided by operating activities	**$438,685**
INVESTING ACTIVITIES	
1740 Accum Depreciation - Furniture, Computers, Equipmnt	10,537
1320 Inventory	1,980
1805 Flanigan Endowed Chair Investment	-140,686
1806 Foley Investment Account	-32,806
1807 Francis Family Endowment	-274,572
1860 457(b) Deferred Compensation Plan	150,677
Net cash provided by investing activities	**$ -284,869**
FINANCING ACTIVITIES	
2410 Deferred Revenue	-50,000
2810 457(b) Deferred Compensation Liability	-150,677
3300 Temporarily Restricted Funds	57,645
Net cash provided by financing activities	**$ -143,032**
NET CASH INCREASE FOR PERIOD	**$10,784**
Cash at beginning of period	172,129
CASH AT END OF PERIOD	**$182,912**