UC DAVIS LAW REVIEW ONLINE

VOL. 58 APRIL 2025

RESPONSE

Facts from the Frontline: A Response to "Inequitable Organ Allocation"

Alexandra K Glazier, JD, MPH[*]

Benjamin McMichael's article *Inequitable Organ Allocation*[1] seems designed for a news cycle rather than a Law Review, citing emails and online media more than the law in the first twenty pages. And for good reason: after years of litigation in multiple jurisdictions, no court has overturned the organ allocation policy reforms to which he objects. In fact, despite loud complaints from a small number of transplant centers — including the University of Alabama which is affiliated with McMichael's employer at the University of Alabama Law School, and was a plaintiff in an unsuccessful legal attempt to stop the equitable

 President & CEO, New England Donor Services; Adjunct Professor of Health Policy and Practice, Brown University, School of Public Health.

[1] Benjamin J. McMichael, *Inequitable Organ Allocation*, 58 U.C. DAVIS L. REV. 1 (2024).

allocation policy reforms from being implemented for kidneys[2] — the policy reforms to more equitably allocate organs among the sickest patients nationwide have now been in place for over six years.[3] Broader allocation of organs received explicit support from the National Academy of Science in 2022 with a recommendation to "[a]ccelerate finalizing continuous distribution allocation frameworks for all organs" as a priority towards a more equitable allocation system.[4]

Allocation policy was reformed to eliminate artificial boundaries in organ allocation, while still considering geographic proximity in a more rational and patient-centric way.[5] McMichael claims that I personally believe "organ allocation policy should facilitate the flow of donated livers from South Carolina to Massachusetts as long as Massachusetts patients *on the waitlist* are sicker."[6] This misrepresents both my views and how organ allocation policy actually works. Contrary to McMichael's misrepresentation, under current policy, livers should not *and in fact do not* "flow" from South Carolina to Massachusetts; rather, from 2020 to 2024, since the allocation reform was implemented, there have been 51,706 deceased donor livers donated for transplant[7] and *only a single* liver has gone from a donor in South Carolina to a patient in Massachusetts.[8]

---

[2] Adventist Health Sys./Sunbelt, Inc. v. U.S. Dep't of Health & Human Servs., No. 3:20-cv-00101, 2021 WL 973445, at *1-3, *20 (S.D. Iowa Mar. 12, 2021), *aff'd* 17 F.4th 793 (8th Cir. Nov. 8, 2021).

[3] *See Policy Modification to Lung Distribution Sequence*, ORGAN PROCUREMENT & TRANSPLANTATION NETWORK (Nov. 22, 2017), https://optn.transplant.hrsa.gov/news/policy-modification-to-lung-distribution-sequence/ [https://perma.cc/LKJ3-AXPL].

[4] *See* NAT'L ACADEMY OF SCI., ENG'G & MED., REALIZING THE PROMISE OF EQUITY IN THE ORGAN TRANSPLANTATION SYSTEM 8 (Kenneth W. Kizer, Rebecca A. English & Meredith Hackmann eds., 2022), https://www.ncbi.nlm.nih.gov/books/NBK578320/pdf/Bookshelf_NBK578320.pdf [https://perma.cc/45K8-3WQJ].

[5] *See id.* at 123.

[6] McMichael, *supra* note 1, at 9.

[7] Build Advanced, ORGAN PROCUREMENT & TRANSPLANTATION NETWORK, https://optn.transplant.hrsa.gov/data/view-data-reports/build-advanced/ (Under step 1: select state "Donor"; then, under step 2 select "Donor Type"; then, under step 3, select "Donation Year"; leave step 4 as is; then, under the "Organ" drop down menu, select "Liver"; finally, under Step 5, press "go" to run report).

[8] State Data, ORGAN PROCUREMENT & TRANSPLANTATION NETWORK, https://optn.transplant.hrsa.gov/data/view-data-reports/state-data/ (Under step 1: select

I would encourage those interested in understanding my views to read in full the communications that were produced in the still active litigation over liver policy (of which Vanderbilt Medical Center is a plaintiff, another entity McMichael has been professionally aligned with through his academic work at Vanderbilt University) — rather than the out of context, cherry-picked excerpts quoted in McMichael's article from the hundreds of my private emails that were produced in one-sided discovery.[9] A complete review would make clear that I was expressing frustration over efforts by some surgeons to manipulate organ allocation to mask larger issues of inequitable access to healthcare in states that do a poor job of providing health insurance coverage to disadvantaged populations.

An unbiased reading of my emails shows a discussion on improving equitable access to healthcare including access to the transplant waitlist, which varies widely by state. My primary point is this: "Using organ allocation as a tool to address social inequities (as serious and significant as they are) is not only ethically inappropriate and bad public policy, it is contrary to federal law."[10] Keeping organs "local" through use of Donation Service Areas in organ allocation policies will not help patients where poor public insurance prevents them from getting on the transplant waitlist at all. A patient's access *to the transplant waitlist* needs to be addressed before organ allocation policies even come into play because federal policy only permits the allocation of donated organs to patients who have been medically evaluated for transplant, accepted, and placed on the waitlist.[11] As a result, using organ allocation policies

"Massachusetts" and then press "go"; then, under step 2, select "Donor" from the "Choose Category" tab and select "Liver" from the "Choose Organ" tab; then, under step 3, click on the "Deceased Donors by DSA" hyperlink).

[9] *See* Callahan v. U.S. Dep't of Health & Hum. Servs., 434 F. Supp. 3d 1319 (N.D. Ga. 2020) (summary judgment pending).

[10] Alexandra K. Glazier, *It Is Bad Policy and Contrary to Federal Law to Prioritize Local Allocation of Livers to Address Geographically Based Social Inequities*, 17 AM. J. TRANSPLANTATION 3257, 3257 (2017).

[11] *See* Organ Procurement and Transplantation Network, 42 C.F.R. § 121.2 (2025); *Ethical Principles in the Allocation of Human Organs*, ORGAN PROCUREMENT & TRANSPLANTATION NETWORK, https://optn.transplant.hrsa.gov/professionals/by-topic/ethical-considerations/ethical-principles-in-the-allocation-of-human-organs/#:~:text=CONCLUSION,of%20scarce%20organs%20for%20transplantation (last updated June 2015) [https://perma.cc/EK8R-

as an attempt to address geographic disparities in — as McMichael terms "transplant amenable deaths"[12] — will not actually provide organs to those potentially in need of a transplant if they do not actually have access to the waitlist. Instead, such a policy would only preferentially allocate organs in those areas to those who already have access to the waitlist and would do so based on "place of residence," directly contrary to the law and in conflict with well-established ethical principles.[13]

McMichael does not mention that the plaintiffs in the liver lawsuit are fifteen transplant programs (out of more than 250 nationwide), *with a financial interest* in maintaining prior policy as stated in their court filings.[14] Interestingly, since implemented, twelve of fifteen plaintiff liver programs (80%) have nonetheless experienced *increased* transplants — in some cases, substantial (>100% increase in liver transplant at Virginia Commonwealth University Health System since 2019 through 2024).[15] For those with decreased volumes, such as University of Iowa, livers donated from the area are not "flowing" to the Northeast, but rather to neighboring transplant patients at midwestern centers in Minnesota and Nebraska.[16] The clear majority of the transplant community supported the equity reform as the liver policy passed in a 30–7 vote including every patient representative on the OPTN Board.[17] This is because broader sharing of organs prioritizes patients. But, like the lawsuit plaintiffs, McMichael focuses on programs and geographies rather than on transplant patients. My position,

NN3D] ("Access to the waiting list for an organ transplant is the fundamental prerequisite to organ allocation.").

[12] McMichael, *supra* note 1, at 7.

[13] *See* 42 C.F.R. § 121.2; *Ethical Principles in the Allocation of Human Organs*, *supra* note 11.

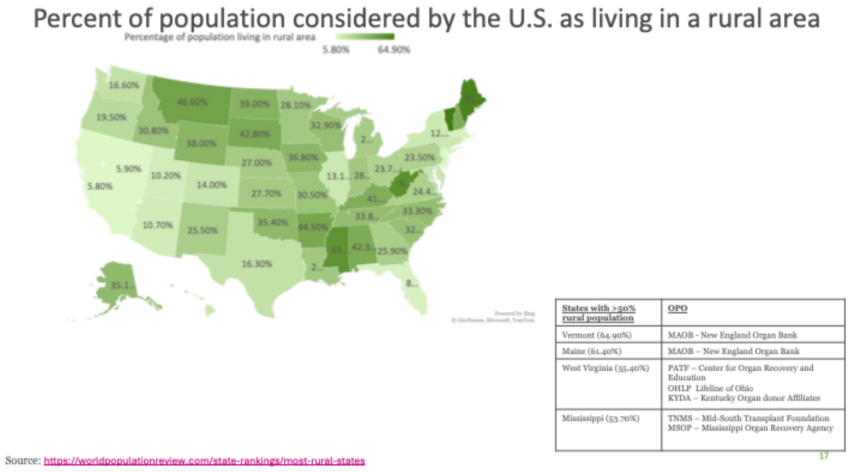
[14] *See* Complaint for Declaratory and Injunctive Relief at 9, Callahan v. U.S. Dep't of Health & Hum. Servs., No. 19-cv-1783-AT (N.D. Ga. April 22, 2019).

[15] Center Data, ORGAN PROCUREMENT & TRANSPLANTATION NETWORK, https://optn.transplant.hrsa.gov/data/view-data-reports/center-data/ (Under step 1: select state "Virginia" and press "go"; then, under step 2 select "VCU Health System Authority" from the "Choose Center" menu, select "Transplant" from the "Choose Category" menu, and "Liver" from the "Choose Organ" menu; finally, under step 3, click on the "Transplant by Donor Type" hyperlink).

[16] OPTN data by transplant program on file with author.

[17] *See* Memorandum in Opposition to Plaintiffs Motion for Temporary Restraining Order at 12, Callahan v. U.S. Dep't of Health & Hum. Servs., No. 19-cv-1783-AT (N.D. Ga. May 1, 2019).

consistent with the law, is that patients are equally deserving of the opportunity for transplant regardless of where they are waitlisted; there is no ethical basis for organ allocation priority based on where a patient lives.



States with >50% rural population	OPO
Vermont (64.90%)	MAOB - New England Organ Bank
Maine (61.40%)	MAOB – New England Organ Bank
West Virginia (55.40%)	PATF – Center for Organ Recovery and Education OHLP Lifeline of Ohio KYDA – Kentucky Organ donor Affiliates
Mississippi (53.70%)	TNMS – Mid-South Transplant Foundation MSOP – Mississippi Organ Recovery Agency

New England Donor Services, the Organ Procurement Organization ("OPO") in the Northeast that I lead, serves Vermont and Maine, the two most rural states in the nation (by percentage of rural population) and also serves four of thirteen states in the U.S. — Maine, New Hampshire, Rhode Island and Vermont — that only have either a single kidney-only transplant program or no transplant program at all.[18] This means residents of Maine, New Hampshire and Rhode Island must travel out-of-state and to a city to receive liver, heart, or lung transplants. For Vermonters, it means leaving the state for any type of organ transplant.[19] So, when McMichael talks about "urban" transplant candidates and recipients,[20] it is important to understand that may include patients who travel significant distances and even across state

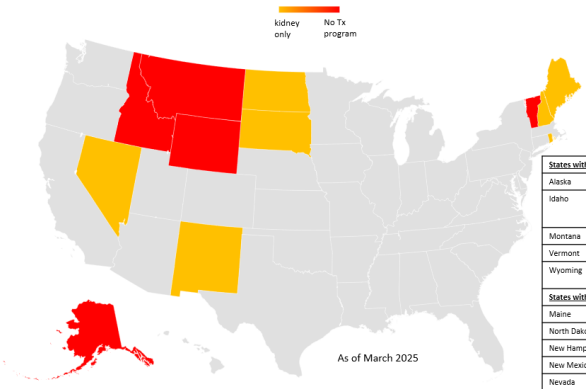
[18] *Search Membership*, ORGAN PROCUREMENT & TRANSPLANTATION NETWORK, https://optn.transplant.hrsa.gov/about/search-membership/?memberType=Transplant%20Hospitals&organType=%27AL%27&state=0&region=0 (last visited April 9, 2025) [https://perma.cc/53BZ-CFZH].

[19] *See id.*

[20] McMichael, *supra* note 1, at 67.

lines from rural areas to be waitlisted at and receive organ transplants in urban areas.

States with no Tx programs or a single kidney-only Tx program



States with no Tx programs	OPO
Alaska	WALC – LifeCenter Northwest
Idaho	WALC – LifeCenter Northwest ORUO – Cascade LifeAlliance UTOP - DonorConnect
Montana	WALC – LifeCenter Northwest
Vermont	MAOB – New England Organ Bank
Wyoming	CORS – DonorAlliance UTOP - DonorConnect
States with a kidney-only Tx Ctr	**OPO**
Maine	MAOB – New England Organ Bank
North Dakota	MNOP – LifeSource Upper Midwest OPO
New Hampshire	MAOB – New England Organ Bank
New Mexico	NMOP – New Mexico Donor Services
Nevada	NVLV – Nevada Donor Services
Rhode Island	MAOB – New England Organ Bank
South Dakota	MNOP – LifeSource Upper Midwest OPO

There is much in McMichael's article that misses facts from the frontline. For example, the actual organ donation rate is not the same as the donor registration (or designation) rate because OPOs approach families to authorize donation when a potential donor is not registered.[21]

Mostly what is missing from McMichael's law review article is a legal analysis. There is no analysis of the statutory limitation of the OPTN to control the allocation of organs only to patients who are waitlisted at designated transplant centers and how this legally confines allocation policies.[22] Equally absent is any analysis of the legal complexities of how to address disparities in patient access to the waitlist (including regulating the practice of medicine and insurance coverage issues).

The bottom line is that there is no allocation policy proposed by McMichael that will deliver an organ to a patient who has not been listed

[21] Alexandra K. Glazier, *Organ Donation and the Principles of Gift Law*, 13 CLIN. J. AM. SOC. NEPHROLOGY 1283, 1284 (July 17, 2018).

[22] *See* 42 U.S.C § 274(b)(2) (Establishing the statutory requirements for the OPTN to match available organs and patients "in the list" for the "nationwide distribution of organs equitably among transplant patients" who are waitlisted at transplant centers, including specific criteria for doing so such as preparation and distribution of "samples of blood sera from individuals who are included *on the list*." (emphasis added)).

for transplant. And that was precisely my point in the emails that McMichael mischaracterizes. Addressing equitable access to transplant must start with patient access to the waitlist, and that cannot be fixed through national organ allocation policy.