



4-1-2014

Dissecting the Heart of Organ Allocation Policy: Evaluating the Eastern District of Pennsylvania's Grant of Life in Murnaghan v. U.S. Department of Health and Human Services

Jocelyn Cooper

Follow this and additional works at: <https://digitalcommons.law.villanova.edu/vlr>



Part of the [Administrative Law Commons](#), and the [Health Law and Policy Commons](#)

Recommended Citation

Jocelyn Cooper, *Dissecting the Heart of Organ Allocation Policy: Evaluating the Eastern District of Pennsylvania's Grant of Life in Murnaghan v. U.S. Department of Health and Human Services*, 59 Vill. L. Rev. 269 (2014).

Available at: <https://digitalcommons.law.villanova.edu/vlr/vol59/iss2/2>

This Article is brought to you for free and open access by the Journals at Villanova University Charles Widger School of Law Digital Repository. It has been accepted for inclusion in Villanova Law Review by an authorized editor of Villanova University Charles Widger School of Law Digital Repository.

DISSECTING THE HEART OF ORGAN ALLOCATION POLICY:
EVALUATING THE EASTERN DISTRICT OF PENNSYLVANIA'S
GRANT OF LIFE IN *MURNAGHAN v. U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES*

JOCELYN COOPER*

I. INTRODUCTION

Mommy, I knew I was dying I just didn't want to tell you that I was dying because I knew it would upset you."¹ Ten-year-old Sarah Murnaghan was correct when she told her mother that she had been dying.² For eighteen months, Sarah waited for a life-saving set of donated lungs and without judicial intervention, Sarah probably would have lost her battle with end-stage cystic fibrosis while waiting.³

* J.D. Candidate, 2015, Villanova University School of Law; M.A. 2010, University of Maryland; B.A. 2008, Franklin & Marshall College. I would like to thank my husband, Derek Hines, and my family for their continued love and support. I would also like to thank the editors of the *Villanova Law Review* for their hard work and advice.

1. See Chris Welch & Jason Carroll, *Lung Transplant Gives Sarah Murnaghan Chance to Live Her Dreams*, CNN (Aug. 26, 2013, 10:25 AM), <http://www.cnn.com/2013/08/26/health/sarah-murnaghan-update/> (questioning Sarah's parents, Janet and Francis Murnaghan, about their feelings on Sarah's hospital discharge).

2. See Michael Martinez & Steve Almasy, *Family of Girl Desperate for Transplant Says She Can't Wait for Policy to Change*, CNN (June 3, 2013, 2:57 AM), <http://www.cnn.com/2013/06/02/health/pennsylvania-girl-lungs/index.html> (stating that Sarah's parents felt that she had essentially been "left to die").

3. See *About Cystic Fibrosis*, CYSTIC FIBROSIS FOUND., <http://www.cff.org/aboutcf/> (last visited Jan. 31, 2014) (providing general information on nature and symptoms of cystic fibrosis). Cystic fibrosis is an inherited chronic disease that affects the lungs and digestive system of about 30,000 children and adults in the United States. See *id.* (noting 70,000 children and adults worldwide are affected). A defective gene and its protein product cause the body to produce unusually thick, sticky mucus that clogs the lungs and leads to life-threatening lung infections. See *id.* (explaining that most people are diagnosed before reaching two years old). The mucus also obstructs the pancreas and stops natural enzymes from helping the body break down and absorb food. See *id.* (stating that there is no cure for cystic fibrosis, but that there are aggressive treatments and therapies which can improve quality of life). People with cystic fibrosis can have a variety of symptoms including: "very salty-tasting skin; persistent coughing, at times with phlegm; frequent lung infections; wheezing or shortness of breath; poor growth [and] weight gain in spite of a good appetite; and frequent greasy, bulky stools or difficulty in bowel movements." See *id.* (describing symptoms of cystic fibrosis). The predicted median age of survival for a person with cystic fibrosis is in the late thirties. See *id.* (noting that there is no definitive method of predicting how long people with cystic fibrosis will live, as various factors affect any person's health).

As of October 2013, Sarah was one of 76,910 tragic stories of people waiting for a donated organ.⁴ For many of those 76,910 people, placement on the waitlist is a death sentence.⁵ Unfortunately, demand in the United States for donated organs far exceeds the supply and inherent in the nature of scarcity is the terrible reality that not everyone can receive a donated organ.⁶ While Sarah was lucky enough to receive her donated lungs after filing a temporary restraining order and preliminary injunction against the United States Department of Health and Human Services (HHS), the courts cannot save all remaining 76,909 waiting list candidates.⁷ Rather, judicial intervention into any individual transplant candidate's case upsets the delicate balance of bioethical principles underlying organ allocation policy and risks destroying the carefully crafted system designed to benefit all 76,910 candidates.⁸

Certainly, Sarah Murnaghan's parents are glad that Sarah now will be able to go ride horses and play soccer like other healthy children.⁹ However, the Complaint in *Murnaghan v. U.S. Department of Health and Human Services*¹⁰ raises pervasive questions regarding the judiciary's reach into administrative agency rulemaking and the bioethical consequences of judicial intervention into organ allocation policy.¹¹ How much influence

4. See Data, OPTN: ORGAN PROCUREMENT & TRANSPLANTATION NETWORK, U.S. DEP'T OF HEALTH & HUMAN SERVS., <http://optn.transplant.hrsa.gov/data/> (last visited Feb. 10, 2014) [hereinafter *OPTN Data*] (providing data regarding current number of active waiting list candidates).

5. See *Organ Procurement Organizations*, U.S. DEP'T OF HEALTH & HUMAN SERVS., <http://www.organdonor.gov/index.html> (last visited Jan. 31, 2014) (stating that eighteen people die every day waiting for organs).

6. See Marc Siegel, *The Troubling Shortage of Organ Donors in the U.S.*, FORBES (Feb. 28, 2011), <http://www.forbes.com/sites/marc siegel/2011/02/28/the-troubling-shortage-of-organ-donors-in-the-u-s/> (acknowledging national organ shortage).

7. See *OPTN Data*, *supra* note 4 (providing most current numbers for active waiting list candidates).

8. For further discussion of the destructive impacts that arise from judicial intervention into any individual transplant candidate's case, see *infra* notes 177–90 and accompanying text.

9. See Rebekah Marcarelli, *Sarah Murnaghan: 11 Year Old to Head Home After Double Lung Transplant; Looks Forward to Horseback Riding and Soccer "I'm Not Going for Easy, I'm Just Going for Possible"*, HEADLINES & GLOBAL NEWS (Aug. 26, 2013 12:48 PM), <http://www.hngn.com/articles/10932/20130826/sarah-murnaghan-11-year-old-head-home-double-lung-transplant.htm> (discussing Sarah's future dreams after having received double-lung transplant).

10. Complaint for a Temporary Restraining Order and Preliminary and Permanent Injunctive Relief, *Murnaghan v. Dep't of Health and Human Servs.*, No. 13-CV-03083, 2013 WL 2433840 (E.D. Pa., June 5, 2013) [hereinafter *Complaint*].

11. See Sydney Lupkin, *Girl Prompts Small Change to Organ Transplant Policy*, ABC NEWS (June 11, 2013), <http://abcnews.go.com/Health/girl-prompts-small-change-organ-transplant-policy/story?id=19373685> (statement of Professor R. Alta Charo, Warren P. Knowles Professor of Law and Bioethics at the University of Wisconsin-Madison) ("It is unlikely that courts are the best place to make [organ allocation] decisions The reasons for giving priority to one category of patients over another are usually due to a complicated combination of factors.").

should the judiciary have in an administrative agency's formulation of policy, especially in the creation of organ allocation policy?¹² Does the *Murnaghan* decision violate primary ethical principles of organ allocation policy as promulgated by the Organ Procurement and Transplantation Network (OPTN)?¹³

This Note argues that the *Murnaghan* decision demonstrates how judicial interference with the organ allocation system destroys the balance of bioethical principals upon which the system is formed.¹⁴ Furthermore, this Note argues that *Murnaghan* violates Supreme Court precedent in *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*¹⁵ because the judiciary failed to defer to organ allocation policy formed by administrative agencies and based upon expert scientific and medical knowledge.¹⁶

Part II of this Note examines the history of the OPTN under the National Organ Transplant Act (NOTA), the mechanics of organ transplantation, and the fundamental bioethical principles underlying organ allocation policy.¹⁷ Part III discusses the relationship between the judici-

12. See Minutes of the OPTN/UNOS Executive Committee Meeting, Lung Allocation Policy Review (June 10, 2013), available at http://optn.transplant.hrsa.gov/ContentDocuments/OPTN_Exec_Comm_mtng_materials_06-10-13.pdf (expressing discontent with judicial intervention, which forced OPTN/UNOS committee to reevaluate its policy regarding organ allocation to pre-adolescent candidates).

13. For a further discussion of the bioethical impacts of judicial intervention in cases of individual transplant candidates, see *infra* notes 177–90 and accompanying text.

14. For a discussion of the ethical principles guiding organ allocation policy, see *infra* notes 58–90 and accompanying text. For a discussion of the impact of the *Murnaghan* decision on those principles, see *infra* notes 177–200 and accompanying text.

15. 467 U.S. 837 (1984).

16. For a discussion of judicial authority and deference to administrative agency decisions, see *infra* notes 91–116 and accompanying text.

17. See National Organ Transplantation Act of 1984, 42 U.S.C. § 274a–g (2006) (establishing OPTN).

The Secretary shall by contract provide for the establishment and operation of an Organ Procurement and Transplantation Network

(b) Functions

(1) The Organ Procurement and Transplantation Network shall carry out the functions described in paragraph (2) and shall—

(A) be a private nonprofit entity that has an expertise in organ procurement and transplantation, and

(B) have a board of directors—

(i) that includes representatives of organ procurement organizations . . . transplant centers, voluntary health associations, and the general public; and

(ii) that shall establish an executive committee and other committees

(2) The Organ Procurement and Transplantation Network shall—

(A) establish in one location or through regional centers—

(i) a national list of individuals who need organs, and

(ii) a national system, through the use of computers and in accordance with established medical criteria, to match organs and individ-

ary and administrative agencies and the general concept of judicial deference to administrative agency rulemaking and expertise in *Chevron*.¹⁸ Part IV sets forth the facts leading up to *Murnaghan* and the justification behind the court's decision to direct the OPTN to cease enforcement of Policy 3.7 (Under 12 Rule).¹⁹ Part V critically analyzes the court's intervention into administrative agency action and the bioethical consequences of that intervention.²⁰ Part VI suggests several approaches to solve excessive judicial intervention into organ allocation policy.²¹

uals included in the list, especially individuals whose immune system makes it difficult for them to receive organs,

(B) establish membership criteria and medical criteria for allocating organs and provide to members of the public an opportunity to comment with respect to such criteria, . . .

(D) assist organ procurement organizations in the nationwide distribution of organs equitably among transplant patients, . . .

(G) coordinate, as appropriate, the transportation of organs from organ procurement organizations to transplant centers, . . .

(K) work actively to increase the supply of donated organs, . . .

(M) recognize the differences in health and in organ transplantation issues between children and adults throughout the system and adopt criteria, policies, and procedures that address the unique health care needs of children,

(N) carry out studies and demonstration projects for the purpose of improving procedures for organ donation procurement and allocation, including but not limited to projects to examine and attempt to increase transplantation among populations with special needs, including children and individuals who are members of racial or ethnic minority groups, and among populations with limited access to transportation

Id. § 274(a)–(b) (setting forth functions of OPTN and role of HHS).

18. *See Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 866 (1984) (determining that federal judges must defer to administrative agency policy decision).

When a challenge to an agency construction of a statutory provision, fairly conceptualized, really centers on the wisdom of the agency's policy, rather than whether it is a reasonable choice within a gap left open by Congress, the challenge must fail. In such a case, federal judges—who have no constituency—have a duty to respect legitimate policy choices made by those who do.

Id. (recognizing that statutory interpretation should not be attempted by judges but rather by administrative agencies).

19. *See* Letter from John Roberts, President, OPTN Bd. of Dirs., to Kathleen Sebelius, Sec'y, U.S. Dep't of Health & Human Servs. (May 30, 2013), *available at* http://optn.transplant.hrsa.gov/ContentDocuments/OPTN_Exec_Comm_mtng_materials_06-10-13.pdf (discussing OPTN's Policy 3.7 (Under 12 Rule), which governs lung allocation policy for pediatric candidates and severely limited Sarah's ability to receive donated lungs).

20. For further discussion of the interplay between *Chevron* and key bioethical principles of organ allocation in *Murnaghan*, see *infra* notes 156–90 and accompanying text.

21. For a further discussion of the approaches, which might be used to limit excessive judicial intervention in organ allocation policy, see *infra* notes 191–217 and accompanying text.

II. THE ANATOMY OF ORGAN ALLOCATION POLICY

To understand the difficulties facing Sarah Murnaghan and the OPTN in navigating organ allocation policy, it is critical to understand the substantial background information concerning organ transplantation.²² As the OPTN developed under NOTA, organ transplantation technology expanded the scope of transplant candidates and the need for donated organs.²³ Thus, it became necessary to develop an organ allocation system that balanced the severity of individual cases with overall fairness to all the candidates on the waiting list.²⁴ The bioethical principles of utility, distributive justice, and autonomy help policymakers decide how to distribute resources such as organs where demand is high and the supply is scarce.²⁵

A. History and Mechanics of NOTA and the OPTN

Modern advances in technology and medicine continue to expand the number of patients able to benefit from organ transplantation, yet the supply of organs is unable to meet the increasing demand.²⁶ In October 2013, there were 76,910 active waiting list candidates for organ transplants and only 5,694 organ donors.²⁷ Given the scarcity of donated organs, the OPTN, under the authority of NOTA, must continually strive to promulgate effective organ allocation policies and to maintain an efficient organ transplantation network.²⁸ This section will provide a background on the implementation of NOTA and the establishment of the OPTN.²⁹ This section then examines the mechanics of organ allocation and, more specifi-

22. For a discussion of the court's decision in *Murnaghan*, see *infra* notes 117–55 and accompanying text.

23. See Jed Adam Gross, Note, E Pluribus UNOS: *The National Organ Transplant Act and Its Postoperative Complications*, 8 YALE J. HEALTH POL'Y L. & ETHICS 145, 149 (2008) (“[A]s more patients were able to benefit from transplant surgery, the available supply of organs did not keep up with the demand . . .”).

24. For a further discussion of the history of NOTA, see *infra* notes 31–36 and accompanying text. For a further discussion of the text of NOTA, see *supra* note 17.

25. For a discussion of utility, see *infra* notes 62–72 and accompanying text. For a discussion of distributive justice principles, see *infra* notes 73–84 and accompanying text.

26. See Gross, *supra* note 23, at 147 (claiming that there is persistent scarcity of donated organs).

27. See *OPTN Data*, *supra* note 4 (showing that number of organ donors, 5,694, only includes donations from January 2013 to May 2013).

28. See *About OPTN: Program Goals*, OPTN: ORGAN PROCUREMENT & TRANSPLANTATION NETWORK, U.S. DEP'T OF HEALTH & HUMAN SERVS., <http://optn.transplant.hrsa.gov/optn/programgoals.asp> (last visited Feb. 3, 2014) (stating OPTN's hopes to achieve dramatic increases in supply of transplantable organ and number of deceased donors).

29. For a discussion of the historical and legislative background of NOTA and the OPTN, see *infra* notes 31–36 and accompanying text.

cally, how lungs are allocated amongst adults and children under the age of twelve.³⁰

1. *The History of NOTA and the OPTN*

The first successful organ transplant in 1954 propelled the medical field into a new area of life-saving technology but at the same time, increased the need for legislation governing growing health and social policy concerns.³¹ In 1984, Congress enacted NOTA to facilitate the process of matching donor organs with patients needing transplants.³² NOTA articulated a consistent, national policy for allocating organs, established the

30. For a discussion of the organ donation process, see *infra* notes 37–53 and accompanying text.

31. See *Organ Transplant History*, N.Y. ORGAN DONOR NETWORK, <http://www.donatelifeny.org/all-about-transplantation/organ-transplant-history/> (last visited Jan. 31, 2014) (noting that first successful living-related kidney transplant, led by Dr. Joseph Murray and Dr. David Hume at Brigham Boston, was between identical twins and occurred on December 23, 1954); see also Gross, *supra* note 23, at 153–78 (examining history of organ transplantation prior to and after NOTA). Organ transplantation became a viable option in the 1950s. See *id.* at 153 (noting that 1950s organ transplantation technology was primitive and transplantation could be performed only between identical twins). At that time, there was no existing formal organ allocation system. See *id.* (explaining that because of newness and inefficiency of organ transplant technology there was no need for any formal organ donation system). In the late 1970s and early 1980s, the development of cyclosporine therapy, which was highly effective in preventing the rejection of donated organs, changed the nature of organ transplantation by increasing transplant survival rates. See *id.* at 170–71 (describing major technological advances in organ transplantation medicine). The development of cyclosporine therapy highlighted several “difficult and unusual social conditions,” including “dire scarcity amid material abundance . . . , a profound dependence on strangers . . . , a lack of reliable legal rules . . . , and stubborn, seemingly innate inequalities” in the distribution of organs. See *id.* at 172–73 (explaining need for structured organ donation system). In July and October of 1983, congressional hearings similarly emphasized several bioethical concerns regarding the allocation of organs after the introduction of cyclosporine. See *id.* at 181 (recounting beginning stages of NOTA in Congress). Specifically, the introduction of cyclosporine was likely to limit the persons who would benefit from organ transplantation because of the lack of money and donor organs. See *id.* at 182 (describing major concern for legislature in conceiving NOTA).

32. See Gross, *supra* note 23, at 149 (noting that accounts differ about legislative concerns or desires that prompted NOTA). Frank Sloan, an economist who has written extensively about health policy, suggested that Congress desired to establish a formalized organ donation system in order to expand the “relatively low rate of organ procurement” and to expand the national computerized matching system to include not just kidneys, but also livers and hearts. See *id.* (arguing that problems were on supply side of organ allocation, rather than demand side). Dr. Arthur Caplan, bioethicist at New York University’s Langone Medical Center, states that Congress was concerned that wealthy international patients were travelling to the U.S. in order to receive organs that should have been directed to Americans first. See *id.* (“[P]roblems were on the demand side of organ allocation, rather than supply side.”). Jeffrey Protas, a political scientist specializing in health policy, emphasized the role of organized professional interests rather than public policy concerns and stated that NOTA was a “response to lobbying by medical practitioners seeking an expansion of reimbursement for transplant therapy following the

OPTN to maintain the organ donation system, and increased the number of organs available for transplant.³³

The OPTN is composed of transplant centers and organ procurement organizations (OPOs) across the country linked together by the OPTN's computer network, which sends and receives donor information.³⁴ To manage the network of OPOs, the OPTN facilitates the organ matching and placement process through the use of a centralized computer system, develops policies and procedures for organ procurement based on medical expertise and public consensus, harvests and transports donated organs, and collects national data about organ donation and transplantation.³⁵ In 1999, the Secretary of the HHS promulgated the Final Rule under NOTA, which supplements the statute by requiring that

introduction of . . . cyclosporine." *See id.* (theorizing that economic concerns were important in NOTA's development).

33. *See* Gail L. Daubert, *Politics, Policies, and Problems with Organ Transplantation: Government Regulation Needed to Ration Organs Equitably*, 50 ADMIN. L. REV. 459, 463 (1998) (providing background on NOTA and discussing current problems with OPTN organ allocation system). Additionally, NOTA established the OPTN and directed the Secretary of HHS to contract with a private, non-profit organization to manage the OPTN. *See id.* (looking at Congress's intent behind deciding to contract with private entity). Congress decided to contract with a private entity because private entities had taken the "initiative in developing the original organ transplantation networks." *See id.* ("Congress feared that government bureaucracies would not keep pace with the rapidly changing medical field, and government intervention would impede the adoption of new policies."); *see also* *About OPTN: History*, OPTN: ORGAN PROCUREMENT & TRANSPLANTATION NETWORK, U.S. DEP'T OF HEALTH & HUMAN SERVS., <http://optn.transplant.hrsa.gov/optn/history.asp> (Feb. 3, 2014) (noting that United Network for Organ Sharing (UNOS) was awarded initial OPTN contract on September 30, 1986 and has continued to operate OPTN for more than sixteen years and four successive contract renewals).

34. *See Organ Procurement Organizations*, *supra* note 5 (delineating OPO responsibilities and explaining that OPOs are federally regulated). OPOs are principally responsible for obtaining donor organs. *See id.* (detailing OPO methods for increasing organ donation including community outreach, advertising campaigns, and school and worksite programs); *see also* *About OPOs*, ASS'N OF ORGAN PROCUREMENT ORGS., <http://www.aopo.org/about-opo> (last visited Jan. 31, 2014) (revealing OPO structure and goals). There are fifty-eight federally-designated OPOs throughout the United States and its territories. *See About OPOs*, *supra* ("OPOs utilize cutting edge technology to facilitate medical advancements that place hope within reach for tens of thousands of Americans waiting for a life-saving organ transplant."). OPOs are "generally structured to include clinical services, hospital development, donor family services, and public education." *Id.* (reporting that each OPO is tailored to serve its local community).

35. *See About OPTN: Profile*, OPTN: ORGAN PROCUREMENT & TRANSPLANTATION NETWORK, U.S. DEP'T OF HEALTH & HUMAN SERVS., <http://optn.transplant.hrsa.gov/optn/profile.asp> (last visited Feb. 9, 2014) (listing OPTN's responsibilities). These responsibilities include: collecting and managing organ transplantation statistics for the government, the public, students, and researchers to use for future improvements in organ allocation and transplantation and "developing . . . and maintaining a secure web-based computer system," which matches organ donors and available organs nationally. *See id.* (noting that in handling all of its responsibilities, OPTN strives to be efficient and effective).

the OPTN develop policies that provide organs to those with the greatest medical urgency through an “equitable” allocation system.³⁶

2. *The Mechanics of Organ Allocation*

Generally, when any donor organ becomes available, the OPO enters information about the donor organ into the OPTN’s computerized match system in order to identify a list of potential recipients needing that type of organ.³⁷ The list of candidates identified by the OPTN’s matching system is then ranked according to objective criteria.³⁸ While each organ has its

36. See 42 C.F.R. § 121.8(b)(2) (2007) (emphasizing that organ allocation must be decided by medical urgency). Before the Final Rule, organs in the United States were distributed on a regional basis to patients based upon their need. See Dulcinea A. Grantham, *Transforming Transplantation: The Effect of the Health and Human Services Final Rule on the Organ Allocation System*, 35 U.S.F. L. REV. 751, 752 (2001) (discussing background and development of the Final Rule). This system was greatly criticized by health professionals because it often resulted in inequitable distribution based on location and was medically ineffective. See *id.* at 770 (showing that prior to Final Rule, organ distribution was localized in smaller geographic regions rather than favoring one national, need-based system). The Final Rule transformed the organ allocation from a “local first” system to a national system, which achieved organ distribution in “regions broad enough to assure that those patients with greatest medical urgency are provided for.” See *id.* at 766 (imposing additional requirement that Secretary of HHS has ultimate power to determine way in which organs are distributed). The ultimate goal of the Final Rule was to ensure an equitable nationwide system for donated organs. See *id.* at 757 (showing legislative intent behind NOTA). The Final Rule was criticized for allocating organs to patients with low potential survival rates, for forcing small OPOs out of business, and for discouraging organ donations. See *id.* at 774–77 (discussing disadvantages of having one nationwide equitable donation system); see also Letter from John Roberts to Kathleen Sebelius, *supra* note 19 (describing process used to develop OPTN allocation policy). An OPTN committee with special knowledge of the particular organ develops all allocation policy for that organ. See *id.* (asserting that OPTN committees formulate policy based on objective medical evidence and current clinical practice). The specialized committee develops a proposal that is forwarded to the public in order to allow comments by any interested parties or organizations. See *id.* (explaining that all policy is open to public comment and committee will further refine proposal based on public comment before presenting it to OPTN/UNOS Board of Directors for review and vote). Approved policies are made available to the Department of Health and Human Services and are subject to the Secretary’s discretion for enforcement or reconsideration, under the provisions of the Final Rule. See *id.* (highlighting distinction between OPTN’s role in creating policy based on extensive medical knowledge and Secretary’s governance role in approving policies created by OPTN).

37. See *About Transplantation: Donor Matching System*, OPTN: ORGAN PROCUREMENT & TRANSPLANTATION NETWORK, U.S. DEP’T OF HEALTH & HUMAN SERVS., <http://optn.transplant.hrsa.gov/about/transplantation> (last visited Feb. 9, 2014) (detailing process by which donor organs are matched with waiting list candidates).

38. See *id.* (“Ethnicity, gender, religion, and financial status are not part of the computer matching system.”).

own specific criteria for organ matching, all organs share certain allocation policy commonalities.³⁹

For lung transplant candidates, all candidates ages twelve and older are given an individualized lung allocation score (LAS) to prioritize them for matching organ offers.⁴⁰ Factors determining a potential recipient's LAS and priority on the waitlist include: the probability of surviving the next year while remaining on the waitlist, the medical urgency of the candidate, the probability of surviving the first year after the transplant, the probability of surviving long term after the transplant and the raw allocation score.⁴¹ Candidates with the highest LAS are offered donated organs

39. See Letter from John Roberts to Kathleen Sebelius, *supra* note 19 (summarizing shared commonalities of organ matching policy for all organs). The shared policy criteria that OPTN considers when matching donated organ with potential recipients include:

[A] local/zonal/national sequence of organ offers, to minimize organ preservation time and maximize the chance of a successful transplant[;] priority in matching for identical blood type matching between donor and candidate, then for compatible but not identical blood types[;] use of individual waiting time as an ultimate tiebreaker among two candidates who have otherwise equal priority[;] discretion for the individual transplant center to apply individual acceptance criteria for offers for individual candidates, including donor size and age range.

Id. (listing various factors taken into account when matching donors with organs).

40. See *A Guide to Calculating the Lung Allocation Score*, UNITED NETWORK OF ORGAN SHARING, http://www.unos.org/docs/lung_allocation_score.pdf (last visited Feb. 9, 2014) (discussing various factors which contribute to calculating potential recipient's LAS and providing hypothetical computation of LAS). Factors determining a potential recipient's LAS and priority on the waitlist include: the waiting list survival probability during the next year, the waitlist urgency measure, the post-transplant survival probability during the first post-transplant year, the post-transplant long-term survival measure, and the raw allocation score. *See id.* (noting complexity and highly technical nature of calculating LAS). "The specific emphasis in developing the LAS score for adolescents and adults was to base organ allocation on a balanced, 'net-benefit' concept." Letter from John Roberts to Kathleen Sebelius, *supra* note 19. There are not enough donated organs currently available to meet all needs. *See id.* (emphasizing importance of designing one efficient organ allocation system). Organ allocation based purely on distributive justice principles (i.e., preferentially offering organs to those with the highest need) would result in lower overall survival rates because candidates may be so debilitated that post-transplantation survival would be unlikely. *See id.* (presenting pattern of distribution relying on distributive justice). Conversely, offering organs preferentially to those with the greatest chances of post-transplantation survival, "would lead to higher waitlist mortality among urgent candidates who could be helped." *See id.* (presenting distribution relying on utility). The LAS score balances these conflicting priorities. *See id.* (taking into account both utility and distributive justice).

41. See *A Guide to Calculating the Lung Allocation Score*, *supra* note 40 (discussing various factors contributing to calculating potential recipient's LAS and priority of waitlist).

first.⁴² The LAS formula is only used for adolescent and adult candidates.⁴³

Instead of an LAS, children under the age of twelve needing lung transplants are given either a Priority 1, the highest medical urgency status, or a Priority 2 medical urgency status for ranking purposes.⁴⁴ Priority 1 candidates either have respiratory failure or pulmonary hypertension, or have been approved as an exception case by the OPTN Lung Review Board.⁴⁵ Waitlist placement among Priority 1 candidates is determined by the amount of time a candidate has been on the waitlist with the candidates who have been on the waitlist the longest being placed at the top.⁴⁶ Priority 1 candidates are offered donated organs from all donors younger than twelve within a thousand-mile radius before the donated organs are offered to any candidates older than twelve in the same area.⁴⁷ Pediatric candidates can receive lungs from adolescent donors but only if transplant programs decline them for all adolescent candidates between the age of twelve and seventeen within the same allocation area.⁴⁸ Pediatric candidates can also receive lungs from adult donors but only if transplant programs decline them after all adolescent and adult candidates within the

42. *See id.* (illustrating that ranking transplant candidates relies on several complex calculations which take into account various elements).

43. *See* Letter from John Roberts to Kathleen Sebelius, *supra* note 19 (describing lung allocation policy for candidates under twelve years old). Dr. John Roberts states that:

The LAS formula is used for adolescent and adult candidates. Its applicability among pre-adolescents is unknown. There are very few of these patients, and the diagnosis and progression of lung diseases may be different in this population. . . . For this reason, the [Thoracic Organ Transplantation Committee] felt that extrapolating the LAS below age 12 was inappropriate and, because of the small numbers, also concluded that waiting time for this population should remain the method of prioritizing patients in this group. Because there was no way to appropriately prioritize 0–11 year old patients with the list of patients ordered by LAS, it was decided to provide 0–11 candidates first priority for organs best suited for them—those from 0–11 year old donors.

Id. (explaining why it is not appropriate for children under twelve and adults to be prioritized by similar standards).

44. *See Policy 3.7.6.2, Allocation of Thoracic Organs, Candidates Age 0–11*, OPTN: ORGAN PROCUREMENT & TRANSPLANTATION NETWORK, U.S. DEP'T OF HEALTH & HUMAN SERVS. (Feb. 1, 2013), http://optn.transplant.hrsa.gov/ContentDocuments/OPTN_Exec_Comm_mtng_materials_06-10-13.pdf [hereinafter *Policy 3.7.6.2*] (defining criteria for candidates to be placed in either Priority 1 status or Priority 2 status); *see also* Letter from John Roberts to Kathleen Sebelius, *supra* note 19 (illustrating unlikelihood that children will receive acceptable adult organs).

45. *See Policy 3.7.6.2, supra* note 44 (explaining how Priority 1 candidates are categorized).

46. *See* Letter from John Roberts to Kathleen Sebelius, *supra* note 19 (explaining how Priority 1 candidates are ranked).

47. *See id.* (noting children receive child-donated organs first).

48. *See id.* (stating children receive adolescent organs after adolescents decline them).

same allocation area have turned them down.⁴⁹ Any transplant candidate who does not meet the criteria to be listed as a Priority 1 candidate is automatically listed as a Priority 2 candidate.⁵⁰

For all donated organs including lungs, after receiving a list of potential recipients, the OPO contacts the transplant surgeon caring for the top-ranked patient and depending on various factors, the transplant surgeon determines if the organ is suitable for the patient.⁵¹ Doctors determine whether organs are medically suitable by looking to the medical health history of the donor, the current health of the recipient, and the condition of the donated organ.⁵² If the organ is suitable, the OPO arranges transportation and schedules the transplant surgery.⁵³ Because donated organs are in such high demand, organ allocation is guided by bioethical principles.⁵⁴

B. *Ethical Principles Governing Equitable Organ Allocation*

Organ allocation presents a unique and tragic bioethical dilemma.⁵⁵ While available organs surround us in abundance, eighteen people still die every day on the waitlist.⁵⁶ Because our donation system relies on donor altruism, it is an impossible task for the OPTN to reconcile the scarce supply of donated organs with the vast demand.⁵⁷ Thus, the OPTN is compelled to make life and death decisions about who should receive a donated organ and who will have to remain on the waitlist.⁵⁸

49. *See id.* (stating children receive adult lungs only after all adolescent and adult candidates decline them).

50. *See id.* (stating children are given adult organs after adults and adolescents decline them).

51. *See About Transplantation: Donor Matching System, supra* note 37 (highlighting that donated organs cannot always be used).

52. *See id.* (explaining how doctors determine whether organs are medically suitable for donation).

53. *See id.* (stating that recovered organs are stored in cold organ preservation solution and transported from donors to recipient hospitals). For heart and lung recipients, it is best to transplant the organ within six hours of organ recovery. *See id.* (illustrating time-sensitive nature of organ transplantation).

54. For a discussion of utilitarianism in OPTN organ allocation policies, see *supra* notes 62–72 and accompanying text. For a discussion of distributive justice in OPTN organ allocation policies, see *supra* notes 73–84 and accompanying text. For a discussion of autonomy in OPTN organ allocation policies, see *supra* notes 85–90 and accompanying text.

55. *See Gross, supra* note 23, at 172 (explaining that one “difficult and unusual” condition of organ allocation is “dire scarcity amid material abundance”).

56. *See Statistics, DONATE LIFE AM.*, <http://donatelife.net/understanding-donation/statistics/> (last visited Feb. 9, 2014) (providing organ donation statistics).

57. *See OPTN Data, supra* note 4 (illustrating vast difference in number between organ transplants and people waiting for organs).

58. *See Memorandum from the OPTN/UNOS Ethics Comm. to the OPTN/UNOS Exec. Comm.* (June 10, 2013), http://www.optn.transplant.hrsa.gov/ContentDocuments/OPTN_Exec_Comm_mtng_materials_06-10-13.pdf [hereinafter OPTN/UNOS Memorandum] (noting significant role that OPTN decisions play in lives of thousands of transplant candidates).

For the purposes of determining who is given a donated organ, the OPTN justifies their policies based on principles of utility, distributive justice, and autonomy.⁵⁹ It is important to understand the fundamental role these bioethical principles play in OPTN organ allocation policy in order to recognize the destructive bioethical impacts that the *Murnaghan* decision and the special review of Sarah's case caused to the entire organ allocation system.⁶⁰ This part discusses utility, distributive justice, and autonomy in the context of organ allocation.⁶¹

1. *Utility*

The principle of utility holds an action to be ethically right if it produces the greatest aggregate good and minimizes the harms for the greatest amount of people.⁶² The goal of utilitarianism is to maximize the aggregate happiness of the whole society by distributing benefits to those who are going to maximize the benefit.⁶³ Utility disregards the process by which a resource is maximized and rather, strives to reach the best possible outcome in the distribution of a resource.⁶⁴ Developing policy that maximizes benefits requires that lawmakers compare the allocation methods "in some manner so that at least a rough estimate can be made determining which allocation produces the greatest good."⁶⁵

Thus, as applied to organ allocation, the principle of utility requires that policymakers create organ allocation policy that maximizes the "best

59. *See id.* ("The transparent balancing of utility and [distributive] justice combined with a predictable and stable application of allocation policy is critical to the fairness of the national system.").

60. For a further discussion of the bioethical consequences resulting from special review of any individual transplant candidate's case, see *infra* notes 177–90 and accompanying text.

61. For a discussion of utilitarianism in OPTN organ allocation policies, see *infra* notes 62–72 and accompanying text. For a discussion of distributive justice in OPTN organ allocation policies, see *infra* notes 73–84 and accompanying text. For a discussion of autonomy in OPTN organ allocation policies, see *infra* notes 85–90 and accompanying text.

62. *See* OPTN/UNOS ETHICS COMM., U.S. DEP'T OF HEALTH & HUMAN SERVS., ETHICAL PRINCIPLES TO BE CONSIDERED IN THE ALLOCATION OF HUMAN ORGANS (2010), available at <http://optn.transplant.hrsa.gov/resources/bioethics.asp?index=10> [hereinafter OPTN/UNOS, ETHICAL PRINCIPLES] (discussing ethical principles to be considered in organ allocation); *see also* *The Principle of Beneficence in Applied Ethics*, STAN. ENCYC. PHIL. (Oct. 3, 2013), <http://plato.stanford.edu/entries/principle-beneficence/> [hereinafter *Principle of Beneficence*] (discussing intersection between utility and beneficence). Beneficence is an ethical principle that requires that a person do good and avoid doing harm. *See Principle of Beneficence, supra* (noting that both utility and beneficence attempt to maximize benefits and minimize burdens).

63. *See* BARRY R. FURROW ET AL., BIOETHICS: HEALTH CARE LAW AND ETHICS 6 (1987) (noting that there are several, varying definitions of "happiness").

64. *See Principle of Beneficence, supra* note 62 (explaining that utility determines moral righteousness of action by looking at outcome, not process).

65. *See* FURROW ET AL., *supra* note 63, at 6 (stating that utility is essential for thorough review of any allocation policy and requires system wide measurement).

use” of donated organs while minimizing possible negative consequences of transplantation.⁶⁶ Organ allocation policy, which makes the most efficient and the “best” use of donated organs maximizes, “the saving of life, the relief of suffering and debility, the removal of psychological impairment, and the promotion of well-being.”⁶⁷ Conversely, the harms that a utilitarian-based organ allocation policy attempts to minimize are patient post-transplantation mortality and mortality resulting from organ rejection and medicinal complications.⁶⁸ Because of the scarce supply of donated organs in the face of ever-growing demand, utility remains an essential component of organ allocation policy, and the OPTN continues to rely on utility to efficiently manage its organ allocation system.⁶⁹

However, too much emphasis on utility and maximizing the best use of organs in allocation policy may result in persistent inequities in the distribution of organs.⁷⁰ For instance, a system based solely on utility would seek, without regard to the pattern of distribution, to save the lives of as many organ transplant candidates as possible by taking into account factors including post-transplantation survival rates, long-term survival rates, and even an individual’s social worth.⁷¹ The result would be that certain groups, like the elderly, would have little chance at meeting these criteria and thus, would always be passed over for candidates who have a greater chance at maximizing the best use of donated organs.⁷²

2. *Distributive Justice*

Unlike utility, distributive justice focuses solely on the process by which a resource is distributed among potential beneficiaries and requires

66. See OPTN/UNOS, *ETHICAL PRINCIPLES*, *supra* note 62 (noting that organ procurement and transplantation is undertaken to benefit groups of critically ill patients).

67. See *id.* (providing examples of utilitarian goals underlying organ allocation policies).

68. See *id.* (stating that utility takes into account all possible goods and harms that could be envisioned).

69. See OPTN/UNOS Memorandum, *supra* note 58 (noting that allocating in manner that maximizes best use of organ is in accordance with requirements of NOTA and Final Rule, and defining “best” in accordance with utility as that which maximizes greatest amount of good for greatest amount of people).

70. See F. Daniel Davis, *The Ethics of Organ Allocation: Policy Questions Concerning Geography, Age, and Net Benefit*, PRESIDENT’S COUNCIL ON BIOETHICS (2007), http://bioethics.georgetown.edu/pcebe/background/ethics_of_organ_allocation.html (examining organ allocation policy in light of utility and distributive justice). Utilitarians would be inclined to discriminate against the elderly in allocating organs since transplantations in senior citizens would generally result in low survival rates. See generally ROBERT M. VEATCH, *TRANSPLANTATION ETHICS* (2000) (explaining that utility ignores patterns of distribution of goods being allocated).

71. See VEATCH, *supra* note 70, at 293–94 (discussing problems with a purely utilitarian organ allocation system).

72. See *id.* (stating that utilitarians seek efficiency in distribution of donated organs not fairness).

that equal persons be given equal access to the resource.⁷³ Distributive justice attempts to create an allocation policy based on fair and equitable distribution of benefits and requires that people in similar situations be treated equally.⁷⁴ The principle of distributive justice suggests that “society has a duty to the individual in serious need and that all individuals have duties to others in serious need.”⁷⁵ In decisions regarding the allocation of resources, distributive justice does not evaluate the quality or social value of a candidate, but requires that the benefits and burdens should be distributed in an equitable manner.⁷⁶

In the context of organ allocation, distributive justice requires that all people in need of organs should have a fair opportunity to receive them and that no potential transplant candidate is denied organs because of personal, economic, or social qualities.⁷⁷ Policies grounded in distributive justice and fairness take into account a variety of factors including medical urgency, time spent on the waitlist, number of past transplants, and age of the candidate.⁷⁸ In response to NOTA’s requirement that donated organs

73. See OPTN/UNOS Memorandum, *supra* note 58 (“[M]orally relevant differences may justify unequal distribution of goods[].”); see also Friedrich Breyer, *Health Care Rationing and Distributive Justice*, 0 RATIONALITY MARKETS & MORALS 395, 401 (2009), http://www.rmm-journal.de/downloads/028_breyer.pdf (presenting several different meanings of “equal” in context of resource allocation).

74. See *Principle of Distributive Justice*, ASCENSION HEALTH, http://www.ascensionhealth.org/index.php?option=com_content&view=article&id=80:principle-of-distributive-justice&Itemid=171 (last visited Feb. 10, 2014) (“[D]istributive justice is . . . closely linked to the concepts of human dignity, the common good, and human rights.”).

75. See *id.* (emphasizing basic human right to health care).

76. See *id.* (noting society’s duty to individuals in serious need of any resource is not lessened because of beneficiary’s societal or financial status, or nature of illness). Well-known medical ethicist Georg Marckmann has suggested a set of criteria relevant to designing a just allocation policy. See Breyer, *supra* note 73, at 400 (discussing interchange between rationing scarce health care resources and distributive justice). Marckmann states that the criteria includes: “the transparency of the [allocation] process,” “the implementation by a democratically legitimized institution,” the possibility for important groups of interested parties to participate, consistency, and opportunities for appeal of decisions. See *id.* (illustrating that distributive justice focuses not on outcome but on pattern of distribution of goods).

77. See OPTN/UNOS Memorandum, *supra* note 58 (noting that when considering individuals, distributive justice requires that “likes be treated alike” and suggesting that “morally relevant differences may justify unequal distribution of goods”). Distributive justice requires that two patients who are equal in all “morally relevant” considerations should have the same chance of getting a donated organ. See *id.* (“[I]f one person has an objectively higher probability of dying without an organ than another person, that difference would be considered morally relevant [to allocation] and would justify giving the organ to first person.”).

78. See OPTN/UNOS, ETHICAL PRINCIPLES, *supra* note 62 (presenting these factors as ones which might be included in allocation policy because they seem necessary to treat potential recipients fairly and to give everyone fair chances of getting donated organs). Allocation schemes based on distributive justice may give consideration to the most medically urgent patients, who are unlikely to have long-term post-transplantation survival rates even if it is predictable that other patients

be distributed equitably, the OPTN balances all of these distributive justice factors when they rank transplant candidates.⁷⁹

Too much emphasis on distributive justice may generate inefficiencies and waste donated organs for which the supply is limited and the demand is always growing.⁸⁰ For instance, an organ allocation system designed purely with distributive justice in mind would hold as their principal goal that all people should have an equal opportunity to be as well-off and healthy as all other people.⁸¹ The implications of such a system would result in placing the sickest people at the top of the organ transplantation waiting list.⁸² However, the people with the greatest need for donated organs may also have higher post-transplantation mortality rates.⁸³ While a system based solely on distributive justice would be fair in that it would allow for equal access to donated organs, arguably the number of people ultimately saved through organ transplantation would be fewer than a system balanced with utility.⁸⁴

3. *Autonomy*

The principle of autonomy holds that actions are ethically right insofar as those actions respect an individual's exercise of self-determination and freedom to make decisions affecting one's own person.⁸⁵ Autonomy preserves an individual's free will and right "to live one's life according to reasons and motives that are taken as one's own and not the product of manipulative or distorting external forces."⁸⁶ The central principle of au-

who are not as sick may have better post-transplantation survival rates. *See id.* (emphasizing that distributive justice is concerned with fairness and equity).

79. *See id.* (pointing out that UNOS has continued to express concern for distributive justice in organ allocation); *see also A Guide to Calculating Lung Allocation Score, supra* note 40 (illustrating balancing of distributive justice factors and utility factors for purposes of ranking transplant candidates).

80. *See* Davis, *supra* note 70 (reflecting on attempt to balance utility and distributive justice in organ allocation policy). Because utility and distributive justice often conflict, an efficient, utilitarian system focused on maximizing a benefit will probably not be the most equitable or the most fair. *See* VEATCH, *supra* note 70, at 295 (showing that conversely, pure distributive justice systems will probably be inefficient).

81. *See* VEATCH, *supra* note 70, at 295 (demonstrating goals and results of distributive justice allocation system).

82. *See id.* (explaining how distributive justice organ allocation system would operate to distribute organs).

83. *See id.* (noting negative results of organ allocation system based solely on distributive justice).

84. *See id.* (stating need for organ allocation system balancing utility and distributive justice).

85. *See* OPTN/UNOS, ETHICAL PRINCIPLES, *supra* note 62 (discussing importance of autonomy in creating organ allocation policy).

86. *See Autonomy in Moral and Political Philosophy*, STAN. ENCYC. PHIL. (Aug. 11, 2009), <http://plato.stanford.edu/entries/autonomy-moral/> ("[T]o be autonomous is to be one's own person, to be directed by considerations, desires, conditions, and characteristics that are not simply imposed externally upon one, but are part of . . . one's authentic self.").

tonomy is that a person has complete control to make decisions regarding their own person as long as those decisions do not impose upon the rights of others.⁸⁷

When autonomy conflicts with utility and distributive justice in the creation of organ allocation policy, the OPTN often prioritizes utility and distributive justice over autonomy.⁸⁸ However, the principle of autonomy deserves consideration in creating organ allocation policies as it preserves an individual's free will and right to make decisions about organ transplantation.⁸⁹ Factors relevant to the creation of organ allocation policies protecting autonomy include: "1) the right to refuse an organ; 2) [the right of] free exchanges among autonomous individuals; 3) allocation by directed donation; and 4) transparency of processes and allocation rules to enable stakeholders to make an informed decision."⁹⁰

III. PRESCRIBING LIMITS TO THE JUDICIARY'S REACH INTO ADMINISTRATIVE AGENCY RULEMAKING AUTHORITY

This section explores the parameters of judicial authority in the scope of administrative agency rulemaking and expertise.⁹¹ Because the *Murnaghan* decision highlights the relationship between the judiciary and an administrative agency, especially in light of bioethical considerations, it is essential to understand the respective authorities of the judiciary and administrative agencies.⁹² The relationship between the judiciary and an administrative agency is largely determined by fundamental separation of powers principles and Supreme Court precedent on judicial deference to administrative agency rulemaking expertise in *Chevron*.⁹³

87. See OPTN/UNOS, ETHICAL PRINCIPLES, *supra* note 62 ("Persons and their actions are never 'fully' autonomous, but nevertheless it is possible to recognize certain individuals and their decisions as more or less substantially autonomous.").

88. See *id.* (noting that "sometimes autonomy must give way," "when it conflicts with other ethical principles" in determining equitable distributions of organs).

89. See *id.* ("If one of the characteristics of actions or practices that tend to make them right is that they respect autonomy, then it is possible that certain policies could be morally right, at least *prima facie*, even if they do not maximize utility and do not promote equitable distributions.").

90. *Id.* (listing factors to consider when forming organ allocation policy grounded in autonomy).

91. For a further discussion of the relationship between the judiciary and administrative agencies, see *infra* notes 92–116 and accompanying text.

92. See Emergency Motion for a Temporary Restraining Order and Preliminary Injunction, *Murnaghan v. Dep't of Health and Human Servs.*, No. 13-CV-03083, 2013 WL 3363500 (E.D. Pa. June 5, 2013) [hereinafter Emergency Motion] (emphasizing that plaintiff filed suit against HHS, as administrative agency and that OPTN/UNOS are private organizations under HHS authority).

93. See *Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 866 (1984) (questioning judiciary's ability to interpret Clean Air Act provisions). For a discussion of the role of administrative agencies in a tripartite government system, see *infra* notes 94–103 and accompanying text.

A. *Administrative Agencies and the Judiciary: Separation of Powers*

An administrative agency is a government authority with quasi-judicial power that promulgates, enforces, and interprets regulations for recently passed statutes.⁹⁴ Unlike the judiciary, an administrative agency is not an independent branch of the government.⁹⁵ Rather, legislative acts establish an administrative agency, and Congress delegates, through that act, the “jurisdiction, function, powers, and resources available to administrative agencies.”⁹⁶ Administrative agencies specialize in developing and implementing policy in complicated areas of legislation, and with their expert and specialized knowledge, they solve complex problems arising from ambiguous congressional legislation.⁹⁷ In adopting this role, administrative agencies lighten the burden on the legislature and the judiciary by clarifying the law.⁹⁸

The relationship between administrative agencies and the judiciary continues to change in response to evolving social, political, and economic concerns.⁹⁹ While the judiciary generally acts to control and to monitor unreasonable actions taken by administrative agencies, the judiciary has not always drawn a consistent line between judicial and administrative au-

94. See Christopher M. Rosselli, Note, *Standards for Smart Growth: Searching for Limits on Agency Discretion and the Georgia Regional Transportation Authority*, 36 GA. L. REV. 247, 257 (2001) (discussing role of administrative agencies in government’s tripartite system).

95. See Patrick M. Garry, *The Unannounced Revolution: How the Court Has Indirectly Effected a Shift in the Separation of Powers*, 57 ALA. L. REV. 689, 694–95 (2006) (analyzing doctrine of separation of powers). The separation of powers doctrine provides a system of checks and balances and seeks to control governmental power by splitting it between the executive, legislative, and judicial branches. See *id.* (“[E]ach branch must be confined to the exercise of its own function and not allowed to encroach upon functions of other branches.”).

96. See E.P. Krauss, *Unchecked Powers: The Supreme Court and Administrative Law*, 75 MARQ. L. REV. 797, 806 (1992) (placing administrative agencies in tripartite system of governance and explaining process by which administrative agencies gain authority).

97. See Rosselli, *supra* note 94, at 257 (noting that administrative agencies have both quasi-judicial and quasi-legislative powers such that “they may take on administrative, investigative, rulemaking, determinative, enforcement, or oversight functions”). “The justifications for the delegation of congressional power to administrative agencies include Congress’s inability to handle technical issues and act efficiently and effectively. In addition Congress’s limited resources often make it unable to articulate meaningful standards for particular problems.” Peter Marra, *Have Administrative Agencies Abandoned Reasonability?*, 6 SETON HALL CONST. L.J. 763, 767–68 (1996) (footnotes omitted) (addressing manner in which administrative agencies embody role of rational decision-makers).

98. See Marra, *supra* note 97, at 766 (“[A]dministrative agencies may provide the mechanism through which Congress can respond to specific issues in a reasonable manner without having to draft highly technical legislation.”).

99. See ALEXANDER J. CELLA ET AL., 40 MASS. PRAC. ADMIN. L. & PRAC. § 1631 (2013) (showing that as administrative law has developed, courts have changed their methods of controlling agencies in response).

thority.¹⁰⁰ In earlier years, courts “attempted to review the substance of [administrative] agency decisions by reviewing the agency’s interpretation of the law and findings of fact.”¹⁰¹ However, due to the technical nature of many agency decisions, the courts recognized their inability to truly comprehend the intricacies of agency policy and decided that judicial review of agency procedure was a “more familiar and arguably fairer review mechanism.”¹⁰² The courts now review the responsibilities and functions delegated to the administrative agency and determine whether they “have been performed within the confines of the traditional standards of procedural and substantive fair play.”¹⁰³

B. *Supreme Court Precedent: Endorsing Judicial Deference to Administrative Rulemaking and Expertise*

The seminal case by which the courts adopted their present approach to judicial review of the procedure rather than the substance of agency decisions is *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*¹⁰⁴ In *Chevron*, the Supreme Court analyzed the District of Columbia (D.C.) Circuit Court of Appeals’ interpretation of the Environmental Protection Agency (EPA) regulations under the Clean Air Act and ruled that the D.C. Circuit erred when it substituted its own construction of Clean Air Act

100. See Marra, *supra* note 97, at 798–800 (explaining that courts act as restraints on administrative agencies, yet courts’ role is limited to after agency action has been taken).

101. See *id.* (detailing changes in courts’ approach to controlling administrative agency action).

102. See *id.* (citing *Chevron* to illustrate decisive change in courts’ approach to reviewing administrative action).

103. See Joel A. Smith, *Separation of Powers Redux—Receded Scope of Judiciary*, 44 MD. B.J. 18, 20 (2011) (quoting *Dep’t of Natural Res. v. Linchester Sand & Gravel Corp.*, 334 A.2d 514, 522–23 (Md. 1975)). Smith noted that courts serve to provide forums for redress and restraint of illegal administrative action. See *id.*; see also Administrative Procedure Act, 5 U.S.C. §§ 701–06 (2012) (allowing judicial review of agency action when it is made reviewable by statute or when agency action is final and there is no other adequate remedy).

104. See *Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842–43 (1984) (establishing two-step test by which reviewing courts are to evaluate interpretation of regulatory statute by any agency that administers statutes).

First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress. If, however, the court determines Congress has not directly addressed the precise question at issue, the court does not simply impose its own construction on the statute, as would be necessary in the absence of an administrative interpretation. Rather, if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency’s answer is based on a permissible construction of the statute.

Id. (questioning first whether agency construction of any statute is permissible on its merits and second whether agency’s interpretive choice resulted from reasoned decision-making).

provisions in place of the EPA's.¹⁰⁵ The Supreme Court found that the judiciary was unable to truly comprehend the lengthy, technical, and highly complex nature of the Clean Air Act and determined that the D.C. Circuit "misconceived the nature of its role in reviewing the regulations at issue."¹⁰⁶ According to the Supreme Court, federal judges have a duty to respect the legitimate policy decisions made by administrative agencies because of the expertise and knowledge underlying those decisions.¹⁰⁷

The Court further determined that where Congress fails to clearly define statutory provisions, the court may not impose its own construction.¹⁰⁸ Rather, Congress's express delegation of statutory authority to administrative agencies requires the agencies to formulate policy and to make rules that resolve uncertainties.¹⁰⁹ An administrative agency's formulation of policy combines the accommodation of competing interests and a thorough knowledge of highly technical and complex issues.¹¹⁰ Judges are not experts in technical fields nor are they part of either political branch of the government.¹¹¹

Thus, the Supreme Court established that in evaluating administrative policy, the judiciary should defer to the expertise of the administrative agency except when the policies are arbitrary, capricious, or manifestly contrary to the statute.¹¹² The scope of review under the arbitrary and capricious exception used in *Chevron* is narrow and courts must not attempt to substitute their interpretation of legislative acts for that of an agency.¹¹³ For agency action to avoid being found arbitrary, the agency must look to all of the information relevant to the creation of the policy

105. *See id.* at 866 (discussing whether court of appeals should have constructed its own meaning of "stationary source" in interpreting certain Clean Air Act provisions).

106. *See id.* at 845 (illustrating that once court of appeals recognized congressional gaps in any statute's meaning, that court should have left interpretation of those gaps to EPA authority).

107. *See id.* at 843–44 (establishing that principles of deference to administrative action have been consistently followed by Supreme Court whenever interpretative decisions requiring more than ordinary knowledge, and regarding meaning or reach of any legislative act, necessitate reconciliation of conflicting policies and full understanding of that policy's effects in any given situation).

108. *See id.* at 844 ("[A] court may not substitute its own construction of a statutory provision for a reasonable interpretation made by the administrator of an agency.").

109. *See id.* at 843 (discussing administrative agency power to administer policy and to make rules where there are congressional gaps in legislature).

110. *See id.* at 865 (explaining why administrative agencies rather than judiciary should be interpreting statutes).

111. *See id.* (claiming that courts in some instances are reconciling competing political interests but that it is not appropriate to do so on basis of judges' personal policy preferences).

112. *See id.* at 844 (stating standard by which policies must be analyzed under Administrative Procedure Act).

113. *See Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983) (reviewing arbitrary and capricious standard of Administrative Procedure Act).

and must be able to demonstrate a “rational connection” between the evaluated information and the policy implemented.¹¹⁴ Even if the agency is able to show a rational connection, agency action might still be found arbitrary if the agency action relies on information which Congress did not intend for the agency to use, “entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.”¹¹⁵ The arbitrary exception is a very high standard to meet and even if the administrative agency creates policy with “less than ideal clarity,” the courts may not interfere with that policy if the agency’s goal is reasonably apparent.¹¹⁶

IV. CASE STUDY: *MURNAGHAN V. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES*

Battling with cystic fibrosis, ten-year-old Sarah Murnaghan never led an easy or normal life.¹¹⁷ For the eighteen months that Sarah waited on the transplant waitlist, her chance of survival, much less a normal life, steadily diminished until her parents took action by filing a temporary restraining order against HHS.¹¹⁸ The court’s justifications for granting the temporary restraining order included the nature of Sarah’s injury, the likelihood of the Murnaghans prevailing on the merits of the case, and the public interest in the case.¹¹⁹ These justifications reveal the dangers of ruling on an emotionally appealing individual transplant candidate’s case without knowledge and expertise of the rationale behind organ allocation policy.¹²⁰

114. *See id.* (setting forth criteria which must be met to avoid arbitrary exception).

115. *See id.* (listing various considerations which would cause administrative agency action to fall within arbitrary exception).

116. *See id.* (citing *Bowman Transp. Inc. v. Arkansas-Best Freight Sys.*, 419 U.S. 281, 286 (1974)).

117. *See* Emergency Motion, *supra* note 92 (describing Sarah Murnaghan’s battle with cystic fibrosis).

118. *See id.* (noting that Sarah was in hospital for 106 consecutive days but on ninety-second day her condition took drastic turn for worse).

119. For a further discussion of the factors the court considered in deciding whether to grant the temporary restraining order, see *infra* notes 135–55 and accompanying text. For a further discussion of the events leading up to *Murnaghan*, see *infra* notes 122–34 and accompanying text.

120. For a discussion of the impact of changing policy for the sake of an emotionally appealing individual, see *infra* notes 156–76 and accompanying text.

A. *Sarah's Battle*

Sarah Murnaghan was diagnosed with cystic fibrosis at eighteen months old, at which time she already had severe lung damage.¹²¹ As Sarah grew older, her lung function steadily declined, despite drugs and multiple forms of therapy.¹²² Every year Sarah made multiple trips to the hospital, staying for four to five days at a time. Yet, Sarah attended school and her life remained relatively normal.¹²³

In December 2011, Sarah's condition drastically deteriorated and her lung capacity diminished to only thirty percent of its normal capacity.¹²⁴ On December 7, 2011, Sarah was placed on the pediatric lung transplant waitlist, categorized as a Priority 1 candidate for a set of child-donated lungs and given an LAS of 40.¹²⁵ Sarah remained on the pediatric lung transplant list for eighteen months.¹²⁶ In May 2013, Sarah was admitted to the intensive care unit of the Children's Hospital of Philadelphia (CHOP) after her condition worsened.¹²⁷

After the doctors told Sarah's parents that she only had weeks to live, the Murnaghans began a petition on Change.org in order to mobilize sup-

121. See Declaration of Sharon Ruddock Ex. E at 1, No. 13-CV-03083, 2013 WL 2433840 (E.D. Pa., June 5, 2013) [hereinafter Ruddock Declaration] (presenting testimony from Sarah's aunt regarding Sarah's past medical history). Eighteen months is a late diagnosis for a child with cystic fibrosis. See Marie McCullough, *Phila. Family Fights Lung-Donor Rule for Dying Girl*, PHILLY.COM (May 26, 2013), http://articles.philly.com/2013-05-26/news/39523457_1_cystic-fibrosis-lung-function-lung-transplant (discussing Sarah's need for donated lungs).

122. See McCullough, *supra* note 121 (noting that with available drugs and therapies, cystic fibrosis patients can remain relatively healthy through their teens and beyond).

123. See Ruddock Declaration, *supra* note 121, at 4 (revealing that in addition to Sarah's visits to hospitals, she also needed additional medical care at home).

124. See *id.* at 5 (stating that Sarah has been on supplemental oxygen twenty-four hours a day since December 2011).

125. See *id.* at 11 (illustrating gradual increase of Sarah's condition from when she was placed on lung transplant waiting list in December 2011 until June 2013). Unlike adults, an LAS is not used to determine a child's placement on the waiting list but rather UNOS gives children an LAS for data purposes. See *id.* (noting that Sarah was categorized as Priority 1 for purposes of placing her on child waiting list). In December 2011, Sarah's LAS was at 40 and on June 3, 2013, Sarah's LAS was at 66. See *id.* (showing drastic turn that Sarah's condition had taken). If Sarah was an adult with an LAS of 66, she would be very likely to receive a donated lung. See Complaint, *supra* note 10, at 36 (revealing that, according to UNOS data, in 2011, LAS of 50 would put patient in top six percent of organ donor candidates).

126. See Ruddock Declaration, *supra* note 121, at 5 (emphasizing that Sarah remained on waitlist because Under 12 Rule kept her from receiving donor organ offers).

127. See *id.* at 12 (noting that Sarah had been at CHOP since April 2013). As of May 2013, Sarah had not received any offers for a set of adult donated lungs. See Complaint, *supra* note 10, at 34 (illustrating difficulty of receiving offer of lungs pursuant to OPTN's Under 12 Rule). She had received three offers of donated lungs from children, but her doctors advised against taking any of them on the grounds that they were not medically suitable. See *id.* (explaining why Sarah had not been able to accept previous offers of donated lungs).

port for changing the OPTN's Under 12 Rule.¹²⁸ In response to the petition, the Secretary of the HHS directed the President of the OPTN Board of Directors to review the lung allocation policy for pediatric candidates.¹²⁹ Recognizing that the OPTN's formal review of policy could take weeks, on June 3, 2013, Sarah's parents requested that the Secretary set aside the Under 12 Rule on an emergency basis.¹³⁰

On June 5, 2013, the Secretary had not responded to the Murnaghans' request and the Murnaghans filed a motion in the Eastern District of Pennsylvania for a temporary restraining order and preliminary injunction to compel the HHS to cease enforcement of the Under 12 Rule.¹³¹ That same day, the court held a hearing on the motion and granted the temporary restraining order.¹³² On June 10, 2013, the OPTN Board of Directors unanimously passed a resolution to allow children under the age of twelve to be considered for the adult lung transplant list

128. See Ruddock Declaration, *supra* note 121, at 21 (stating that on May 16, 2013 Sharon Ruddock and Janet and Francis Murnaghan decided to start media campaign to fight "inequity"); see also *Petition to Kathleen Sebelius: Allow Transplants of Adult Lungs to Children*, CHANGE.ORG (June 2013), <http://www.change.org/petitions/allow-transplants-of-adult-lungs-to-children> [hereinafter *Petition to Kathleen Sebelius*] (presenting petition sent to Kathleen Sebelius and John Roberts, Director of OPTN, urging them to change OPTN policies and make exceptional rulings allowing Sarah to get donated lungs). Change.org is the world's largest petition platform. See *About*, CHANGE.ORG, <http://www.change.org/about> (allowing anyone to create petition and recruit others to support petition). Sarah's petition details OPTN policies regarding organ allocation to pediatric candidates and discusses the difficulties that Sarah has faced in receiving a set of donated lungs. See *Petition to Kathleen Sebelius*, *supra* (discussing OPTN's Under 12 Rule and archiving various online news articles covering Sarah's story).

129. See Letter from Kathleen Sebelius, Sec'y of U.S. Dep't of Health & Human Servs., to Dr. John Roberts, Dir., Organ Procurement & Transplantation Network (May 29, 2013), available at http://optn.transplant.hrsa.gov/ContentDocuments/OPTN_Exec_Comm_mtng_materials_06-10-13.pdf (requesting that OPTN forward information regarding protocol for pediatric lung transplants, in response to attention from national media, Congress, and others); see also *id.* (asking OPTN to consider new approaches for promoting pediatric organ donation).

130. See Complaint, *supra* note 10, at 45 (submitting request under 42 C.F.R. § 121.4(d), which allows any interested party to submit critical comments about OPTN policy to Secretary and allows Secretary to direct OPTN to change policies). Through Sarah's doctors at CHOP, Sarah's parents twice asked the OPTN Thoracic Committee if an appeal could be made to the OPTN Lung Review Board and the OPTN rejected both requests on the grounds that the OPTN Lung Review Board had no discretion to set aside the Under 12 Rule. See *id.* at 39 (discussing other methods plaintiff had tried prior to petitioning HHS).

131. See *id.* at 46 (claiming that time sensitive nature of Sarah's case forced plaintiff to file suit).

132. See Audio Recording: Temporary Restraining Order Hearing at 59:31, Murnaghan v. Dep't of Health and Human Servs., No. 13-CV-03083, 2013 WL 3363500 (E.D. Pa. June 5, 2013), available at http://www.pepperlaw.com/pdfs/Courtroom_3A_6-5-2013_B.mp3 [hereinafter TRO Audio Recording] (ordering HHS to immediately cease application of Under 12 Rule to allow children under twelve to be considered as recipients for donated lungs from adults based on medical severity of their conditions as compared to medical severity of persons over twelve in OPTN system).

on a case-by-case basis by the OPTN's Lung Review Board.¹³³ Sarah received a set of adult donated lungs on June 12, 2013.¹³⁴

B. *Granting Life*

Before granting the temporary restraining order, the court heard arguments from Sarah's doctor, the Director of the Lung Transplant Program at CHOP.¹³⁵ Sarah's doctor explained that Sarah was in the end stages of organ failure and that a lung transplant was the only way that Sarah would be able to live.¹³⁶ When the court asked Sarah's doctor about OPTN's Under 12 Rule, which was limiting Sarah's ability to get a donated lung, he claimed that age twelve "seemed like an arbitrary number," and he did not see a basis for the Under 12 Rule for ten or eleven year-old children.¹³⁷

Before making its decision, the court stated that it was relying on the testimony of Sarah's doctor that the Under 12 Rule was arbitrary and that the court was "in no way, shape, or form dictating who gets an organ trans-

133. See OPTN/UNOS Ethics Comm., *Policy 3.7.6.4, Lung Candidates with Exceptional Cases*, OPTN: ORGAN PROCUREMENT & TRANSPLANTATION NETWORK, U.S. DEP'T OF HEALTH & HUMAN SERVS. (June 10, 2013), http://optn.transplant.hrsa.gov/ContentDocuments/OPTN_Exec_Comm_mtng_materials_06-10-13.pdf (supplementing previous pediatric lung allocation policy with review mechanisms for individual cases). The new policy states that "in the case of candidates aged 0–11 years old, transplant programs may request classification as an adolescent candidate for the purposes of Policy 3.7.11 (Sequence of Adult Lung Allocation) while maintaining their pediatric classification for the purposes of Policy 3.7.11.1 (Sequence of Pediatric Donor Lung Allocation)." *Id.* While the new policy became effective immediately, it will expire on July 1, 2014 at which time the OPTN Board of Directors and committees will reconsider whether it should be renewed. See *OPTN/UNOS Executive Committee Approves Discretionary Listing of Pediatric Lung Transplant Candidates*, OPTN: ORGAN PROCUREMENT & TRANSPLANTATION NETWORK, U.S. DEP'T OF HEALTH & HUMAN SERVS. (June 10, 2013), <http://optn.transplant.hrsa.gov/news/newsDetail.asp?id=1598> (publicizing policy changes made by OPTN Board of Directors following Murnaghan).

134. See *Sarah Murnaghan, 11, Home After Controversial Lung Transplant*, ABC NEWS (Aug. 27, 2013), <http://abcnews.go.com/Health/sarah-murnaghan-11-home-controversial-lung-transplant/story?id=20080946> (revealing that after Sarah's first lung transplant on June 12, 2013 failed, she had her second double-lung transplant surgery on June 15, 2013).

135. See generally TRO Audio Recording, *supra* note 132 (hearing arguments on impact that Under 12 Rule has had on Sarah's circumstance and OPTN's reasoning why courts should not intervene in OPTN policy-making); cf. Liz Szabo, *Ethicists Debate Girl's Second Lung Transplant*, USA TODAY (July 1, 2013), <http://www.usatoday.com/story/news/nation/2013/07/01/girls-second-lung-transplant/2477699/> (statement of Dr. David Cornfield) ("When physicians take on the responsibility for an individual patient, they will continue to advocate powerfully and unremittingly for the patient who is before them.").

136. See TRO Audio Recording, *supra* note 132, at 6:39–6:53 (explaining that Sarah needs bilateral lung transplant to survive).

137. See *id.* at 17:08–18:13 (arguing that age twelve seemed arbitrary cutoff because cystic fibrosis presents itself in children and adults in similar manner).

plant.”¹³⁸ The court also recognized that “this is a serious and sensitive issue and has caused a great deal of concern by hundreds of people across the United States.”¹³⁹ The court then set forth several factors underlying its grant of the temporary restraining order.¹⁴⁰ The following sections will analyze each of these factors including the nature of Sarah’s legal injury, the likelihood that the Murnaghans would prevail on the merits of the case, and the public’s interest in the outcome of the case.¹⁴¹

1. *An Irreparable Injury*

The court first considered the nature and circumstance of the injury inflicted on Sarah by the OPTN’s Under 12 Rule.¹⁴² The court explained that the nature and circumstance of Sarah’s condition were very serious.¹⁴³ The court determined that under the present Under 12 Rule, Sarah would die.¹⁴⁴ The court distinguished the nature of Sarah’s illness stating that it easily met the *threshold requirement* for injunctive relief since it was irreparable.¹⁴⁵ Moreover, the court emphasized that it would be a “terrible tragedy” if it did not grant the temporary restraining order and a donated set of lungs were to become available for Sarah but she was unable to take them because she was under the age of twelve.¹⁴⁶

138. *See id.* at 43:44–44:40 (stating that decision does not dictate that Sarah will receive organ).

139. *See id.* at 43:41–43:51 (recognizing sensitive nature of organ allocation policy for transplant candidates dealing with life and death decisions).

140. *See id.* at 53:45–56:33 (discussing factors behind granting TRO).

141. For a further discussion of the irreparable nature of Sarah’s injury, the likelihood of success on the merits of the claim, and the public interest involved in this case, see *infra* notes 142–55 and accompanying text.

142. *See* TRO Audio Recording, *supra* note 132, at 53:45–54:01 (hearing testimony from Sarah’s doctor, CHOP’s Director of Lung Transplant Program).

143. *See id.* at 3:39–6:39 (describing nature of Sarah’s condition). The testimony of Sarah’s doctor revealed that Sarah had end-stage organ failure and she required support from a noninvasive ventilator to live on a daily basis. *See id.* (stating that Sarah had continually been on ventilators since March). Sarah’s doctor stated that the only thing that would allow her to continue to live would be a lung transplant. *See id.* at 6:39–6:53 (explaining that Sarah needs bilateral lung transplant to survive).

144. *See id.* at 20:11–20:39 (discussing Sarah’s chances of survival without lung transplant). Sarah’s doctor stated that over the first days of June 2013, Sarah’s condition had significantly deteriorated. *See id.* at 20:45–21:13 (answering question of urgency of Sarah’s situation). She had issues with fluid balance and her heart had shown signs of significant strain. *See id.* (answering court’s question of whether doctors had decided to intubate Sarah). After intubation, statistics show that patients generally have only weeks to live. *See id.* at 22:25–23:19 (discussing process after any patient is intubated). Sarah’s doctors believed that Sarah would need to be intubated within the week. *See id.* 22:07–22:24 (emphasizing that intubation is last resort for patients).

145. *See id.* at 53:45–54:01 (recognizing that Sarah’s injury is not any kind of damage that could be compensated other than by injunction).

146. *See id.* at 57:51–58:28 (acknowledging time sensitivity of Sarah’s case).

2. *Likelihood of Prevailing on the Merits*

The court struggled to assess the Murnaghans' likelihood of prevailing on the merits of the case.¹⁴⁷ The court explained that there was no Supreme Court or Third Circuit precedent governing discriminatory pediatric organ allocation policy.¹⁴⁸ However, the court stated that it had a great deal of experience with cases involving discrimination against children.¹⁴⁹ According to the court, Congress has been especially concerned with protecting children against discrimination and has enacted several laws to secure the interests of children.¹⁵⁰ Additionally, the court gave great weight to the testimony of the Director of the Lung Transplant Program at CHOP who was an expert in lung allocation policy and stated that the Under 12 Rule was arbitrary.¹⁵¹

3. *Public Interest*

Finally, the court considered the impact of granting the temporary restraining order on the public.¹⁵² The Director of the Lung Allocation Program at CHOP informed the court that only sixteen children across the United States would be affected by the decision.¹⁵³ The court recognized that the benefit to those sixteen children would be great and that it would do little to affect the chances of adult and adolescent candidates to

147. *See id.* at 54:02–54:20 (relating Sarah's case to other cases involving discrimination against children because there is no legal precedent dealing with discriminatory organ allocation policy).

148. *See id.* (emphasizing lack of guidance on this issue).

149. *See id.* at 54:21–55:19 (relating this case to cases involving educational policies which discriminate against children because of their disabilities or mental handicaps).

150. *See id.* (showing that protection of children's interests has always been of special concern to Congress, which implies that children should be protected against discriminatory organ allocation policy).

151. *See id.* at 15:53–18:13 (arguing that OPTN's Under 12 Rule is arbitrary). The Director of the Lung Allocation Program at CHOP claimed that the justification behind the Under 12 Rule was due to the difference in the disease process between children and adults. *See id.* (explaining differences between disease process in children under the age of five compared to adults were incomparable). The Director testified that the Under 12 Rule was only helpful in classifying children under the age of five from adults and that there was little difference in the disease process between adults and kids over the age of five. *See id.* (testifying that Under 12 Rule was developed nine years ago before medical and scientific advances made that policy obsolete as applied to children five to eleven years old). The Director stated he felt that there was no medical justification for the Under 12 Rule and that the age of twelve seemed like an arbitrary number. *See id.* at 18:32–18:40 (arguing that only justification for rule is that "you don't disadvantage one population to another").

152. *See id.* at 56:09–56:11 (noting significance of public interest in this case).

153. *See id.* at 56:52–56:54 (finding that there was one other child under twelve years old waiting in Eastern District of Pennsylvania for donated lungs who would be affected by *Murnaghan* decision).

receive donated lungs.¹⁵⁴ Therefore, the court determined that granting the temporary restraining order would greatly benefit the plaintiff and scarcely burden the defendant.¹⁵⁵

V. A CRITICAL EXAMINATION OF *MURNAGHAN*

The court's controversial intervention into Sarah's case highlights several problematic issues for dealing with future cases requesting judicial review of administrative agency policy.¹⁵⁶ While the *Murnaghan* court justified its intervention into OPTN policy by using the "arbitrary" exception set forth in *Chevron*, the technical nature of organ allocation policy makes judicial intervention inappropriate in light of *Chevron's* guiding principle that courts should defer to administrative agency expertise.¹⁵⁷ Especially where administrative agency expertise is grounded in bioethical principles designed to benefit all transplant candidates, courts should not interfere in any individual transplant candidate's case at the expense of utility, no matter how tragic that case is.¹⁵⁸

A. *Directing the OPTN to Cease Enforcement of the Under 12 Rule Fails to Consider OPTN Expertise*

The court made a conscious effort to emphasize the arbitrary nature of the OPTN's Under 12 Rule in order to justify departure from *Chevron* precedent.¹⁵⁹ *Chevron* allows judicial intervention into an administrative agency's policy-making authority only when the legislative regulations are "arbitrary, capricious or manifestly contrary to the statute."¹⁶⁰ Thus, by classifying the OPTN's Under 12 Rule as "arbitrary, capricious and an

154. See *id.* at 56:12–56:21 (stating that comparing burdens on plaintiff and defendant is one significant responsibility of courts).

155. See *id.* at 56:23–56:33 (emphasizing small number of patients affected by *Murnaghan* decision).

156. For a discussion of questions raised by the *Murnaghan* decision regarding judicial review of administrative agency policies, see *infra* notes 159–76 and accompanying text.

157. For a discussion of *Chevron*, see *supra* notes 104–16 and accompanying text. For a further discussion of the role *Chevron* plays in the *Murnaghan* case, see *infra* notes 159–76 and accompanying text.

158. For a further discussion of the bioethical principles used by the OPTN in creating organ allocation policy, see *supra* notes 55–90 and accompanying text. For a further discussion of the bioethical risks implicated by the *Murnaghan* decision, see *infra* notes 177–90 and accompanying text.

159. See TRO Audio Recording, *supra* note 132, at 47:34–47:53 (discussing application of *Chevron*). The court noted that Sarah's doctor, the Director of CHOP's Lung Allocation Program, felt that OPTN's Under 12 Rule was arbitrary. See *id.* (stating that Sarah's doctor's testimony was highly credible). The court highlighted that the Director's language brought the Under 12 Rule under the purview of *Chevron*. See *id.* at 47:53–48:18 ("[A]s we know from the law . . . one of the damning aspects of a regulation is that it's arbitrary. . . . I think that is something that has a lot of weight.").

160. *Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 844 (1984) (holding that regulations and policy should control unless they are "arbi-

abuse of discretion,” the court acted within the language of *Chevron* when it directed the OPTN to cease enforcement of the Under 12 Rule.¹⁶¹

However, whether the court’s ruling adhered to the *spirit* of *Chevron* is a more contentious question.¹⁶² The answer to this question weighs the OPTN’s scientifically constructed allocation algorithms designed to distribute an extremely scarce resource in the most equitable way possible against the tragic story of a dying ten-year-old girl.¹⁶³

The OPTN is entrusted with developing and continually improving a donor system that distributes donated organs as equitably as possible according to principles consistent with carefully considered law.¹⁶⁴ The donor system shoulders the heavy responsibility of organ allocation and inherent in that role is the acknowledgement that the donated organ system will never be perfect.¹⁶⁵ Despite scientific algorithms and vast medical expertise behind organ allocation policy, the scarcity of organs prevents the OPTN system from saving every person waiting for a transplant.¹⁶⁶

The court’s directive to the OPTN suggests that any individuals who are unable to gain their desired results in the face of administrative agency policy may turn to the court for immediate relief.¹⁶⁷ The court’s decision

trary, capricious, or manifestly contrary to the statute”). For a further discussion of *Chevron*, see *supra* notes 104–16 and accompanying text.

161. See Complaint, *supra* note 10 (“[APA] authorizes a court to ‘set aside agency action, findings, and conclusions of law found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law’”).

162. See *Chevron*, 467 U.S. at 844 (establishing that judges should provide “considerable weight” to administrative agency regulation and policy because such agencies have technical knowledge and expertise about complex issues in specific field).

163. See OPTN/UNOS Exec. Comm., *Lung Allocation Policy Review*, OPTN: ORGAN PROCUREMENT & TRANSPLANTATION NETWORK, U.S. DEP’T OF HEALTH & HUMAN SERVS. 143 (June 10, 2013), http://optn.transplant.hrsa.gov/ContentDocuments/OPTN_Exec_Comm_mtng_materials_06-10-13.pdf [hereinafter *OPTN/UNOS, Lung Allocation Policy Review*] (responding to court’s directive to OPTN Executive Committee members to cease enforcement of OPTN’s Under 12 Rule). The OPTN Executive Committee emphasized that “[i]t is critically important for this discussion [of reviewing lung allocation policy] to separate the elements of policy that specifically drive allocation from the elements of policy that afford transplant centers the opportunity to speak on behalf of an individual patient.” *Id.* (expressing reluctance to review policy on behalf of individuals). The OPTN Executive Committee maintained that “[c]hanges to the former must not be made in response to the plea of an individual.” See *id.* (noting danger of creating policy based on individual cases is that such process fails to properly balance utility concerns).

164. See *id.* (reiterating heavy responsibility inherent in OPTN’s role of distributing organs).

165. See *id.* (noting that not every candidate’s needs can be met because of donated organ scarcity).

166. See *id.* (balancing scarcity of donated organs with large number of candidates needing organ transplants).

167. See *Dying Girl Intubated as She Awaits Transplant*, FOX NEWS (June 10, 2013), <http://www.foxnews.com/health/2013/06/10/parents-file-lawsuit-in-girl-lung-transplant-case/> (citing Dr. Arthur Caplan, bioethicist at New York University

threatens the stability of administrative agency authority by exposing it to individual exceptions.¹⁶⁸ Furthermore, the court's decision presents an opportunity for future transplant candidates to request judicial intervention when they are unable to receive an organ thereby increasing the scope and number of individual causes of action.¹⁶⁹

In addition to the practical impacts of the *Murnaghan* decision, the case implicates many of the underlying justifications of *Chevron*.¹⁷⁰ The reason why judicial deference to administrative authority is appropriate is because administrative agencies have extensive experience and knowledge of highly complex and technical issues.¹⁷¹ Lung allocation policy is highly scrutinized and evaluated by experienced medical professionals before it is implemented.¹⁷² The integrity of the system is at risk, however, when a judge has the authority to change the policy on behalf of an individual.¹⁷³

In *Murnaghan*, judicial intervention into the sphere of administrative authority saved the life of a ten-year-old girl and certainly, the preservation of human life is the OPTN's highest priority.¹⁷⁴ Yet, the OPTN's subsequent examination of pediatric lung allocation policy revealed little evidence that the policy was "arbitrary, capricious and an abuse of discretion"

Langone Medical Center, who believes that *Murnaghan* opened doors allowing future transplant candidates to turn to courts).

168. See OPTN/UNOS, *Lung Allocation Policy Review*, *supra* note 163, at 142 (explaining that special OPTN Executive Committee meeting was convened because one transplant center and one family believe that allocation policies did not sufficiently provide for circumstances of one individual patient). The OPTN noted the dangerous precedent set in the *Murnaghan* decision of using the federal court as a mechanism for special review of individual cases. See *id.* (calling *Murnaghan* "an avalanche of events").

169. See *Girl's Need Breathes Life into Debate over Organ Allocation*, NAT'L PUB. RADIO (June 6, 2013), <http://www.npr.org/blogs/health/2013/06/10/189270798/Girls-Need-Breathes-Life-Into-Debate-Over-Organ-Allocation> (presenting Dr. Caplan's concerns over *Murnaghan* decision's precedential value). Dr. Caplan states, "And then I can start to see other people saying, 'You know what, I need a liver. I need a heart. Where's a federal judge?'" *Id.* (claiming that future transplant candidates will also seek judicial aid after *Murnaghan*).

170. For a further discussion of *Chevron*, see *supra* notes 104–16 and accompanying text.

171. See *Pauley v. BethEnergy Mines, Inc.*, 501 U.S. 680, 696–97 (1991) (discussing relationship between judiciary and administrative agencies in creation of policy). The Court noted that where there is a complex and highly technical policy, which necessarily requires significant expertise the court should appropriately defer to the administrative agency's interpretation of policy. See *id.* (following *Chevron* precedent).

172. See OPTN/UNOS, *Lung Allocation Policy Review*, *supra* note 163, at 24–68 (providing scientific algorithms underlying OPTN lung allocation policy).

173. See *id.* ("The development of lung allocation policy, as with all OPTN allocation policy, follows a deliberative approach consistent with the OPTN Final Rule. It considers objective medical evidence, current clinical practice and input from all interested parties.").

174. See UNITED NETWORK FOR ORGAN SHARING, <http://www.unos.org> (last visited Feb. 9, 2014) ("Success at UNOS means more lives being saved.").

as would justify judicial intervention.¹⁷⁵ Without findings showing that pediatric lung allocation policy was significantly underperforming or discriminating, the rationale for judicial intervention into OPTN policy fails to justify the substantial impacts resulting from review of individual cases.¹⁷⁶

B. *Judicial Intervention in Individual Cases Violates the Bioethical Principles Underlying OPTN Policy*

Granting the temporary restraining order directing the OPTN to cease enforcement of the Under 12 Rule is especially controversial when viewed in light of the bioethical principles underlying OPTN organ allocation policies.¹⁷⁷ Guided by the Final Rule, OPTN organ allocation poli-

175. See Memorandum from Thoracic Organ Transplantation Comm. & Pediatric Transplantation Comm. to OPTN/UNOS Exec. Comm. (June 10, 2013), available at http://optn.transplant.hrsa.gov/ContentDocuments/OPTN_Exec_Comm_mtng_materials_06-10-13.pdf (discussing OPTN findings after reviewing pediatric lung allocation policy following *Murnaghan*). In accordance with *Murnaghan*, the Thoracic Organ Transplantation Committee and the Pediatric Transplantation Committee held an emergency conference to determine if there was sufficient evidence available to support an immediate modification of the Under 12 Rule. See *id.* (describing process OPTN took after *Murnaghan*). The Committees found that “since the implementation of the policy dividing priority one and priority two pediatric lung candidates . . . the wait list death rate for lung transplant candidates between six and 11 years old is identical to the death rate for lung transplant candidates over age 18.” See *id.* (“[W]aitlist mortality for children is not significantly higher than it is for adults waiting for lungs.”). Furthermore, the Committees found that there was “no significant discrepancy between the death rates on the waiting list or the transplant rates amongst the pediatric lung candidates and patients over 18 years of age.” See *id.* (revealing that there is little discrepancy between transplant rates of children and adults). After reviewing the data, the Committees found that there was no imminent threat to pediatric lung candidates by the current lung allocation policy and that no emergency action should be taken to modify the Under 12 Rule. See *id.* (noting that long-term reassessment of OPTN system following OPTN policy development methods should be pursued). In response to the suggestion that the OPTN adopt an interim policy change allowing special review on individual pediatric cases, the Committees concluded that policy modification compelled by exigent circumstances was not an appropriate solution and that “potentially unintended consequences to other candidate groups awaiting lung transplantation would need to be carefully reviewed” before making any policy modifications. See *id.* (emphasizing need for policy to be made through deliberative processes and not in emergencies).

176. See *id.* (stating that OPTN Committees are committed to reviewing policy in deliberate and thorough manner, in order to identify problems, and if necessary, develop solutions based on objective medical evidence and anticipated effects on *all* lung transplant candidates).

177. See Sally Satel, *How to Fix the Organ Transplant Shortage*, AM. ENTERPRISE INST. (June 20, 2013), <http://www.aei.org/article/society-and-culture/how-to-fix-the-organ-transplant-shortage/> (statement of David Magnus, bioethicist at Stanford University) (“If the distribution of organs becomes subject to the success of individual publicity campaigns, with organs going to those who hire best PR firms and lawyers, who on the waiting list would remain confident that their priority would be decided on the merits?”). Further, waitlist candidates might feel that organ allocation is decided on popularity rather than merit. See *id.*

cies are based upon the ethical principles of utility, distributive justice, and autonomy.¹⁷⁸ OPTN organ allocation policy combines these ethical principles to develop an ideal donor organ system, which simultaneously maximizes the aggregate amount of medical good, distributes organs in a just manner, and preserves individual self-determination.¹⁷⁹

“The transparent balancing of utility, [distributive] justice combined with a predictable and stable application of allocation policy is critical to the fairness of the [donated organ] system.”¹⁸⁰ Thus, there is a significant ethical risk in special review or exceptions to the allocation policy based on the circumstances and experiences of one particular organ transplant candidate.¹⁸¹ Reviewing the fairness of allocation policy through the experience of any individual transplant candidate’s case inevitably subordinates utility to distributive justice concerns.¹⁸²

The *Murnaghan* decision highlights several significant ethical concerns including the risk of undermining public trust.¹⁸³ The OPTN’s organ donation system is effective because it is based on public trust.¹⁸⁴ If individual transplant candidates perceive judicial intervention as a way to circumvent OPTN policies and gain more favorable access to donated organs, “the result is likely to be significant chaos and inherent unfairness because access to the courts is not equal.”¹⁸⁵ Where the court gives immediate relief to individuals requesting reevaluation of organ allocation policy, it suggests that candidates ought to use lawsuits to implement more favorable organ allocation rather than trusting in the expertise of administrative agencies.¹⁸⁶

178. For a further discussion of the Final Rule, see *supra* note 36 and accompanying text. For a further discussion of utility, see *supra* notes 62–72 and accompanying text. For a further discussion of distributive justice, see *supra* notes 73–84 and accompanying text. For a further discussion of autonomy, see *supra* notes 85–90 and accompanying text.

179. See OPTN/UNOS, ETHICAL PRINCIPLES, *supra* note 62 (“[I]t is unacceptable for an allocation policy to strive single-mindedly to maximize aggregate medical good without any consideration of justice in distribution of the good, or conversely for a policy to be single-minded about promoting justice at the expense of the overall medical good.”).

180. OPTN/UNOS Memorandum, *supra* note 58 (evaluating bioethical risks which arise out of failing to balance utility and distributive justice).

181. See *id.* (noting that appeal to unique features of specific individual cases is not appropriate to make fairness claims against complex algorithms of allocation policy).

182. See *id.* (reiterating that effective organ allocation policy is achieved through balancing utility and distributive justice).

183. See *id.* (describing dangers of modifying organ allocation policy in hastily convened committees without open public comment).

184. See *id.* (noting that public trust in organ allocation policy is determined through transparent processes that minimize potential for bias or conflict).

185. See *id.* (stressing importance of donors’ faith in OPTN systems and belief that it is fair).

186. See *id.* (implicating principles of *Chevron*).

Additionally, in reviewing any individual transplant candidate's case, the court becomes susceptible to the "Rule of Rescue."¹⁸⁷ Especially in cases involving children, it is emotionally appealing to circumvent carefully constructed systems of equitable allocation, which may not offer the best chance at survival, in order to rescue the individual.¹⁸⁸ For utility purposes, allocation policy often requires "dispassionate reasoning and extensive [medical] experience."¹⁸⁹ When judges intervene in the complex and highly technical algorithms of organ allocation, they are often well-intentioned; however, they, "fail to consider all the moral variables that must be balanced at the macro level rather than through an individual candidate's experience."¹⁹⁰

VI. CONCLUSION: CURING THE ILLS OF EXCESSIVE JUDICIAL INTERVENTION IN ORGAN ALLOCATION POLICY

Judicial intervention in any individual organ transplant candidate's case should remain limited under *Chevron* because judicial intervention undermines essential bioethical principles of organ allocation policy.¹⁹¹ The fundamental mission of *Chevron* is to promote judicial deference to administrative agency expertise and knowledge.¹⁹² The need for judicial deference to administrative agency expertise is especially apparent in organ allocation policy.¹⁹³ First, organ allocation policy is composed of highly complex scientific algorithms.¹⁹⁴ Without any medical expertise, judges cannot expect to comprehend all the nuances and implications of organ allocation policy.¹⁹⁵ Second, judicial intervention into any individ-

187. See Satel, *supra* note 177 (describing how Jonsen's Rule of Rescue is applicable in *Murnaghan*). The Rule of Rescue, defined by ethicist A.R. Jonsen, evidences the imperative people feel to rescue "identifiable individuals facing avoidable death." See *id.* ("People may expend heroic efforts that either put others at risk or pose costs to society that could be more efficiently spent to prevent abstract deaths in the larger population.").

188. See *id.* (claiming *Murnaghan* imposed Jonsen's Rule of Rescue because media attention surrounding case was eye-catching and effective).

189. See OPTN/UNOS Memorandum, *supra* note 58 (noting that it is emotionally appealing for politicians or judges to intervene).

190. See *id.* (describing why it is necessary for OPTN committees to make policy rather than courts).

191. For a further discussion of why judicial intervention undermines essential bioethical principles of organ allocation policies, see *supra* notes 177-90 and accompanying text.

192. See *Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 866 (1984) (holding that "responsibilities for assessing the wisdom of such policy choices and resolving the struggle between competing views of the public interest are not judicial ones," but rather are vested in political branches).

193. For a further discussion of why judicial deference is especially important in lung allocation policy, see *supra* notes 173-76 and accompanying text.

194. See *A Guide to Calculating the Lung Allocation Score*, *supra* note 40 (illustrating complexities of calculating LAS).

195. See David Kemp, *Doctors and Lawyers and Such: A Pediatric Lung Transplant Case Illustrates the Complex Relationship Between the Government and Medical Providers*,

ual transplant candidate's case upsets the central bioethical principles underlying organ allocation policy and risks the stability of the entire organ donation system.¹⁹⁶ Thus, the problem of excessive judicial intervention must be remedied in the context of organ allocation policy in order to achieve the goal of *Chevron* and to preserve fundamental bioethical principles.¹⁹⁷ There are several approaches available to reduce instances of judicial intervention in organ allocation policy.¹⁹⁸

First, Congress and the OPTN must take greater action to increase the supply of donated organs.¹⁹⁹ With greater access to organs, fewer individuals will have a need to turn to the judiciary for aid in obtaining donated organs.²⁰⁰ One strategy, which has been proposed to increase the supply of organs, is to create an organ market and to allow individuals to broker contracts with other persons interested in selling an organ.²⁰¹ Another suggested strategy is to enact laws that create presumed con-

JUSTIA (June 17, 2013), <http://verdict.justia.com/2013/06/17/doctors-and-lawyers-and-such> (explaining that decision to place organ transplant candidates on waitlist should be made only by medical experts and professionals with actual knowledge of individual circumstances).

196. See OPTN/UNOS Memorandum, *supra* note 58 (explaining that "circumvention of organ allocation through judicial appeals or other mechanisms is likely to undermine the main ethical directive of an equitable allocation system" based on utility and distributive justice).

197. See *Transplant Officials Decide Against Emergency Change to Lung Policy*, ADVISORY BD. CO. (June 11, 2013), <http://www.advisory.com/Daily-Briefing/2013/06/11/Transplant-committee-reconsiders-lung-allocation-policy> (arguing that judicial intervention is not appropriate for managing organ donation because it fails to consider ethical issues involved in creating rules for all transplant candidates across country).

198. For a discussion of the solutions to organ scarcity, see *infra* notes 199–217 and accompanying text.

199. See Arthur L. Caplan, *Organ Transplantation: The Challenge of Scarcity*, in THE PENN CENTER GUIDE TO BIOETHICS 679 (2009) (discussing organ transplantation problems resulting from donated organ scarcity). Before presenting possible solutions for expanding the donor pool, Caplan notes that the organ supply problem most likely will not be fixed at any time in the near future. See *id.* (stating that until scientists learn how to grow new organs for transplant, policymakers must continue to make life and death decisions about who gets organs). However, because it is obviously important to try and save more lives, it is necessary for policymakers "to consider options that might increase the supply of transplantable organs without risking the willingness of those now involved to donate." See *id.* at 680 (noting legislature's important role in increasing organ supply).

200. See Satel, *supra* note 177 (arguing that organ shortage drove Sarah's parents to plead for Sarah's life and to bring claims against Sebelius).

201. See Caplan, *supra* note 199, at 681–82 (presenting ethical challenges to organ markets). Dr. Caplan argues that even if the United States adopted an organ market it is unlikely that more people would donate. See *id.* at 682 ("[D]is incentive to cadaver donation has more to do with aesthetic, emotional, or religious concerns than lack of payment."). Moreover, an organ market most likely would exploit the poor and encroach on individual free will and autonomy. See *id.* (illustrating that poor individual with little choice other than selling organs to live is free to donate or not donate but has relatively little choice about the matter). An additional bioethical concern is that allowing individuals to sell organs violates the core ethical norm of nonmaleficence. See *id.* (explaining that

sent.²⁰² In such a system, the presumption is that everyone wants to be an organ donor upon their death and people who do not want to be organ donors upon death must register with the state to provide otherwise.²⁰³ Additionally, doctors have suggested that persons for whom a determination of brain death cannot be made could be considered donors in order to expand the donor pool.²⁰⁴

Second, the OPTN should permanently adopt a special exceptions policy to allow OPTN committee review of individual pediatric lung candidates.²⁰⁵ If the OPTN provided a mechanism by which individual candidates could seek further review of their particular circumstance, candidates would perceive the donor system as fairer and would be less likely to turn to the judiciary to seek aid.²⁰⁶ Moreover, providing individual candidates with the opportunity to seek a special exception through OPTN internal processes would keep issues regarding organ allocation policy within the OPTN's scope of authority rather than in the hands of the judiciary.²⁰⁷

Third, judges must restrain from being influenced by emotionally aggressive media campaigns and compelled to make hasty decisions.²⁰⁸ The

removing organs from healthy person violates essential tenet of "do good, avoid harm" of nonmaleficence).

202. *See id.* at 682–83 (discussing presumed consent as one option for increasing organ supply and as being practiced in other countries). The advantage of a presumed consent system is that people still have the right to choose whether they want to donate or not since they have the right to opt out of the system. *See id.* (showing that in such systems procuring organs is consistent with fundamental medical ethics).

203. *See id.* (indicating that based on other countries' success, United States could increase donor supply by shifting to presumed consent system).

204. *See id.* (explaining that lack of consistent national standards for determining cardiac death could hinder this solution).

205. *See Proposed Policy Modification for Executive Committee Consideration, OPTN: ORGAN PROCUREMENT & TRANSPLANTATION NETWORK, U.S. DEP'T OF HEALTH & HUMAN SERVS.* 144–45 (June 10, 2013), available at http://optn.transplant.hrsa.gov/ContentDocuments/OPTN_Exec_Comm_mtng_materials_06-10-13.pdf (presenting proposed policy modification to pediatric lung allocation policy which expires on July 1, 2014 and which would allow individual pediatric candidates to request special classification as adults).

206. *See Improving Lung Donor Availability and Allocation—Without the Courts, PENN MEDICINE* (June 24, 2013), http://www.uphs.upenn.edu/news/News_Releases/2013/06/halpern/ (statement of Dr. Halpern, medical ethicist at University of Pennsylvania) (suggesting several methods by which OPTN committees could make OPTN donated organ systems more efficient, stating, "Not only would these steps provide more patients with access to life-extending interventions, but by being more proactive the transplant community can protect the system it has worked so hard to build from future judicial intervention.").

207. *See generally* OPTN/UNOS, *Lung Allocation Policy Review*, *supra* note 163 (emphasizing that courts are not proper venues for individuals to plead their case on organ allocation policy).

208. *See Improving Lung Donor Availability and Allocation—Without the Courts, supra* note 206 (questioning medical ethicists from Penn Medicine). Dr. Halpern, medical ethicist at the University of Pennsylvania believes that organ allocation

most effective way to do this is to defer to OPTN authority and if necessary, to make decisions based on extensive and thorough medical expert testimony.²⁰⁹ When the media highlights the tragic stories of individuals facing certain death, there is a greater public initiative to save these individuals immediately and by any means necessary.²¹⁰ Judges may be influenced by the public's plea and by the emotionally appealing nature of the case to grant relief to individual transplant candidates.²¹¹ However, if judicial intervention is necessary, judges should be making fully informed decisions after extensive and thorough expert testimony.²¹² By avoiding hasty decisions, encouraged by emotional media campaigns, judges can realize their own insufficient knowledge of organ allocation policy and can choose to defer to the expertise of the OPTN.²¹³

By enacting any of the preceding changes, we can limit judicial intervention into OPTN organ allocation policy and prevent controversial departures from *Chevron* precedent like that in *Murnaghan*.²¹⁴ The tragedy inherent in organ allocation is never more apparent than in the case of

policies should not favor the most popular or richest transplant candidates who can run the most successful media campaign, or who have the closest connections with lawyers and judges. *See id.* (statement of Dr. Halpern) (“Even if policies are imperfect, the integrity of the system is completely undermined when judges make medical decisions, particularly when they do so without considering the medical facts as happened in the Philadelphia cases.”).

209. *See* Katie Drummond, *Need a Kidney, Please RT: How Social Media Is Changing Organ Donation*, THE VERGE (Sept. 26, 2013), <http://www.theverge.com/2013/9/26/4773486/organ-donation-and-social-media-impact> (expressing concern that media threatens to turn organ donation into popularity contests).

210. *See* Tom Tominson, *Lungs for Sarah Murnaghan Raise Ethical Questions*, CTR. FOR ETHICS & HUMANITIES LIFE SCI. MICH. ST. U. (June 27, 2013), <http://msubioethics.com/2013/06/27/lungs-for-sarah-murnaghan-raise-ethical-questions/> (expressing concerns about having organ distribution systems driven by sympathy for individual patients who manage to capture public hearts).

211. *See Pennsylvania Girl's Double-Lung Transplant a Success, Family Says*, FOX NEWS (June 13, 2013), <http://www.foxnews.com/health/2013/06/13/philadelphia-girl-double-lung-transplant-success-family-says/> (statement of Dr. Arthur Caplan, New York University Langone Medical Center) (“[T]he road to a transplant is still to let the system decide who will do best with scarce, lifesaving organs. And it's important that people understand that money, visibility, being photogenic . . . are factors that have to be kept to a minimum if we're going to get the best use out of the scarce supply of donated cadaver organs.”).

212. *See Szabo, supra* note 135 (statement of Dr. Kevin Donovan, Director of the Edmund D. Pellegrino Center for Clinical Bioethics at Georgetown University Medical Center) (“The courts will have the same sympathy that we all would, but not the same medical information as doctors at the bedside.”).

213. *See Transplant Review Board Seek Medical, Legal Balance*, USA TODAY (June 11, 2013), <http://www.usatoday.com/story/news/nation/2013/06/11/transplant-vote-balance/2413207/> (stating that while members of OPTN committees voiced sympathy for anyone who is waiting for organs, they argued that making sudden changes to OPTN organ donation systems to help one group risks harming some other group).

214. For a further discussion of the changes needed to decrease the effects of judicial intervention in organ allocation policy, *see supra* notes 199–213 and accompanying text.

children and the heartbreaking story of a dying ten-year-old girl instinctively inspires the need to protect and rescue.²¹⁵ However, donated organs are a scarce resource and the court must recognize that, even with the expertise and knowledge of the OPTN, not all of the tragic stories can be redeemed.²¹⁶ Checking judicial intervention into OPTN organ allocation authority will ultimately preserve an organ allocation system, which seeks to maximize the benefits of donated organs for all 76,910 active waiting list transplant candidates.²¹⁷

215. See OPTN/UNOS, *Lung Allocation Policy Review*, *supra* note 163 (noting that candidates will continue to die on waiting lists until organ supply increases and that OPTN committees should use Sarah's story to ensure that each person imploring OPTN committees to make donation systems better also makes that person commit to organ donation).

216. See *id.* (increasing organ supply would drastically raise number of lives that could be saved).

217. See *OPTN Data*, *supra* note 4 (providing active waiting list data for number of active waiting list transplant candidates, number of donors, and number of transplants done).

