Alcoholics and Liver Transplantation

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Two arguments underlie a widespread unwillingness to consider patients with alcoholic cirrhosis of the liver as candidates for transplantation. First, alcoholics are morally blameworthy, their condition the result of their own misconduct; such blameworthiness disqualifies alcoholics in unavoidable competition for organs with others who are equally sick but blameless. Second, because of their habits, alcoholics will not exhibit satisfactory rates of survival after transplantation; good stewardship of a scarce lifesaving resource therefore requires that alcoholics not be considered for liver transplantation. These arguments are carefully analyzed and shown to be defective. There is not good moral or medical reason for categorically precluding alcoholics as candidates for liver transplantation. It would, in addition, be unjust to implement such a preclusion simply because others might respond negatively if we do not.

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ALCOHOLIC cirrhosis of the liver—severe scarring due to the heavy use of alcohol—is by far the major cause of end-stage liver disease.[1] For persons so afflicted, life may depend on receiving a new, transplanted liver. The number of alcoholics in the United States needing new livers is great, but the supply of available livers for transplantation is small. *Should those whose end-stage liver disease was caused by alcohol abuse be categorically excluded from candidacy for liver transplantation?* This question, partly medical and partly moral, must now be confronted forthrightly. Many lives are at stake.

See also pp 1223, 1295, 1302, and 1305.

Reasons of two kinds underlie a widespread unwillingness to transplant livers into alcoholics: First, there is a common conviction—explicit or tacit—that alcoholics are morally blameworthy, their condition the result of their own misconduct, and that such blameworthiness disqualifies alcoholics in unavoidable competition for organs with others equally sick but blameless. Second, there is a common belief that because of their habits, alcoholics will not exhibit satisfactory survival rates after transplantation, and that, therefore, good stewardship of a scarce lifesaving resource requires that alcoholics not be considered for liver transplantation. We examine both of these arguments.

THE MORAL ARGUMENT

A widespread condemnation of drunkenness and a revulsion for drunks lie at the heart of this public policy issue. Alcoholic cirrhosis—unlike other causes of end-stage liver disease—is brought on by a person's conduct, by heavy drinking. Yet if the dispute here were only about whether to treat someone who is seriously ill because of personal conduct, we would not say—as we do not in cases of other serious diseases resulting from personal conduct—that such conduct disqualifies a person from receiving desperately needed medical attention. Accident victims injured because they were not wearing seat belts are treated without hesitation; reformed smokers who become coronary bypass candidates partly because they disregarded their physicians' advice about tobacco, diet, and exercise are not turned away because of their bad habits. But new livers are a scarce resource, and transplanting a liver into an alcoholic may, therefore, result in death for a competing candidate whose liver disease was wholly beyond his or her control. Thus we seem driven, in this case unlike in others, to reflect on the weight given to the patient's personal conduct. And heavy drinking—unlike smoking, or overeating, or failing to wear a seat belt—is widely regarded as morally wrong.

Many contend that alcoholism is not a moral failing but a disease. Some authorities have recently reaffirmed this position, asserting that alcoholism is "best regarded as a chronic disease."[2] But this claim cannot be firmly established and is far from universally believed. Whether alcoholism is indeed a disease, or a moral failing, or both, remains a disputed matter surrounded by intense controversy.[3-9]

Even if it is true that alcoholics suffer from a somatic disorder, many people will argue that this disorder results in deadly liver disease only when coupled with a weakness of will—a weakness for which part of the blame must fall on the alcoholic. This consideration underlies the conviction that the alcoholic needing a transplanted liver, unlike a nonalcoholic competing for the same liver, is at least partly responsible for his or her need. Therefore, some conclude, the alcoholic's personal failing is rightly considered in deciding upon his or her entitlement to this very scarce resource.

Is this argument sound? We think it is not. Whether alcoholism is a moral failing, in whole or in part, remains uncertain. But even if we suppose that it is, it does not follow that we are justified in categorically denying liver transplants to those alcoholics suffering from end-stage cirrhosis. We could rightly preclude alcoholics from transplantation only if we assume that qualification for a new organ requires some level of moral virtue or is canceled by some level of moral vice. But there is absolutely no agreement—and there is likely to be none—about what constitutes moral virtue and vice and what rewards and penalties they deserve. The assumption that undergirds the moral argument for precluding alcoholics is thus unacceptable. Moreover, even if we could agree (which, in fact, we cannot) upon the kind of misconduct we would be looking for, the fair weighting of such a consideration would entail highly intrusive investigations into patients' moral habits—investigations universally thought repugnant. Moral evaluation is wisely and rightly excluded from all deliberations of who should be treated and how.

Indeed, we do exclude it. We do not

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seek to determine whether a particular transplant candidate is an abusive parent or a dutiful daughter, whether candidates cheat on their income taxes or their spouses, or whether potential recipients pay their parking tickets or routinely lie when they think it is in their best interests. We refrain from considering such judgments for several good reasons: (1) We have genuine and well-grounded doubts about comparative degrees of voluntariness and, therefore, *cannot pass judgment fairly.* (2) Even if we could assess degrees of voluntariness reliably, we *cannot know what penalties different degrees of misconduct deserve.* (3) *Judgments of this kind could not be made consistently in our medical system*—and a fundamental requirement of a fair system in allocating scarce resources is that it treat all in need of certain goods on the same standard, without unfair discrimination by group.

If alcoholics should be penalized because of their moral fault, then all others who are equally at fault in causing their own medical needs should be similarly penalized. To accomplish this, we would have to make vigorous and sustained efforts to find out whose conduct has been morally weak or sinful and to what degree. That inquiry, as a condition for medical care or for the receipt of goods in short supply, we certainly will not and should not undertake.

The unfairness of such moral judgments is compounded by other accidental factors that render moral assessment especially difficult in connection with alcoholism and liver disease. Some drinkers have a greater predisposition for alcohol abuse than others. And for some who drink to excess, the predisposition to cirrhosis is also greater; many grossly intemperate drinkers do not suffer grievously from liver disease. On the other hand, alcohol consumption that might be considered moderate for some may cause serious liver disease in others. It turns out, in fact, that the disastrous consequences of even low levels of alcohol consumption may be much more common in women than in men.[10] Therefore, penalizing cirrhotics by denying them transplant candidacy would have the effect of holding some groups arbitrarily to a higher standard than others and would probably hold women to a higher standard of conduct than men.

Moral judgments that eliminate alcoholics from candidacy thus prove unfair and unacceptable. The alleged (but disputed) moral misconduct of alcoholics with end-stage liver disease does not justify categorically excluding them as candidates for liver transplantation.

MEDICAL ARGUMENT

Reluctance to use available livers in treating alcoholics is due in some part to the conviction that, because alcoholics would do poorly after transplant as a result of their bad habits, good stewardship of organs in short supply requires that alcoholics be excluded from consideration.

This argument also fails, for two reasons: First, it fails because the premise—that the outcome for alcoholics will invariably be poor relative to other groups—is at least doubtful and probably false. Second, it fails because, even if the premise were true, it could serve as a good reason to exclude alcoholics only if it were an equally good reason to exclude other groups having a prognosis equally bad or worse. But equally low survival rates have not excluded other groups; fairness therefore requires that this group not be categorically excluded either.

In fact, the data regarding the post-transplant histories of alcoholics are not yet reliable. Evidence gathered in 1984 indicated that the 1-year survival rate for patients with alcoholic cirrhosis was well below the survival rate for other recipients of liver transplants, excluding those with cancer.[11] But a 1988 report, with a larger (but still small) sample number, shows remarkably good results in alcoholics receiving transplants: 1-year survival is 73.2%—and of 35 carefully selected (and possibly non-representative) alcoholics who received transplants and lived 6 months or longer, only two relapsed into alcohol abuse.[12] Liver transplantation, it would appear, can be a very sobering experience. Whether this group continues to do as well as a comparable group of non-alcoholic liver recipients remains uncertain. But the data, although not supporting the broad inclusion of alcoholics, do suggest that medical considerations do not now justify categorically excluding alcoholics from liver transplantation.

A history of alcoholism is of great concern when considering liver transplantation, not only because of the impact of alcohol abuse upon the entire system of the recipient, but also because the life of an alcoholic tends to be beset by general disorder. Returning to heavy drinking could ruin a new liver, although probably not for years. But relapse into heavy drinking would quite likely entail the inability to maintain the routine of multiple medication, daily or twice-daily, essential for immunosuppression and survival. As a class, alcoholic cirrhotics may therefore prove to have substantially lower survival rates after receiving transplants. All such matters should be weighed, of course. But none of them gives any solid reason to exclude alcoholics from consideration categorically.

Moreover, even if survival rates for alcoholics selected were much lower than normal—a supposition now in substantial doubt—what could fairly be concluded from such data? Do we exclude from transplant candidacy members of other groups known to have low survival rates? In fact we do not. Other things being equal, we may prefer not to transplant organs in short supply into patients afflicted, say, with liver cell cancer, knowing that such cancer recurs not long after a new liver is implanted.[13,14] Yet in some individual cases we do it. Similarly, some transplant recipients have other malignant neoplasms or other conditions that suggest low survival probability. Such matters are weighed in selecting recipients, but they are insufficient grounds to categorically exclude an entire group. This shows that the argument for excluding alcoholics based on survival probability rates alone is simply not just.

THE ARGUMENTS DISTINGUISHED

In fact, the exclusion of alcoholics from transplant candidacy probably results from an intermingling, perhaps at times a confusion, of the moral and medical arguments. But if the moral argument indeed does not apply, no combination of it with probable survival rates can make it applicable. Survival data, carefully collected and analyzed, deserve to be weighed in selecting candidates. These data do not come close to precluding alcoholics from consideration. Judgments of blameworthiness, which ought to be excluded generally, certainly should be excluded when weighing the impact of those survival rates. Some people with a strong antipathy to alcohol abuse and abusers may, without realizing it, be relying on assumed unfavorable data to support a fixed moral judgment. The arguments must be untangled. Actual results with transplanted alcoholics must be considered without regard to moral antipathies.

The upshot is inescapable: there are no good grounds at present—moral or medical—to disqualify a patient with end-stage liver disease from consideration for liver transplantation simply because of a history of heavy drinking.

SCREENING AND SELECTION OF LIVER TRANSPLANT CANDIDATES

In the initial evaluation of candidates for any form of transplantation, the central questions are whether patients (1) are sick enough to need a new organ

and (2) enjoy a high enough probability of benefiting from this limited resource. At this stage the criteria should be noncomparative.[15,16] Even the initial screening of patients must, however, be done individually and with great care.

The screening process for those suffering from alcoholic cirrhosis must be especially rigorous—not for moral reasons, but because of factors affecting survival, which are themselves influenced by a history of heavy drinking—and even more by its resumption. Responsible stewardship of scarce organs requires that the screening for candidacy take into consideration the manifold impact of heavy drinking on long-term transplant success. Cardiovascular problems brought on by alcoholism and other systematic contraindications must be looked for. Psychiatric and social evaluation is also in order, to determine whether patients understand and have come to terms with their condition and whether they have the social support essential for continuing immunosuppression and follow-up care.

Precisely which factors should be weighed in this screening process have not been firmly established. Some physicians have proposed a specified period of alcohol abstinence as an "objective" criterion for selection—but the data supporting such a criterion are far from conclusive, and the use of this criterion to exclude a prospective recipient is at present medically and morally arbitrary.[17,18]

Indeed, one important consequence of overcoming the strong presumption against considering alcoholics for liver transplantation is the research opportunity it presents and the encouragement it gives to the quest for more reliable predictors of medical success. As that search continues, some defensible guidelines for case-by-case determination have been devised, based on factors associated with sustained recovery from alcoholism and other considerations related to liver transplantation success in general. Such guidelines appropriately include (1) refined diagnosis by those trained in the treatment of alcoholism, (2) acknowledgment by the patient of a serious drinking problem, (3) social and familial stability, and (4) other factors experimentally associated with long-term sobriety.[19]

The experimental use of guidelines like these, and their gradual refinement over time, may lead to more reliable and more generally applicable predictors. But those more refined predictors will never be developed until prejudices against considering alcoholics for liver transplantation are overcome.

Patients who are sick because of alleged self-abuse ought not be grouped for discriminatory treatment—unless we are prepared to develop a detailed calculus of just deserts for health care based on good conduct. Lack of sympathy for those who bring serious disease upon themselves is understandable, but the temptation to institutionalize that emotional response must be tempered by our inability to apply such considerations justly and by our duty *not* to apply them unjustly. In the end, some patients with alcoholic cirrhosis may be judged, after careful evaluation, as good risks for a liver transplant.

OBJECTION AND REPLY

Providing alcoholics with transplants may present a special "political" problem for transplant centers. The public perception of alcoholics is generally negative. The already low rate of organ donation, it may be argued, will fall even lower when it becomes known that donated organs are going to alcoholics. Financial support from legislatures may also suffer. One can imagine the effect on transplantation if the public were to learn that the liver of a teenager killed by a drunken driver had been transplanted into an alcoholic patient. If selecting even a few alcoholics as transplant candidates reduces the number of lives saved overall, might that not be good reason to preclude alcoholics categorically?

No. The fear is understandable, but excluding alcoholics cannot be rationally defended on that basis. Irresponsible conduct attributable to alcohol abuse should not be defended. No excuses should be made for the deplorable consequences of drunken behavior, from highway slaughter to familial neglect and abuse. But alcoholism must be distinguished from those consequences; not all alcoholics are morally irresponsible, vicious, or neglectful drunks. If there is a general failure to make this distinction, we must strive to overcome that failure, not pander to it.

Public confidence in medical practice in general, and in organ transplantation in particular, depends on the scientific validity and moral integrity of the policies adopted. Sound policies will prove publicly defensible. Shaping present health care policy on the basis of distorted public perceptions or prejudices will, in the long run, do more harm than good to the process and to the reputation of all concerned.

Approximately one in every 10 Americans is a heavy drinker, and approximately one family in every three has at least one member at risk for alcoholic cirrhosis.[3] The care of alcoholics and the just treatment of them when their lives are at stake are matters a democratic polity may therefore be expected to act on with concern and reasonable judgment over the long run. The allocation of organs in short supply does present vexing moral problems; if thoughtless or shallow moralizing would cause some to respond very negatively to transplanting livers into alcoholic cirrhotics, that cannot serve as good reason to make such moralizing the measure of public policy.

We have argued that there is now no good reason, either moral or medical, to preclude alcoholics categorically from consideration for liver transplantation. We further conclude that it would therefore be unjust to implement that categorical preclusion simply because others might respond negatively if we do not.

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