Special Section: Open Forum

Responsibility and Priority in Liver Transplantation

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In a provocative 1991 paper, Alvin Moss and Mark Siegler argued that it may be fair to give individuals with alcohol-related end-stage liver disease (ARESLD) lower priority for a liver transplant than those who develop end-stage liver disease (ESLD) from other factors.[1] Like other organs, there is a substantial gap between the available livers for transplantation and the number of people who need liver transplants. Yet, unlike those with end-stage renal disease, who can survive for some time on dialysis before receiving a kidney transplant, those with liver failure will die without a liver transplant. This makes transplantable livers an absolutely scarce resource. As Moss and Siegler claimed, this absolute scarcity "mandates that distribution be based on unusually rigorous standards."[2] At the time they published their paper, they noted that, "in liver transplantation, ARESLD causes more than 50% of the cases of ESLD."[3] They also emphasized that, unlike most diseases, where a causal connection between behavior and a disease is difficult to establish, chronic drinking is a cause of cirrhosis and liver failure.

More recent data show that alcoholic liver disease is the principal diagnosis of 22.1% of liver transplant recipients in the United States, 16.6% in Canada, and 19.9% in the United Kingdom.[4] The figure from the United Kingdom is the highest among recipients there, and it is the second highest (after hepatitis C cirrhosis) in the United States and Canada. So those with ARESLD constitute a significant percentage of all those needing a liver transplant.

We can distinguish individuals with ARESLD from individuals who develop ESLD due to factors beyond their control. The second group includes individuals with congenital biliary atresia, congenital polycystic liver disease, primary biliary cirrhosis, and primary sclerosing cholangitis. In these cases, there is no causal connection between an individual's behavior and the development of liver disease. Because they have no control over the condition, it would be unfair not to give them equal access to a liver transplant. But it may be fair to give lower transplant priority to those with ARESLD. Genetics and social factors may influence a person's behavior, including chronic drinking. However, these factors do not causally determine but *underdetermine* the outcome of ARESLD. In most cases, an alcoholic's behavior cannot be explained away entirely by genetics or the environment. One may have enough control over one's behavior to play a significant causal role in bringing about liver failure.

I argue for the weaker claim that individuals with ARESLD may be given lower priority for a liver transplant. I defend this claim even if those with ARESLD have transplant outcomes at least as good as those with the conditions I mentioned above. The stronger claim that they should be excluded from transplants is

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not warranted because it may not be the case that their behavior alone causally determines the outcome. What justifies giving them lower priority for a liver transplant is that they are not only causally but also morally responsible for liver failure. They are causally responsible for this outcome to the extent that they were able but failed to behave in a way that would have prevented it. They are morally responsible because, by having but failing to exercise control over their behavior, they acted negligently and failed to discharge a duty that we owe to others in society. This is the duty to act in such a way as not to increase competition for a scarce life-saving resource. That ARESLD is a preventable outcome for which one can be causally and morally responsible is a reasonable social expectation. It is based on the idea that most of us are capable of acting voluntarily and of knowing the causal connection between chronic drinking and liver failure. The normative claim of moral responsibility rests on the empirical claim of causal responsibility.

Following Robert Veatch, I argue that responsibility for ARESLD can be a ''tie-breaker'' in liver allocation decisions.[5] This translates into a slight reduction in one's place on the transplant wait list. When two individuals are in equal need of a liver transplant and have an equal chance of a good transplant outcome, responsibility for liver failure can justify giving one person lower priority than the other. My main concern is to give principled reasons for saying that some may have a weaker claim to a scarce life-saving resource than others and that it may be fair to treat people unequally in this regard.

Fairness consists in giving people what they deserve. Intuitively, fairness means that priority for medical treatment should be given to those with the greatest medical needs. But when a medical resource is scarce, whether or to what extent one deserves to receive that resource may depend on how the medical need for it developed. One may be less deserving of that resource and have a weaker claim to it the more control one has over the development of the need. On these grounds, fairness means meeting people's needs in proportion to the strength of their claims to have these needs met. Those who develop diseases they could have prevented have a weaker claim to receive treatment for them. Insofar as ARESLD is a preventable disease, it may be fair to give those with this disease lower priority for a liver transplant than others whose need for a transplant results from factors beyond their control.

Causal and Moral Responsibility

The argument for responsibility is not an argument about character. It is not about assessing a person in terms of virtue or vice, or the idea that ''good'' organs should not go to ''bad'' people. Instead, the argument focuses on the outcome of chronic drinking as one type of action. Daniel Brudney calls this argument ''The Principle.'' In discussing a fictional person ''Jane'' with ARESLD, Brudney rightly points out that ''The Principle does not assert that drinking is *malum in se*. Its focus is on the consequences of Jane's conduct, not on whether that conduct was intrinsically good or bad. If drinking did not destroy livers, Jane's drinking would not trigger the Principle.''[6] Although a convicted criminal has waived his or her right to liberty, their criminal behavior theoretically would not imply a weaker claim to an organ transplant unless it causally contributed to their organ

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failure. Whether one has a weaker claim to and lower priority for a liver transplant depends on the relevant sort of behavior. My argument for responsibility applies only in cases where (1) there is an established causal connection between a particular type of voluntary behavior and a consequence of that behavior, (2) one is capable of knowing that the behavior can lead to that consequence, and (3) where there is absolute scarcity of the good in question—transplantable livers. I do not argue that people should be given lower priority when they have conditions for which treatment is not absolutely scarce and where there is no established causal connection between voluntary behavior and the condition in question. This preempts a "slippery slope" argument that might be extended to other areas of healthcare.

A person can be causally responsible for an outcome when it falls within the knowable risk of certain behavior. We need to distinguish between different types of behavior and their normative significance. Some types of risk-entailing behavior are supported by social expectations. Policing and firefighting fall within this category. Because we expect them to engage in behavior that poses a risk to their health and lives in order to protect the public, police and firefighters are not penalized for their behavior if they develop health problems as a result of it.[7] Chronic drinking leading to alcoholism and ARESLD is significantly different from police and fire protection because the risk entailed by chronic drinking does not conform to but conflicts with social expectations.

We can spell out the argument for responsibility for ARESLD in five steps:

1) If person A is causally and morally responsible for ARESLD, then A has a weaker claim to and should have lower priority for a liver transplant than person B, who develops end-stage liver disease through no fault of his or her own.
2) A is causally responsible for ARESLD when the disease is causally sensitive to chronic drinking, chronic drinking is sufficiently voluntary, and he or she has the capacity to know that chronic drinking entails a risk of liver failure.
3) A is morally responsible for ARESLD when he or she is causally responsible for it and when he or she is negligent for failing to act on the knowledge that chronic drinking can lead to ARESLD and increased competition for scarce transplantable livers.
4) A is causally and morally responsible for ARESLD.
5) A has a weaker claim to and should have lower priority for a liver transplant than B.

Causal sensitivity can be formulated in counterfactual terms. An outcome is causally sensitive to behavior when that outcome would not have occurred but for the behavior. Causal responsibility presupposes causal control, which consists of voluntariness in one's behavior and knowledge of the probable consequences of that behavior. Each of these volitional and epistemic components of causal control is a capacity that one may or may not exercise in all instances. The normative content in the claim about moral responsibility in (3) rests on social expectations about how people ought to behave toward each other. It rests on social expectations against behavior that increases competition for scarce resources such as transplantable livers.

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Voluntariness

A person behaves voluntarily when he or she is not coerced or compelled to act against the desires and intentions that form his or her motivational states. Coercion and compulsion can impair or undermine voluntariness by interfering with a person's capacity to respond to reasons for or against certain actions. Voluntariness is equivalent to autonomy. A person behaves autonomously when he or she is capable of critically reflecting on and responding to these reasons by acting on or refraining from acting on them.[8] In particular, autonomy requires the capacity to resist the desire to engage in chronic drinking as something contrary to one's best interests and the best reasons for action. Individuals with severe psychiatric conditions such as schizophrenia may not satisfy the criteria of voluntariness, because these conditions are likely to undermine the capacity to control their desires, beliefs, choices, and actions. Accordingly, we can exclude these individuals from judgments of responsibility for their health.

Carl Cohen and Martin Benjamin claim that the voluntariness condition necessary for responsibility in the case at hand cannot be met, because external factors beyond one's control will influence one's behavior and its outcomes.[9] Yet this involves a mistaken inference from the claim that genetic and environmental factors can *influence* one's behavior to the claim that these factors *determine* one's behavior. It is mistaken because, in most cases of ARESLD, the outcome is causally sensitive to one's choices that are not coerced or compelled by external or internal forces. As noted, responsibility for an outcome requires only that the outcome be causally sensitive to one's autonomous choices and actions. It does not require that it be causally sensitive *only* to one's actions and not to any other factors. Genetics and the environment may causally influence but do not causally determine one's choices and actions, in the sense that one could not have chosen and acted otherwise. This is what I meant in saying that one's choices need only be sufficiently voluntary. It allows enough room for the person to causally contribute to and be causally responsible for that outcome. Responsibility is not established by a certain threshold of probability for a given outcome, above which one is responsible and below which one is not responsible. The point is not what percentage of one's voluntary choices causally contributes to the outcome of ARESLD, but that these choices play a causal role in bringing about this outcome.

In the early 1990s, researchers discovered an association between the A1 allele of the dopamine D2 receptor gene and alcoholism.[10] More recent research has further clarified the genetic factors in alcohol addiction.[11] The research in molecular genetics suggests that people with this allele are more susceptible to developing alcoholism than others who do not have it. But from the fact that a person has a disease with a genetic component, it does not follow that one has no control over and cannot be causally responsible for developing the disease. A gene that makes one susceptible to alcoholism only indicates a higher probability of developing the disease, not that the gene by itself causally determines the disease. At least some of an alcoholic's choices would be a function of his or her own motivational states.

My account is consistent with an Aristotelian default conception of voluntariness and responsibility. Aristotle plausibly assumes that one acts voluntarily and can be responsible for one's actions when one is not forced or compelled to act and is not ignorant of the circumstances of action.[12] The onus is on those claiming

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that the condition of voluntariness is not met in the argument for responsibility for ARESLD to demonstrate that voluntariness is undermined. Simply saying that genetics or a difficult social upbringing predisposes one to alcoholism is not enough to prove that an alcoholic is forced to act against his or her will and therefore cannot alter his or her behavior to prevent liver failure and the need for a liver transplant. Like other addictions, it is presumed that alcoholism undermines voluntariness by compelling one to act against one's considered desires and best interests. Chronic drinking alters brain pathways that ordinarily mediate the desire to drink, converting desire into craving and compulsion. If one accepts this, then one might claim that alcoholics cannot be responsible for developing liver failure because they lack sufficient control over this outcome.

We need to separate two stages of addiction: how one develops it, and how one behaves once one becomes addicted to a particular substance. Addictions usually develop from taking a particular substance repeatedly over time. Taking cocaine, nicotine, or alcohol repeatedly perturbs the dopamine system that regulates the ''high'' and craving characteristic of addictions. This perturbation makes the system adapt by making dopamine less effective in the relevant brain receptors. Once these receptors assume this defensive maneuver and become less responsive, they are left without normal levels of this neurotransmitter. These changes in the dopamine system cause a person to crave more of the drug. Addiction becomes established as dopamine dependence and produces chronic unpleasant feelings, which triggers the desire to take more of the drug to feel better.[13] But having an addiction does not explain why a person first takes the substance that results in the addiction. If one is not compelled to begin drinking by genetic or environmental factors beyond one's control, and if one is not so cognitively disabled or immature as not to be capable of knowing the probable addictive consequences of chronic drinking, then one can be responsible for the addiction, as well as for the liver failure that may result from it. The history of how this condition came about may involve enough control for a person to be causally responsible for the addiction and subsequent liver failure.

The fact that many addicts give up their addictions voluntarily shows that the desire for the addictive substance does not always compel an addict to act and does not always undermine autonomy. This suggests that addicts have some degree of control over their behavior. The typical addict goes through withdrawal several or more times. Some deliberately abstain for prolonged periods in order to lower their tolerance for the drug and thereby decrease their need for the high. To the extent that addicts can structure their environment so that the cues that remind them of the drug are absent, they can exercise some restraint over their craving for that drug.[14] The literature on consumptive behavior indicates that compulsions do not explain why addicts exponentially discount the future in taking a substance. They prefer consumption of the drug now and abstention only later.[15] The addict chooses what he or she prefers at the moment, even though the choice is not in his or her long-term best interests. Choosing consumption over abstention does not mean that the addict chooses against his or her will. It is an imprudent, irrational choice, but as such is not a sign of compulsive behavior and not an unfree choice. Thus an addict may be responsible for this choice. Stephen Morse supports this view: ''When the addict is not in a strong drive state, he or she is capable of taking the steps to prevent maladaptive behavior that the addict knows will result when craving revives.

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The addict is responsible for later nonresponsible behavior because the addict is responsible for failure to avoid the later behavior.''[16] Responsibility transfers from the earlier to the later time.

Epistemic Factors

I have claimed that an epistemic condition is necessary in addition to a voluntariness condition to establish causal and moral responsibility for ARESLD. One must have the capacity to know that chronic drinking can result in liver failure and the need for an organ transplant. One must also have the capacity to know that such a claim would increase competition for a scare life-saving resource. Assuming that one has this epistemic capacity, that one's behavior is sufficiently voluntary, and that liver failure is causally sensitive to this behavior, it can be fair to give one lower priority for a liver transplant.

Alcoholics appear to discount the future in the same way other addicts do. But temporal discounting does not excuse one from responsibility for the future consequences of one's voluntary actions. Similar to what Morse claims in the passage cited above regarding addiction, the capacity to foresee the consequences of excessive drinking suggests the following transfer principle of responsibility. If one is responsible for excessive drinking at an earlier time and is capable of knowing that this behavior entails a risk of developing end-stage liver disease at a later time, then one can be causally responsible for this outcome. Further, if one is causally responsible for ARESLD and knows that chronic drinking and ARESLD can result in a claim to an absolutely scarce life-saving organ and increase competition for it, then one acted negligently and as such is morally responsible for ARESLD. The combination of causal and moral responsibility can give one a weaker claim to a liver transplant.

Brudney argues that this judgment would not be fair to one with ARESLD unless there were a condition of advance notice that excessive chronic drinking could result in a weaker claim to a transplant.[17] He asserts that this ''fair warning'' condition is necessary because lower priority in this case is functionally equivalent to punishment with a potentially grave consequence. Brudney argues that, because this condition has not been met, the cases in which we could justifiably say that some people are less deserving than others for a liver transplant would be rare.

This argument may have had considerable force 20 years ago. But the connection between chronic drinking and liver failure has been common knowledge for some time. Thanks to the media and public education about health, most people are capable of knowing the risk of their behavior on health outcomes. In particular, most people are capable of knowing that chronic drinking for a period of 10–20 years entails a significant risk of liver failure. They are also capable of knowing that there is a significant gap between the availability of and need for transplantable livers. It would not be unreasonable to expect any competent person to infer from this that behavior resulting in liver failure would increase the number of claims to a limited number of liver transplants. A person who voluntarily engaged in chronic consumption of alcohol and who was capable of knowing the risk of developing liver failure from it would be negligently engaging in conduct that increased competition for transplantable livers. We owe it to each other as social beings to try to avoid this situation. Contrary to what Brudney claims, the cases in which it would be fair to give one lower priority for

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a liver transplant on the basis of knowledge of the link between drinking and liver failure would not be so rare.

Moss and Siegler distinguish between the causal sequence extending from chronic drinking to a diagnosis of alcoholism and the causal sequence extending from the time of diagnosis to the development of ESLD. For them, the relevant sort of responsibility does not apply to the first causal sequence but only to the second. Moss and Siegler assert that, "in view of the dire, absolute scarcity of donor livers, we believe it is fair to hold people responsible for their choices."[18] They qualify their point about choices: "Although alcoholics cannot be responsible for their disease, once their condition has been diagnosed, they can be responsible for seeking treatment and for preventing the complications of ARESLD."[19] One may be given lower priority for a liver transplant only if, once diagnosed with alcoholism, one fails to seek treatment to control the progression of the condition. But Moss and Siegler hold that one would not be responsible for ARESLD if one sought treatment and the treatment failed. In that case, one would have an equal claim to and be equally deserving of a transplant, and thus it would be unfair to give one lower priority.

Yet if we accept the transfer principle, then it may still be fair for one to have a weaker claim to a transplant in spite of a failed attempt at controlling the progression of the disease. It can be fair if, when one begins to drink chronically, one can foresee that liver failure is a probable consequence of this behavior. The consequence would fall within the knowable risk of the behavior, even if the consequence occurred 10–20 years later. The fact that the consequence lies further in the future does not weaken one's causal or moral responsibility for it. Assuming that we possess the necessary volitional and epistemic capacities, temporal discounting does not excuse us from responsibility for the consequences of our actions. If one knows at an earlier time that engaging in certain behavior entails the risk of a condition that can only be treated with an absolutely scarce resource at a later time, one can be responsible for the outcome and have a weaker claim to a transplant if, between these times, one attempted to control the condition but failed. This claim about responsibility extending from the initial behavior to the outcome of liver failure is more difficult to defend than the more limited claim about control and responsibility extending from a diagnosis of a condition to the outcome. Yet if one has the necessary volitional and epistemic capacities but fails to prevent the outcome by failing to exercise these capacities, then lower priority can be fair and morally justified in these cases.

Entitlements or Weaker Claims?

The view I am defending is supported by an interpretation of egalitarianism espoused by some political and moral philosophers. They argue that society should indemnify people against poor outcomes that are the consequences of causes beyond their control, but not against outcomes that are the consequences of causes within their control.[20] Neutralizing luck, or lack of control, is the fundamental motivation of egalitarianism. "Luck egalitarianism" says that inequalities in advantages or disadvantages that people enjoy or suffer are unjust if they result from involuntary factors, but just if they result from voluntary choices. Indemnification in the distribution of social goods that is sensitive to luck is one way of ensuring that all citizens have equal access to these goods.

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This would amount to an entitlement to certain goods, which could include transplantable organs. If people have control over and are responsible for the relevant consequences, though, then they are not entitled to indemnification.

In the case at hand, people who could have exercised control over their behavior and prevented ARESLD but failed to do so would not be entitled to the same consideration for a liver transplant as those who could not prevent it. A weaker claim to indemnification would be based on responsibility for the condition generating the need for and claim to a transplant. The basic idea is that those who had a functional liver but caused it to fail should not have the same claim to a new liver as those who had a defective liver in the first place. As noted, the second group would include congenital biliary atresia, congenital polycystic liver disease, primary biliary cirrhosis, and primary sclerosing cholangitis, conditions that one develops through no fault of one's own. Similar remarks apply to acute liver failure resulting from a toxic reaction to certain foods, when one could not have foreseen such a reaction.

The liver allocation formula is based on the Model for End-Stage Liver Disease (MELD) score. This is an empirical measure predicting short-term mortality from liver disease for patients on the waiting list. A higher score means a higher probability of death from liver failure. Those with the highest risk of mortality are given priority for a liver transplant, even though those with lower scores may benefit more from a transplant. Thus the MELD system is not utility maximizing but is based on a principle of justice that gives priority to the worst off.

Veatch has proposed what amounts to a small reduction in the MELD score for individuals with ARESLD. He says that, "with a limited number of livers, those who got a defective first liver ought to have priority over those whose first liver was healthy."[21] Veatch frames the issue in metaphorical terms: "The issue here is whether someone deserves seconds when he or she has had a good first helping. There are many issues of allocation in which everyone can claim an initial share, and enough surplus will remain for some seconds. Those whose first portion was defective should get a crack at the leftovers before those whose first helping was adequate but squandered."[22] Similarly, Moss and Siegler believe that "it is fairer to give a child dying of biliary atresia an opportunity for a *first* normal liver than it is to give a patient with ARESLD who was born with a normal liver a *second* one."[23]

Significantly, Veatch asserts that "entitlement to a second portion does not depend on whether one understands that there won't be enough seconds to go around."[24] For Veatch, the epistemic condition of responsibility is not necessary to justify lower priority. Although I agree with Veatch on most of his reasoning and his general conclusion, I disagree with his claim that alcoholics deserve lower priority for scarce livers even if they are deficient in the knowledge of the implications of scarcity for liver allocation. Most philosophical accounts of responsibility stipulate that one must have the capacity to know the circumstances in which one acts and the consequences of these actions. Consistent with these accounts, I maintain that both voluntariness and knowledge capacities are necessary for responsibility underlying the claim about giving lower priority to alcoholics for liver transplants.

Substantive Responsibility

Many would say that this policy is punitive. It is punitive to give some people lower priority than others with an equal need for a scarce life-saving resource.

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Let us suppose that it is punitive. The question is whether it is justifiably punitive. The discussion thus far rests on the idea that, even if this policy is punitive, it does not always involve punishing the ''victim.'' Those who can control and are responsible for their actions and their consequences are not victims of them. This reasoning applies to those who are causally responsible for developing diseases they could have prevented as well as to those who are responsible for failing to take steps to control diseases once they have them. We can appeal to Thomas Scanlon's conception of social responsibility for support of the view that it may be fair to give alcoholics with ARESLD lower priority and a weaker claim to a liver transplant.

What Scanlon calls ''substantive responsibility'' means that, when one is deemed responsible for a certain outcome, ''that person cannot complain of the burdens or obligations that result.''[25] Although Scanlon does not discuss it, the burden in question here is a weaker claim to a liver transplant. This type of responsibility involves ''substantive conclusions of what we owe to each other.''[26] For present purposes, the content of this obligation is preventing behavior whose consequences will increase claims on and competition for a scarce life-saving resource. Scanlon's notion of substantive responsibility rests on what he calls the ''value of choice,'' or the ability to choose between alternatives. More specifically, ''when a person could have avoided a certain result by choosing appropriately, this fact weakens her grounds for rejecting a principle that would make her bear the burden of that result.''[27] For Scanlon, what makes a moral principle justifiable is that it is a principle that no moral agent could reasonably reject. What one could not reasonably reject would be a principle whereby a person deemed causally and morally responsible for liver failure could be given lower priority for a liver transplant. If this person could not reasonably reject and justifiably complain against this principle, then it would not be unfair.

Implicit in Scanlon's reasonableness rule is a condition similar to Brudney's fair warning condition. An individual would have to be warned or otherwise be aware of the consequences of not taking steps to avoid certain behavior and prevent a certain outcome. If one was aware of the risk of liver failure from certain behavior and aware of having a weaker claim to a transplant as a consequence of this behavior but failed to heed this warning, then one could not complain if one received lower priority for a transplant. Given the well-known gap between the availability of and need for transplantable livers, it would not be unreasonable to expect any competent person to infer from the shortage of organs that preventable behavior resulting in liver failure would increase the number of claims to a limited number of liver transplants. Insofar as ARESLD is preventable, an individual with this condition would be acting negligently by increasing competition for a scarce resource. Assuming that we can control our behavior, we owe it to each other to try to avoid this situation and cannot complain of any burdens that befall us if we do not exercise this control.

Luck and the Doctor–Patient Relationship

Another challenge to the position I am defending appeals to the notion of moral luck in holding some but not other people responsible for an outcome that occurs as a matter of chance. Consider the following hypothetical case. Person A drinks as much alcohol as person B. A's liver is unaffected by his chronic drinking,

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whereas B develops cirrhosis and liver failure, due, in part, to genetic differences between them. It seems a matter of luck that A does not and B does develop liver failure. Therefore it seems unfair to penalize B by giving him lower priority than others who need a liver transplant. If drinking played no causal role in B's liver failure, then it would indeed be unfair to give him lower priority than others in need of a transplant. However, if B's drinking did play such a role, then his disease would have fallen within the knowable risk of his drinking. If he was capable of knowing this risk, then he would have cognitive control over the sequence of events resulting in his need for a transplant. A person's knowledge of what risky behavior entails enables him or her to influence the probability of developing a condition such as liver failure by engaging in or avoiding the behavior. It would not be entirely a matter of luck, and, accordingly, it would not be unfair to give that person a weaker claim to a liver transplant.

This is a situation in which A and B play a type of lottery by engaging in risk-entailing behavior. As such, their behavior leaves something to chance.[28] If A drinks and does not develop liver failure, then he wins the lottery. If B drinks and develops liver failure, then he loses the lottery. But it is not entirely up to chance. Provided that B's choices are voluntary, that the outcome is causally sensitive to these choices, and that he has the capacity to know what the outcome might be, B has some causal control over and can be responsible for the outcome. In this regard, it would not be unfair to give B lower priority than others for a liver transplant. What *does* seem unfair is to deny a transplant to individuals who lack the social support to ensure adherence to immunosuppressive drugs following transplantation. Individuals can be excluded from transplants for this reason. Yet it is entirely a matter of luck whether they have or lack the social support to ensure a successful outcome. It is entirely beyond their control, which intuitively seems more punitive than giving people with at least some volitional and epistemic control over ARESLD lower priority for a transplant.

Some might object that adopting the principle I have defended would mean that doctors could deny life-saving treatments to patients. Yet the issue of whether responsibility should be a criterion in the allocation of scarce medical resources is not limited to but goes beyond the doctor–patient relationship. Doctors have duties to society as well as to patients. They are part of an expansive system of healthcare that has to be managed responsibly. Doctors have to be good stewards of that system and not just practitioners working with individual patients. The question of how a scarce resource can be allocated fairly requires a deliberative process that involves not only physicians and their patients but also society at large. In the United States, UNOS and regional transplant agencies play a critical role in allocation decisions, and these decisions are made by a broad range of healthcare professionals with public input. Decisions about how public goods such as transplantable livers should be allocated are social decisions. The practice of medicine, including organ transplantation, cannot be divorced from the broader social network that influences how it is practiced. Questions about priority in access to organ transplants pertain not only to the relationship between the patient and the doctor but also to the relationship between the patient and society.

Autonomy and responsibility are mutually entailing concepts. Autonomy involves the capacity to take responsibility for one's choices, actions, and their consequences. Responsibility for choices, actions, and their consequences presupposes

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autonomy. To say that people cannot be responsible for ARESLD because alcoholism is a disease threatens to separate autonomy from responsibility. If people can make autonomous choices about lifestyle that have adverse health consequences, then they can be responsible for these consequences, even if they include serious diseases. People can make imprudent choices that are nonetheless autonomous and for which they can be responsible. To say that people cannot be responsible for their health risks a return to paternalism and the idea that people are incapable of knowing what is in their best interests and taking responsibility for what they do. If we are to uphold autonomy, then we must also uphold personal responsibility for the health consequences of our autonomous choices.

This position is consistent with Kant's imperative to treat people as ends in themselves. What makes us human beings and gives us dignity is the capacity for rational and moral agency. We are all members of the "kingdom of ends," in the sense that we are members of a community of moral agents. It is on the basis of the capacity for rational and moral agency that we can and should be held morally responsible for our actions. For Kant, the moral law is a practical law governing mutual relations between and among persons. Ignoring or excusing what people do as moral agents is to ignore or fail to appreciate the basis of their dignity. It also shows a culpable lack of concern for the effects of their actions on other persons as ends in themselves.[29] The same can be said of those who are able but fail to control behavior that results in liver failure and the need for a liver transplant.

Conclusion

In most cases, individuals with ARESLD have sufficient control over their behavior to be causally responsible for their condition. They may be morally responsible for ARESLD if they act negligently by failing to prevent this outcome and increasing competition for scarce transplantable livers. This can justify giving them lower priority for a liver transplant. "Most cases" leaves open the possibility that some individuals who drink may not have the requisite control over their behavior and thus may not be responsible for alcoholism and its consequences. There may be extenuating environmental factors that would effectively constitute a form of coercion or compulsion and thus undermine control and excuse individuals from responsibility for liver failure. People living in extreme poverty or extreme social isolation might fall within this category. Generally, though, the Aristotelian default assumption that a person acts voluntarily and responsibly unless there is evidence of coercion, compulsion, or ignorance of the circumstances of action and their consequences is a reasonable assumption. The onus is on those claiming that lower priority would be unfair to some people with liver failure to show that these responsibility-undermining factors are present. They would have to argue that one's actions are not sufficiently voluntary and that one does not have the capacity to know the medical and social consequences of chronic drinking. The arguments that have been advanced for this position have not been persuasive.

If we affirm the interdependence of autonomy and responsibility, then we can be responsible for a disease we contract when we are able but fail to exercise control over the events that cause the disease. This may mean giving lower priority to some people regarding claims to scarce life-saving medical resources

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such as transplantable livers. But provided that these decisions are based on a clearly defined and reasonable conception of causal and moral responsibility, it may be fair to treat people unequally on these grounds.

Notes

1. Moss A, Siegler M. Should alcoholics compete equally for liver transplantation? *JAMA* 1991;265: 1295–8.
2. See note 1, Moss, Siegler 1991:1296.
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