LIVER TRANSPLANT DILEMMA:

THE ALCOHOLIC, MEDICAID PATIENT

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CASE SCENARIO

Ivan Bradford is a fifty-five year old, white male in need of a liver transplant. Ivan has been an alcoholic since he was thirty-two years old, and has developed an irreversible advanced liver disease, cirrhosis. In essence, the disease is the end result in scarring of the liver due to prolonged alcohol abuse. This scarring prevents the liver from performing many of its vital functions. Without a liver transplant Ivan will die.

The father of three, Ivan is now divorced. His children are now grown, two with children of their own. Before he checked into Alcoholics Anonymous, Ivan was neither a great husband nor a great father. Although he never physically abused his family, he did verbally abuse them when he had been drinking. This led to his divorce when he was thirty-eight years old. By age forty-seven, Ivan began trying to get his alcoholism under control. While Ivan never had a close relationship with his family, they encouraged him as he tried to stay off alcohol. Ivan's relapses sometimes lasted a week, other times a few years. Except for one brief relapse, Ivan had been alcohol free for the year prior to diagnosis of his liver disease. Ivan moved from job to job since age thirty-five, but has not been able to find stable work in the last five years. Due to his small income, he is eligible for state Medicaid support.

When tests revealed that Ivan needed a transplant, his transplant team, represented by Dr. Quandary, estimated that, without a new liver, Ivan had about one year to live. Ivan's cirrhosis had progressed so far that a transplant was Ivan's only chance of survival.

Though alcoholism frequently causes other health complications, Ivan does not have other significant medical problems. Nevertheless, Dr. Quandary and the team have some concern about accepting Ivan as a patient and about placing him on the transplant waiting list because he is an alcoholic. The team knows that Ivan is a recovering alcoholic who has tried to stay off alcohol but is somewhat prone to relapses. As they are the

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only transplant center in the area, the team knows that if they do not treat Ivan he will not be able to obtain treatment locally. The team knows it should provide the treatment beneficial to Ivan by performing a liver transplant. However, providing a liver for Ivan necessarily means that there will be one less liver available for other people on the waiting list. The team is concerned about achieving what is best for society, and about using the livers most appropriately. Bearing these goals in mind, the team must decide whether or not to accept Ivan as a patient and put him on the transplant list.

Dr. Quandary and the team know the arguments for and against transplanting livers in alcoholics. While the survival rate of patients receiving transplants due to alcoholic cirrhosis does not appear to be any lower that non-alcoholic transplant patients, reasons for not providing transplants for alcoholics include the fact that they frequently have other alcohol-related disorders, such as chronic pancreatitis, and cerebral atrophy.[589] Furthermore, alcoholics may have severe nutritional deficiencies that hurt their prognosis.[590] Another concern is the likelihood of recidivism. Not surprisingly alcoholics who remain abstinent have a better prognosis than those who do not. One study found the five year survival rate of abstinent patients to be 63% and only 40.5% for non-abstinent patients.[591] However, there is no significant evidence that alcoholics are more likely than non-alcoholics to drink after their transplant. Alcoholics usually find receiving a transplant to be a very sobering experience. In fact, some studies suggest that alcoholics and non-alcoholics consume similar amounts of alcohol following their transplantations.[592] It must be recognized that alcoholics who had such transplants likely went through a pre-transplant screening. Therefore, patients with a low likelihood of success, perhaps due to other serious medical problems or due to a high risk of recidivism, would not normally be given transplants. In that sense, the studies are not reflective of recidivism rates for every alcoholic, but rather only those deemed suitable for transplantation. For instance, "[r]ates of recidivism are reported to be fairly low and considerably lower for [alcohol-related end-stage liver disease] patients not selected for transplant."[593]

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[589] *See, e.g.,* Carl Cohen & Martin Benjamin, *Alcoholics and Liver Transplantation*, 265 JAMA 1299, 1300 (1991); Ruud A.F. Krom, *Liver Transplantation and Alcohol: Who Should Get Transplants?*, 20 HEPATOLOGY 28S, 30S–31S (1994) (noting patient survival between 1987 and 1991 for 826 patients with alcoholic liver disease was seventy-nine percent at one year and sixty-five percent at three years, and noting the survival rate for 5658 patients with other causes of liver disease was seventy-six percent at one year and sixty-seven percent at three years).

[590] Willis C. Maddrey et al., *Selection of the Patient for Liver Transplantation and Timing of Surgery in Transplantation of the Liver*, 23, 41 (Willis C. Maddrey ed., 1988).

[591] *Id.*at 42, 44.

[592] Nickie L. Blandford & Ann Moore, *Liver Transplants in Alcohol-Related End Stage Liver Disease*, 23 ANNA J. 345 (1996).

[593] *Id.*

The reason Dr. Quandary and the team find their decision difficult is that there is a scarcity of livers available for transplantation. In 1995, there were 2621 new liver registrants between the ages of 50 and 64, and the median waiting time was 270 days.[594] As technology has advanced so, too, has the number of people eligible for liver transplants increased. For example, the number of new registrants for livers increased from 2141 in 1988 to 7206 in 1995.[595] At the same time however, the median waiting time for the transplant increased from 33 days to 254 days.[596] The fact that transplants can help more people is a great achievement, but the problem is that the supply of organs is not keeping up with the demand. The number of liver donors between 1988 and 1995 jumped from 1834 to 4325.[597] While it is encouraging that these numbers are increasing, the supply is still short of the demand. In 1995, for example, 799 people died while waiting for a liver.[598] Herein lies the first problem: how to determine who should receive these organs.

Even if the transplant team decides to accept Ivan as a patient, they know that he may have payment problems. In their state, the legislature is deciding whether it will use the state Medicaid funds to pay for liver transplants. This creates a second problem: should the state's Medicaid funds pay for the transplant?

To analyze these problems it is helpful to look at the ethical framework as well as the medical and legal requirements underlying the organ transplant dilemma.

ETHICAL BACKGROUND

The United Network for Organ Sharing (UNOS), discussed in more detail later in the paper, manages and directs the allocation and distribution of organs.[599] UNOS operates under the ethical theories of justice and utility, trying to recognize the needs of patients while maximizing the benefits of transplantation.

All allocation [policies are] designed to provide all patients in need of a transplant continuous fair and equal treatment, regardless of race, gender, geography, socioeconomic status, celebrity status or

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[594] OPTN/SR 1996 Annual Report, Median Waiting Times: Liver, at 41.
[595] *Id.*
[596] *Id.*
[597] OPTN/SR 1996 Annual Report, Cadaveric Donor Characteristics: Liver, at 41.
[598] UNOS Facts and Statistics, Reported Deaths on the Waiting List 1988–1996, http://www.unos.org/sta_dol.htm (visited Mar. 31, 1997).
[599] UNOS Liver Allocation Policy Fact Sheet, http://www.unos.org/livalocpol/evoluton.htm (visited Mar. 31, 1997).

personal/behavioral history. At the same time, these equitable policies must maximize utilization of the limited supply of donated organs in a way that will benefit as many patients as possible.[600]

These theories are the basis of my ethical analysis of whether or not to treat an alcoholic patient whose funding is limited to Medicaid.

Distributive justice "refers to fair, equitable, and appropriate distribution in society determined by justified norms that structure the terms of social cooperation."[601] Due to a scarcity of livers available for transplantation, society needs to determine the best allocation of these livers. Material principles of justice, such as equal share, need or merit, specify the relevant characteristics for equal treatment in that allocation.[602] The application of these principles could lead to different conclusions in our scenario.

Another technique which may be used in analyzing this dilemma is the Utilitarian theory. Utilitarianism is a consequence-based theory which looks towards the good and bad consequences of an act to determine if it is right or wrong.[603] Utilitarians believe in maximizing the positive value over the negative value, but they do not always agree on what values are most important. So, while they are concerned about the greatest good for the greatest number of people, there is debate as to what is the most important good.[604]

A distributive justice theory based upon equal share or need would suggest that Ivan should have his transplant. While a theory based upon merit may suggest that Ivan is undeserving of a transplant. The utilitarian theory may also led to conflicting results, depending upon what is considered the most important good for society. Life rather than death is most likely considered a good, and in that case the greatest good concerning liver transplants could mean ensuring that all people had access to livers. On the other hand, maybe the greatest good for society would be achieved if people were aware that they would not receive a liver transplant if they were alcoholic, which could in turn lead to a drop in the number of alcoholics in society.

The theory of distributive justice may be applied not only to the allocation of the livers but also to the resources that pay for those transplants. If we base this decision on the material principles of equal

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[600] *Id.*
[601] TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 327 (4th ed. 1994).
[602] *Id.* at 329.
[603] *Id.* at 47.
[604] *Id.* at 48.

share, need, or merit, then an indigent person should be entitled to a transplant. However, if the material principle is based upon the ability to pay, then that same indigent person would not be entitled to a transplant.

The utilitarian theory also brings an interesting analysis to the funding question. How do we allocate resources so that the greatest number of people are helped? Oregon wanted to help the greatest amount of people eligible for Medicaid. In 1989, Oregon wanted to change the state's Medicaid program because only 160,000 of the 300,000 Oregonians living below the Federal Poverty Level were currently covered under their program.[605] To accomplish this goal, Oregon decided to rank medical services and authorized a Health Services Commission to determine which services the state plan would cover.[606] As a result, the only service which ranked lower than organ transplantation was cosmetic plastic surgery.[607]

THE LEGAL/MEDICAL FRAMEWORK

There are federal guidelines in place regarding organ transplants. In 1984, Congress passed the National Organ Transplant Act[608] with the objective of creating a framework for considering organ transplantation policy.[609] To do so, the Secretary of the Department of Health and Human Services contracted with UNOS in 1986 to operate an Organ Procurement and Transplantation Network (OPTN).[610] "The purpose of UNOS is to promote and scientifically advance transplantation and to increase the availability of donor organs."[611] UNOS maintains a waiting list which is only open to, and accessible by, members of UNOS. Therefore, in order to perform organ transplant operations in the United States, organizations essentially must be a member of UNOS and follow their guidelines. The UNOS waiting list is comprised of all patients, registered by UNOS members, awaiting an organ transplant. When an organ becomes available, relevant information is entered into the computerized matching system, eliminating potential recipients whose size or blood type are

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[605] Maxwell J. Mehlman, *The Oregon Medicaid Program: Is It Just?*, 1 HEALTH MATRIX 175 (1991).
[606] *Id.* at 176.
[607] *Id.* at 186–87.
[608] Pub. L. No. 98-507, 98 Stat. 2339 (1984).
[609] Benjamin Mintz, *Analyzing the OPTN Under the State Action Doctrine—Can UNOS's Organ Allocation Criteria Survive Strict Scrutiny?*, 28 COLUM. J.L. & SOC. PROBS. 339, 342–43 (1995).
[610] *Id.* at 343.
[611] UNOS, FINANCING TRANSPLANTATION: WHAT EVERY PATIENT NEEDS TO KNOW iv (3d ed. 1996).

incompatible with the donor.[612] The system then ranks the potential recipients in accordance with the ranking system set out below.

Patients awaiting a liver transplant are assigned a status code in accordance with their medical urgency.[613] There are essentially four status codes: one, two, three, and seven. A status one patient has acute liver failure with a life expectancy of less than seven days.[614] These patients account for less than 0.1% of patients on the waiting list.[615] A status two patient is one who is "continuously hospitalized in an acute care bed for at least five days, or is intensive care unit (ICU) bound."[616] A status three patient is one who needs continuous medical care.[617] The final status, seven, is for patients whose status is temporarily inactive (e.g. not listed as currently in need of a liver). Status seven patients are allowed to continue accruing waiting time for a maximum of thirty days.[618]

Patients receive points for blood type similarity and the amount of time waiting on the transplant list.[619] Using this status prioritization, livers are allocated locally, then regionally, and then nationally.[620] The liver will be offered to the local status one patients in descending point order, then to the status two patients in descending point order, and then to all other local patients in descending point order.[621] The same process is then followed regionally and nationally.[622]

It is important to note that the "final decision whether to use the organ will remain the prerogative of the transplant surgeon."[623] This allows the doctor to determine the suitability of a specific organ to a specific patient, and whether her patient is in the proper state in which to receive a transplant. The transplant team in any given situation can decide whether or not it wants to accept a patient who is in need of a transplant. However, specific medical criteria must be confirmed before adding a patient to the waiting list.[624] Despite this, the treating doctor does have a large say, and

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[612] UNOS, ORGAN DISTRIBUTION 3-1 (3d ed. 1996) [hereinafter UNOS, ORGAN].
[613] UNOS, ALLOCATION OF LIVERS 3-19 (1996).
[614] UNOS, ORGAN, *supra* note 24, at 3-20.
[615] UNOS Liver Allocation Policy Fact Sheet, http://www.unos.org/livalocpol/policy.htm (visited Mar. 31, 1997).
[616] UNOS, ORGAN, *supra* note 3-20.
[617] *Id.*
[618] *Id.* at 3-19.
[619] *Id.* at 3-18.
[620] *Id.*
[621] *Id.*
[622] *Id.*
[623] *Id.*
[624] UNOS Liver Allocation Policy Fact Sheet, http://www.unos.org/livalocpol/q_and_as.htm (visited Mar. 31, 1997).

this is an important decision because status one patients are first in line for a transplant.

Specific to Ivan's situation, we need to know if there are any restrictions on alcoholics receiving liver transplants. UNOS has no such restrictions. While some physicians maintain that past substance abuse should not be a factor as long as the patient has been in a recovery program for six months, many organizations require an arbitrary period of abstinence before performing a transplant in order to reduce the chance that the patient will return to alcohol.[625] Such recidivism appears to be the cause of some of the reluctance to provide transplants for alcoholics.[626]

Some argue however that there is no proof that a required period of abstinence reduces the chance of recidivism. One study in Pittsburgh found that the outcome of patients with alcoholic cirrhosis was as good as the outcome of other patients, even though abstinence was not a criteria in selecting patients.[627] One commentator argues that the "imposition of an arbitrary period of abstinence before going forward with transplantation would seem medically unsound or even inhuman if criteria such as the will to live, explicit admission of alcoholism, and expression of determination to effect behavioral change are valid criteria for candidate screening."[628] Indeed, he argues that by waiting unnecessarily, patients may progress into a weakened state, or die.[629]

The courts have also become involved in this issue. In *Allen v. Mansour* the court held that a state-required two year period of abstinence was arbitrary and unreasonable and violated Medicaid standards.[630] The court held that the state did not provide evidence showing the necessity of the abstinence period, and noted that the University of Pittsburgh, the largest liver transplant center in the United States, did not require an abstinence period.[631] The court also held that the waiting time was unreasonable because the patient in most dire need of a transplant usually could not survive a two year waiting period.[632]

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[625] Phyllis Coleman, *"Brother, Can You Spare a Liver?" Five Ways to Increase Organ Donation*, 31 VAL. U. L. REV. 1, 13 (1996) (paraphrasing opinion of doctors at Baylor University Medical Center).
[626] Maddrey, *supra* note 2, at 41.
[627] George L. A. Bird, *Liver Transplantation in Patients with Alcoholic Cirrhosis: Selection Criteria and Rates of Survival and Relapse*, 301 BRIT. MED. J. 15, 15 (1990) (citing Kumar et al., *Orthotopic Liver Transplantation Alcoholic Liver Disease*, 11 HEPTATOLOGY 159 (1990)).
[628] Thomas E. Starzl et al., *Orthotopic Liver Transplantation for Alcoholic Cirrhosis*, 260 JAMA 2542 (1988).
[629] *Id.* at 2544.
[630] Allen v. Mansour, 681 F. Supp. 1232, 1238 (1986).
[631] *Id.* at 1238 n.10.
[632] *Id.* at 1238.

The question of whether or not states should fund transplants through Medicaid is a subject of both legislative and judicial discussion. Medicaid is a medical assistance program for the "categorically needy" funded by both the federal and state governments.[633] States devise their own program, providing assistance in seven broad areas of medical treatment set out by the federal government.[634] These areas include: inpatient and outpatient hospital services; x-ray and laboratory services; physician, nurse practitioners, and nurse-midwife services; nursing facility services for persons age twenty-one and over, and early and periodic screening, diagnostic, and treatment services for people under age twenty-one.[635] States do not have to fund every procedure within the categories, but they are required to have "reasonable standards . . . for determining . . . the extent of medical assistance under the plan which . . . are consistent with the objectives of [Medicaid]."[636] Therefore, states have fairly broad discretion in formulating their plan. The Medicaid provision governing organ transplants, 42 U.S.C. § 1396b(I)(1), states that federal payments will not be made for transplants unless the state has written standards for coverage of such procedures providing that similarly situated individuals are treated alike, and that any restrictions on facilities or practitioners are consistent with the accessibility of high quality care.[637] The Eighth and Ninth Circuits have interpreted this provision to mean that states have discretion over whether or not to fund transplants.[638] If the state chooses to fund transplants, then it must comply with §1396b(I)(1) in order to receive money form the federal government. In *Ellis v. Patterson*, the Eighth Circuit held that Arkansas was not required to fund organ transplants under the Medicaid Act.[639] Instead, § 1396b(I)(1) was interpreted to give the states discretion over what kind of transplants, if any, to fund.[640] The Health Care Finance Administration (HCFA), which administers the Medicaid program, agreed with this interpretation.[641] The Ninth Circuit, in *Dexter v. Kirschner*, also agreed with *Ellis*. This court determined that 1396b(I)(1) did not make payments for transplants necessary.[642] The state does not need to pay for the transplants, even if

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[633] David L. Weigert, *Tragic Choices: State Discretion Over Organ Transplant Funding for Medicaid Recipients*, 89 NW. U. L. REV. 268, 271–72 (1994).
[634] *Id.*
[635] Harris v. McRae, 448 U.S. 297, 302 (1980), *quoted in* Weigert, *supra* note 45, at 272–73.
[636] *Harris*, 448 U.S. at 302, *quoted in* Weigert, *supra* note 45, at 274–75.
[637] Weigert, *supra* note 45, at 274–75.
[638] *See, e.g.*, Ellis v. Patterson, 859 F.2d 52 (8th Cir. 1988); Dexter v. Kirschner, 972 F.2d 1113 (9th Cir. 1992), *modified*, 984 F.2d 979 (9th Cir. 1992).
[639] *Ellis*, 859 F.2d at 55.
[640] David Flower, *State Discretion in Funding Organ Transplants Under the Medicaid Program: Interpretive Guidelines in Determining the Scope of Mandated Coverage*, 79 MINN. L. REV. 1233, 1247–48 (1995).
[641] Weigert, *supra* note 45, at 270.
[642] Dexter v. Kirschner, 972 F.2d 1113 (9th Cir. 1992), *modified*, 984 F.2d 979 (9th Cir. 1992).

they are medically necessary because they are not among the list of required services.[643] This court, like the one which decided *Ellis*, relied upon legislative history to arrive at this conclusion.

The Fourth and Eleventh Circuits have held that this interpretation is incorrect.[644] In *Pereira v. Kozlowski*, the Fourth Circuit held that the Medicaid organ provision did not affirmatively grant states discretion in funding transplants, but rather only laid out the criteria to receive matching funds.[645] The Eleventh Circuit, in *Pope v. Secretary, Florida Department of Health and Rehabilitative Services*, also held that the state must fund transplants. However, this court relied on the provision requiring states to provide all medically necessary services to children receiving early and periodic screening, diagnostic, and treatment services, instead of determining the scope of state discretion under § 1396b(I)(1).[646]

More recently, in 1994 the Supreme Court of Arizona, in *Salgado v. Kirschner*, rejected the states practice of denying organ transplants on the basis of age.[647] By denying a transplant based upon age, the state program was not treating similarly situated people in the same manner as required under the Medicaid statute. It also failed the "reasonable standards" requirement by denial based upon age.[648] The Court recognized that there was a split in the circuits as to whether or not states must fund transplants as medically necessary, but it did not need to address this issue because, at the time, Arizona had chosen to fund transplants. The Court arguably agreed that states had the discretion on whether or not to fund transplants. This may create an interesting situation in Arizona where coverage may not be denied based upon age, but it may be universally denied.[649]

So, while the courts have touched upon the subject of Medicaid funding, there is no set answer. The funding decision may very well be left up to the states. With limited funds available, states need to decide what is best for their constituency. The decision behind the funding involves more than just dollars, it involves ethics.

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[643] *Id.*

[644] *See, e.g.,* Pereira v. Kozlowski, 996 F.2d 723 (4th Cir. 1993); Pope v. Secretary, Florida Dep't of Health and Rehab. Servs., 998 F.2d 887 (11th Cir.) (per curiam), *cert. denied*, 114 S. Ct. 650 (1993).

[645] *Pope*, 998 F.2d at 891–92.

[646] *Id.*; *see also* Flower, *supra* note 45, at 1253–54.

[647] 878 P.2d 659 (Ariz. 1994); *see also* Leanne E. Dodds-Eastman, *Salgado V. Kirschner: May Arizona Deny Life-Sustaining Organ Transplant Coverage to Adult Medicaid Recipients Under the Federal Medicaid Statute?*, 27 ARIZ. ST. L.J. 251 (1995).

[648] Dodds-Eastman, *supra* note 59, at 256–57.

[649] *Id.* at 259.

Should the fact that someone has essentially caused their own disease eliminate them from the chance of having a transplant? In Ivan's case, alcoholism led to his cirrhosis. After decades of drinking, his liver is finally failing. Despite attempts to quit, he is prone to relapses and the years of drinking have already taken their toll. It helps to know a little about the disease of alcoholism before making the decision of whether or not it should affect Ivan's ability to receive a transplant.

In 1991, the "National Council on Alcoholism and Drug Dependency defined alcoholism as a primary chronic disease with genetic, psychosocial, and environmental factors that often proves to be progressive and fatal."[650] Heredity, and biochemistry are also said to play a role in alcoholism.[651] This means that while some people can drink socially and not become addicted, others may find if difficult to stop drinking. As some people are more prone to alcoholism, some are also more prone to alcoholic cirrhosis,[652] a condition which occurs in about 10-15% of alcoholics.[653] For instance, alcoholism is more likely to lead to cirrhosis in women then in men.[654] It is, of course, true that the amount of alcohol consumed and the duration of heavy drinking can affect ones chances of developing cirrhosis.[655]

Alcoholism brings interesting questions into the allocation discussion. UNOS has no restrictions against supplying livers to alcoholics. While some transplant centers require a mandatory abstinence period, case law suggests that this period cannot be for an unreasonable amount of time.[656] It appears, therefore, that Ivan has every legal right to obtain a liver transplant. Does he have a right to a transplant ethically?

The idea that some people have an opportunity to receive a new liver when they were not responsible with their first one, is offensive to many people. Simply because it seems offensive however, does not make it just to deny someone the right to live because of their past actions. The theory of distributive justice would ask what is the fair, equitable and appropriate distribution of these livers. It may be fair for everyone to have

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[650] Ruud A.F. Krom, *Liver Transplantation and Alcohol: Who Should Get Transplants?*, 20 HEPATOLOGY 28S, 28S–29S (1994).
[651] Alvin H. Moss & Mark Siegler, *Should Alcoholics Compete Equally for Liver Transplantation*, 265 JAMA 1295, 1296 (1991).
[652] Carl Cohen & Martin Benjamin, *Alcoholics and Liver Transplantation*, 265 JAMA 1299, 1300 (1991).
[653] American Liver Foundation, Alcohol and the Liver: Myths v. Fact (Sept. 23, 1991).
[654] Robert L. Schwartz, *Life Style, Health Status, and Distributive Justice*, 3 HEALTH MATRIX 195, 204 (1993).
[655] Moss & Siegler, *supra* note 63, at 1296.
[656] *See supra* notes 42–44 and accompanying text.

an equal chance of getting the resource. Equitable allocation would suggest a lottery system, in which everyone would have an equal chance of receiving the organ. But a lottery system presents problems in the allocation of livers. For instance, who would be able to play in this lottery? Only people with acute liver failure or all people with some future need of a transplant? Also, there is a need to match the organ donor and the recipient, so it could not be a pure lottery system. However, even if you used a lottery system based upon the UNOS ranking system, you would still not get satisfactory results. Such a lottery system would assume that all people with the correct blood type and size would be allowed on the waiting list, including people with no chance of survival, the very elderly, and people suffering from other serious diseases. It sounds great that everyone, no matter who they are or what their condition is, would have an equal chance of the liver, but it would not be an efficient use of a scarce resource. It is not a justifiable allocation of a scarce resource to use it on someone who is not going to survive the operation.

If patients cannot have a completely equal chance of receiving a liver, then perhaps their chance should be based upon merit. Under distributive justice it would be right to allocate resources this way because people would get what they deserve. If you have led a healthy life, and are unfortunate enough to get a liver disease, then you should be placed at the top of the list. An alcoholic, on the other hand, arguably caused his own problems and is not worthy of help. This is harsh commentary, but it may be what many feel is right, or justified. When this theory is taken to its logical conclusion, however, it does not provide justice.

"It is hard to find a life style 'choice' or a health condition that is not, at least in part, a consequence of genetics, family environment, social environment, gender, life trauma, ethnicity, community, education, (and especially, health education) and, probably most significantly, wealth."[657] Smoking, over eating, lack of exercise, stress, all contribute to unhealthy lifestyles. a distributive justice theory based upon merit would find it is just to deny all of these people treatment. Of course, these situations may be somewhat different because they do not deal with a scarce resource. So, failing to revive a person who has had a heart attack due mainly to their obesity seems much more repulsive to us than not using a scarce resource to treat an alcoholic. However, if you consider the fact that money is always a scarce resource, why should we waste it on people who have not taken good care of themselves?

Commentators have suggested that people with alcohol related liver disease should be allowed transplants, but that they should receive a

[657] Schwartz, *supra* note 66, at 1296.

lower ranking.[658] Their argument rests on the principles of fairness, and policy considerations. They feel it is justifiable to hold alcoholics responsible for their actions because though alcoholism is a disease, alcoholics have a duty to get treatment.[659] Furthermore, under the theory of formal justice, alcoholic patients with liver disease are unequal to other patients with liver disease because "their liver disease was preventable; therefore, it is acceptable to treat them differently."[660] These commentators further felt that giving donated livers to alcoholics may undermine the public support of transplantation.[661]

This argument has several faults. Livers cannot be allocated based upon merit because it creates unfair results, the opposite goal of distributive justice. Basing a decision upon merit requires making a determination as to what is worthy of merit. If alcoholics are "penalized because of their moral fault, then all others who are equally at fault in causing their own medical needs should be similarly penalized."[662] Such a determination of moral fault would be based upon the biases of society, and would led to such intrusiveness into the patient's lives as to unjustly violate their autonomy. We should not pass judgment on people because we "cannot pass judgment fairly . . . we cannot know what penalties different degrees of misconduct deserves . . . [and] judgments of this kind could not be made consistently in our medical system."[663] It is unfair to hold alcoholism as morally unjust because it is a disease, rather than a vice, meaning that the action of alcoholics is at least to some degree involuntary. Furthermore, some people are more predisposed to liver disease than others. Someone who was able to conquer this problem and remain off alcohol would in some ways be more worthy of a transplant. As for the idea that public support would decline if alcoholics are given livers, there seems to be no evidence of this, and it is probably one of the least concerns in the quest for increasing liver donation.

While this comment raises the interesting argument that alcoholics have a responsibility to get treatment, treatment is no guarantee that they will remain sober. In January of 1996, there were approximately 1,153,795 members in Alcoholics Anonymous (AA).[664] Despite its large membership, there is a fairly large dropout rate, and the success rate is far from 100%.[665] For instance, in 1989, approximately 35% of the members

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[658] Moss & Siegler, *supra* note 63, at 1296.
[659] *Id.*
[660] *Id.*
[661] *Id.* at 1297.
[662] Cohen & Benjamin, *supra* note 64, at 1300.
[663] *Id.*
[664] Membership, http://www.alcoholics-anonymous.org/factfile/doc07.html (visited Apr. 14, 1997).
[665] John N. Chappel, *Long-Term Recovery from Alcoholism*, 16 PSYCHIATRIC CLINICS OF N. AM. 177, 182 (1993).

were sober less than a year; 36% were sober between one and five years; and 29% were sober more than five years.[666] While it is wonderful that this program can help even 29% of its members remain off alcohol, requiring a patient to enter AA will not guarantee their sobriety. While proponents of ranking alcoholics lower on the waiting list cite that tw-thirds of alcoholics who accept therapy improve, they could only cite that 54% were abstinent a minimum of one year after treatment.[667] Requiring treatment would be more persuasive argument if the treatment or therapy were 100% effective for alcoholics, but this is not the case. As our understanding of alcoholism increases, so may the effectiveness of treatment. Until then, to require a person to have a lower ranking to a life saving technique because they have not attempted a far from guaranteed treatment, is unjust.

The best argument under the theory of distributive justice is to distribute the livers on the basis of need. Alcoholics recover as well as non-alcoholics from liver transplants. The recidivism rate of alcoholics has not proven to be high enough to justify non-treatment. There is no basis to deny them a transplant. Instead, allocation should be based upon need. This is essentially the policy of UNOS. Assuming the liver is a suitable match, allocation should be based upon those who are most in need. There is consideration given to the amount of time on the waiting list. However, that criteria does not override the position of those who are the most medically needy. With a scarce resource, this seems the most fair and equitable means of allocation. I do think that consideration should be given to the likelihood of success of the procedure. As with all potential liver transplant patients, an alcoholic patient must be examined for suitability. If the transplant is not going to prolong a person's life, then that person should not have the operation. Complications arising from alcoholism, patient knowledge of the alcohol problem, and the availability of social support necessary for immuno-suppression and follow-up care are all considerations which must be taken into account.[668]

Furthermore, if the patient poses a real risk of recidivism, which may not only harm the transplanted liver but also may affect their ability to comply with the medical regimen, then they should not be placed on the transplant list. It is fair to require the alcoholic to be sober for some time prior to the operation, but only if this is an effective way of decreasing the chance of recidivism. As with other patient conditions, if the success of the operation is thought to be in jeopardy these requirements are justified. Livers are a scarce resource and attempts should be made to ensure their usefulness.

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[666] *Id.* at 182.
[667] Moss & Siegler, *supra* note 63, at 1296.
[668] Cohen & Benjamin, *supra* note 64, at 1301.

The theory of utility also suggests allowing alcoholics to be transplant recipients. "Since alcohol-induced liver injury is the most frequent cause of cirrhosis in the United States and other Western countries, the largest number of potential candidates for liver transplantation are alcoholics."[669] To help the greatest number of people therefore, alcoholics should be allowed access to liver transplants. This good however, would only be fully achieved if there were an unlimited number of organs available. But as the situation now stands, there is a finite number of livers available no matter to whom they are allocated. Hence, the greatest good is hard to achieve. While alcoholics may constitute the largest section of people who can benefit from transplants, perhaps we should address their problem in a different way. For instance, if we could get treatment to alcoholics years earlier, and prevent their disease from requiring a transplant, then the livers that would have been allocated to them can be used elsewhere. One study showed that even patients with end-stage alcoholic liver disease who did not receive transplants achieved a 60%, five year survival rate through sobriety.[670] This type of strategy should not be limited to alcoholics. If other liver disease patients can be given preventative care so that a liver transplant is unnecessary, then it too should be done.

As already discussed however, treatment is not always successful, and for "some patients alcoholic liver disease is progressive even with a successful alcohol treatment program and complete abstinence."[671] Furthermore, the poor would be disadvantaged because of their inability to afford treatment.[672] Effective preventative treatment, and finding cures are certainly worthy goals, but they are not the reality of today. These developments, like an increase in the supply of donated livers, would ease the allocation dilemma. Until that time, under the utilitarian theory, the greatest good for the greatest amount of people would be achieved by providing medical technology to all of those in need, including alcoholics.

It could be argued that the greatest good would be achieved by eliminating alcoholism, and therefore we should deny alcoholics treatment. However, we run into the same problem as before that alcoholism is a disease. If alcoholism is a disease, and therefore to some extent involuntary, then the threat of denied treatment when they are very ill is not going to deter alcoholism. Further, this may lead to society wishing to curb many harmful activities. Smoking, bungy jumping, eating fast food. The invasion on people's autonomy would be unacceptable.

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[669] Maddrey, *supra* note 2, at 41.
[670] Krom, *supra* note 62, at 29S.
[671] *Id.*
[672] Theresa K. Killeen, *Alcoholism and Liver Transplantation: Ethical and Nursing Implications*, 29 PERSPECTIVES IN PSYCHIATRIC CARE 7, 8 (1993).

{42}Whether or not Medicaid should fund transplants also presents interesting arguments. The legal guidelines suggest that it is currently unsettled as to whether or not a state must fund transplants. This being the case, individual states must decide how they want to handle the situation. Certainly medical care should ideally be available to all people regardless of cost. This however, is not the reality of the world in which we live. The truth of the matter is that transplants are expensive procedures. The average cost of a liver transplant in 1993 dollars was $302,900, plus $21,900 annual follow-up charges.[673] This, needless to say, is a significant amount of money, and the dilemma becomes whether to spend the money on transplants for a few people or spend the money on basic health care for thousands of others.

Assuming that the Medicaid Statute does give the states discretion over whether or not to fund transplants, how should they make the decision? Denying people on Medicaid access to a life-saving device is not a comfortable proposition. The denial of basic health coverage to people who may develop future health problems due to this denial is similarly uncomfortable.

Oregon's proposal presents an interesting example of resource allocation. Oregon created an eleven member committee to develop a priority list of treatments to be funded.[674] In order to solicit community involvement, the committee held eleven public hearings, conducted a phone survey, and allowed a citizen advocacy group to conduct more community meetings.[675] The list was submitted to the Oregon General Assembly and approved. This process allowed Oregon to cover 42% more of the state's poor population, but reduced the benefits provided to each person.[676] In order for Medicaid to reach more needy people, Oregon needed to come up with funding for the expansion. This meant increasing taxes or reducing Medicaid benefits so that the money could be spread farther. Apparently, Oregon had been hit by a taxpayer revolt and higher taxes did not seem to be an option.[677] So, it seemed the only way to achieve its goal was to decrease the benefits to each recipient.

The theory of distributive justice may be used to analyze this situation. If the material principle for distribution is the ability to pay, then it would appear that the Oregon proposal is just. The theory of justice may say that this is a fair allocation of goods, because if the adults on Medicaid had worked harder they could have provided insurance for themselves that would have covered their transplant. However, basing the

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[673] UNOS, FINANCING TRANSPORTATION, *supra* note 23, at 4.
[674] Weigert, *supra* note 45, at 310.
[675] *Id.*
[676] *Id.*
[677] Mehlman, *supra* note 17, at 175–76.

right to life saving treatment on someone's ability to pay offends the notion of fairness. Someone could have to rely on Medicaid because they were down on their luck, or because they were born into poverty. If the material principle is based on equal share, need, or merit then the proposal would not be just. Based upon these principles, people unable to pay are just as worthy as others to receive a transplant.

Though indigents may be just as worthy, this does not solve the problem of funding. The medical procedures must be paid for. The doctor has to be able to make a living, and the hospital has to be able to maintain itself. The money has to come from somewhere. Taxes could be raised on a national level to provide funding to the states. Of course, this is always hugely unpopular especially in light of the deficit reduction talks. The Oregon plan was quite a democratic way to handle the situation. If people want these treatments covered, then state taxes will have to be raised. The community essentially voted not to fund these procedures. However, each person's vote is based upon the reasonable assumption that they will not need such treatment. The question could be presented to society in a better way. One extra dollar on taxes will mean saving a certain number of lives. This approach may gain community encouragement of such a tax increase. Alternatives should also be looked at more closely. Do all of these people need state coverage? Presumably they do if they are under the Federal Poverty level. Could any of the services be operated more cost effectively? Simply denying the coverage based upon ability to pay is the easy way out of a difficult situation.

The utilitarian theory is central to the Oregon plan. The ranking scenario is itself a utilitarian concept. Services providing the greatest benefit are ranked highest.[678] The ranking is calculated by considering the duration of benefit, the probability of occurrence, and the importance of that benefit as determined by the committee and the public.[679] One commentator points out that the ranking decisions are artificial because they are based upon what healthy people think about future hypothetical situations.[680] It is true that people are more quickly able to see the need for pre-natal or in-patient care in their future than the need for a transplant. Therefore, these services will be ranked higher. While this may artificially devalue an organ transplant, basic services such as in-patient care will benefit a larger number of people than transplants. Even if this is so, life-saving treatment is essentially being taken away from one person and being given to another. Is it fair to shift the resources from the worst off to the slightly better off?[681]

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[678] *Id.* at 183.
[679] *Id.*
[680] *Id.* at 184.
[681] *Id.* at 192.

If, under the utilitarian theory, we deem access to health care as the good we are trying to achieve then this system is certainly just. But this is not a satisfying result. True, only one person may die while many others would be helped, it still seems unfair to deny medically necessary treatment solely on the ability to pay. If the good we are trying to achieve is comprehensive health care for all people, then an Oregon type proposal is not just. Yes, this may be an idealistic good, but it is a worthy goal. While funding problems may force stopping short of this goal today, it should nonetheless be the goal of tomorrow.

CASE STUDY CONCLUSION

The team decided that the benefit to Ivan is not contrary to the needs of society. Knowing that there are no restrictions under UNOS regarding alcoholics as recipients for liver transplants, the team has determined that there are no medical or ethical reason why Ivan should not receive a transplant. Ivan's prognosis with the transplanted liver is positive. His cirrhosis is the only real damage that alcoholism has caused to his body, he is determined to remain sober, and his family is willing to help him through the recovery process. Distribution based upon need results in the fairest allocation of this resource. Furthermore, the greatest number of people needing liver transplants, those with alcoholic cirrhosis, will be helped if alcoholics are allowed transplants. The greatest number of people would truly be helped if we could effectively treat alcoholics early on so that they would not need a liver transplant, or if we could increase the supple of donated livers. Until these successes ease our dilemma, however, the greatest good for the greatest amount of people will be achieved by providing all of those in need with the best medical treatment.

The state Medicaid statute will fund Ivan's transplant. They have determined that distributive justice based upon need produces the most fair result. His state decided that helping the greatest amount of people includes providing them with all medically necessary treatment, and while distribution based upon ability to pay is an easy way to allocate resources it is does not produce a just result. The state is, therefore, willing to raise taxes and to run its programs more efficiently in order to pay for the coverage.