

With a shortage of organs and finite healthcare resources, some argue that people who need them owing to lifestyle choices should be denied transplants

# Should lifestyle choices affect access to transplant?

## In this article...

- A summary of lifestyle issues related to organ transplantation
- The case for denying transplants on the basis of lifestyle
- The case against denying transplants on the basis of lifestyle

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With new health and safety laws and better emergency response times, the availability of transplantable organs has diminished. This is not just an issue of finite resources – it is also an issue for all healthcare workers who care for transplanted patients and those on the waiting list. This article presents a debate that covers some of the ethical issues surrounding organ transplantation.

This occasional series of ethical debates discusses issues pertinent to nursing, presenting all sides of an argument and leaving readers to decide what they believe is the correct course of action.

The proposition for this debate is:

**Organ transplants should only be given to people whose illness is not as a result of lifestyle choice.**

In the first three-quarters of 2013-14, 20,069,640 people were on the UK's organ donor register (32% of the population); however, with a waiting list exceeding 7,000, only 3,740 people received a transplant in 2013 (NHS Blood and Transplant, 2014a).

An organ is a mass of specialised cells and tissues that work together to perform a function in the body (Paul et al, 2004). An organ transplant is a surgical procedure in which a failing or damaged organ is removed and replaced with a new one.

Organ transplantation has a major role in managing failure of single organs or systems, and combined organ failure (Box 1). Transplants may be needed because of primary organ disease, such as chronic inflammatory disease of the kidneys or cardiomyopathy, or because of secondary effects, which would include kidney, islet cell and pancreas transplants in people with diabetes, and lung transplants in people with cystic fibrosis (National Institute for Health and Care Excellence, 2011).

The introduction of health and safety laws, such as making wearing seat belts in cars mandatory, and better response rates by emergency services have gradually diminished the number of organs available for donation, and this trend is likely to continue. This makes transplantable organs a finite resource, which means there is much debate as to who should receive those that do become available.

One high-profile case that brought the issue into the public eye was that of the former footballer George Best. In 2005, Mr Best received a liver transplant due to cirrhosis of the liver, but died three years later after resuming his consumption of alcohol. According to Doward and Campbell (2009), one in four liver transplants are given to people who need them due to alcohol consumption, which is the cause of much controversy in both healthcare and the general population. Sample (2005) reported that the surgeon who performed Mr Best's liver transplant said urgent measures were needed to identify patients likely to misuse alcohol after their operations, so they could be removed from hospital waiting lists. Doward and Campbell (2009) reported how the mother of a young woman whose organs had helped to keep

## 5 points for discussion

**1** Should people who have received one organ be offered a second transplant or should people who have not had a transplant be given priority?

**2** Should people whose lifestyle choices damaged their organ be given a transplant?

**3** Should someone with young children have priority over a childless or an older person?

**4** Is it ethical to place a person who is rejecting a new organ due to non-concordant behaviour on the same ward as someone waiting for a transplant?

**5** With organs in short supply, should England and Scotland adopt Wales' opt in/opt out law?

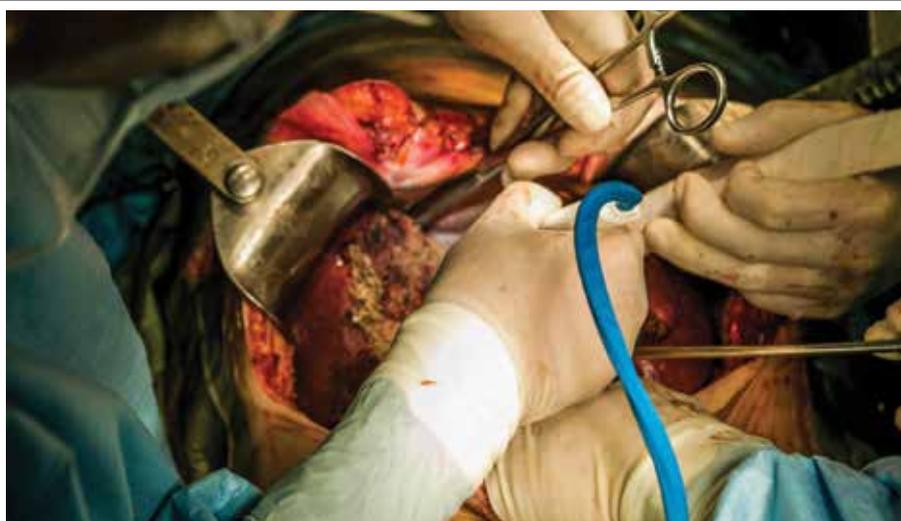
five people alive after she died in a road traffic collision said it was “offensive, terrible and unfair” that an increasing proportion of livers were being given to people with serious alcohol problems. She believed that donated livers should go to people who had not created their health problems through lifestyle choices.

However, excessive alcohol consumption is an increasing problem, with 34% of men and 28% of women in the UK drinking more than the recommended maximum (four units for men, three for women) at least one day a week. These statistics from Alcohol Concern (2014) reveal a startling increase in hospital admissions for people aged under 30 with alcohol-related liver disease; the number has increased by 117% in England as a whole, and by 400% in the north east of England (no time period for this rise is given). This growing health problem has highlighted the debate about organ transplantation and use of this finite resource.

Liver transplants are just one example of transplants needed as a result of health problems related to lifestyle or behaviour; lifestyle also affects other transplantable organs such as lung transplants for people who smoke or heart transplants for people who are obese and have coronary heart disease. The debate about who should be eligible for organ transplant will never go away while there are not enough organs to meet demand – or while healthcare resources are limited.

**Argument for the proposition  
Organ transplants should be given only to people whose illness is not a result of their lifestyle choices**

If ethical principles are to be applied to this argument, then Beauchamp and



Liver transplant: these are often needed because of damage caused by alcohol misuse

Childress’ (2009) principle of justice is the most appropriate. Their concern is with distributive justice, in particular the distinction between distributions of healthcare that are just and those that are unjust (Edwards, 2009).

In the debate about organ donation and transplantation, the concept of distributive justice or how to divide resources fairly is apparent. In Waldron’s (2011) qualitative study, 188 participants (105 women and 83 men) completed batteries of scales that measured organ donation willingness and prosocial personality levels, and read vignettes describing patients in need of liver transplants. Participants rated a patient with a history of alcohol misuse who was no longer drinking as a significantly lower priority for transplant surgery than one with a genetic liver condition. This implied that patients with alcoholic liver disease were perceived as less deserving of liver transplants.

The second ethical principle that could be applied to the argument in support of the proposition is that of beneficence or “the moral obligation to act for the benefit of others” (Beauchamp and Childress, 2009). When referring to “others”, the theory of utilitarianism, proposed in the 18th century by Jeremy Bentham, offers the strongest argument. The key principle of the theory is utility – that is, “what is the greatest good for the greatest number?”. According to the utilitarian approach to ethics, in the event of there being a choice between two or more possible courses of action, the morally right act is that which results in the greater “good” (Edwards, 2009). It can be argued that transplanting an organ into a person who has caused the damage leading to the need for a transplant is less likely to yield

the greatest good for the greatest number.

Waldron’s (2011) research and the view of the mother whose daughter died in the RTC discussed above show that public opinion is opposed to transplanting organs into people who are “less deserving”; the “greater good”, therefore, would be seen only if the organ was transplanted into a person whose illness was not caused by lifestyle choices.

To argue further for the greater good, the most compelling line of reasoning is that of cost. In a healthcare system with finite resources, economics plays an important role in guiding the allocation of those resources to maximise benefits.

Agthoven et al (2001) looked into the costs and benefits derived from undertaking liver transplantation for acute and chronic liver failure in the Netherlands. They found that a transplant performed on a patient with acute liver failure was less expensive than one performed on a patient with chronic liver failure (in which they placed post-alcoholic cirrhosis); the one-year costs of liver transplantation for acute liver failure were almost 16% lower than those for chronic liver failure. Agthoven et al (2001) concluded that liver transplantation for acute liver failure is much less expensive than liver transplantation for chronic liver failure.

Societal benefits also need to be taken into consideration. It is well documented that people from deprived backgrounds living in areas with high levels of unemployment have a greater tendency to smoke, drink alcohol and misuse drugs (NICE, 2012); these lifestyle choices contribute to the need for medical intervention when body systems start to fail. The outcome of the NHSBT (2014b) analysis would be heavily biased according to the

**BOX 1. ORGANS USED IN TRANSPLANTATION**

**Single organs or systems**

- Kidneys
- Small bowel
- Liver
- Pancreas
- Heart
- Lung
- Thymus

**Combined organs**

- Heart and lung
- Kidney and pancreas
- Liver and kidney
- Liver and small bowel

employment status of patients – transplantation would yield large benefits if sample group members were all company directors but, if they were all unemployed, the benefit would be very small.

To conclude the argument in support of the proposition, it can be seen that it is not just to give such a precious gift to someone who has caused the initial damage through lifestyle choices. It does not provide a “greater good” to the community as a whole because recipients, as in Mr Best’s case, may decide to continue with their damaging lifestyle choices and destroy the gift they were given.

### Argument against the proposition Organ transplants should be given to anyone who has a clinical need regardless of lifestyle choice

Several ethical and humanist approaches can be taken to counter the argument for the proposition. If one was to take the principle-based approach of ethics, the greatest single argument is that of autonomy.

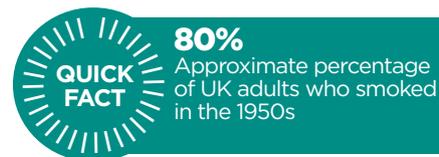
The term “autonomy” derives from a Greek word meaning “self-governing” (Beauchamp and Childress, 2009). In other words, people are capable of making their own decisions about matters that concern their own life. If people want to smoke, eat fatty foods or drink alcohol, then surely this is their right? If we take steps to prevent them from exercising free will regardless of any damage they may cause to themselves, are we not becoming a “nanny state”? Robinson (2014) argues that Wales has already become a nanny state because even when people choose a “healthier” (or less damaging) alternative to tobacco such as electronic cigarettes, the Welsh Government has proposed to ban using electronic cigarettes in public places.

It is only in recent years that disease has been shown to be attributed to lifestyle. For example, in the 1950s it was “cool” to smoke cigarettes. Hollywood icons, such as James Dean and Humphrey Bogart, were never without one and screen beauties, such as Audrey Hepburn and Marlene Dietrich, made smoking look sensual and sophisticated; in the UK, up to 80% of adults smoked. Tobacco was cheap, legal and socially acceptable (Rodrigues, 2009). However, this was before a correlation had been made between smoking and cancer and permeated public consciousness, so many of the people who now need a transplant were unaware of the health risks when they started to smoke.

As with drinking too much alcohol or misusing drugs, even if a smoker does

want to quit, their addiction will often prevent the autonomous choice. Being placed on a transplant waiting list may help patients to exercise autonomous choice and beat their addiction. To be placed on a transplant waiting list, patients are required to adopt a healthy lifestyle; sometimes restrictions are placed on individuals, such as abstaining from alcohol or stopping smoking (NHSBT, 2014a). Support is often available to help people to “stay on the wagon”, which benefits all.

If lifestyle choices inhibit people from having a transplant, then the same should apply to other “risky” activities. People who drive cars, ride motorbikes, ski, go parachuting, scuba dive or take part in extreme sports would expect to receive the most appropriate care in the event of an accident; in severe cases, this may include a transplant. Should these people also be excluded from transplant lists?



In recent years, there has been a great deal of debate about what services should be available on the NHS; this is known as rationing healthcare. Lock (2014) reported that the NHS is not spending taxpayers’ money effectively, claiming too much is spent on hospital buildings it cannot afford and that the service is failing to reduce spending on drug treatments that do not work. However, rationing healthcare to control costs is regarded as an explosive issue in politics.

If people who make unhealthy lifestyle choices are unable to get the transplants they need to survive, where is the line drawn? Organ transplantation is an expensive business and the government wants to get value for money. The next step could be to say that organs go only to, for example, parents of young children or people in valued professions, rather than older people, the unemployed or the childless.

When the health service was launched by the then minister of health, Aneurin Bevan, in July 1948, it was based on three core principles:

- » That it meets the needs of everyone;
- » That it is free at the point of delivery;
- » That it is based on clinical need, not ability to pay (NHS, 2014).

If the argument is to prevent certain people from receiving the care they need, then this truly goes against everything the

NHS stands for. This service is envied by many countries around the world and yes, reform is needed, but not at the expense of patient care.

Additionally, if one considers the ethical principle of justice and the moral requirement to treat others fairly (Edwards, 2009), then restricting organ transplants as a result of lifestyle choice is clearly immoral.

### Conclusion

Biomedical ethics affect everyday life and nursing practice, and this article has presented some of the key arguments on both sides of the case regarding access to organ transplantation. However, many other perspectives could be considered; if you would like to continue this debate, you can do so on the *Nursing Times* website at <http://www.nursingtimes.net/Organ-Transplants-NT>

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