



Policy Analysis

Moral Complexity in Triaging Transplant Candidates with Substance Use History

Ines Marques^{1*}, Miguel Brenner² and Ines Fernandez²

¹Department of Bioethics, Shannon University Centre for Bioethics, Ireland

²Institute for Health Policy and Ethics, Baltic Institute of Medical Humanities, Sweden

³Institute for Health Policy and Ethics, Baltic Institute of Medical Humanities, Sweden

ABSTRACT

Substance use history has long shaped access to solid-organ transplantation, most visibly through the fixed pre-transplant abstinence period historically required of candidates with alcohol-associated liver disease.

This policy analysis traces how that behavioral criterion emerged, why its evidentiary basis has eroded as outcomes data on early transplantation for severe alcoholic hepatitis has accumulated, and how comparable skepticism toward candidates with opioid use disorder has persisted even for those stabilized on evidence-based medication-assisted treatment.

We examine the philosophical difficulty of conditioning access to a scarce resource on judgments about a patient's responsibility for a relapsing medical condition, and the role that stigma plays in the subjective components of psychosocial evaluation.

Evidence on listing patterns further suggests that the shift from fixed sobriety rules toward individualized assessment has not eliminated disparity, with race, ethnicity, and structural social disadvantage continuing to shape outcomes independent of documented clinical risk.

We argue for organ-specific, evidence-based, and transparently applied behavioral criteria that can be audited in the way a MELD score or ejection fraction already can, rather than criteria left to unexamined evaluator discretion.

Keywords: organ transplantation; substance use disorder; resource allocation; psychosocial evaluation; transplant ethics

Citation: Marques I, Brenner M and Fernandez I (2026) Moral Complexity in Triaging Transplant Candidates with Substance Use History. *Bioethics*. 1(1):01-05.

Corresponding Author: Ines Marques

E-mail Address: i.marques@sucb.ie

Article History: Received 12 December 2025 | Accepted 18 March 2026 | Published 12 June 2026

Copyright: © 2026 Ines Marques, et al. This is an open access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited (<https://creativecommons.org/licenses/by/4.0/>).

INTRODUCTION

Transplant teams have never had the luxury of

allocating organs on medical criteria alone. Every waitlist decision already smuggles in a judgment about who is likely to benefit, for how long, and at what risk

of losing the graft -- and for decades, a documented history of substance use has been one of the sturdiest levers pulling a candidate down that list or off it entirely [1]. The clearest example is the liver: patients with alcohol-associated liver disease have long been asked to demonstrate a defined period of abstinence, commonly six months, before being listed, on the theory that continued drinking predicts graft loss and that scarce organs should go to those most likely to use them well [2]. That rule has outlived the evidence that was supposed to justify it, and the last decade of hepatology and transplant literature has been steadily dismantling it, one study at a time [3].

The question this raises is not narrowly medical. It sits at the intersection of clinical prognosis, distributive justice, and a set of moral intuitions about responsibility and desert that transplant medicine has rarely examined as carefully as it examines liver function tests [4]. A policy that conditions access to a scarce, life-saving resource on a patient's past behavior treats substance use disorder differently from every other chronic illness with a behavioral component -- coronary disease shaped by diet, or lung disease from smoking, rarely trigger a comparable waiting period -- and that asymmetry is difficult to defend once addiction is understood as a relapsing medical condition rather than a moral failing [5]. This review examines how substance use history has shaped triage across organ types, what the underlying ethical arguments for and against sobriety requirements actually are, and where the evaluation process itself introduces inequities that have little to do with either medicine or ethics properly construed.

SUBSTANCE USE AS A CONTRAINDICATION: THE LIVER TRANSPLANT PARADIGM

The six-month rule for alcohol-associated liver disease was never based on a single well-designed study; it emerged in the 1990s as a pragmatic proxy, easy to apply and intuitively linked to relapse risk, at a time when transplant programs needed some defensible way to ration a desperately scarce resource [6]. Its persistence for thirty years says more about institutional inertia than about its evidentiary basis. Multiple cohort studies of early liver transplantation for severe alcoholic hepatitis -- patients who by definition cannot have accumulated six months of sobriety because they will die within weeks without a graft -- have found survival outcomes comparable to, or better than, transplantation for other indications, which has forced a genuine reckoning within hepatology about whether the rule was ever measuring the right thing [2].

Careful psychosocial evaluation has emerged as the field's preferred alternative to a fixed abstinence period, on the theory that structured assessment of insight, social support, and relapse risk predicts post-transplant outcomes better than a calendar does [6]. That shift is defensible in principle, but it

substitutes one hard problem for another: psychosocial evaluation instruments were built and validated on populations that were not representative of the patients now being triaged through them, and their scoring inevitably imports the evaluator's own judgments about credibility, insight, and moral seriousness -- judgments that are notoriously vulnerable to bias [5]. Early transplantation for alcoholic hepatitis remains ethically contested for a further reason: because these patients are the sickest and most time-pressured on the list, the argument for prioritizing them collides directly with concerns about fairness to candidates who have already served a waiting period under the old rules [6].

Table 1. Historical approach to substance use history across major solid-organ transplant evaluations.

Organ	Traditional behavioral criterion	Recent shift	Main critique
Liver (alcohol-associated disease)	Fixed pre-transplant abstinence period (commonly 6 months)	Early transplantation for severe alcoholic hepatitis; individualized psychosocial assessment	Arbitrary cutoff not tied to relapse-risk evidence; excludes sickest patients
Heart / Lung (opioid use disorder)	Categorical wariness of candidates on opioid agonist therapy	Growing acceptance of methadone/buprenorphine maintenance as standard of care, not disqualifying use	Confuses evidence-based treatment with active addiction
Kidney	Substance use history weighed informally within broader psychosocial score	Consensus workgroup guidance against automatic disqualification	Scoring instruments not validated across the populations they are applied to

Figure 1. Schematic illustration of how strictly substance use history has traditionally been weighted in candidacy evaluation across organ types, relative to how much current outcomes evidence supports that weighting (illustrative, not derived from a single empirical study).

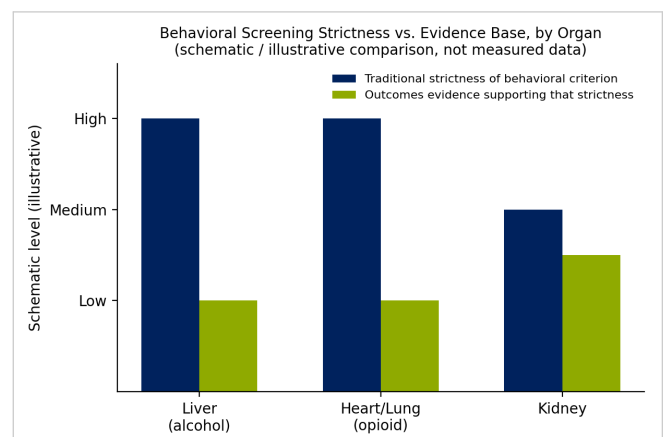


Table 1 summarizes how eligibility criteria for

substance-related candidacy have typically differed across the major solid organs, and Figure 1 presents a schematic comparison of how strictly behavioral history has historically been weighted in each organ's evaluation process, a pattern that has more to do with programmatic tradition than with any organ-specific evidence about relapse risk.

BEYOND THE LIVER: OPIOID USE DISORDER AND OTHER ORGANS

Liver transplantation has absorbed most of the bioethical attention, but opioid use disorder raises structurally similar questions for heart and lung transplantation, often with less institutional flexibility. Patients maintained on evidence-based medications for opioid use disorder -- methadone or buprenorphine -- have historically faced skepticism from transplant teams who regard ongoing opioid agonist therapy itself as a marker of active addiction, despite its status as the standard of care for the underlying disorder [7]. That confusion between treatment and disease has real consequences: a candidate stabilized on buprenorphine can be treated as higher-risk precisely because they are adherent to guideline-recommended therapy, which inverts the clinical logic that would apply to almost any other chronic condition.

More recent outcomes data cuts against the older skepticism. Retrospective analyses of lung transplant recipients with a history of opioid use disorder who remained on medication-assisted treatment have generally not found the survival penalty that categorical exclusion policies implicitly assumed [8]. The consensus workgroup recommendations issued for substance use screening across transplant programs explicitly caution against treating any single substance-use history, opioid or otherwise, as an automatic disqualifier, urging instead individualized assessment of current use, treatment engagement, and social support [8]. Programs have been slow to operationalize that guidance uniformly, and considerable variation remains in how aggressively any given center screens candidates with a history of injection drug use, independent of what the current evidence on outcomes would support [9].

RESPONSIBILITY, STIGMA, AND THE LIMITS OF BEHAVIORAL CONDITIONS

Underneath the clinical debate sits a harder philosophical question: is it legitimate to condition access to a scarce medical resource on judgments about a patient's responsibility for their own illness? A recent and pointed critique argues that responsibility-based liver allocation policy fails on its own terms, because it applies a standard of personal culpability inconsistently -- no comparable behavioral test is imposed on candidates whose organ failure results from diet, inactivity, or other behaviorally mediated disease -- and because it conflates a chronic, relapsing brain disorder with a simple failure of

willpower [4]. That asymmetry is not merely rhetorical; it shapes who gets listed and who does not, in a domain where the practical effect of "you brought this on yourself" is a denial of care that would not be tolerated for other conditions with a behavioral etiology.

Stigma compounds the problem in a way that outlasts any specific eligibility rule. Clinicians and psychosocial evaluators, like the general public, tend to view substance use disorders as more blameworthy than other psychiatric or medical conditions, a pattern documented across mental health treatment settings generally and one that has no reason to disappear specifically inside a transplant evaluation [10]. Because so much of the assessment for transplant candidacy in substance-use cases turns on subjective judgments -- insight, motivation, credibility during an interview -- stigma has an unusually direct route into the decision, compared to domains where eligibility rests on more objective laboratory or imaging criteria [11]. Proposals for a harm-threshold model of organ allocation attempt to make this more transparent by specifying, in advance, what degree of documented harm or risk should count against candidacy, rather than leaving the weighting to individual evaluator discretion exercised case by case [11].

STRUCTURAL INEQUITIES IN PSYCHOSOCIAL EVALUATION

The move away from fixed sobriety periods toward individualized psychosocial evaluation was intended to make triage fairer, but the evidence on how that evaluation actually functions in practice is not encouraging. Analyses of listing patterns have found that race and ethnicity interact with documented substance use history in ways that cannot be explained by clinical risk factors alone, with Black and Hispanic candidates disproportionately less likely to be listed once any substance use history is present in the chart, compared with white candidates presenting similar histories [12]. Broader studies of racial disparities in psychosocial evaluation for liver transplant waitlisting have reached a similar conclusion: the subjective components of the evaluation, rather than objective medical contraindications, account for a meaningful share of the disparity in whether candidates are ultimately listed [13].

These findings sit inside a wider literature on structural barriers to equitable transplantation, which describes a cascade of disadvantage beginning well before a patient is ever referred for evaluation -- unequal access to the specialty care that generates a referral in the first place, uneven insurance coverage for the pre-transplant workup, and social determinants of health that shape both substance use itself and a patient's ability to present the kind of stable social support psychosocial evaluators are trained to look for [14,15]. A national review commissioned to examine

inequities across the organ transplantation system concluded that psychosocial evaluation criteria, including those bearing on substance use, remain one of the least standardized and most subjectively applied components of candidacy determination nationwide [16]. Recent commentary within transplant medicine itself has acknowledged that psychosocial "fitness" for transplant is being measured by instruments that were never adequately validated against the outcomes they are meant to predict, which leaves considerable room for exactly the kind of bias the disparities literature documents [17].

Journalistic accounts of people who use drugs navigating the transplant system describe the practical effect of this uneven, discretion-heavy process: candidates report being excluded not on the basis of a documented clinical criterion but on an evaluator's impression, an outcome that is difficult to appeal precisely because it was never written down as a formal rule in the first place [18].

TOWARD A DEFENSIBLE ALLOCATION FRAMEWORK

None of this implies that substance use history is ethically irrelevant to transplant candidacy -- ongoing, uncontrolled use genuinely does predict worse outcomes for some organs, and ignoring that would be its own kind of injustice to other candidates on the list [19]. The more defensible position, and the one increasingly reflected in specialty guidance, is that any behavioral criterion used in triage should be organ-specific, evidence-based, applied consistently across candidates regardless of race or socioeconomic status, and framed around a patient's current clinical trajectory rather than a fixed, one-size-fits-all waiting period untethered to individual risk [19]. The core allocation principles that transplant ethics committees already endorse -- medical utility, urgency, and equity of access -- provide the vocabulary for this without inventing anything new; the work still needed is making the actual application of those principles to substance-use histories as transparent and auditable as it is for a MELD score or an ejection fraction [20].

CONCLUSION

The six-month rule and its analogues elsewhere in transplant medicine were built as a workable compromise between clinical caution and organizational necessity, not as a considered bioethical judgment about how responsibility for illness should bear on access to scarce resources. As that empirical basis has eroded, transplant medicine has moved toward individualized psychosocial evaluation, which is the ethically correct direction but has so far reproduced, rather than eliminated, the discretion and disparity that a bright-line rule at least made visible. Getting this right will require organ-specific criteria grounded in actual outcomes data, evaluation instruments validated against the populations they are

applied to, and enough transparency in how those criteria are applied that a denial based on substance use history can be distinguished, by the candidate and by outside review, from a denial based on an evaluator's unexamined assumptions about who deserves a graft.

DECLARATIONS

Acknowledgements

The authors are grateful to colleagues in their respective bioethics and health policy departments for helpful conversations that sharpened the argument of this review.

Funding

This review received no external funding.

Conflict of Interest

The authors declare no conflicts of interest relevant to this work.

Author Contributions

Ines Marques conceived the review, conducted the literature synthesis on liver transplantation and responsibility-based policy, and drafted the initial manuscript. Miguel Brenner developed the sections on opioid use disorder and cross-organ comparisons and critically revised the manuscript. Ines Fernandez synthesized the literature on structural and racial disparities in psychosocial evaluation and provided final approval of the submitted version. All authors read and approved the final manuscript.

Ethics Statement

As a literature review synthesizing previously published, publicly available research and policy analysis, this article did not involve new data collection from human participants and did not require institutional ethics committee approval.

Data Availability

No new data were generated or analyzed for this review. All sources discussed are cited in the reference list and are publicly available through their respective publishers.

REFERENCES

1. General Considerations in Assessment for Transplant Candidacy. HRSA/OPTN Ethics Committee.
2. Why the 6-Month Sobriety Rule for Liver Transplantation Is Being Abandoned: Evolution in Alcohol-Associated Liver Disease Care (2023) AASLD Liver Fellow Network Core Series.
3. Pullen LC (2022) Alcohol Transforms Liver Transplantation. American Journal of Transplantation, DOI:[10.1111/ajt.16643](https://doi.org/10.1111/ajt.16643).
4. Blaming the Patient: The Ethical Failures of

Responsibility-Based Liver Transplant Policy in Alcohol Use Disorder (2025), PMID:42153301.

5. Ethical Considerations of Transplantation and Living Donation for Patients with Alcoholic Liver Diseases (2016) AMA Journal of Ethics.
6. Sedki M, et al. Ethical and allocation issues in liver transplant candidates with alcohol related liver disease (2023) Translational Gastroenterology and Hepatology.
7. Ivkovic ML, et al. (2018) Personal viewpoint on opioid agonist therapy and transplantation. American Journal of Transplantation, DOI:[10.1111/ajt.15109](https://doi.org/10.1111/ajt.15109).
8. Substance use screening in transplant populations: recommendations from a consensus workgroup (2022) Transplantation Reviews.
9. Debating Medical Utility, Not Futility: Ethical Dilemmas in Treating Critically Ill People Who Use Injection Drugs (2019).
10. Ethical Considerations Related to Stigma in Mental Health Aspects of Treating Substance Use Disorders (2024) Focus, DOI:[10.1176/appi.focus.20240033](https://doi.org/10.1176/appi.focus.20240033).
11. A harm-threshold model for ethical organ allocation (2025) Frontiers in Health Services, DOI:[10.3389/frhs.2025.1726252](https://doi.org/10.3389/frhs.2025.1726252).
12. The Combined Roles of Race/Ethnicity and Substance Use in Predicting Likelihood of Kidney Transplantation (2022) Transplantation.
13. Racial and ethnic disparities in psychosocial evaluation and liver transplant waitlisting (2023).
14. A Cascade of Structural Barriers Contributing to Racial Kidney Transplant Inequities (2024).
15. Social Determinants of Health: Going Beyond the Basics to Explore Racial Disparities in Kidney Transplantation (2020) Transplantation.
16. Confronting and Eliminating Inequities in the Organ Transplantation System (2022) National Academies Press.
17. Psychosocial fitness for transplant: factors yet unmeasured (2023) American Journal of Transplantation.
18. Organ Transplants: Why People Who Use Drugs Rarely Get Them (2021) Filter Magazine.
19. Ethical models in bioethics: theory and application in organ allocation policies (2011), PMID:21196904.
20. Ethical Principles in the Allocation of Human Organs. HRSA/OPTN Ethics Committee.