

Wickedness, Moral Responsibility, and Access to Transplantable Livers

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Abstract: Under the current conditions of scarcity of transplantable livers, difficult decisions need to be made about access. There is a growing consensus that it is morally justified to give people with ARESLD lower priority than those whose need is not self-caused. The purpose of this article is to critically examine the conditions under which such prioritization is morally justified, by challenging arguments put forth by Walter Glannon and Daniel Brudney. There are serious theoretical and practical problems with these views, which have to do with the nature and scope of the (putative) moral duty not to contribute to the competition for scarce transplantable livers, and the difficulty in determining whether people are responsible for their weakness or even wickedness of character. These problems need to be resolved if we are to be morally justified in determining access based on causal and moral responsibility for being in need.

Keywords: allocation of transplantable livers; causal responsibility; moral responsibility; alcohol-related end-stage liver disease; wickedness of character; Daniel Brudney; Walter Glannon

Introduction

Under the current conditions of scarcity of transplantable organs, difficult decisions need to be made regarding allocation. There has been some recent philosophical and bioethical discussion about whether being the cause of one's own end-stage organ disease is a legitimate justification for being given lower priority for available organs. This is typically discussed as being a "tie-breaker," as medically relevant information (e.g., about anticipated prognosis and posttransplant health) is still meant to play a primary role in decisions about allocation. Debate in this area has, therefore, largely assumed that medically relevant differences between two prospective organ recipients can serve as justifiable grounds for prioritization decisions. The focus of this article is on whether nonmedical (*moral*) features of prospective organ recipients can also serve as justifiable grounds for making decisions regarding allocation of transplantable organs.

In the name of being consistent with the literature I am engaging with here, I limit my discussion to alcohol-related end-stage liver disease (ARESLD), which leads to one being in competition for scarce transplantable livers.

There seems to be a growing consensus that it is morally justifiable to give people who have caused their own end-stage organ failure lower priority for accessing the pool of available organs, in times of scarcity.^{1,2,3} The goal of this article is to advance thinking in this area, mainly through a critique of the views recently developed by Glannon⁴ and Brudney.⁵ Ultimately, it is concluded that the arguments advanced by these authors are incomplete in important ways, and that, therefore, as they stand, they are insufficient for establishing the moral justifiability of giving such people lower priority. The main conclusion is a conditional one: *if* the medical community wants to incorporate nonmedical (*moral*) features of

prospective organ recipients as part of the justification for making decisions about priority in access to scarce transplantable organs, then it will be necessary to find different grounds for doing so than those suggested by Glannon and Brudney.

Causal and Moral Responsibility for Organ Failure

The central elements of these views have to do with causal responsibility for end-stage organ disease, and the epistemic conditions that need to accompany such causal responsibility, in order to establish a moral responsibility for end-stage organ disease, which is to serve as the basis for justifiable lower priority. If someone had been sufficiently able to have behaved otherwise than in the way that led to that person's end-stage organ disease, and can reasonably be assumed to have known that the particular behavior would have predictably led to end-stage organ disease, which would put the person in need of new organs, which in turn would put the person in direct competition with other people for such scarce medical resources, then that person would be considered causally *and* morally responsible for now being in need of transplantable organs, and those in control of such resources are justified in giving that person lower priority because of this (*all else being equal* between the candidates for the transplantable organs in question).

If a person is causally responsible for his or her ESLD, then there is reason to *consider* giving that person a lower priority for the livers available for transplantation, compared with someone who is not causally responsible for his or her ESLD. Assuming that one could have done otherwise than to bring about his or her ESLD, the issue then becomes the extent to which that person should have (and could have) known that the behavior in question would constitute legitimate grounds for giving him or her lower priority for a transplantable liver. Glannon concedes that "those who lack sufficient maturity" or have a serious mental disorder cannot be reasonably expected to have known better. One may also imagine an isolated group of individuals in a remote land first being introduced to alcohol. Those people would not meet the epistemic conditions for being morally responsible for their ESLD, even if they are causally responsible, as they could not have known that their consumption of alcohol was likely to bring about such long-term effects.

For Glannon and Brudney (and others), causal responsibility is *morally* significant if certain epistemic conditions are also met. In cases in which persons are causally responsible for their ARESLD, being *morally* responsible for their ARESLD requires that the following epistemic conditions be met. The ARESLD person needs to reasonably be assumed to be aware that:

Alcohol can cause liver disease

Alcohol can be addictive, and, therefore, difficult to stop consuming (for some people)

There is some genetic component to alcoholism and addictive behavior, and that one might have such genetic predispositions

Having ESLD means that one will die prematurely if one does not receive a liver transplant—in this context, part of this may include a recognition that available treatments are imperfect

Not everyone who needs a liver transplant receives one, because of current conditions of scarcity

There are many others competing for the available livers and, importantly, many of them are not causally responsible for their ESLD

If one receives one of the livers, then this means that someone else is *not* getting that liver, and that the other person will likely die because of this⁶

Persons who cause their ESLD and who meet the above epistemic conditions are thought to be morally responsible for their ESLD, and it is justified to give those persons a lower priority for accessing the scarce transplantable livers available, compared with someone who is not causally (and therefore not morally) responsible (all else being equal). For Glannon, putting oneself in a position of need, when doing so was avoidable and where one knew that this could be a potential outcome of his or her behavior, means that the person's demands on society to meet his or her need is less forceful than the demands on society to meet someone else's need that is not self-caused.

A central aspect of Glannon's account, which is meant to serve as the connection between causal and moral responsibility, is what he identifies as a moral obligation to not contribute to the competition for scarce medical resources. The person who is causally responsible for developing ARESLD and who meets the above-mentioned epistemic conditions is

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 failure⁷

Not acting appropriately in the face of sufficient knowledge makes one morally culpable. For Glannon, a person is morally responsible for developing ARESLD when that person is causally responsible (i.e. that person could have done otherwise) for being in that disease state, and failed to act on his or her knowledge that the behavior could have the consequences that it ended up having (i.e., have met the epistemic conditions outlined previously, but did not alter the behavior in light of that knowledge).⁸ For Glannon, this means that the individual had been "negligent," and it is this negligence that connects causal responsibility to moral responsibility, and justifies giving that person lower priority for access.

This, in a nutshell, is the standard view of justified lower priority for ARESLD patients, defended by philosophers such as Brudney and Glannon.⁹ As argued for in the remainder of this article, there are serious practical and theoretical problems with this sort of strategy for attempting to justify giving people who have caused their ARESLD lower priority for access to transplantable livers. This is not to conclude that it can never be justified to give such people lower priority, but rather that standard arguments for this position as they are currently articulated

in the literature are incomplete in important ways, and that, therefore, different grounds for this justification are required.

Have the Causal and Epistemic Conditions Been Met?

The first challenge to this standard approach to justifying lower priority is a practical one, having to do with determining whether someone meets the causal and epistemic conditions, which needs to be done in order to know whether it is justified to give that person a lower priority. Not being able to assess whether specific conditions hold in practice would be a significant barrier to reliably and fairly implementing this framework in practice. (There are also theoretical problems with such views, which I discuss later in the article).

Part of the trick is to determine whether someone should have known that, for example, his or her behavior could potentially result in someone else dying in the future. To a significant extent, this is an empirical issue, about whether there is sufficient public awareness of the relevant facts (e.g., the conditions on access to transplantable organs in one's country, the current scarcity of organs available for transplantation, etc.). Barring the availability of such empirical evidence about public awareness of alcoholism and the organ shortage problem (among other matters), one is left with speculative judgments about what it is reasonable to expect others to have known. For example, including information on the labels of alcoholic beverages warning of the effects of drinking while pregnant makes this information available to consumers of such alcoholic beverages (although it may not always be available if the alcohol is purchased in a pub or restaurant). However, the question is then about the extent to which it can reasonably be expected that all who consume those beverages will have read and understood those labels (and are literate), and, importantly, the extent to which this initiative is sufficient to establish the necessary degree of awareness of the potential consequences of one's drinking behavior. It very well may be; but this needs to be demonstrated.

The issue is complicated by the fact that medical professionals/transplant teams would need to be able to determine (and not just assume) whether the causal and epistemic conditions have been met, for each particular individual. It is very difficult in practice to gather reliable and detailed information about a patient's (nonmedical) history of the sort required to know whether, for example, such persons began drinking heavily at the age of 9 or 11 or 14 or 22; whether such persons were aware that there was an acute organ shortage problem in their country (at a time prior to being addicted to alcohol), whether they had the foresight to anticipate that someone else could die in the future because of their drinking behavior, and whether events in their lives had a sufficient effect on their behavior (in the past) to indicate whether or not they were sufficiently in control of their self and their resulting behavior. In short, there is reason to be skeptical about whether medical professionals/transplant teams could have the resources, time, and detail requisite for making accurate assessments about whether particular patients meet the causal and epistemic conditions, on a case by case basis. If medical professionals/transplant teams do not have the requisite resources, then even if there are no *principled* reasons against putting nonmedical conditions on access to medical resources, time-constrained and resource-deprived medical professionals ought to restrict their attention to medical information when making decisions about allocation of scarce transplantable livers.

The same difficulties are not attached to assessing or making judgments on *medical* information about the patients, in part because medical professionals will typically have the resources necessary for determining the current health status of their patients, and their likely prognosis and long-term health concerns. Although there may be difficulties in *guaranteeing* accuracy in the assessment of (even) medical information about the patients, patients' medical information is more easily empirically verified (and, therefore, doing so does not rely on patient cooperation and honest disclosure) and is something that medical professionals are expertly trained in understanding and assessing, and making such medical judgments does not depend on making (moral) judgments about desert or the character of patients, judgments about aspects of patients in which medical professionals do not have any particular expertise.

Perhaps this difficulty of assessing matters on a case by case basis *could* be overcome if general thresholds for access were established (e.g., age of onset of alcoholism, before which one is not morally responsible and after which one is morally responsible), which would not require medical professionals to have as much detail about the patient's nonmedical history available for analysis. However, if the expected long-term health outcome is the same between a person with ESLD and a person with ARESLD, it is not justifiable to appeal to *general* rules of thumb or to establish *general* thresholds for causal/moral responsibility. Giving those with ARESLD lower priority is justified only if they *are* causally responsible and meet the epistemic conditions, and is not justified based on their membership in a certain age group (or a similar criterion). This is to say that such general guidelines would still necessitate confronting the difficulties noted previously about case by case assessment, because it could not be justified to merely assume that everyone who began drinking after the age of x is causally responsible for developing ARESLD and met the corresponding epistemic conditions.

Perhaps these practical issues could be resolved. However, even if such practical hurdles could be overcome, there are other, more serious, problems with this general strategy for determining fair prioritization of livers.

Is There a Moral Duty to Not Increase Competition for Scarce Medical Resources?

As discussed earlier, a central aspect of Glannon's argument is that we all have a duty to not willingly, avoidably increase the competition for "absolutely" scarce medical resources, such as human livers. However, Glannon's discussion of the epistemic conditions does not include an acknowledgment that it is not enough that such a moral obligation exists (if it does exist). It would also be necessary to show that agents must be reasonably assumed to be aware of this moral obligation that they have (just as they need to be aware that, e.g., alcohol consumption could lead to ARESLD). Therefore, if Glannon is correct, the list of epistemic conditions included previously would need to be expanded, to include knowledge of this moral obligation on each of us to not contribute to the competition for scarce medical resources, just as the medical community would be unjustified in giving an individual from an isolated community that was first introduced to alcohol and unaware of the long-term effects a lower priority for transplantable livers. If this moral duty is to play a role in decisionmaking about allocation, then individuals would need to know that they have such a moral duty.

Is it true that people can be reasonably assumed to be aware that they have a moral duty not to increase competition for scarce medical resources? I suspect that most people are not aware of this moral duty that they have—although this is an empirical question—even if they have a sense that harming others is wrong. At the very least, it seems plausible to suggest that they are less likely to meet *this* epistemic condition than they are to meet the ones regarding the effects of alcohol consumption on liver functioning and the current scarcity of transplantable livers, and recent empirical data suggest that public awareness of the relationship between alcohol consumption and liver disease, cancer, and fetal alcohol syndrome, for example, is surprisingly low.^{10,11} None of this means that no such moral duty exists, but my point here is not (yet) about whether such a duty exists, but rather whether people can be reasonably expected to have been aware of *this* moral obligation on them at the time that they began the causal history of their ESLD. There is *some* indication that general public awareness of this moral duty is not high at all.

It is worth noting that this is not an inherent problem with the project of giving lower priority to individuals who have failed to meet this moral duty (if it exists). If there is a lack of public awareness of this moral duty, this could be remedied, over time, by increasing public awareness of this duty, and its connection to allocation of scarce transplantable livers. Perhaps the labels on alcoholic beverages could be redesigned to include a statement of this moral duty. However, if there is a current lack of awareness of this moral duty, and this moral duty is to play a role in decision making about access to transplantable livers, then it is (currently) unjustified to give lower priority for this reason in the face of such a lack of awareness.

Furthermore, assuming that a moral obligation not to increase the competition for scarce lifesaving resources exists, it is important to ask about its nature and scope. People contribute to the competition for absolutely scarce lifesaving resources (and scarce medical resources in general) *all the time* and in many different ways. Many of these ways are not obviously morally unacceptable. For example, bringing new children into existence is an activity that in obvious and unavoidable ways contributes to the competition for scarce medical resources, at least because there are now more people in the world competing for those resources. Another example is the class of voluntary but risky behavior, which includes activities such as driving cars on busy highways, rock climbing, boxing, and professional fire-fighting. Another example of a contribution to the competition for scarce lifesaving resources is the decision *not* to be a cadaveric organ donor. Perhaps the most telling example of an activity that is not immoral but that contributes to the competition for scarce medical resources is the invention/development of human organ transplant technology and immunosuppressant drugs, which make it possible for anyone to have access to safe and effective organ transplantations in the first place. One (collateral) implication of such inventions is that doing so has a very significant impact on increasing the number of people who are now in competition for the resources required for receiving successful organ transplants. The “organ shortage problem” is only a problem because safe and effective organ transplantation technology is available. One of the major contributing factors to increasing the competition for absolutely scarce lifesaving medical resources is the development of the technology that makes such life saving a real possibility in the first place. There is enough here to suggest that Glannon’s proposed moral duty to not contribute to the competition for scarce lifesaving resources is (far) too wide.

To distinguish voluntarily causing oneself ARESLD, as an activity that contributes to the competition for scarce medical resources, from other activities (such as the development of transplant technology or bringing new children into existence) that also contribute to the competition for scarce medical resources, perhaps Glannon could say something about the ways in which that duty is breached or unmet. Perhaps some ways of failing to meet this moral obligation are acceptable, whereas others are unacceptable, but *this* needs to be argued for, and is not something included in Glannon's view as it stands.

As a first attempt, consider the following. One could increase the competition for scarce medical resources by, for example, stealing all but one of the dialysis machines in a particular hospital, leaving those who require dialysis to fight over access to the remaining machine. We might think that this is an unacceptable way of failing to meet one's moral obligation, in part because it seems to have an inherent maliciousness in intent. On the other hand, something such as inventing dialysis technology or cyclosporine may be to fail to meet one's moral obligation in an *acceptable* way, because the main motivation behind doing so is meant to be in line with benefiting people, rather than harming them. Therefore, perhaps Glannon's account could be tweaked to make it clear that not all ways of breaching or failing to meet one's moral duty not to increase the competition for absolutely scarce life-saving medical resources are *negligent* (and, therefore, not all of them are morally unacceptable), and that it is only the negligent ones that could justifiably be given lower priority to accessing those resources.

However, then the question becomes whether voluntary alcohol consumption (that leads to ARESLD) is an *unacceptable* way of failing to meet one's moral obligation to not increase the competition for scarce medical resources. This strikes me as being a contentious claim, especially if one wants to say that rock climbing, boxing, firefighting and not being a cadaveric organ donor are acceptable/not unacceptable ways of failing to meet this moral obligation. The sort of harm caused by the firefighter who requires a lung transplant and the alcoholic who requires a liver transplant are comparable.

It is important to note that there may be a way to get around this implication. Glannon could respond by agreeing that alcohol consumption is relevantly similar to boxing and rock climbing and firefighting, and that such like cases ought to be treated alike. This would mean that if those in the medical community want to give lower priority to people who have caused their own ARESLD, then they also need to give lower priority to those who have caused, for example, their own rock-climbing-related end-stage organ failure, and their own firefighting-related end-stage lung disease.

None of this is meant to suggest that those in control of the transplantable livers available are unjustified in giving ARESLD people a lower priority than others who are not responsible for their ESLD, or who are responsible for it for different reasons, but rather that basing such prioritization on appealing to a putative moral obligation to not contribute to the competition to scarce medical resources, as described by Glannon, is insufficient (as it stands) for establishing that justifiability.

Even if the scope of this moral duty can be reined in (e.g., by *consistently* giving lower priority to rock climbers who need new organs because of their rock climbing behavior, giving firefighters lower priority for lung transplants because of the hazards of their career choice), there is good reason to think that such a duty

is an “imperfect” one, rather than a “perfect” one. It is impossible to *never* increase competition for scarce medical resources, especially if we take scarce medical resources to mean *global* medical resources (and not just domestic ones), and include *all* such resources, not just transplantable livers (or human organs and tissues in general). By choosing to remain alive, one will need food and clean drinking water, and these are scarce lifesaving resources. By seeking lifesaving medical treatment that is in any way needed because of behavior that was avoidable *at all*, individuals seem to be breaching their moral duty not to contribute to the competition for scarce lifesaving resources. Because of this, an argument would then be needed to show that any and all (unacceptable) failures to meet this duty are *moral* failures, or else distinguish between the ones that are the result of a moral failure and the ones that are not. More than this, if it is correct to think of this duty as *imperfect*, then a method is needed for gauging whether a patient has fulfilled this moral obligation in other ways, even if that patient is failing to meet it in one or more ways as well. Are such patients meeting their imperfect duty not to contribute to the competition for scarce lifesaving resources *on balance*?

This duty being an imperfect one means that we are allowed, morally speaking, to sometimes do things that to some extent increase the competition for scarce medical resources, as long as we are not doing so in *too* many ways, or not mitigating the competition in other ways, but this means that there may not be anything *special* about ARESLD as a way of not meeting one’s moral duty, given that it is impossible to *never* contribute to the competition for such resources. We can imagine, for example, that some people who have caused their own ESLD may attempt to educate their children more fully about the consequences of poor health decisions, which could lead to *them* not becoming in need of organ transplants in the future (and, therefore, their parents are indirectly decreasing the competition for scarce medical resources in this way), or people who require a liver transplant might donate their heart or corneas after their death, thereby balancing out their *overall* impact on the competition for scarce medical resources.¹² Or perhaps people who bring new children into existence contribute to the competition for scarce medical resources, but *also* neutralize that increase to some extent, because those children (in theory) could also increase the number of organs available for donation in the future (if they take care of their organs and become registered organ donors, and die in a way that allows for their organs to be harvested, for example).

To return to an earlier point about practicality, whether or not persons are satisfying their imperfect moral duty *overall* may be quite difficult to determine in practice, on a case by case basis. This means that it would be very difficult to determine whether it is justified to give a particular individual a lower priority for a transplantable liver, even if it could be shown that the individual is causally responsible and has met the epistemic conditions; establishing moral responsibility requires that it is determined whether a particular person has *on balance* failed to meet his or her moral obligation to not increase the competition for scarce lifesaving medical resources (negligently). If we cannot demonstrate the moral failing of the ARESLD person, then we have not answered the question about why *that person* deserves lower priority. As will be discussed subsequently, there may be other ways to flesh out this moral connection. However, it is clear at this point that Glannon’s appeal to a moral obligation to not contribute to the competition for scarce medical resources faces difficult philosophical and practical issues, and,

therefore, is inadequate (as it stands) for establishing a basis for morally justified lower prioritization of ARESLD patients for access to scarce transplantable livers.

Wickedness of Character and Moral Responsibility

Perhaps the moral duty examined previously could be more aptly articulated as (something such as) *a duty to not prioritize one's own life over someone else's*, when one is causally responsible for one's life being at stake (and other people vying for the liver are not causally responsible for their lives being at stake), rather than as a duty to never contribute to the competition for scarce medical resources. For Brudney, putting oneself in a position in which one is in need of a life-prolonging organ when one could have done otherwise and should have known better, and then asking for that organ, knowing that some other person will die if one's request is heeded, says something important, and troubling, about one's character.¹³ Brudney suggests something similar to Glannon (quoted earlier):

When information has been adequately distributed, Jane's voluntary conduct [which caused her ARESLD] becomes a form of callous disregard for and indifference to others' dire needs. The harm of her conduct is negligently to make herself a competitor for a scarce, lifesaving resource. Under those circumstances, it is appropriate for a publicly funded institution to judge that Jane is morally less deserving than [those that have not caused their ESLD].¹⁴

If all of the causal and epistemic conditions are met, and one has the audacity to make a request for that scarce medical resource, this suggests "a deep callous disregard and indifference to the plight of others," some of whom will die on the transplant waiting list because of the person making the request (if that person's audacious request is heeded). Perhaps giving those who are callous a lower priority could be justified, because being callous in this way is unacceptable. Perhaps we could justify lower priority because only *wicked* people would actually ask for one of the available livers (under those conditions) in the first place.

Whereas I am sympathetic to this way of understanding things in this context, there are problems with this way of capturing the moral duty not to increase the competition for scarce medical resources, and for establishing moral grounds for lower priority more generally. One point to make is that *this* now needs to make up part of the epistemic conditions (listed previously). One must be aware that being callous and indifferent to others will be taken to be relevant to the decision-making processes about who will have access to scarce medical resources. (Perhaps this could be added to the labels on alcoholic beverages as well).

It *may* be possible to establish cases in which such failure of moral character has occurred. However, it ought not to be *assumed* that everyone who asks for a transplantable liver and who meets the causal and epistemic conditions is *necessarily* wicked. There could be reasons why people are asking for a new liver, even though they meet the causal and epistemic conditions, that do not necessarily indicate *wickedness of character*. Perhaps they are deeply remorseful, but their desire to stay alive for their children's sake, for example, is overpowering. Or perhaps they have good reason to believe that their staying alive will have a very significant benefit to society (e.g., if they are on the brink of curing a devastating disease). In addition

to this, there are important (presently unanswered) questions about whether the wickedness that is necessary for disqualifying someone from having equal access to scarce life-prolonging medical resources needs to be a *stable* character trait, and presented without (e.g.) cowardliness, and their wickedness unfettered by remorse, etc.. Perhaps asking for the liver is an *uncharacteristically* callous act on behalf of this particular person. We may not think that performing *one* wicked act in one's life makes one a wicked person, or that a proportional response to one act of wickedness is to sentence that person to death. Or perhaps this person is *deeply afraid of dying prematurely*, and, therefore, is cowardly rather than wicked; the request for a new liver stems from cowardliness rather than any real presence of callous disregard and indifference to the plight of others, in which case such cowardliness would need to be shown to be sufficient grounds for lower priority or disqualification. Or perhaps one is being wicked but also vows to change their ways. Therefore, wickedness of character cannot be assumed, but rather must be demonstrated, and there needs to be a fuller understanding of the role of wickedness in this context than is currently available.

There are more serious problems with this basis for attempting to justify lower priority, which emerge as a rejuvenated problem with establishing causal responsibility. Even *if* it is true that all people who meet the causal and epistemic conditions for being morally responsible for their ARESLD are wicked people (which I have suggested cannot merely be assumed to be the case), more needs to be established for it to be justified to give them a lower priority. Given the importance of *causal* responsibility in this context (at least according to Glannon and Brudney), in the sense of whether someone could have done otherwise, it seems that it would need to be asked whether Brudney's callously indifferent organ requester were *sufficiently responsible for being wicked*; one must be responsible for one's wicked character, it seems, in order to be causally responsible for the accompanying moral failing; one is not *negligent* insofar as one could not have done (or been) otherwise. If one were asking for a liver out of a wicked character, but one is not responsible for having that wickedness of character, then it would seem unfair to deny that person's request *because of the person having a wicked character*. This would be to hold people responsible and blameworthy for something out of their control, something that Glannon and Brudney are both reluctant to do, as evidenced by their emphasis on causal responsibility for alcoholic behavior, for example.

Contemporary empirical research suggests that we can no longer *merely assume* that people are sufficiently in control of their moral character. For example, situationism challenges the idea that character is strong and stable, and shows that it is susceptible to outside influences, often even quite subtle cues unbeknownst to the agent, which can have significant impacts on the manifest "character" that one displays.^{15,16} Moreover, what makes someone have a particular kind of character is still quite poorly understood, and there are a number of possible causes of/influences toward wickedness of character: there could be genetic components and predispositions at play; wickedness could be learned during upbringing or ingrained by unsavory parental and other social influences early in life; wickedness may be environmentally or contextually triggered; wickedness could be influenced by background firings in the brain. Importantly, given that wickedness of character in a particular individual could have any or all of these origins, it cannot be *assumed* that someone's wickedness was sufficiently avoidable or sufficiently under that person's control so as to make him or her responsible

for being wicked. In other words, it seems plausible to suggest that, under certain (perhaps rare) circumstances, a wicked person could not have been otherwise than wicked. Because of this, and in order to determine whether that person *is* morally responsible for developing ARESLD, there needs to be a way to determine in practice whether specific individuals are responsible for their character, on a case by case basis, something that will be very difficult to do.

Brudney may suggest that the wicked person is not being denied a liver *because of* his or her wickedness. Rather, it is justifiable to give that person a lower priority because the person meets the causal and epistemic conditions. The person's wickedness of character is being used *as an explanation* to him or her for why the request for the liver is misplaced, and, therefore *why* turning down that request is justified.

Even assuming that the problems raised earlier can be overcome, one way to respond to this is to say that it is not (only) the wickedness *of the request* that is at issue here, but rather the callous disregard for the plight of others at the time(s) when decisions were made about beginning and continuing voluntary action toward ARESLD. It is only wicked to request a scarce transplantable liver *if* one meets all of the causal and epistemic conditions that began the causal history and that led to ARESLD, because if one is *not* causally responsible and/or has *not* met the epistemic conditions, then (presumably) it is *not* wicked to make such a request for a new liver: one has not behaved wickedly because one has not behaved negligently, because one could not have done otherwise and/or cannot be reasonably assumed to have been able to know any better. This means that in order for the wickedness of character to play a moral, justificatory role, it must have been present enough throughout the causal history leading up to that person now being in need of a liver transplant; if the wickedness was *not* present, then the individuals under discussion would have been persuaded to stop drinking in light of the knowledge that they have (e.g., that their drinking to the point of ARESLD put other peoples' lives at stake), or they did not have sufficient control over their will so as to be able to stop drinking, in which case they would not be *causally* responsible. During the deliberative process about whether to continue to drink one's liver to death, or in one's decision about whether to ignore or take seriously the knowledge one has about the impacts of one's drinking behavior on oneself and others, it is the wickedness of character that was *the driver towards* ARESLD for which one is genuinely responsible (rather than towards behavioural reform). In this sense, being wicked plays a causal role in continuing that (sufficiently voluntary) behavior toward ARESLD.

For Brudney's argument for the moral justifiability of giving ARESLD people lower priority in obtaining a new liver to succeed, it needs to be determined whether someone's wickedness of character is *something for which that person is responsible*, which is necessary for determining whether he or she is causally (and, therefore, morally) responsible for developing ARESLD (and subsequent requesting a scarce transplantable liver). If it could not be determined whether certain individuals could have reasonably *been otherwise than being wicked*, then it seems as though it cannot be established whether those individuals are morally responsible for being in the situation that they find themselves in now. This means that it would not have been demonstrated that giving these persons a lower priority is morally justifiable. Whereas I do not mean to rule out this possibility, there is good reason to suggest that enough is not *yet* known about the causes of character to be

able to make any nonspeculative conclusions in this regard, pending much more empirical research. Moreover, I for one am skeptical about whether those making the decisions about access to transplantable livers would have enough information, resources, and appropriate expertise available to be able to reliably determine the nature of the moral character of individual patients, on a case by case basis.

Conclusion

There are serious problems with mainstream attempts at justifying giving those responsible for their ARESLD lower priority for transplantable livers. This is not to conclude that such attempts cannot be revised so as to establish more plausible grounds for making the prioritization recommendations that are made. Rather, the grounds for such justifiability have yet to be demonstrated, and will likely be very difficult to implement and gauge in practice (even if they can be established). This is because in order to justify such prioritization recommendations in practice, medical professionals/transplant teams would require the resources and tools for accurately determining (on a case by case basis) whether particular individuals (1) are causally responsible for their ESLD, (2) meet all of the (now expanded) epistemic conditions at the time when their ARESLD causal history began, which is necessary for establishing moral responsibility, (3) are not fulfilling their imperfect moral duty to not increase the competition for scarce medical resources in other ways, and that the ways in which they are breaching this duty are unacceptable, (4) are wicked (i.e., callously detached from and indifferent to the plight of others), and (5) are sufficiently in control of their wickedness of character so as to make them blameworthy for having it. Only then does it seem that one could know whether particular persons are causally *and* morally responsible for their ESLD, and do not deserve to have access equal to that of others who are not causally and morally responsible for their being in need.

Notes

1. Moss AH, Siegler M. Should alcoholics compete equally for liver transplantation? *JAMA* 1991; 265(10):1295–8.
2. Thornton V. Who gets the liver transplant? The use of responsibility as the tie breaker. *Journal of Medical Ethics* 2009;35(12):739–42.
3. Veatch RM, Ross LF. *Transplantation Ethics*. Washington, DC: Georgetown University Press; 2014.
4. Glannon W. Responsibility and priority in liver transplantation. *Cambridge Quarterly of Healthcare Ethics* 2009;18(1):23–35.
5. Brudney D. Are alcoholics less deserving of liver transplants? *Hastings Center Report* 2007; 37(1):41–7.
6. See note 5, Brudney 2007.
7. See note 4, Glannon 2009, at 24.
8. See note 4, Glannon 2009, at 25.
9. This is not to suggest that there is no disagreement between Glannon and Brudney. For one thing, these authors disagree about the extent to which individuals actually meet these conditions in reality. For example, see note 4, Glannon 2009, at 28.
10. Burnham B, Wallington S, Jillson IA, Trandafili H, Shetty K, Wang J, et al. Knowledge, attitudes, and beliefs of patients with chronic liver disease. *American Journal of Health Behavior* 2014;38(5): 737–44.
11. Sanderson SC, Waller J, Jarvis MJ, Humphries SE, Wardle J. Awareness of lifestyle risk factors for cancer and heart disease among adults in the UK. *Patient Education and Counseling* 2009; 74(2):221–7.

12. This could be part of the motivation behind some jurisdictions giving higher priority to organ donors on organ transplant waiting lists than to nondonors. Whether this tool for prioritization is a morally justifiable one is interesting to consider, but is beyond the scope of this article.
13. See note 5, Brudney 2007.
14. See note 5, Brudney 2007, at 45
15. Doris JM. Persons, situations, and virtue ethics. *Nous* 1998;32(4):504–30.
16. Varga S. Embodied situationism. *Australasian Journal of Philosophy*. June 20, 2017; available at <http://dx.doi.org/10.1080/00048402.2017.1341538> (last accessed 15 Aug 2017).