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Justice and Liability in Organ Allocation

THE DISTRIBUTION OF ORGANS FOR TRANSPLANTATION

SUPPOSE THAT THERE ARE TWO PEOPLE, BOTH OF WHOM WILL DIE VERY soon without an organ transplant. One organ becomes available. It is a perfect match for both people, one of whom can therefore be saved. It is virtually certain that no other organ will become available in time to save both. How ought the choice between the two people to be made? There are indefinitely many distributive principles that might be followed. The organ could, for example, be sold to the highest bidder. Or it could be given to the person whose need was manifest first: first come, first served. Many people believe that both possible recipients should have an equal chance of being selected. They may think that the decision should therefore be made randomly—for example, by flipping a coin. Both of these last two proposals seek to avoid being discriminatory. They appeal to considerations that are essentially arbitrary and irrelevant. By refusing to distinguish between the two potential recipients on substantive grounds, they seek to treat both people as equals—though it is worth noting that because these criteria do not require any exercise of judgment, they also enable those in charge of the distribution of organs to avoid any sense of responsibility for the outcomes of the selection procedure.

One common view, which in fact guides our practice in certain cases, is that priority should be given to the patient whose medical need is greater. Medical need might then be measured in terms of a patient's probable survival time in the absence of a transplant. Part of the ratio-

nale for allocating organs to those who will otherwise die sooner is that other organs may later become available for those who can survive longer. Giving priority to those whose medical need is greater is thus a means of maximizing the number of people who can be saved.

Some people think that just as it is important to save the greatest number of lives, so it is also important to achieve the greatest possible benefit per person by giving a certain priority to those individuals who will otherwise suffer a greater loss in dying. Those who hold this view think that decisions about allocation should be sensitive to the number of years a transplant recipient could reasonably be expected to live following the transplant. Suppose there are two patients who will both die tomorrow without a transplant and one organ becomes available. If one of them would die within a month even with the transplant while a transplant would enable the other to survive another 50 years, surely the organ ought to go to the latter.

Yet many people think that to allocate organs on the basis of a comparison of the benefits that the possible recipients are likely to receive is discriminatory and thus incompatible with treating patients as equals. Others, however, claim that what attention to equality really requires is not a random distribution that gives each patient an equal chance. Instead, what is needed is a distribution that would achieve the greatest equality among the potential beneficiaries in terms of some important respect in which people ought to be equal. One plausible respect in which people ought ideally to be equal is the number of years of life they get to experience. It seems unfair if, through no fault or choice of their own, one person gets to live 90 years while another gets to live only 20. So if, for example, an organ could be used either to enable a 20-year-old to live another 20 years or to enable a 40-year-old to live another 30 years, this ideal of equality would favor allocating the organ to the 20-year-old, even though he or she would derive a lesser benefit, measured in terms of the value we would seek to equalize.

Still others go further in claiming that length of life is a crude measure of both benefit and equality. We should, they argue, be concerned not just with quantity of life but also with quality of life.

On their view, if an organ could be used either to enable a 50-year-old to live another 20 years, though with a greatly reduced quality of life, or to enable a 45-year-old to live another 15 years with a high quality of life, there would be a strong case for giving it to the latter, if other considerations were equal. Giving the organ to the 45-year-old would arguably provide the greater benefit and reduce rather than increase the inequality between the two lives. Most people, however, find this sort of calculation disturbingly presumptuous and utilitarian.

Thus far I have merely offered some samples of the distributive principles to which we might appeal in allocating organs in cases in which the number of people who need an organ to survive exceeds the number of organs available for transplantation. The options are many and the debate about them is lively. In this essay I will not attempt to defend a complete account of the morality of organ allocation in conditions of scarcity. But I will defend one criterion, or the relevance of one consideration, that I have so far not mentioned. If I am right that this consideration is significant and ought to have a role in decisions about allocation, then at least some of the views mentioned above are unacceptable. At least in those cases in which the consideration I will discuss arises, we ought not to distribute organs by the use of a randomizing selection procedure, and many of the other criteria, such as medical need, likely degree of benefit, and so on, ought to be subordinated to the criterion I will defend.

KILLING IN SELF-DEFENSE

The best way to introduce this criterion is, surprisingly, to consider the ethics of killing in self-defense. Suppose that someone is rushing at you with a meat cleaver, determined to chop off your head. You have done nothing to provoke this attack; you are entirely innocent in all relevant senses of that word. The attack is unjustified and the attacker culpable. It is uncontroversial that if killing this culpable attacker is necessary to prevent him from killing you, then you are morally permitted to kill him. Yet while the permissibility of self-defense is uncontroversial in this situation, the explanation of why self-defense is permissible is not.

One view is, in effect, that self-defense needs no justification; it is always self-justifying. This is the view that informs the currently dominant theory of the just war. According to this theory, the reason combatants on both sides in a war are permitted to attack and kill combatants on the opposing side is simply that their adversaries pose a threat to them. This is the criterion of liability to attack in war: posing a threat to others. This is why all combatants are legitimate targets while noncombatants are not. It makes no difference, on this view, whether a combatant is fighting for a just cause or for an unjust cause. If he poses a threat to others, he is morally liable to attack.

This understanding of the justification for self-defense has no plausibility outside the context of war (nor even, in my view, within that context). According to this understanding of liability to defensive violence, if you engage in morally justified self-defense against the culpable assailant with the meat cleaver, you will then pose a threat to him and he will be justified in killing you. But that is clearly false; he cannot become justified in killing you by provoking you to engage in justified self-defense. We should conclude, as virtually everyone does outside the context of war, that there is no right of self-defense against a morally justified attacker.

Many people have thought that what is missing in the account of self-defense associated with the just war theory is an insistence that the attacker must be culpable—that is, that his action must be wrong and that he must be blamable for it—in order to be liable. That would exclude the possibility that people could become liable to attack merely by acting in justified self-defense. But to insist on culpability is to require too much. Suppose that the person rushing at you with a meat cleaver has been credibly threatened with being slowly tortured to death unless he kills you now. The level of duress may have overwhelmed his will and we may regard him as entirely blameless, or fully exculpated. But most people still believe that you would be fully justified in killing him in self-defense on the ground that he had made himself liable to defensive attack.

Some philosophers have argued that what makes a person liable to defensive attack is simply his posing an objectively wrongful or

unjust threat, a threat to which the victim has done nothing to make herself morally liable. What matters is not whether the threatening person is blamable; it is whether he poses a threat *permissibly*. If he does, he does not thereby make himself morally liable to defensive attack. This view therefore explains why you do not make yourself liable to defensive attack when you engage in justified self-defense against the assailant with the meat cleaver. But if a person poses a threat that lacks a moral justification, and in particular if his act threatens to violate the victim's *rights*, then he will be liable to defensive action if the other conditions of justified defense (necessity, proportionality, etc.) are also met. This is true even if he acts under conditions that fully excuse his action, so that he is in no way blamable or culpable.

While the culpability criterion is too restrictive, the idea that posing an unjust threat is sufficient for liability is too permissive. It is right to insist that the threat must be objectively wrongful, and right to insist that the threatening person need not be culpable to be liable. But this view fails to insist on a condition that I believe is necessary for liability: namely, moral responsibility for the threat. Suppose that the story behind the person brandishing the meat cleaver is this. An hour earlier, he drank a glass of orange juice not knowing that a villain had put a powerful mind-control drug in it. The effect of this drug is to make the person who takes it incapable of resisting commands given by the first person he sees. The villain made sure that he was the first person his victim saw; he then commanded him to kill you.

In this version of the example, your assailant lacks all responsibility for the threat he poses to you. We might, to make it as clear a case as possible of lack of responsibility, imagine that the assailant is a helpless observer of the movement of his own body. His conscious mind is locked inside his head, watching in dismay as his body pursues you, wholly unable to exert his will to stop it. He is, in effect, an innocent bystander in relation to the movements of his own body. If this is the situation, there is no basis for the attribution of liability to this person. He does not threaten to violate your rights. For rights are moral constraints; they constrain the action of moral agents. But in posing

a threat to you, this person is, temporarily, not a moral agent. Moral constraints do not apply to him in his present state; he therefore cannot violate them. If there is a justification for your killing him, it will apply equally to your killing an innocent bystander as a means of self-preservation—something that most of us believe is impermissible.

In short, moral responsibility for an unjust threat is a necessary condition for liability to defensive violence. It is also (together with the satisfaction of the ancillary conditions of necessity, proportionality, and so on) sufficient. It is moral responsibility for an unjust threat, and not merely posing the threat, that is the basis of liability to both self-defensive and self-preserved violence. Of course, the two usually go together: those who pose an unjust threat are normally responsible for it and vice versa. But in this last version of our example, the two have come apart: the assailant poses the threat but is not morally responsible for it, while the villain is responsible for it but does not pose it. Suppose that the villain cannot now stop the assailant from trying to kill you but that you can somehow avert the threat from the assailant by killing the villain, and that this will also have the effect of releasing the assailant from the effects of the drug. (I have tried to invent details for the story to make these stipulations plausible, but everything I have thought of sounds silly. So please just grant this general description.) In these conditions, the assailant would not be liable to attack but the villain would be. It would be permissible for you to kill the villain as a means of saving yourself from the assailant. In killing the villain, you would neither wrong him nor violate his rights; he would have no justified complaint against you. For he is himself responsible, through his own wrongful action, for the situation in which you must choose between his life and your own. It is not unfair to make him pay the cost of his own voluntary action.

This explains not only why it is permissible for you to kill the villain in this version of the example, but also why it is permissible for you to kill the assailant in the first version, in which the assailant is himself culpable for attacking you. In both cases, it is a person's moral responsibility for an unjust threat that makes him liable to necessary

and proportionate defensive violence by the potential victim, or by third parties.

Notice, finally, that responsibility for an unjust threat is a matter of degree. And if responsibility is the basis of liability, then liability should be a matter of degree as well. This is recognized in the law. In general, for example, a person will be liable to criminal sanctions to a lower degree if he causes harm recklessly than if he causes the same harm willfully or intentionally, and lower still if he causes it negligently rather than recklessly.

THE RELEVANCE OF RESPONSIBILITY

How could any of this possibly be relevant to the allocation of organs for transplantation in conditions of scarcity? I will try to work toward a demonstration of the relevance of these considerations by degrees. I will do so by presenting a series of examples.

Reckless Driver (ex ante version)

A person is driving recklessly, aware of but indifferent to the fact that he is creating unreasonable risks to others. He is about to hit and kill a pedestrian. (It would be helpful to imagine that the impact would destroy her liver, causing her to die a few days later, though of course it is unrealistic to suppose that anyone could know this in advance.) Someone—either the pedestrian herself or a third party—could save the pedestrian by blowing up the car and with it the driver. (We might imagine that this occurs in a country, such as Israel, in which armed military personnel frequently have occasion to walk on public sidewalks.)

This is just one more case, albeit and unusual one, of defense against a person who culpably poses a threat to another. It is uncontroversial, in law and morality, that it is permissible to kill the driver if that is necessary to save the pedestrian. And we know why: the driver is morally responsible, to a high degree, for an unjust threat to the life of the pedestrian.

Villainous Patient (ex ante version)

A person needs a liver transplant to survive. He is at the top of the waiting list for a transplant but his tissue type is very rare and it has become evident that the probability is negligible that an organ will become available in the standard manner before he dies. Somehow he learns, however, that your liver is the only known liver that is exactly the same tissue type as his. He therefore attacks you with the intention of killing you in order to make your liver available for transplantation.

Again it is uncontroversial that it would be permissible for you or a third party to kill him if that were necessary to prevent him from killing you. This is even clearer than in the case of the ex ante version of the Reckless Driver case, since the villainous patient is culpable to a higher degree than the driver is.

Villainous Patient (ex post version)

A person needs a liver transplant to survive. Learning that your liver is of a matching tissue type, he arranges to have you abducted and then has your liver extracted and transplanted into his body. You are nonetheless able to survive for a few days through the use of a new device that can temporarily perform most of the functions of the liver. It is therefore possible for you and your assistants to track him down, remove your liver from his body, and transplant it back into your own. Although he may survive a few days with the same device you have used, your removal of the liver from his body will cause his death.

Assume that by the time the cumbersome mechanisms of the legal system could be mobilized on your behalf, it would be too late to save you, so that the only effective option for recovering your liver is self-help. In these circumstances, I am not sure what the law would

say about your forcibly taking it back. But this much is true: it would not be an act of self-defense. The opportunity for defense passed when the thief successfully removed your liver and had it transplanted into his body. To remove your liver from his body now would be an act of killing in self-preservation, not self-defense. The thief is no longer a threat; he is now a bystander to your impending death, albeit a *guilty* bystander. Whatever the law might say, common sense morality says that you would be justified in taking back your liver, even if that would count as killing him. (I think it would not be a case of killing but a case of actively allowing him to die, but we need not pursue this here.) And again we have an explanation of why it would be permissible to do what would result in his death: he is morally responsible—indeed culpable—for the unjust threat to your life. He, not you, should pay the cost of his own wrongful action.

It might be argued that the difference between killing in self-defense and killing in self-preservation is relevant even in this case. In this *ex post* version of the case of the Villainous Patient, killing the villain to preserve your life involves *using* him in a harmful way, whereas in the *ex ante* version, killing him in self-defense does not. In Warren Quinn's useful terminology, killing the villain in self-defense is merely "eliminative" agency, whereas killing him in self-preservation is "opportunistic": it involves using him as a resource. But while the distinction between eliminative and opportunistic agency seems to have moral significance in many cases, it does not seem to matter in these cases. I think this is because in both the *ex ante* and *ex post* versions of the case of the Villainous Patient, the villain is fully liable to be killed because of his responsibility for the unjust threat to your life.

Next consider a variant of the case of the Reckless Driver.

Reckless Driver (first ex post version)

A person needs a liver transplant to survive. He is at the top of the waiting list for a donor organ. But he is driving recklessly and hits a pedestrian, destroying her liver. Now both he and the pedestrian will die soon without a trans-

plant. Remarkably, they are of the same tissue type. One organ becomes available that is thus a perfect match for both of them, but is unsuitable for anyone else on the waiting list. It can therefore be given either to the driver, who is at the head of the queue, or to the pedestrian, who has just joined the queue and thus would have a lower priority than the driver, according to rules of distribution that take into account the length of time that a person has been on the list, even though the pedestrian's medical need is the same as his.

It would, I believe, be unjust to give the organ to the driver. It must instead be given to the pedestrian. The driver has forfeited whatever claim he had to the organ in favor of the pedestrian, whose life he has culpably endangered. If the organ were unsuitable for the pedestrian, then of course the driver would retain his claim to it. It is not that he deserves to be passed over, or deserves to die. It is rather that by having culpably caused the pedestrian to need a transplant in order to survive, he is required to save her if he can, even at a cost to himself that is equivalent to, or even greater than, that which his action would otherwise impose on her. Having culpably created a forced choice between his life and hers, he must pay the cost of his own voluntary action.

Recall that it is uncontroversial that *if* the pedestrian or a third party could have prevented the reckless driver from hitting her and destroying her liver, it would have been permissible to kill him preemptively in order to do so. But the opportunity for defensive action has now passed. The only option is corrective or restorative action. I believe that if she or a third party could permissibly have *killed* him to prevent his action from killing her, it must now also be permissible to *allow* him to die (by denying him the organ he would otherwise have received) in order to prevent his action from killing her, even though his action now lies in the past. Indeed, I think two even stronger claims are true. I believe that if a third party could, at no cost to himself, have killed the driver to save the pedestrian, he would have been morally *required* to do

so. Similarly, once the driver has hit the pedestrian and destroyed her liver, there is a moral requirement to give the available donor organ to the pedestrian rather than to the driver.

There is one more case in the sequence of reckless driver cases that is essential to my argument in this essay. But before turning to that example, I will introduce one further case that, though inessential for my purposes here (but not irrelevant, as we will see), nevertheless presents formidable challenges to common sense moral views.

Reckless Driver (second ex post version)

A perfectly healthy person is driving recklessly, aware of but indifferent to the fact that he is creating unreasonable risks to others. He hits a pedestrian, destroying her liver. She will now die soon unless she has a liver transplant, but there is no prospect of a suitable organ becoming available in time in the ordinary way. It is known, however, that the reckless driver's liver would provide an exact match. If his liver were extracted and transplanted into her body, she would survive, though he of course would die.

In this case there is no doubt what the law would say. It would be murder to take the driver's liver to save the pedestrian. I am not confident of my ability to speak for common sense morality here, but I suspect that most people would also think it morally wrong to kill the driver as a means of saving the pedestrian and that this moral belief is at least part of the explanation of why the law is as it is. Yet the challenge is to explain why it would be impermissible to kill the reckless driver in this case when it is uncontroversial that it would have been permissible, and perhaps even required of a third party, to kill him *ex ante* had that been possible and necessary in order to prevent the pedestrian from being hit by him in the first place. Why should he gain protection from the mere fact that his wrongful action lies in the past?

It is true that many people think that *defense* is nearly always justified, that it is privileged among possible justifications for the

infliction of harm. And it is also true, as I have noted, that if the action that inflicts a harm has already occurred, defense is no longer possible. But I think it is an illusion that defense has a privileged place among justifications for the infliction of harm. It can be a matter of justice not just to prevent wrongful harms but also to rectify them once they have occurred. There is, indeed, an entire area of the law devoted to the rectification of previously inflicted losses: the law of torts. In tort law, if one person is objectively at fault in injuring another who was not herself negligent, the injurer owes the victim compensation as a matter of justice to restore her to the level of well-being she would have enjoyed in the absence of the injury. Of course, the compensation that is owed takes the form of a payment. And in the ex post versions of the case of the Reckless Driver, compensation cannot take the form of a monetary payment. Compensation in tort law is generally measured by an indifference criterion. A payment is deemed to compensate a victim for a loss if she would be indifferent between 1) not suffering the loss, and 2) suffering the loss and then receiving the payment. But for most people there is no amount of money that could compensate them, by this criterion, for the loss of their life. In the second of our ex post versions of the case of the Reckless Driver, the only way that the driver can come close to compensating the pedestrian is give her his liver—and even this would not fully compensate her. If we accept that it is just to force injurers to compensate their victims through monetary payments when compensation can take this form, why should we draw back when the only form of compensation is a vital organ?

One thought people tend to have at this point is that to cut a person open and remove his liver would be an extreme violation of his bodily integrity, and we tend to think of people's rights to bodily integrity as nearly absolute. In law, for example, a parent may not be coerced to donate bone marrow for her child, even if her child would be enabled to survive by a bone marrow transplant but will die without it. For even though it involves virtually no risk and is largely painless, the extraction of bone marrow from the parent's body does require the

insertion of a needle into her pelvic bone, and thus, if done without her consent, counts as an invasion of her bodily integrity.

The suggestion that the issue here is one of bodily integrity finds support if we consider a further variant of the example. Suppose that instead of having destroyed the pedestrian's liver, the reckless driver has destroyed both her kidneys and that she needs a single kidney transplant in order to survive. The driver has two healthy kidneys and could easily survive with only one. Yet the law forbids the forcible extraction of one of his kidneys to save the pedestrian's life and I suspect that most people would agree that this would be forbidden by morality as well. If we may not take his kidney even when this would not threaten his life, this suggests that the main objection to taking the reckless driver's liver in the original case is not that this would kill the driver but that it would violate his bodily integrity.

Yet the problem with this appeal to the right of bodily integrity is that if it makes it impermissible to take the driver's liver after he has hit the pedestrian, it should also make it impermissible to kill him *ex ante* to prevent him from hitting the pedestrian. For we are imagining that in order to prevent him from hitting the pedestrian, one would have to blow him up along with the car he is driving. And it could hardly be true that while inserting a needle into a person's bone is a violation of her bodily integrity, blowing a person's body to bits is not.

I have discussed this example because it raises disturbing questions but, as I observed earlier, it has no essential role in the main argument of this essay. There is, however, one further *ex post* version of the case of the Reckless Driver that does.

Reckless Driver (third ex post version)

A person needs a liver transplant to survive. Her need for a transplant is the result of years of infection with the Hepatitis C virus, which she acquired from a blood transfusion administered with her parents' consent when she was a small child. (We might, just to bias the example a bit more in the direction I favor, imagine that she needed the trans-

fusion because of the loss of blood occasioned by being hit by a reckless driver as she was walking along the sidewalk.) She and another patient join the waiting list for a donor organ at the same time. This other person, whose medical need is the same as hers, needs a transplant because of an injury suffered in a single-car accident caused entirely by his own reckless driving. As one would expect at this point, he and the hepatitis patient share the same tissue type. A single donor organ becomes available that is an ideal match for both of them but is unsuitable for anyone else on the waiting list.

Had we not already discussed the other cases involving reckless drivers and villainous patients, it might not occur to us to suppose that the driver in this case might have a lesser claim to the organ than the hepatitis patient. But a consideration of the previous cases does pressure us to accept that he has a diminished claim relative to hers. He is morally responsible for his own need for an organ; she is not. This makes him morally liable to the assignment of a lower priority.

This is not, like the second *ex post* version of the Reckless Driver case, an instance in which, in order to save the pedestrian, one must kill the driver as a means. In this case, the reckless driver would not be killed but merely allowed to die; and he would not be used as a means. This is a simple case of choosing whom to save when not all can be saved.

One obvious difference between this case and the previous two *ex post* cases involving reckless drivers is of course that in the other cases the driver is responsible for the *pedestrian's* need for a transplant. In this case he is not. He is responsible only for his own need. This case is therefore fundamentally different in what seems to be a morally significant way.

In one sense it is of course true that the driver in this case is not responsible for the threat to the pedestrian. He is in no way responsible for her need for a transplant. Yet in another sense he *is* responsible for a threat to her life. If he had not driven recklessly and injured himself,

the organ that has become available would have gone to her. She could have been saved from the effects of the disease over which she has never had any control. But now, through his own reckless action, he has put himself in competition with her for the organ. He has, in other words, created a forced choice between his life and hers. And he has done so through action that recklessly endangered himself and others, action that now endangers the hepatitis patient, although in a rather indirect way.

It is true, of course, that the hepatitis patient threatens the driver in the same way that the driver threatens her. If she were not on the waiting list, the organ that has become available would go to him. So each poses a threat to the other. But the difference is that he is responsible for his need for the organ while she is not responsible for her need. He is therefore responsible for the threat he poses to her whereas she is not responsible for the threat she poses to him.

One might argue that the degree of his responsibility is too slight to make him liable to cede his claim to the organ to the hepatitis patient. All he is guilty of, after all, is reckless driving, and the only person he hurt is himself. I concede that this is relevant. I noted earlier that responsibility is a matter of degree and that liability should vary with responsibility, if other things are equal. To see how this is relevant in the present case, suppose that both the driver and the hepatitis patient could survive with only a partial liver transplant, though their quality of life and long-term survival prospects would be diminished relative to what they could expect from a full transplant. If the donor organ could be divided so that each could be given a partial transplant, that would probably be the best solution. If the division could be asymmetrical, it would probably be ideally fair to give the hepatitis patient the larger part, thereby enabling both of them to survive but offering her a somewhat better quality of life as well as better survival prospects. But she would not be entitled to demand the entire organ at the cost of allowing the driver to die.

I believe that the situation would be different, however, in a further variant of the first ex post version of the Reckless Driver case.

The driver is again a patient at the head of the waiting list for a liver transplant. But in this variant, he does not drive recklessly but instead intentionally and maliciously hits the pedestrian with his car and in doing so destroys her liver. Again a single organ that is a match for both of them becomes available, but in this variant it can be divided, so that each could have a partial transplant. Here it seems to me that the driver's claim to any part of the organ is very weak relative to the claim of the pedestrian. It would not be unjust, in my view, to give the entire organ to the pedestrian in an effort to compensate her as fully as possible for what the driver has done to her, while allowing the driver to die.

In the third *ex post* version of the Reckless Driver case—the version in which the reckless driver injures himself and thus puts himself in competition for survival with the hepatitis patient—it is not possible to divide the donor organ between the two. In this case, one of them can be saved and the other must die. In this situation, even though the degree of the driver's responsibility for his need for a transplant is modest, it is sufficient to give the hepatitis patient priority, since she is in no way responsible for her need for a transplant. In these circumstances, and in the absence of other considerations that might favor the driver, this asymmetry in responsibility decisively favors the hepatitis patient.

It is worth noting, before going on, that what I have said would not justify killing the reckless driver preemptively, to prevent him from injuring his own liver. Nor would there be a justification to kill him afterward, to eliminate the threat that his appearance on the waiting list poses to the hepatitis patient. For there is no necessity of defensive harming in this case. The threat to the hepatitis patient can be eliminated simply by allocating the organ to her. But suppose that, as is presently true, the allocation system does not take considerations of responsibility into account? Suppose that the officials who make decisions about the allocation of organs see that both the driver and the hepatitis patient appeared on the waiting list at the same time and have equivalent medical needs; and suppose that to decide between

them the officials then flip a coin, with the result that the organ is scheduled to go to the driver. If the hepatitis patient, or a third party, could kill the driver in a way that would make it appear that he had died a natural death, would it be permissible to kill him to prevent his reckless action from depriving the hepatitis patient of the organ that she needs to survive and that would otherwise have been hers?

I do not have an answer to this question, which is similar to the question raised by the second ex post version of the Reckless Driver case, in which the driver recklessly damages the pedestrian's liver and has a liver that could be used to save her. In the present case, in which the driver is responsible only for his own need for a transplant, both the law and common sense morality clearly prohibit the killing of the driver. And no doubt there are many reasons why it would be morally objectionable to kill him to remove him from the waiting list. But this leaves open the question whether killing him would *wrong* him, or violate his *rights*, when he will otherwise survive by taking for himself an organ that, on the view for which I have argued here, ought as a matter of justice to be used to save someone else.

ALLOCATION OF LIVERS TO ALCOHOLICS

Many readers will have anticipated where this discussion is leading. Cases in which one potential transplant recipient is responsible for causing another person to need the same sort of transplant rarely, if ever, occur. But cases in which people are responsible for causing themselves to need a transplant, and thus for placing themselves in competition with others for an organ when there are not enough organs for all who need them, are common. The most notorious cases involve alcoholics who cause themselves to suffer from cirrhosis of the liver and continue to drink until they reach end-stage liver disease, when a liver transplant offers their only chance of survival. (Some people who are not alcoholics but who nevertheless drink heavily on a regular basis for many years can also cause themselves to suffer from the same liver problems that afflict some alcoholics. But these people account for only a small percentage of the number of cases of alcohol-induced liver fail-

ure. Thus, for simplicity I will refer only to alcoholics.) This is not a marginal phenomenon. In the United States, excessive consumption of alcohol is the leading cause of liver disease, so the problem is quite serious. And the cases, considerations, and arguments I have been discussing have implications for how this problem ought to be addressed.

The view I have sought to defend is that when a person is responsible to a significant degree for his own need for an organ transplant, and when there are not enough organs for all who need them, so that this person is responsible for placing himself in competition for an organ with others who are not responsible for their need for a transplant, priority ought to be given to those who lack responsibility for their condition, other things being equal. This view is, I believe, implied by the same principles that govern the ethics of killing in self-defense. These principles assert a strong connection between moral responsibility for conditions in which someone must die and moral liability to be the one who is killed or allowed to die. Because of this, a person's responsibility for his own need for a transplant is not a trivial factor; it is, rather, a factor that is not easily outweighed by other considerations.

Most alcoholics are aware that drinking threatens their health, and in particular their liver. Most are aware, particularly as a result of the publicity given to liver transplants undergone by numerous alcoholic celebrities (such as Mickey Mantle), that alcoholics have a high risk of eventually needing a liver transplant in order to survive. Many are aware, or ought to be aware, that organs donated for transplantation are scarce and that many people die because of the chronic shortage of donor organs. That these facts are common knowledge is important, since awareness of the risks they run seems to be a condition of significant responsibility for their own predicament when alcoholics reach the point at which they need a transplant to survive. Responsibility requires foreseeability. If we were to discover tomorrow that broccoli causes liver disease, we would not conclude that those who now require a transplant because of their high consumption of broccoli in the past are responsible for their need for a transplant. But

because the facts about the connection between alcoholism and liver disease are well known, it is reasonable to regard most alcoholics who need a liver transplant to survive as responsible to a significant degree for their own condition.

If this is the case, the view for which I have argued implies that they should have lower priority in the distribution of livers for transplantation than those who have not contributed to their need for a transplant. When an alcoholic who needs a liver transplant has been aware, even if only vaguely (since even a vague awareness establishes a ground for negligence), that his continued drinking placed him at risk of liver failure, he is responsible to a significant degree for his own condition and therefore for the fact that others must now choose between saving him and saving the life of someone else who has not had the choice, as he had, of avoiding the need for a transplant. If he is allowed to compete with others for an organ, he then becomes responsible for a threat to them, though they are not similarly responsible for the threat they pose to him. Justice dictates in these cases that the organ be given to a person who lacks responsibility for her condition, if other things are equal (and they would have to be very unequal to outweigh considerations of responsibility).

OBJECTIONS

Equality

The suggestion that alcoholics should have lower priority in the allocation of organs for transplantation strikes many people as an affront to the equal worth of persons. It is worse than invidious; it is overtly discriminatory.

Yet to make responsibility for one's condition relevant to one's entitlement to treatment in conditions of scarcity is importantly different from other proposed departures from a system of distribution, such as an unweighted lottery, that would give all potential recipients and equal chance of receiving an organ. Most other proposed criteria for ranking potential recipients focus on factors that are beyond people's control: age, ability to benefit from treatment, social worth, and so

on. To allow such factors a role in the allocation of organs may indeed seem incompatible with respect for the equal worth of persons. But responsibility for one's own condition is different. To hold alcoholics responsible for their action is to recognize their capacity for responsible agency and to hold them liable for their exercise of it. This is no less compatible with equal respect than recognizing the permissibility of self-defense or the legitimacy of punishment.

Punishing Vice

It is frequently argued that the idea of assigning lower priority to alcoholics derives from a Prohibition-era mentality, from religiously motivated moralizing about demon alcohol and the wickedness of those who imbibe it. To integrate this idea into policies for the allocation of organs would simply be a way of rewarding supposed moral virtue and punishing vice.

It should be obvious that there is nothing punitive, nothing retributive, in the argument I have given. I conceded earlier that even someone who bears the highest degree of responsibility, through morally culpable action, for his need for a transplant, may be perfectly entitled to a donor organ if there is no one else who needs it to survive but is not responsible for her condition. We may, however, go further than this. Nothing I have written implies that a person's general moral virtuousness or wickedness is relevant to his entitlement to an organ transplant. Suppose that there are two people of the same tissue type whose medical need for a transplant is the same. One is a convicted murderer serving a life sentence in prison who as a child was infected with Hepatitis C through a blood transfusion, while the other is a thoroughly nice person who destroyed his own liver in an accident caused by his own uncharacteristic reckless driving. Suppose that an organ becomes available that is an ideal match for both and is unsuitable for everyone else on the waiting list. Nothing I have written implies that it ought to be given to the nice person; rather, my argument favors giving it to the murderer. Whether there are further considerations that outweigh the nice person's responsibility for his own condition is

a matter I will leave open—though for the record I will note my intuition that the organ ought, all things considered, to be given to him rather than to the murderer. The point here is that the argument I have advanced for assigning lower priority to alcoholics does not depend on any assessment of the moral virtues or vices of alcoholics.

Notice that a similar objection is still sometimes made to the imposition of a “vice tax” on cigarettes. But most people now understand that the purpose of the high tax on tobacco products is not to punish vice but to make smokers bear the costs of their own action. Because smokers make disproportionate demands on the health care system, thereby burdening others with increased taxes (under a national health system) or increased insurance premiums, the tax is meant to redistribute the costs of their action back to them, rather than allowing them to impose the costs of their own voluntary action on others.

Addiction and Responsibility

Another objection that is frequently stated is that even if a person’s responsibility for her need for a transplant is a relevant factor in the allocation of organs, this has no bearing on the priority that ought to be given to alcoholics, since they are not in fact responsible for their liver disease. Alcoholism is itself a disease. Among the defining characteristics of the disease are *addiction* and *denial*. Addiction is a form of compulsion while denial involves an inability to recognize and thus to try to combat the compulsion. Together they absolve the alcoholic of all responsibility for behavior—such as continuing to drink even when it is known to be damaging to the alcoholic’s health—that is entirely attributable to the disease. Thus, according to the deputy director of the National Institute on Alcohol Abuse and Addiction, which is a division of the National Institutes of Health, “although taking the first drink is a willful behavior, once the person is addicted, it’s beyond their control” (quoted in Munson, 2002: 62).

There is much that could be said in response to this objection. I will make only a few brief points. The most obvious and important point is that many alcoholics do stop drinking and continue to abstain

from drinking for the rest of their lives. I know many alcoholics who have done this. Most adults probably also know at least several alcoholics who have stopped, some even without professional assistance. So it just cannot be true that once a person is an alcoholic, it ceases to be within his control whether or not he continues to drink.

Many alcoholics are not unaware of their condition. They recognize that they are alcoholics and make efforts to control their drinking but fail. Still, the opportunity to exercise control remains with them, however many times they fail. Many of them make the decision to drink every day. In many cases, the reasons they perceive for stopping are insufficient to counter the temptation they experience to drink. If the incentives for stopping were stronger, many would stop. If, for example, it were true of some particular alcoholic that if he were ever to have just one more drink, he would immediately die an agonizing death, and if he knew this was true, it is highly probable that he would never have another drink. Most alcoholics could stop drinking in these conditions. So one way to help alcoholics in general would be to increase the costs to them of continued drinking in order to provide greater incentives for stopping. And of course one obvious possibility would be to assign them lower priority in the allocation of livers for transplantation. Many alcoholics know that under the current rules, if they destroy their liver by drinking, they will compete with others on equal terms for a transplant and thus will have a reasonable chance of surviving. If it were instead true, and they knew it to be so, that they would have almost no chance of receiving a donor organ if they were to destroy their liver by continued drinking, that would give them a significant incentive to stop drinking before it is too late.

We should, of course, recognize that alcoholics have diminished responsibility for their continued drinking. It seems undeniable that alcoholic addiction makes it extremely difficult not to drink, and that alcoholism does impair a person's ability to appreciate the nature of his problem. But diminished responsibility is not absence of responsibility, and even a small degree of responsibility can be morally significant. Negligence, for example, is treated as a basis of liability even when it

is slight, and even though there are puzzles about how it can be a basis of liability. (How can we hold that a person ought to know what he does not know? Suppose he does not know that there is something that he ought to know. Is he then negligent for not knowing that there is something that he ought to know? And so on.) If, however, we were to rewrite the first ex post version of the Reckless Driver example so that the driver was guilty of negligence rather than recklessness, I would still think that he would forfeit his position on the waiting list in favor of the pedestrian he had injured.

Policy

Perhaps the most powerful objection to giving alcoholics lower priority in the distribution of organs for transplantation on the ground that they are responsible for their condition is that there are notorious problems in implementing the responsibility criterion as a matter of policy. Alcoholics with end-stage liver disease are a fairly clear example of people who have caused their own need for treatment. But people contribute to the causation of their illnesses in a great many ways and to varying degrees. Smoking and obesity are, for example, widely known to be causal factors in the etiology of many diseases, and they are matters over which people can exercise varying degrees of control. Yet it is difficult to determine in many cases whether and to what extent either factor has in fact contributed to a patient's condition. And it is even harder to determine the contribution that a patient's failure to get exercise or adequate nutrition might have made to his or her condition. There are, moreover, both chronic and acute conditions that result from people's choices to engage in ordinary activities such as sport, or from hazards to which they are exposed through their occupations, and so on.

It would be impossible to gather relevant information on all the ways in which most people have foreseeably contributed to their own illnesses. And even if we had perfect information on people's behavior, we still would be unable to determine in most cases the extent to which their informed choices had actually made a causal contribution to their

disease. And even if we could somehow overcome both these epistemic obstacles, the task of weighing and comparing different people's responsibility for their illnesses (where responsibility is a matter not just of causation but also of foresight, control, and so on) would elude our best efforts. Finally, any genuine attempt to overcome these obstacles would inevitably be a costly bureaucratic quagmire.

So the responsibility criterion cannot be a factor in general decision making about the distribution of scarce medical resources. There remains the question whether we should employ it in limited areas in which its application is arguably not ruled out by epistemic limitations—for example, in choices between giving a liver for transplantation to an alcoholic and giving it to someone else who clearly has had no role in causing her need for a transplant. If we were to do this, the targeted group—alcoholics—would have a justified complaint about the comparative unfairness of our policies. They could complain that it would be unfair to assign them lower priority among potential recipients of liver transplants while not assigning lower priority to overweight or obese patients among potential recipients of heart transplants. I will not attempt to resolve this further problem of comparative justice. My aim in this essay has been limited: to show that responsibility for one's own illness is a morally relevant criterion in the allocation of organs and other scarce medical resources.

REFERENCES

Munson, Ronald. *Raising the Dead: Organ Transplants, Ethics, and Society*. New York: Oxford University Press, 2002.