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Open Peer Commentary**

Social support is not the only problematic criterion, but if used at all, “lack of social support,” should count in favor of listing, not against.

Besides lacking robust empirical support, Berry et al. argue that the “lack of social support” listing criterion violates the moral principles of equity and respect for persons. Hence, only strong empirical evidence (evidence tying lack of social support to transplant failure, or risks to the patient outweighing the benefits) could overcome these violations (2019:18). Equity concerns include the disproportionate impact on minority populations, especially minority populations who already face difficulties in accessing medical care (2019:12). Problems arise with the respect for persons principle, argue Berry et al., because a lack of social support is often due to lifestyle choices and value preferences. Some persons simply prefer a more private, solitary, life. Respecting these persons means respecting this choice (2019:12). Moreover, it might be disrespectful to expect patients’ family members to give up their own lives so they can become a full-time caretaker for their post-transplant relative (2019:18).

 By my lights, Berry et al. appear largely correct, i.e., the reasons they give for excluding social support as a listing criterion seem good ones. But if I and Berry et al. are correct about this, then these justificatory reasons must also be applied to other psychosocial listing criteria, for instance, criteria like mental health problems or a history of substance abuse. Admittedly, mental health problems and substance abuse are conditions more highly stigmatized than lack of social support, and often looked at via a guise of negative judgement. Yet such social attitudes toward mental health issues and drug use do not undermine the argument; the same points apply. The main point is this: only *robust evidence* that clearly connects mental health problems, or substance abuse, or other psychosocial criteria *with transplant failure, or undue patient risk*, can justify using the aforementioned as grounds for listing exclusion.
 Similar to social support trends, certain minority communities have higher rates of substance abuse problems, mental health problems, and often face great difficulties finding treatment for these issues.[[1]](#footnote-1) Hence, this criterion would disproportionally impact certain minority communities. Moreover, those with mental health problems are already a minority community. This minority group has long been stigmatized, and in virtue of their condition, often have a harder time finding appropriate medical care. Even more, when those with mental health problems also fit into other minority groups, this stigma and treatment difficulties can be made even worse.[[2]](#footnote-2) Hence mental health problems and substance abuse are criteria that seriously undermines the principle of equity.

 Respect for persons, also, speaks against using other psychosocial conditions as a listing criterion. A glaring lack of such respect is shown in using almost any statistical evidence as exclusion grounds.[[3]](#footnote-3) Or at the very least, using this evidence without offering the patient a chance to provide counter evidence (i.e. updates to the statistical prior). After all, there are vast differences between types of substance abuse and types of mental health disorders. Any evidence that lumps these conditions together shows a lack of respect to the patient as an individual. Many persons with mental health problems are capable and competent in many areas of life. And those that are not might have methods to help them through. Likewise, substance abuse comes in many different forms, e.g. some might have abused substances because this behavior is common in their social group. As Berry et al argue, there is something problematic with denying life-saving treatment in virtue of socialization choices (2019:13).

 There is a simple alternative to the problematic practice of psychosocial listing exclusion: If an individual’s mental health, or substance abuse issue, or any other social problem, makes the transplant operation a likely failure, or if there is more patient risk than reward, (and this is demonstrated with robust evidence) then listing exclusion follows. This justification, however, is grounded in operation failure and undue risk, *not* psychosomatic factors themselves. Moreover, such justifications must be provided to the patient, along with a response opportunity. Medical personal, after all, are not always privy to the same information as patients. If, for instance, there is low survival rates for persons with past suicide attempts, the patient should have the chance to demonstrate that since their attempts, they have started a new medication that drastically improved their mental health. Past mental health problems should not be a death sentence. To exclude a chance at life while allowing no rebuttal shows extreme disregard to the patient’s ownership of their healthcare, or actually, their life.

 While Berry et al. claim that the financial listing criteria are ethically distinct from the psychosocial, (2019:5) it seems the same arguments apply. The real issue is this: would the lack of financial resources (necessarily) result in an unsuccessful operation, or extreme patient risk? The parenthetical is important: there should be attempts to find funding for patient care. To exclude those who lack financial resources has obvious equity concerns. It is also putting a price-tag on respect and autonomy. The financially privileged are treated as autonomous persons, insofar as they at least have a chance at life, while those without funds are given no chance to live. Those without any life cannot have an autonomous life, and arguably, the living cannot respect the dead.

 The arguments thus far speak to a more substantial point: *Any criteria* unrelated to transplant success is ethically troubling.
 Imagine that the medical community decides that organ allocation should be made with an eye toward “deservingness.” Any such deservingness principle will support using lack of social support as a criterion that *favors* listing., i.e., patients who lack social support should gain access to transplant treatment *before* those who have social support. Many see the following as plausible: equal persons should get an equal amount of life’s cherished goods. For instance, what is sometimes known as “the fair innings principle”[[4]](#footnote-4) recommends saving the young over the old. After all, the old have already had many years lived that the young have not. This is plausible enough, but one criticism of the principle is it considers *only* quantity but not quality, even though few would contend that 10 extra years of a miserable life is better than 9 years of a happy one. Quality matters. It is fair not merely that persons get to live a similar amount, but that persons have similar access to valuable goods.

 Measuring quality of life is challenging. Persons have different values, and it is wrong for medical experts to force values on anyone. However, self-reports of happiness, or conversely, reports of the absence of pain, anxiety, and depression are not paternalistic or elitist; they instead seriously respect subjective value. And while we lack robust empirical grounds to connect lack of social support and successful transplant, *there is* empirical grounding to connect social support to higher subjective satisfaction, and also lower dissatisfaction (Berry et al., 2019:7) Hence, those with a history of social isolation are missing their fair share of an especially cherished (yet value neutral) life resource. The socially isolated therefore deserve a chance at what they have missed. A chance at life means a chance at social connection and subjective satisfaction. The other option is giving the chance to someone who has already won. Just like an older person has lived years the young have not, the socially connected have already experienced social benefits that the unconnected have not. [[5]](#footnote-5) Hence, the latter are more deserving in both cases.

**Reference**

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1. Alegria et al., 2010; Hughes, 2010; Goldbach, 2013. [↑](#footnote-ref-1)
2. Eisenberg et al., 2009; Corrigan, 2004. [↑](#footnote-ref-2)
3. Statistical evidence related to the patient’s transplant related illness is an exception, because the job of the physician is to evaluate the *individual* health of the patient, and the physician is an expert. But this physician is typically not doing the same type of evaluation on the patient’s psychosocial conditions, or financial condition, or many others. Hence, the patient might very well have relevant information that medical personal lack. [↑](#footnote-ref-3)
4. For discussions related to the fair innings principle, see Daniels 1995 and 2001. [↑](#footnote-ref-4)
5. I would also argue that this criterion should be excluded in other areas, for similar reasons. In my paper, “Transgender Children and the Right to Transition,” I argued that children should be able to get access to puberty-blocking hormones, even without parental consent. One objection is that a strong social support system is seen as a criterion for considering children appropriate candidates for hormone-blockers. Yet it is not clear this should be a criterion, for reasons similar to what Berry et al. argue.
 [↑](#footnote-ref-5)