Whereas, In 2017, liver cirrhosis was the 11th leading cause of death in the United States (over 144,000 deaths), and among all cirrhosis deaths, 50% were alcohol associated; and

Whereas, From 2010 to 2016, alcohol-associated liver disease was the primary cause of nearly 1 in 3 liver transplants in the United States, replacing hepatitis C virus infection as the leading cause of liver transplantation due to chronic liver disease; and

Whereas, Liver transplants in patients presenting with life-threatening severe alcoholic hepatitis due to alcohol-associated liver dysfunction without 6-month sobriety have major improvements in mortality (1 year survival of 94% compared with a 6-month predicted survival of less than 20%) with low post-transplant alcohol relapse rates; and

Whereas, Patients suffering from either severe acute alcoholic hepatitis or acute-on-chronic liver failure and not responding to medical therapy have high 3-month mortality rates ranging from 60%-70%, even reaching as high as 90% within the first year; and

Whereas, The justification for the 6-month rule in 1997 at the conference of the American Association for the Study of Liver Diseases and American Society of Transplantation cited three studies that were confounded by small sample sizes and methodological flaws; and

Whereas, Subsequent studies have failed to show the 6-month rule affects patient survival after liver transplant and instead can be lethal; and

Whereas, Studies have shown that alcohol relapse rates among liver transplant recipients are identical whether or not there is a 6-month wait before transplant if there is careful selection of patients with factors such as a strong social support, awareness of the role of alcohol in their condition, free of severe comorbid psychiatric or comorbid disease; and

Whereas, Transplant centers such as Johns Hopkins University regularly transplant livers into patients with alcohol-related liver disease whose sobriety does not reach the six-month threshold and transplant centers such as the University of California, Los Angeles, University of Chicago, and others consider listing patients without 6-month sobriety after careful selection; and

Whereas, Reluctance to perform liver transplantation in patients with alcohol use disorder is based on the fact that alcoholism is frequently considered to be self-inflicted and due to fears of harmful post-transplant alcoholism recurrence; and
Whereas, Alcohol use disorder is a recognized disease and not a mental failure, diagnosed based on the Diagnostic and Statistical Manual of Mental Disorders, fifth edition, and is due to complex interactions between environmental factors, genetics, psychiatric conditions\textsuperscript{15}; and

Whereas, The utilization of abstinence periods unfairly discriminates against a patient population with a specific medical condition\textsuperscript{16}; and

Whereas, Despite the widespread adoption of a 6-month rule requiring abstinence prior to liver transplant, this has never been a formal recommendation from the International Liver Transplantation Society\textsuperscript{17}, the Organ Transplant Procurement Network or European consensus groups\textsuperscript{9} likely due the fact that it is an indefensible position from a legal standpoint\textsuperscript{18}; and

Whereas, Failure to create national policy on abstinence periods may exacerbate existing inequities and disparities in access to liver transplantation\textsuperscript{2}; and

Whereas, The American Academy of Addiction Psychiatry has a policy (Re: Organ Transplantation) in support of the evaluation of a patient’s candidacy for organ transplantation based on clinical grounds alone, without an arbitrary length of time for a sobriety period, and substance use and the possibility of future substance use being just one clinical factor in evaluation\textsuperscript{19}; and

Whereas, The American Medical Association-Medical Student Section (AMA-MSS) has a policy (370.014MSS) in support of removing cannabis as a contraindication for potential organ transplant; and

Whereas, The AMA-MSS has a policy transmittal (440.101MSS) in support of opposing sobriety requirements for hepatitis C treatment; and

Whereas, The American Medical Association has a policy (H- 370.973) in support of the removal of transplant center policy excluding patients maintained on methadone from liver transplant waiting lists and encouraging transplant centers to assess patients maintained on methadone on a case-by-case basis; and

Whereas, The AMA has a policy (H-370.982) in support of ethical considerations in the allocation of organs among patients, stating allocation decisions should respect the individuality of patients and the particulars of individual cases as much as possible; therefore be it

RESOLVED, That our American Medical Association encourage transplant centers to expand potential recipient evaluation criteria to include patients that may not satisfy center-specific alcohol sobriety requirements on a case-by-case basis, using medically appropriate criteria supportable by peer-reviewed and published research. (New HOD Policy)

Fiscal Note: Not yet determined

Received: 10/12/22
REFERENCES:


RELEVANT AMA POLICY

Methadone Maintenance and Transplantation H-370.973
Our AMA: (1) urges transplant centers across the nation to abrogate any policies that automatically exclude patients maintained on methadone from liver transplant recipient waiting lists; and (2) encourages transplant centers to assess patients maintained on methadone on a case-by-case basis using medically appropriate criteria supportable by peer-reviewed and published research.

Citation: Res. 405, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Medical, Surgical, and Psychiatric Service Integration and Reimbursement H-345.983
Our AMA advocates for: (1) health care policies that insure access to and reimbursement for integrated and concurrent medical, surgical, and psychiatric care regardless of the clinical setting; and (2) standards that encourage medically appropriate treatment of medical and surgical disorders in psychiatric patients and of psychiatric disorders in medical and surgical patients.

Citation: Res. 135, A-99; Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 6, A-15; Reaffirmation: I-18
Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients H-370.982

Our AMA has adopted the following guidelines as policy: (1) Decisions regarding the allocation of scarce medical resources among patients should consider only ethically appropriate criteria relating to medical need. (a) These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment. In general, only very substantial differences among patients are ethically relevant; the greater the disparities, the more justified the use of these criteria becomes. In making quality of life judgments, patients should first be prioritized so that death or extremely poor outcomes are avoided; then, patients should be prioritized according to change in quality of life, but only when there are very substantial differences among patients. (b) Research should be pursued to increase knowledge of outcomes and thereby improve the accuracy of these criteria. (c) Non-medical criteria, such as ability to pay, social worth, perceived obstacles to treatment, patient contribution to illness, or past use of resources should not be considered.

(2) Allocation decisions should respect the individuality of patients and the particulars of individual cases as much as possible. (a) All candidates for treatment must be fully considered according to ethically appropriate criteria relating to medical need, as defined in Guideline 1. (b) When very substantial differences do not exist among potential recipients of treatment on the basis of these criteria, a "first-come-first-served" approach or some other equal opportunity mechanism should be employed to make final allocation decisions. (c) Though there are several ethically acceptable strategies for implementing these criteria, no single strategy is ethically mandated. Acceptable approaches include a three-tiered system, a minimal threshold approach, and a weighted formula.

(3) Decision making mechanisms should be objective, flexible, and consistent to ensure that all patients are treated equally. The nature of the physician-patient relationship entails that physicians of patients competing for a scarce resource must remain advocates for their patients, and therefore should not make the actual allocation decisions.

(4) Patients must be informed by their physicians of allocation criteria and procedures, as well as their chances of receiving access to scarce resources. This information should be in addition to all the customary information regarding the risks, benefits, and alternatives to any medical procedure. Patients denied access to resources have the right to be informed of the reasoning behind the decision.

(5) The allocation procedures of institutions controlling scarce resources should be disclosed to the public as well as subject to regular peer review from the medical profession.

(6) Physicians should continue to look for innovative ways to increase the availability of and access to scarce medical resources so that, as much as possible, beneficial treatments can be provided to all who need them.

(7) Physicians should accept their responsibility to promote awareness of the importance of an increase in the organ donor pool using all available means.