SOME OBSTACLES TO APPLYING THE PRINCIPLE OF INDIVIDUAL RESPONSIBILITY FOR ILLNESS IN THE RATIONING OF MEDICAL SERVICES[1]

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Abstract
Lately, more and more authors have asserted their belief that one of the criteria which, together with the medical ones, can and should be applied in the policy of selecting and/or prioritizing the patients in need for the allocation of medical resources with limited availability, is the principle of individual responsibility for illness. My intention in this study is to highlight some very serious obstacles looming against the attempt to apply this principle in the distribution of the medical services with limited availability. Although there are numerous such obstacles, I shall only discuss five of them (the most important, in my opinion). These are: 1) the impossibility to establish with certainty whether a patient got ill due to his lifestyle; 2) the lack of a feasible and reliable method of establishing an individual's responsibility for his lifestyle; 3) a patient's right to privacy; 4) some moral requirements and principles and, last but not least, 5) the ethics of the medical profession.

Key words: *rationing, medical services, responsibility, medical ethics, justice, moralism.*

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1. The Issue of Rationing Medical Resources with Limited Availability and the Principle of Individual Responsibility for Illness

Medical resources – especially the very expensive ones or those such as transplant organs – are often available in a limited and insufficient supply. For this reason, doctors cannot distribute them to all the patients who need them, at least not at a time. Such situations, unfortunately rather frequent in the medical practice virtually everywhere, raise a question ever more often discussed in the literature of bioethics and medical ethics: what principles, criteria, and procedures can be applied legitimately in the policy of selecting and/or prioritizing the patients awaiting the allocation of medical resources with limited availability?

This is an extremely difficult and vexing matter, one that most of us would rather not encounter. This is because the criteria applied in the process of selection and prioritization of the allocation of medical resources with limited availability are very often criteria for deciding who will live and who will die. The medical resources with limited availability often represent, to the patients who await them, the only chance to live. The decision to refuse a person who needs such a resource or to give him/her low priority may mean, therefore, as it often does, a sentence to death.

Lately, more and more authors have asserted their belief that one of the principles which, together with the medical ones, can and should be applied while making such would-be tragic choices, is individual responsibility for illness. The authors I am considering include David Brudney, Frank Dietrich, Walter Glannon, Eike-Henner Kluge, Julian Le Grand, Alvin H. Moss and Mark Siegler, Eric Rakowski, Re'em Segev, Barry Smart, or Robert Veatch [1]. According to this principle, the people who got ill with no fault of their own deserve or are entitled, more than those who are (demonstrated with certainty to be) responsible for causing the disease they suffer from, to be allocated the medical resources with limited availability. The people responsible for causing their own disease are, essentially, those who got ill as a consequence of a behaviour or lifestyle for which they are morally to blame in a legitimate manner. The principle recommends, therefore, that these people be given low priority in the distribution of medical resources with limited availability when they compete against other people who got ill with no fault of their own. My first and foremost intention in what follows is to highlight some quite notable obstacles looming against our attempt to apply the principle of individual responsibility for illness in the distribution of medical services with limited availability. Although there are numerous such obstacles, I shall only discuss five of them (the most important, in my opinion). These are: 1) the impossibility to establish with certainty whether a patient got ill due to his/her lifestyle; 2) the lack of a feasible and reliable method of establishing an individual's responsibility for his/her lifestyle; 3) the patient's right to privacy; 4) some moral requirements and principles and, last but not least, 5) the ethics of the medical profession.

The thesis sustaining the existence of these obstacles is a controversial one. For example, some supporters of the principle of individual responsibility for illness have argued that at least some

obstacles are not universal, i.e. they do not occur with all categories of patients eligible for an assessment of their equal entitlement to a medical service with limited availability based on this principle. To be more precise, these obstacles do not occur in the policy of implementation, too, of the principle of individual responsibility for illness in the distribution of liver transplant (where most candidates are alcoholics). As a matter of fact, most of the advocates of the principle of individual responsibility for illness do not actually plead for its universal implementation, but only for its implementation in the case of alcoholics who require a liver transplant. Some of these authors, such as Frank Dietrich, even admit that the universal implementation of this principle is both non-feasible and unacceptable, due to some obstacles like those which will be discussed further. However, in Dietrich's opinion, the application of the principle exclusively for alcoholics remains not only possible, but also legitimate.

Are these authors right? Is their position supported by sound arguments? Is it a fact that most of the impediments of implementing the principle of individual responsibility for illness are merely partial and incidental? Can this principle be applied fully only in the case of alcoholics? My hope is that these questions will be answered adequately in the conclusions of this study. Before that point, though, I will go on to discuss and illustrate briefly each of the obstacles mentioned above.

2. A Few Considerations and Arguments on the Obstacles of Using the Principle of Individual Responsibility for Illness

2.1 *The impossibility to establish with certainty whether a patient got ill due to his/her lifestyle*

A *sine qua non* condition for the principle of individual responsibility for illness to be applied in the policy of rationing the medical services is that doctors – or other experts – are able to establish *with certainty* that a patient who applies for medical resources with limited availability is responsible (i.e., legitimately accountable from a moral point of view) beyond any doubt of inflicting upon him/herself the disease that require such resources. In order to reach a clear verdict regarding the degree of a patient's accountability for his/her disease, we must be able, first of all, to affirm with certainty that the disease he/she suffers from is the result of his/her lifestyle (and not of any other factor). Sometimes it is very likely that this condition is easily met. We can assume for sure, for instance, that doctors can establish beyond any doubt whether a patient got ill or injured as a result of practising a more or less extreme sport (like skiing or climbing) or following an irresponsible sexual behaviour (like in the case of patients with HIV). However, as even some of the defenders of the principle of individual responsibility for illness point out, the situation is completely different for the bulk of the other categories of patients who can be suspected of bringing their diseases onto themselves: "There are numerous possible causes for the majority of other diseases, and determining what exactly triggered the development of an illness is usually impossible. Statistical

correlations between consumer behavior and the incidence of certain ailments are often all that can be ascertained. Statistics show, for example, that obese individuals have a higher risk of suffering a cardiac arrest and that smokers are more prone to illnesses of the respiratory system than non-smokers. But one cannot determine beyond all doubt that the respiratory illness of a specific patient was caused by his or her smoking. The possibility that the patient would have become ill even if he or she had wholly abstained from smoking cannot be excluded" [3]. Even for this reason alone, it is virtually impossible therefore to apply the principle of individual responsibility for illness, at least at a large scale.

Still, as we have shown already, most authors who endorse implementing the principle of individual responsibility for illness argue only in favour of its use for illness in the distribution of liver transplant. That is, they only endorse the possibility of diminishing the right of alcoholic patients to apply for such a transplant. But the authors I am considering here assert that, in the particular case of these patients, the doctors are able to certify whether prolongued alcohol abuse caused the liver disease that might justify the transplant.

The adepts of this principle are right if their thesis affirms that there are patients for whom the doctors can establish beyond all doubt that they got ill following alcohol abuse. And yet the thesis (at least) some of them appear to promote is a much stronger one: namely that doctors can always establish beyond all doubt whether a patient got ill as a result of alcohol abuse, only based on his symptomatology. Now this thesis is false. On its own, symptomatology enables doctors to establish at best only that a patient suffers from an alcoholic liver disease. But the alcoholic liver disease and alcoholism are not the same thing. To be more exact, moderate consumption of alcohol, too, can cause an alcoholic disease, as it usually happens with women. Besides, the diagnosis of alcoholic liver disease established only on grounds of symptomatology is not a certain one as a rule, since even the most reliable procedure of establishing this diagnosis, the liver biopsy, is fallible. In most instances, the doctors are sure about the diagnosis or about the patient's history of alcohol abuse only after they have a conversation with him/her or consult other relevant sources of information about the history of his/her lifestyle [4].

2.2 *The lack of a reliable method to establish and assess the degree of individual responsibility for one's lifestyle*

Establishing beyond any doubt that a patient got ill as a result of his/her lifestyle is not the only condition to be met in order to give a clear verdict on his/her accountability for the disease he/she suffers from. It is also necessary to be able to prove that the patient is legitimately accountable from a moral point of view for the kind of lifestyle which resulted in that disease.

Some might believe that all the people with health-threatening lifestyles are legitimately accountable from a moral point of view. This is because all health-threatening lifestyles including those which, at some point, involve addiction, too, are in principle, at least initially, the result of individual choices. Moreover, addiction is not an insurmountable state. Many people manage to overcome it, whether by themselves, or with medical help and family support etc. Not lastly, although

many a time health-threatening conducts or lifestyles are genetically predisposed, this fact is not a triggering factor, but it merely influences an individual in adopting and/or continuing them.

True as these things may be, they do not prove though that all individuals with health-threatening lifestyles are legitimately accountable from a moral point of view. Even if we accept the above-mentioned ideas, it remains possible that at least some of them have very good excuses for choosing or persisting [5] in health-threatening lifestyles (excuses such as age, poverty, social isolation, challenging family environment, mental illness, experience of profound grief, insufficient education, reduced capacity of analysis and understanding, cultural background, etc.). Blaming these, too, may sometimes mean to fall in the trap of "blaming the victims" [6]. What does this mean? It means that, in order to be able to apply the principle of individual responsibility for illness in rationing the medical services without being unjust to at least some of the patients with health-threatening lifestyles, we must have a feasible and reliable procedure to identify those patients who are truly responsible (and accountable) for a lifestyle known with certainty or assumed, more or less plausibly, to represent the cause of the illness for which they need the medical resources with limited availability. But one of the prevailing impediments in applying the principle of individual responsibility for illness in rationing the medical services with limited availability is precisely the lack of such a procedure.

However, this impediment appears to have been overcome recently through a proposition by John Roemer. In his view, doctors or other experts could establish, for instance, whether a patient who smokes is accountable for the lifestyle that resulted in his/her lung cancer, and/or to what extent he/she is accountable, using a four-step formula. Firstly, they should decide what are the relevant circumstances in determining or influencing the people to adopt this unhealthy lifestyle (smoking in our case): e. g., the patient's age, occupation, sex, family environment, income, addiction etc. These circumstances will represent factors beyond the patient's control (i. e., factors for which he/she cannot be legitimately considered responsible). The second step consists in the grouping of smokers in different types, each type including those persons who share similar values for all the features found in the first step (same age, occupation, etc.) One such type could be, for instance, 60-year-old male steel-workers, or, 60-year-old female teachers. Step three is to calculate the average number of years in which the members of each type are likely to smoke. For example, this number might be 30 for the 60-year-old male steel-workers and 10 for 60-year-old female teachers. Both the patient's accountability and the degree of responsibility (if we find that he/she is responsible) are established in the fourth stage function of his/her ranking based on the average number of years calculated in step three within his/her type. Let us assume that our patient is a 60-year-old male steel-worker. If this patient has smoked for a number of years equal to, or smaller than, the average number typical to this type of patients, he will be considered not responsible (since the average typical to his category or to other categories is determined by circumstantial factors which are out of the direct individual control). In other words, the patient will be legitimately considered responsible only if he has smoked for more years than the average within his type (in our case here, for

more than 30 years). Also, the degree of his responsibility will be established depending on the extra number of years of smoking above the average number for his type. If our patient has only smoked for 31 years, then he has a very low degree of accountability. But if, on the other hand, he has smoked for 40 years, then we can legitimately believe that he is responsible to a high or very high degree [7].

As we can see, the Roemerian formula assesses the individual responsibility for one's lifestyle according to its typicality or atypicality. The more similar an individual's lifestyle is to the social type, the less accountable he is. And the more his lifestyle diverges from his social type, the more accountable he is.

Admittedly, this formula is very ingenious. Yet, is it reliable, too? There are several arguments which prove the idea that it isn't [8]. But I shall limit myself here to bringing only Norman Daniels's argument (which is also one of the most powerful). As he points out, the Roemerian formula "does not capture the relevant notion of responsibility. Atypicality is a poor measure of effort or desert or responsibility. For example, it makes responsibility depend largely on what others do, not on what we do. In any case, we still face this outcome: If skiing is a common behavior of the rich but not of the poor, then the poor skier is more responsible for his broken leg in a skiing accident than the rich skier" [9].

The very feasibility of this formula raises some serious questions, too. As we can notice, the doctors – or other experts at the job – need quite a large amount of personal information about patients in order to be able to apply the Roemerian formula. However, this kind of information is not always available, or it is not easily accessible. Under such circumstances, the process of collecting this information may require extremely detailed and complex investigations and, consequently, rather a long time, which doctors, as well as their patients, might not really have. Moreover, this process might also be very costly [10]. But more importantly, the necessary information to apply this formula – and, in general, the information necessary to prove a patient's accountability for his/her lifestyle – come from his/her private life. In other words, the price for collecting this sort of information – and, consequently, for applying the Roemerian formula – is very high, at least in a democratic and liberal society: invading the patients' privacy. This is, in fact, one of the most serious impediments in the use of the individual responsibility for illness as a principle in rationing the medical services.

2.3. *The patients' right to privacy*

Is this a universal obstacle against applying the principle of individual responsibility for illness as a criterion in rationing the medical services? No, in Frank Dietrich's opinion, a defender of the principle. In his view, the right to privacy does not impede the application of the principle of individual responsibility for illness in the case of (alcoholic) patients requesting a liver transplant. This is because the doctors are able to establish whether a patient is responsible for causing the liver disease which requires a liver transplant without violating his right. Dietrich's argument in supporting this thesis is that "a... feature of liver transplantation is the easy availability of the relevant information in any given case of liver damage. The symptoms reliably indicate whether it was caused by alcohol abuse or not. Furthermore, the doctors in attendance

are usually well-acquainted with a patient's case history. There is no need for troublesome investigations to find out whether the potential recipient of a donor liver is an alcoholic" [11].

As we have seen, at least one of the premises of this argument is false. As a matter of fact, the doctors are not able to establish with certainty whether a patient got ill following alcohol abuse, only by relying on his symptomatology. Secondly, Dietrich's considerations are not enough to legitimize the thesis thereof, that the doctors are able to establish whether a patient is responsible for causing his alcoholic liver disease without breaking his/her right to privacy. In order for this thesis to be valid, it is not enough that doctors be able to determine precisely whether a patient got ill as a result of alcohol abuse without having to conduct "troublesome investigations". The doctors might also need to be able to evaluate whether the patient is legitimately accountable – that is, whether he/she has an acceptable excuse – for the fact that he/she was an alcoholic without resorting to such inquiries. And this is impossible, for reasons such as those presented above. Consequently, the thesis that the right to privacy does not represent an impediment to applying the principle of individual responsibility for illness in the distribution of the liver transplant is false.

2.4. *A few moral requirements and principles*

Let us assume that Dietrich's argument is acceptable. Does this mean that it is just that the principle of individual responsibility for illness be applied for alcoholics exclusively, as he believes, along with other authors who support this principle? I believe it is not. Applying this principle only partially is, in my opinion, as in other authors' view [12], illegitimate. I consider that it would be discriminatory and, consequently, unfair. Justice requires that if, for various reasons, this principle cannot be applied to all patients accountable for their illness, then it must not be applied at all. Otherwise, the subjects of this principle would be unjustly discriminated since they would be the only patients punished for a liability that might be shared by other categories of patients as well. This requirement of justice is not the only moral requirement standing against the application of the principle of individual responsibility for illness in rationing the medical services. Another requirement of this sort is the principle of (equal) respect for everyone's human dignity. This principle forbids humiliating or demeaning treatment. But there are serious reasons to doubt the compatibility between this principle and the way the patients are assessed as to their entitlement to the medical services with limited availability on grounds of their responsibility for their illness. A patient liable to be tested on his accountability for the disease he/she suffers from, and/or be ranked on the waiting list for a transplant on grounds of morality, would feel humiliated. In other words, these practices would constitute a serious offence to his/her dignity [13]. Moreover, the implementation of such practices would mark the settlement of moralism in the rationing of the medical services [14], which is unacceptable. John Harris explains very aptly why in the following remark: "We all, of course, have a duty to encourage and promote morality, but to do so by choosing between candidates for treatment on moral grounds is to arrogate to ourselves not simply the promotion of morality but the punishment of immorality. And to choose to let one person rather than another die

on the grounds of some moral defect in their behaviour or character is to take upon ourselves the right not simply to punish, but capitally to punish, offenders against morality. Even in the... event of our being satisfied that we were entitled or obliged to do this we would be attempting to discharge a quasi-judicial function without any of the safeguards or rigour of legal proceedings" [15].

2.5. *The ethics of the medical profession*

As a rule, those who support the use of the principle of individual responsibility in rationing medical services are philosophers. But there are also doctors – like Alvin H. Moss and Mark Siegler, or Gregory Tetrault – who have endorsed this idea [16]. This is surprising to me at least, since medical ethics does not allow doctors to consider this principle of rationing (which has been pointed out by their peers) [17]. The fundamental values and principles that stand at the basis of medical ethics include values and principles clearly incompatible with applying the principle of individual responsibility for illness in the rationing of medical services. Such values and principles are, for instance, compassion or solidarity with the suffering person (regardless of his/her responsibility for his/her own illness), professional secret or the principle of beneficence (a principle of Hippocratic origin which urges doctors to act only in their patients' interest, to be their patients' unconditional advocates – and not judges, and to refrain from using the information they have about their patients for purposes other than adequate medical care). One of the primordial reasons which legitimate such professional obligations is the necessity of a relationship of trust between the patient and the doctor. As it has been remarked [18], in the absence of such a relationship, the supreme aim of the medical act, the patient's health, could no longer be met. But the introduction of the principle of individual responsibility for illness in rationing the medical services would result precisely in the break of the doctor-patient relationship, at least in the case of patients with health-threatening lifestyles. Knowing that, one day, the doctors might use the personal information against their interests, these patients will understandably be cautious – if not even deceitful – in providing private data, which would jeopardize their treatment even for diseases for which it is generally available (or at least for which the treatment is not as dramatically limited as is organ transplant).

3. Two Final Remarks

What conclusions can we draw from these explanations and arguments on the obstacles to implementing the principle of individual responsibility for illness in the distribution of the medical services with limited availability? One of the main conclusions is that only the first impediment discussed here – the impossibility to establish beyond any doubt whether a patient got ill as a result of his/her lifestyle – is indeed a partial obstacle, which occurs only with some categories of patients under suspicion of causing their own diseases. If the arguments invoked in this article are correct, all the other obstacles mentioned are universal, and they can also occur in the case of alcoholic patients who apply for a liver transplant. The thesis that the obstacles in question do not occur with these patients, too, is based on more than questionable arguments.

What are the consequences that result from this? We can say that there are no convincing reasons behind the thesis that

only the idea is unacceptable of the universal application of the principle of individual responsibility for illness, while its application remains legitimate in the case of alcoholic patients requiring a liver transplant. In fact, the idea of applying the principle for these patients exclusively is unacceptable as well. The explanation is, I think, obvious. This principle of individual responsibility for illness is applicable only after the obstacles we have discussed have been removed. But to remove some of them – such as the patients' right to privacy, the moral requirements and principles, or the medical ethics – is itself unacceptable for at least as long as we take them seriously.

Bibliography and notes

[1]. See, for example, David Brudney, "Are Alcoholics Less Deserving of Liver Transplants?", *Hastings Center Report,* 37 (1), 2007, pp. 41-47, Walter Glannon, "Responsibility, alcoholism and liver transplantation", *Journal of Philosophy and Medicine*, 23 (1), 1998, pp. 31-49, Walter Glannon, "Responsibility and Priority in Liver Transplantation", *Cambridge Quarterly of Healthcare Ethics*, 18, 2009, pp. 23-35, Re'em Segev, "Well-being and Fairness in the Distribution of Scarce Health Resources", *Journal of Medicine and Philosophy*, 30 (3), 2005, pp. 231-260, or Barry Smart, "Fault and the Allocation of Spare Organs", *Journal of Medical Ethics*, 20 (1), 1994, pp. 26-30.

[2]. Frank Dietrich, "Causal Responsibility and Rationing in Medicine", *Ethical Theory and Moral Practice*, 5, 2002, p. 119.

[3]. The considerations in this paragraph are based on a few data about the diagnosis of the alcoholic liver disease as they appear, for instance, in Carl Cohen, Martin Benjamin, "Alcoholics and liver transplantation", *Journal of the American Medical Association*, 265, 1991, pp. 1299-1301, Michael R. Lucey, Thomas Beresford, "Alcoholic liver disease: to transplant or not to transplant?", *Alcohol and alcoholism*, 27 (2), 1992, pp. 103-108, Thomas Beresford, "The limits of philosophy in liver transplantation", *Transplant International*, 14 (3), 2001, pp. 176-177, or Dien Ho, "When Good Organs Go to Bad People", *Bioethics*, 22 (2), 2008, pp. 77-83.

[4]. Either because they do not try to change them, or because they fail in this attempt despite their best efforts.

[5]. As Charles J. Dougherty, Mike W. Martin, or Daniel Wikler have pointed out following Robert Crawford. See Robert Crawford, "You are Dangerous to Your Health: The Ideology and Politics of Victim Blaming", *International Journal of Health Services*, 7 (4), 1977, pp. 663-680, Charles J. Dougherty, "Bad faith and victim blaming: the limits of health promotion", *Health Care Analysis*, 1, 1993, pp. 115-116, Mike W. Martin, "Responsibility for health and blaming victims", *Journal of Medical Humanities*, 22 (2), 2001, pp.95-114, or Daniel Wikler, "Who should be blamed for being sick?", *Health Education and Behavior*, 14, 1987, pp. 11-25.

[6]. I include here most of the presentation I made of the Roemerian formula in Eugen Huzum, "The principle of responsibility for illness and its application in the allocation of health care: a critical analysis", in Bogdan Olaru (coord.), *Autonomy, Responsibility and Health Care: Critical Reflections*, Zetabooks, Bucharest, 2008, pp. 192-193, note 2. See also John E. Roemer, "A pragmatic theory of responsibility for egalitarian planner", *Philosophy and Public Affairs*, 22 (2), 1993, pp. 146-166, or John E. Roemer, "Equality and responsibility", *Boston Review*, 20 (2), 1995, pp. 3-7.

[7]. See, for instance, Richard Epstein et al., "Social equality and personal responsibility", *Boston Review*, 20 (2), 1995 [http://bostonreview.net/dreader/series/equality.html]., Andrew Mason, "Equality, personal responsibility, and gender socialization", *Proceedings of the Aristotelian Society*, 100, 2000, pp. 235-239, Susan Hurley, "Roemer on

responsibility and equality", *Law and Philosophy*, 21(1), 2002, pp. 39-64, or Mathias Risse, "What equality of opportunity could not be", *Ethics*, 112 (44), 2002, pp. 720-747.

[8]. Norman Daniels, *Just Health: Meeting Health Care Needs Fairly*, Cambridge University Press, New York, 2008, p. 77.

[9]. The economist Robert M. Solow does not believe either in the feasibility of the Roemerian formula. For his arguments, see his intervention in Richard Epstein et al., "Social equality and personal responsibility".

[10]. Frank Dietrich, "Causal Responsibility and Rationing in Medicine", p. 120.

[11]. For example, Hugh V. McLachlan. See Hugh V. McLachlan, "Smokers, virgins, equity and health care costs", *Journal of Medical Ethics*, 21, 1995, pp. 209-213.

[12]. The idea, too, of applying the Roemerian formula in assessing one's entitlement or merit to receive the medical services he needs – with limited availability or not – has been attacked for a similar reason. See Elizabeth Anderson, "What is the point of equality?", *Ethics*, 109 (2), 1999, p. 310.

[13]. As a matter of fact, many of the would-be arguments supporting the principle of individual responsibility for illness are, entirely or partially, moralizing discourses directed at people with health-threatening lifestyles in general and at alcoholics in particular. See, for example, Eike-Henner Kluge, "Drawing the ethical line between organ transplantation and lifestyle abuse", *Canadian Medical Association Journal*, 150 (5), 1994, pp. 745-746 or Gregory Tetrault, "The Morality of Transplantation", *Journal of the American Medical Association*, 266 (2), 1991, pp. 213-214.

[14]. John Harris, *The Value of Life. An Introduction to Medical Ethics*, Routledge, London, 1985, pp. 108-109. I insist that, apart from Harris' argument, the thesis of unacceptability on adopting moralism in the distribution of medical services is also endorsed by the fact that moralism is in itself an unacceptable phenomenon. As has been noted, far from representing a requirement of morality, moralism represents a distortion thereof. For some of the most important arguments which justify this thesis, see the excellent book coordinated by C.A.J. Coady, *What's Wrong With Moralism*?, Blackwell, Malden, 2006.

[15]. See Alvin H. Moss, Mark Siegler, "Should Alcoholics Compete Equally for Liver Transplantation?", in Helga Kuhse, Peter Singer (eds.), *Bioethics: An Anthology*, 2nd ed., Blackwell, Oxford, 2006, pp. 421-427 or Gregory Tetrault, "The Morality of Transplantation".

[16]. See Kevin Schwartzmann, "*In vino veritas*? Alcoholics and liver transplantation", *Canadian Medical Association Journal*, 141, 1989, pp. 1262-1265, Suzanne Van Der Vathorst, Carlos Alvarez-Dardet, "Doctors as judges: the verdict on responsibility for health", *Journal of Epidemiology and Community Health*, 54, 2000, pp. 162–164, or Dien Ho, "When Good Organs Go to Bad People", pp. 80-82.

[17]. Among others, by Einer R. Elhauge (in "Allocating health care morally", *California Law Review*, 92, 1994, pp. 1449-1554), Dien Ho (in "When Good Organs Go to Bad People", p. 81), or Bruce N. Waller (in "Responsibility and health", *Cambridge Quarterly of Healthcare Ethics*, 34, 2005, p. 186).