Liver transplantation in the mentally retarded

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In the field of transplantation, we are facing a gap between available ressources and demand or, more bluntly, the rationing of health care (1). The egalitarian framework of recent decades, before scarcity of available organs became a problem, allowed for enrollment on a waiting list most of the candidates proposed to transplantation. Nowadays, competition for organs focuses on patient selection and ressource allocation (2,3,4). To say that medical goods and services are "rationated" suggests a violation of patients moral and legal rights (5).

In the US, an "Americans with Disabilities Act" (ADA) promotes social justice by protecting disabled persons from discrimination and prejudice. It protects thus their wellbeing by giving them access to goods and services. However, it offers little direction about how to set priorities in case of conflict (6). An effort is now done to help make some difficult choices on morally defensible grounds (7). The use of psychological criteria to assess candidates for organ transplantation may violate the ADA. Anyway, it recognizes that it is often appropriate to take a person's disability into account when allocating organs for transplantation, for example in cases of non-compliance (8,9). To be mentally retarded does not mean non-compliance to treatment, as it is well stated in the paper we are discussing about. The patient it is dealing with is not less compliant than a child, if he is regularly given the appropriate medications. Of course, unwillingness to adhere to therapy after transplantation raises questions of justice, especially in light of the limited number of transplantable organs and the large number of patients awaiting a transplant (8).

Some philosophical concepts remain important for the allocation of organs. One is the "utilitarianism", described as maximising the overall welfare in a society (1) ; this proposition contains a bias against minorities and disabled (10). Another is the concept of "need" ; in this interesting approach, the patient who will be choosen to receive the precious organ is the one with the highest degree of illness but also the most important capacity to benefit from it (10). Even a mentally disabled person may appreciate the improvement in his quality of life brought by the transplantation ; he may also like to live.

When a mentally retarded patient is suffering from an intercurrent disease, if this disease can be cured, it should be cured. As liver transplantation is now recognized as a standard therapy for end-stage liver disease (11), it has to be performed in mentally retarded also, if they have, after grafting, the same theoretical life expectancy than non-mentally retarded patients.

Organ shortage makes this attitude questionable, as the few available grafts should be offered to the most valuable recipients. What physician may decide if one of his patients has "more value" than another ? Should he use economical, social, cultural,… grounds ? When the Titanic was sinking, would Einstein be given a seat in a lifeboat rather than a mentally incapacitated individual ? Is it legitimate to allocate lifesaving ressources predicated upon the perception that one life is worth more than another ? The answer should remain "no" (12).

Finally, a mentally disabled may be an excellent organ donor ; the principle of solidarity makes him also a good recipient (13).

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