More than 2 million Americans have an opioid use disorder (OUD). Although untreated OUD is devastating, most persons who are treated achieve remission, particularly with opioid agonist therapy (OAT), which includes such medications as methadone and buprenorphine. Each year, 12.5 million buprenorphine prescriptions are filled in the United States and 350,000 persons receive methadone (1, 2). This growing population has unique health needs, with higher prevalence of conditions that may require organ transplant, such as hepatitis C. Yet, persons with OUD may be deemed ineligible for transplant, even when they are successfully treated with OAT (3, 4). Excluding OAT recipients who could benefit from transplant may exacerbate disparities and is not based on evidence. Requires patients who are receiving OAT to meet higher standards for pretransplant adherence also sanctions differential treatment. Moreover, requiring patients to stop OAT before transplant forces a choice between a high risk for relapse and overdose death or organ failure. Failing to treat patients with OUD similarly to those with other medical conditions violates the principles of beneficence, nonmaleficence, and justice.

Transplant candidate selection is complex and is influenced by the challenges of allocation and stewardship of a scarce resource. This includes balancing justice (fairness in the distribution of benefits) with utility (maximization of benefits to the public). Formal evaluation criteria exist to balance these principles and ensure judicious allocation of organs. Although most centers require 6 months of abstinence from alcohol, tobacco, and drugs, no formal guidance about OAT exists, leaving it up to clinicians’ discretion. This may result in inconsistent and disparate access to care.

Transplant centers vary in OAT practices, which reduces transparency and equity. In 2000, a survey of liver transplant programs found that 56% accepted patients receiving methadone, but 32% required them to discontinue its use (3). A 2016 survey of 61 liver transplant programs found that 1.6% considered OAT an absolute contraindication and 37.7% considered it a relative contraindication. Of these, 50% required that patients decrease or stop OAT before being listed, which may be due to confusion between active OUD and medical treatment with OAT (4). The generalizability of these estimates nationally and to other organ programs remains unclear.

Ruling out patients because of OAT or forcing them to discontinue is misguided, particularly given the importance of posttransplant adherence. Adherence and clinical outcomes are improved with OAT. For example, patients with HIV who are receiving OAT have greater antiretroviral adherence, lower viral loads, and higher CD4 cell counts. Moreover, all-cause mortality is up to 3 times lower in patients receiving OAT, which emphasizes the importance of continuing treatment (5). Although research is limited, studies examining posttransplant outcomes have not shown worse outcomes or greater risk for relapse. The largest, a national survey of liver transplant programs, found that patients who were treated with methadone and underwent transplant had outcomes equivalent to those among patients with similar transplant indications (3). A study of 36 patients who received liver transplants while using methadone found that only 4 had a posttransplant episode of drug use, and patient and graft survival rates were similar to national averages (6). Data on buprenorphine in transplant are limited to case reports; however, all have shown successful graft function after transplant (7, 8). Given these data, uninterrupted OAT would best prepare patients for transplant.

Disqualifying patients who are receiving OAT raises several ethical concerns. First, excluding those who are likely to benefit without evidence of unjustifiably high risk is unfair and violates the National Organ Transplant Act, which requires that medically qualified patients receive equitable access to transplant. Second, given the stigma associated with OUD, placing additional scrutiny on patients may encourage bias among providers and discourage patients from seeking care. In cases of other stigmatized conditions, such as HIV, the medical community favored consideration of all medically qualified patients demonstrating similar need. Finally, although the transplant community has made strides in outreach to persons affected by OUD to facilitate donation, it must expand outreach to support greater access for those in remission. Between 2000 and 2017, the proportion of overdose-death donors increased from 1.1% to 13.4% of all donors (9). Efforts to increase donation must be balanced with efforts to expand access, reduce stigma, and ensure equitable treatment for persons with OUD. To prevent unequal treatment, patients treated with OAT who otherwise meet standard criteria should be considered eligible for transplant.

Arguments against providing transplants to patients receiving OAT may be grounded in an outdated view of addiction as volitional, misunderstanding about OAT, or concerns about wasting organs. In the past, ascribing culpability to patients for alcohol-related cirrhosis influenced transplant decisions, and similar notions of personal responsibility may underlie approaches to OUD. This is driven by stigma rather than science and improperly places clinicians in the role of moral arbiters determining worthiness rather than medical need. Focusing on personal responsibility misconstrues addiction as willful misconduct rather than a medical illness. This has effects that extend beyond transplant, such as policies that deny valve repair to persons with injection-related endocarditis.
It distorts justice in transplantation by valuing nonmedical criteria, further disadvantaging stigmatized populations. Despite evidence on OAT, some confuse successful treatment with continued addiction. Addiction is defined as compulsive use of substances despite harm; people taking medication to treat OUD do not meet these criteria any more than someone taking antihypertensives. Although utilitarian concerns are important, without data to suggest disproportionate organ waste, patients treated with OAT should not be excluded.

The history of transplantation and HIV highlights the need to update candidacy requirements as science evolves. Although HIV was once considered an absolute contraindication to transplant, improved survival rates with antiretroviral therapy changed that approach. Rates of OUD remission have similarly improved with OAT. Although outcomes after detoxification or psychosocial treatment alone are dismal, opioid abstinence among persons receiving OAT is approximately 85% (10). The time has come to update transplant guidelines to reflect the advancing field of addiction medicine. Just as antiretroviral therapy is not discontinued for transplant, stopping OAT should be equally discouraged. Some transplant guidelines recommend “convincing evidence of risk reduction behaviors” for persons with OUD, and use of OAT is a perfect example.

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