

Additional Q&A from January 15, 2026

PSECOP Ethics Webinar: *“Ethical and Pragmatic Considerations in Early Liver Transplant for Alcohol-Related Liver Disease: Patient Selection, Equity in Access, and Strategies for Success”*

Question	Response	Panelist Name
<p>Ongoing alcohol use after ALD dx was included as a risk factor in Dr. Lee’s slides. This has been proposed in some selection criteria as an absolute contraindication to early LT evaluation for alc hep. This is something our center struggles with - if patients have steatosis on US with elevated liver tests and counseled to cutback on alcohol but also weight loss, is that strictly considered an ALD dx and are those patients still evaluated or no? Overall, what is your approach to patients who have suspected ALD but never previously told about cirrhosis or alc hep and then present with alc hep?</p>	<p>If a patient has ALD but was never told by a medical professional about cirrhosis or alc hep – for our center, they would be evaluated and would have a pathway to transplant.</p>	<p>Joshua L. Sumner, LCSW</p>
<p>Does the SALT criteria of failed rehab account for relapse after long-term sobriety? In other words, does SALT consider all relapse equally -- regardless of duration of sobriety? For example, patient may have had more than 2 instances of rehabilitation but sustained sobriety for 5+ years. Then they present with MELD > 30 due to relapse and aren't candidates</p>	<p>Low SALT score has high negative predictive value, so is valuable to identify candidates at low risk. High SALT score doesn’t have high enough positive predictive value to exclude patients on the basis of high SALT score alone. So in this case, examining why the patient has a high SALT score (e.g. prior failed rehab) with more granularity should be taken into consideration during the transplant evaluation in the context of how you anticipate the patient’s AUD can be managed after transplant.</p>	<p>Brian P. Lee, MD</p>
<p>I'm curious if you could talk about "conditional" or "semi" non-directed living donation in cases where the donor specifies a</p>	<p>For our program, when a potential non-directed donor stipulates their donation to a specific population, their evaluation is</p>	<p>Joshua L. Sumner, LCSW</p>

<p>population they are not willing to donate to (i.e. donate to children but not adults; not patients with AUD, etc.) from a bioethical perspective.</p>	<p>stopped as they are no longer a good fit for donation. We discuss and reframe that we are asking for trust that we will select a recipient that will utilize the donation appropriately. Ethically, we worry about a slippery slope argument, meaning we want to steer clear of selection based on race, sex, ethnicity, orientation, etc.</p>	
<p>What are your recommendations in initiating the discussion regarding abandoning the 6 month sobriety requirement?</p>	<p>For leadership, evidence-based research speaks volumes. My recommendation is to begin by presenting the plethora of published research available. The researcher everyone quotes first is Dr. Philippe Mathurin out of Lille, France.</p>	<p>Joshua L. Sumner, LCSW</p>
<p>Are there any validated instruments to assess insight?</p>	<p>Please refer to the following systematic review on the topic, which includes one example of an insight rating scale (Hopkins Psychosocial Scale). https://pubmed.ncbi.nlm.nih.gov/37016758/</p>	<p>Josée Lynch, MD</p>
<p>Do most folks distinguish between noncompliance and nonadherence terms? I have been using the terms interchangeably but if people generally understand the difference you described I would like to start doing that. Right now I do provide context for why someone is doing what is not recommended.</p>	<p>Often the terms are used interchangeably. Non-adherence is patient-centered and assumes shared decision making with the treatment team (preserves autonomy). Non-compliance is accusatory and punitive, and provider-centered (creates paternalism). Teams using the term “nonadherence” sets a tone of solution focused planning. Examples include: medication affordability, transportation struggles, memory struggles, and misunderstandings. Noncompliance assumes the patient is at fault and is willfully disobedient.</p>	<p>Joshua L. Sumner, LCSW</p>
<p>Can you all share your perspectives of whether these evaluation and selection</p>	<p>If these selection practices are done with care and respect for the patient, and if they</p>	<p>Alexander Zambrano, PhD</p>

<p>practices should really be unique to ALD, or would it be less stigmatizing/more beneficial for this to be applied for all recipient candidates with AUD, regardless of their liver disease etiology?</p>	<p>advance the success of the intervention better than not doing them, they are morally defensible.</p> <p>There needs to be recognition that liver transplant treats end stage liver disease, which can be a byproduct of AUD, but does not necessarily treat or eliminate AUD. Since AUD can affect post-transplant outcomes (e.g. AUD has direct and indirect effects on the graft, including direct liver injury from alcohol, issues with adherence in the setting of alcohol misuse, etc.), it's critical that AUD be thoroughly evaluated and assessed during the transplant evaluation, and appraised both for selection, but also for post-transplant care.</p>	<p>Brian P. Lee, MD</p>
<p>Is there a very easy to read guide to interpreting Peth test results?</p>	<p>PEth test results and interpretation are ultimately left to the physician. For social work, we use this <u>basic guide</u> as a <u>starting point</u>.</p> <p><small>Measured PEth values are often evaluated against the following 3 tiers for the purpose of interpretation:</small></p> <ul style="list-style-type: none"> • <10ng/ml - not detected. • <20 ng/ml - Light or No Consumption - Supports claim of abstinence or low alcohol consumption up to a month prior to specimen collection. Low alcohol consumption is considered as <u>≤1-2 standard alcoholic drinks per day for several days a week.</u> • 20-200 ng/ml - Significant Consumption - Indicates moderate level of alcohol consumption up to a month prior to specimen collection. Significant alcohol consumption is considered as <u>2-4 standard alcoholic drinks per day for several days a week.</u> • >200 ng/ml - Heavy Consumption - Indicates Excessive alcohol consumption up to a month prior to the specimen collection. Heavy alcohol consumption is considered as <u>more than 4 standard alcoholic drinks per day for several days a week.</u> <p><small>Note: The frequency of alcohol consumption can affect PEth results; ten drinks consumed in one episode will produce a higher PEth level than if ten drinks were consumed in five episodes.</small></p> <p><small>Standard drink:</small></p> <ul style="list-style-type: none"> - 12 oz beer at 5% (6 pk 72oz, case 288oz, cube 360oz) - 8.5 oz of malt liquor at 7% - 5 oz of wine at 12% - 1.5 oz of distilled at 40% 	<p>Joshua L. Sumner, LCSW</p>
<p>Regarding the support mentioned (the pt needs to have support, others living with them</p>	<p>Potential candidates who do not have a safe, stable living situation that cannot be</p>	<p>Joshua L. Sumner LCSW</p>

<p>need to commit to sobriety), how does that work for patients with AUD in their family/household or who don't have a stable living situation? It seems interesting that the roommates have a responsibility to be sober for the pt's sake.</p>	<p>remedied may be ineligible for transplant. An important facet of addiction treatment is to remove temptations and triggers. If family/household/roommates are unwilling or unable to remove or reduce temptations or triggers – this can create an extraordinary risk for substance use relapses.</p>	
<p>Can you please speak to how your programs consider higher MELD candidates who do not meet AAH criteria but also do not have 6 months of sobriety? We often see patients who have a non-alcohol related decompensating event after 2-3 months of sobriety and struggle with how to classify them.</p>	<p>Our ALD program in Toronto does not distinguish between AAH and chronic liver disease in terms of selection criteria, or access to integrated addiction treatment. All patients referred for liver transplant consideration whose liver disease is secondary to alcohol (including MetALD) are assessed via the ALD pathway, and provided with addiction follow-up post-transplant.</p>	<p>Josée Lynch, MD</p>
<p>Does lower priority policy apply to other populations of patients such as NAFLD?</p>	<p>It depends on the specific case and whether the patient is morally responsible for their fatty liver disease. The responsibility principle, which undergirds the lower priority policy, applies to any condition that patients are morally responsible for. For this reason, my own view is that it is best to avoid utilizing the lower priority policy in the case of ARLD, since consistency would demand we utilize responsibility as a factor in other contexts where responsibility is a factor.</p>	<p>Alexander Zambrano, PhD</p>
<p>An suggestions for helping patients believe in a "reset" on standards as so many patients are aware of stigma and rules re: use and transplant. Many folks come in already incentivized to not be straightforward about use; how to defuse this and promote openness?</p>	<p>The short answer is nonjudgemental, empathic listening. The incentive to lie is overpowering. I often reframe my questions using an administrative or protocol approach that can elicit a more truthful response. "Accuracy regarding your history is important. This helps with how best to</p>	<p>Joshua L. Sumner LCSW</p>

	<p>assist, maintain surgical safety, and what treatment path is most beneficial to you. Details are important.” This is a struggle for all programs.</p>	
<p>How is ability to maintain sobriety impacted by previous bouts of sobriety? For example, a patient who relapsed but was previously sober for 5 years.</p>	<p>AUD is a relapsing and remitting disease, so relapses should be prevented, are still to be anticipated and expected. I evaluate the circumstances of past sobriety, which includes not only duration, but also why they became sober, what caused them to relapse (i.e. trigger), how much insight and motivation do they have into those circumstances, what would be their plan if they were to face a similar trigger after transplant, etc.? The point of asking these questions is to evaluate whether the patient’s AUD is anticipated to be manageable after transplant - clearly the patient was able to have a period of sustained abstinence in the past, which is a positive sign, so understanding the circumstances in more granularity can help to assist whether sobriety can be sustained after transplant.</p>	<p>Brian P. Lee, MD</p>
<p>Without a period of proving commitment to sobriety, is there a clear boundary set of if you return to significant use you would not be eligible for another liver transplant or would we advocate for retransplanting under this program?</p>	<p>After transplant, if a patient returns to significant alcohol use, they are not eligible for a second transplant.</p>	<p>Joshua L. Sumner LCSW</p>
<p>How do you manage those who drink post TP? They are harder than those waiting as we can make them inactive.</p>	<p>In our program in Toronto, all patients transplanted for ALD have addiction psychiatry follow up. For those who drink post-transplant, this follow up is intensified</p>	<p>Josée Lynch, MD</p>

	<p>to assist patients in re-establishing abstinence. Integrated addiction psychiatry follow up allows for earlier detection of return to drinking, which hopefully translates to earlier re-intensification of treatment to prevent alcohol use from resulting in recurrence of cirrhosis.</p>	
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