The United Network for Organ Sharing (UNOS) — Two Policies

UNOS maintains lists of people who need organs and matches donated organs to them. It also develops policies on how to allocate organs according to the two goals of legislation passed in 1984: to be fair and to be useful (don’t waste organs and do use them well). Under the UNOS organizational system, the United States is divided into 62 local areas, grouped into 11 regions. A local organ procurement organization (OPO) operates within each of the 62 areas.

Pre-1998 UNOS Liver-Allocation Policy

FACT 1: Before 1998, if you needed a liver transplant, you were given a status based on your lab tests, the symptoms of your liver disease, and the amount of time you had spent on the waiting list.

Status 1: Sudden liver failure, transplanted liver failed to function, expected to die in seven days or fewer without transplant.

Status 2A: Chronic liver disease, expected to die in seven days or fewer without transplant based on objective and subjective medical criteria.

Status 2B: Chronic liver disease, need for a liver transplant was becoming more urgent, not as sick as Status 2A patients based on objective and subjective medical criteria.

Status 3: Chronic liver disease but not hospitalized.

FACT 2: If you were waiting for a liver, three other key features of the policy determined when and how you received one:

UNOS allocated livers locally, then regionally, then nationally. When a liver was available in an OPO local area, all Status 1, 2A, 2B, and 3 candidates in that area had a chance to receive the organ before anyone at the regional level. If you were dying and lived close to—but not in—an OPO local area with a liver, a Status 3 patient who lived in the area would receive the liver instead of you.

The severity of the patient’s illness was important. Medical judgment about symptoms figured into the status ranking, yet doctors differed in their interpretation of symptoms. For example, one doctor might decide you were Status 2A; another might say you were Status 2B.

The amount of time a candidate had been on the waiting list for a transplant was important. That amount of time didn’t indicate how sick you were, though. Doctors decided when to put patients on the waiting list, based on their own judgment. One doctor might add his patients to the waiting list early in their disease, and they might still be quite healthy when they reached the top of the list. Another doctor might add patients to the waiting list late in their disease, when they truly needed a liver. By the time a person reached the top of the list, he or she could be quite ill and might not survive.
Current UNOS Liver-Allocation Policy

**FACT 1:** Today, if you are so sick that you will die within one week without a liver transplant, you are **Status 1.**

If you are not expected to die within one week without a liver transplant, you are given a **Model for End-Stage Liver Disease (MELD)** score based on blood tests for

- bilirubin (reflects the liver’s ability to excrete bile);
- INR (reflects the liver’s ability to make blood-clotting factors); and
- creatinine (reflects kidney function—the more severe the liver disease, the more likely someone is to have poor kidney function).

The MELD score predicts your risk of death without a liver transplant over the next three months. The higher your score, the higher the chance you will die. Scores range from 6 to 40 (40 is most sick).

**FACT 2:** If you are waiting for a liver, one will be offered to you depending on your status. Here’s how status is ranked:

1. Status 1 patient within the local area
2. Status 1 patient within the regional area
3. Patient within the local area with a MELD score greater than 15
4. Patient within the regional area with a MELD score greater than 15
5. Patient within the local area with a MELD score less than 15
6. Patient within the regional areas with a MELD score less than 15
7. Status 1 patient within the nation
8. Patient within the nation with the highest MELD score