

# Tragic Choices and Moral Compromise: The Ethics of Allocating Kidneys for Transplantation

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**Context:** For almost a decade, the Kidney Transplantation Committee of the United Network for Organ Sharing has been striving to revise its approach to allocating kidneys from deceased donors for transplantation. Two fundamental values, equality and efficiency, are central to distributing this scarce resource. The prevailing approach gives primacy to equality in the temporal form of first-come, first-served, whereas the motivation for a new approach is to redeem efficiency by increasing the length of survival of transplanted kidneys and their recipients. But decision making about a better way of allocating kidneys flounders because it is constrained by the amorphous notion of “balancing” values.

**Methods:** This article develops a more fitting, productive approach to resolving the conflict between equality and efficiency by embedding the notion of compromise in the analysis of a tragic choice provided by Guido Calabresi and Philip Bobbitt. For Calabresi and Bobbitt, the goals of public policy with respect to tragic choices are to limit tragedy and to deal with the irreducible minimum of tragedy in the least offensive way. Satisfying the value of efficiency limits tragedy, and satisfying the value of equality deals with the irreducible minimum of tragedy in the least offensive way. But both values cannot be completely satisfied simultaneously. Compromise is occasioned when not all the several obligations that exist in a situation can be met and when neglecting some obligations entirely in order to fulfill others entirely is improper. Compromise is amalgamated with the notion of a tragic choice and then used to assess proposals for revising the allocation of kidneys considered by the Kidney Transplantation Committee.

**Findings:** Compromise takes two forms in allocating kidneys: it occurs within particular approaches to allocating kidneys because neither equality nor

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efficiency can be fully satisfied, and it occurs over the course of sequential approaches to allocating kidneys that cycle between preferring equality and efficiency. Ross and colleagues' Equal Opportunity Supplemented by Fair Innings proposal for allocating kidneys best exemplifies the rationality of compromise as a way of achieving the goals of making a tragic choice.

**Conclusions:** The attempt to design a policy for allocating kidneys from deceased donors for transplantation by balancing the values of equality and efficiency is misguided and unhelpful. Instead policymaking should both incorporate compromise into discrete approaches to allocating kidneys and extend compromise over sequential approaches to allocating kidneys.

**Keywords:** allocation of health resources, kidney transplantation, compromise, tragic choices.

The object of public policy must be . . . to define, with respect to each particular tragic choice, that combination of approaches which most limits tragedy and which deals with that irreducible minimum in the least offensive way. Of course, that combination will vary, not only over time . . . but also from society to society, since the object is to find the approach which is least destructive of values fundamentally held in each society.

Guido Calabresi and Philip Bobbitt, *Tragic Choices*

**T**HE TRAGIC CHOICES OF INDIVIDUALS AND SOCIETIES SEEM beyond reason. *Sophie's Choice* is a memorable fictional example (Styron [1976] 1999), in which an SS doctor at Auschwitz forces Sophie to choose which of her two children will die by threatening to send both to the gas chamber if she does not choose. Jillian's choice, however, was not fictional. Jillian Searle is an Australian mother who was caught with her five-year-old son, Lachie, and her twenty-month-old son, Blake, in the tsunamis that swept over Phuket, Thailand, in 2004. In a television interview, she said that she knew all of them would die if they stayed together, so she "had to let go of one of them and I just thought, I had better let go of the one that is oldest" (Blatchford 2005, A3).

As Jillian's explanation reveals, her tragic choice was not beyond reason. In the interview, she discloses that Lachie could not swim and that he "is petrified of water—even the pool at home" (Blatchford 2005, A3). Those features of their desperate situation compounded the tragic nature of her choice but did not move it beyond reason. That a five-year-old child has more capacities than a twenty-month-old infant, and

thus a better chance of surviving, remains a legitimate reason for letting go of her older son. Miraculously, Lachie was able to cling to a pole or doorknob until a second tsunami receded, after which he was found by a security guard. Sophie's dilemma was worse. She, too, could only hope that a miracle would save the child she chose, and she had no morally tolerable reason for choosing between her son and her daughter.

Policymakers are removed from the devastating heartbreak, sorrow, and guilt of personal tragic choices. Their tragic choices on behalf of society enact generic policies or perpetuate the status quo, both of which create faceless vulnerabilities and distribute anonymous risks. How can societies propagate policies that affect their citizens profoundly and irrevocably and implement those policies without resorting to extreme coercion? To be accepted, the policies have to be, and be regarded to be, necessary, effective, fair, and responsible. There are, however, various notions of effectiveness and multiple forms of fairness, none of which can dominate the others and prevail unstintingly, and all of which inevitably conflict. Consequently, the moral burden of legitimacy and responsibility falls not just on the tragic choice itself but also on how the tragic choice is made.

The seminal work of Guido Calabresi and Philip Bobbitt (1978) examines the methods that societies can use to make tragic choices about the allocation of scarce resources and the diverse ways in which three societies—the United States, England, and Italy—have used those methods in shifting policies on conscription, limits on childbearing, and, before transplantation became an option, the allocation of kidney dialysis machines. Compromise is a natural, ultimately inevitable, way of making such tragic choices because it recognizes the fundamental nature of a tragic choice: that even though none of the important conflicting values can be abandoned, a choice must be made.

Compromise pervades our lives and is a helpful way of resolving all sorts of familiar disagreements and conflicts, for example, in mediating the division of property and custody of children after a marriage breakdown, in negotiating the terms of a contract or piece of legislation, in arbitrating a dispute about a labor agreement, and in parental wrangling with children. Moral compromise is occasioned when not all the several obligations that exist in a situation can be met, yet it is improper to neglect some obligations entirely to satisfy others fully. Opting to fulfill one of the conflicting obligations does not remove the other obligations or reduce their force. The persistence of those undiminished, unfulfilled obligations leaves a continuous moral residue, the recognition of which

can produce regret and, sometimes, as in the tragic choices of Sophie and Jillian Searle, remorse and guilt. The extent to which this residue is expressed and how strongly it is expressed differ, of course, in the intimate tragic choices of parents and the detached tragic choices of policymakers. It is the existence, not the expression, of moral residue, however, that is crucial to compromise. Personal tragic choices are used to illustrate features of tragic choices and compromise. The impersonal decisions of policymakers are not the personal decisions of parents—are not personal decisions writ large—but notwithstanding the differences between personal and impersonal decisions, both can require moral compromise. Whether those differences might affect how compromise operates in personal and impersonal decisions is a matter for another occasion.

Despite its usefulness and its ubiquity, compromise is ignored and anathematized by moral philosophy. When moral principles conflict, compromise would preserve the conflict and thereby preserve inconsistency among the principles, which is logically intolerable. Compromise nevertheless plays an essential role in our lives and is rationally and morally warranted. This defense of compromise in moral policymaking proceeds from the challenges of allocating the scarce resource of kidneys from deceased donors for transplantation. Calabresi and Bobbitt focus on the fundamental values of society that tragic choices expose—the preciousness of life, well-being, equality, efficiency, and honesty, for example—and the various methods that can be used to make tragic choices—a lottery, a market, a responsible governmental body, and a nonresponsible parajury, for example. For them the goals in making a tragic choice are to affirm the fundamental values that need to be affirmed and to degrade the fundamental values that have to be degraded in the least destructive manner. Pursuing those goals requires ethics as design and compromise: designing methods for making tragic choices and processes for deciding among those methods that use compromise to both affirm and preserve, to the extent possible, the fundamental values of society.

## The Nature of Tragic Choices

Agonizing choices are sometimes tragic and sometimes not. What is the difference? Why are tragic choices not just hard choices about big stakes? Calabresi and Bobbitt do not offer any criteria for distinguishing

difficult choices from tragic choices; instead, they provide examples of choices they take to be tragic and rely on the ability of readers to identify tragic choices. In introducing their comparison of how Italy, England, and the United States allocate renal dialysis units, for instance, they describe the problem as “a paradigmatic tragic choice” (1978, 177).

Even if a tragic choice cannot be precisely and exhaustively defined, however, it can be elucidated. Distributions of scarce goods that entail “great suffering or death,” Calabresi and Bobbitt explain, “arouse emotions of compassion, outrage, and terror,” which reveal conflicts between, on the one hand, the source of the scarcity and the values used to determine the recipients of the scarce good and, on the other hand, “those humanistic moral values which prize life and well-being” (1978, 18). It is hard to imagine suffering worse than the great suffering of living through the latter stages of amyotrophic lateral sclerosis (Lou Gehrig’s disease), for example, but the suffering that attends a life on dialysis and shadowed by death, if not comparably great, nevertheless is vast. Still, we all die, and not all deaths are tragic, and even great suffering might not be tragic if it somehow could be redeemed.

Moreover, great suffering and death might not be the outcomes of tragic choices. Tragic choices can be tragic when their outcomes are not tragic, as the different outcomes of Sophie’s choice and Jillian Searle’s choice demonstrate. One of Sophie’s children died as a result of her tragic choice. The loss of her daughter was calamitous, grievous, and desolating for Sophie, but that tragic outcome was not only what made her choice tragic. Although both of Jillian’s children survived despite her choice, her choice was nonetheless tragic. The nature and source of a choice, not just the outcome or, for Jillian, not at all the outcome, are what make a choice tragic.

The big stakes in a tragic choice are not those that invite enormous gains but those that threaten momentous losses. Like Sophie’s choice, Jillian’s choice pitted her love for one child against her love for another child. Whatever choice either woman made would have violated the foundational ideals and obligations of motherhood. Good mothers, because they are mothers, care for and treat all their children equally. Both Sophie and Jillian were forced to subjugate their love and their loving for one child to preserve their love and their loving for another child. They had to repudiate fundamental values that could not be repudiated. The tragedy of their choices lies in the irresistible acceptance of

the unacceptable—that even consummate maternal love cannot remain inviolate in the face of fate.

Tragic choices leave a residue because they do not resolve but, rather, perpetuate the conflict that necessitated the choice. Sophie's love for and commitments to Eva did not die with her daughter, and Sophie's despair about her breach of her maternal responsibilities never would disappear. Styron's novel recounts Sophie's subsequent moral and personal disintegration. Although Jillian will not be similarly devastated, she never will forget the tragic choice to abandon her son. Her regret and guilt will be assuaged but not expunged.

The source of a tragic choice also can be part of its tragic nature. The tragic choices of Sophie and Jillian are externally imposed, Sophie's by society and Jillian's by nature. Tragic choices also can be self-imposed. In the afterword to an anniversary edition of *Sophie's Choice*, Styron explained that the book was partly inspired by *Five Chimneys*, a memoir written by Olga Lengyel, who was transported to Auschwitz with her family in 1944. Of the horrors that Lengyel graphically and starkly described, the one that Styron found "most chilling of all, somehow, surpassing the butcheries and beatings," is

the description of the author's arrival at the camp in a boxcar, and the decision she was forced to make about her mother and one of her children. Confused, and unaware of the lethal workings of the selection process, Lengyel lies about her twelve-year-old son's age, telling the SS doctor that the boy is younger than he is, in the mistaken belief that this will save him from arduous labor. Instead of being spared, the boy is sent to the gas chambers, along with his grandmother, whom Lengyel, again in ghastly error, helps kill. She asks the doctor that her mother be allowed to accompany the child in order to take care of him. ([1976] 1999, 601–2)

In the horrors of the situation, her confusion, and her ignorance, Lengyel makes two tragic mistakes. In almost any other circumstances, her lie about her son and her request for her mother would be understandable and reasonable. She is a loving mother and a loving daughter who, caught in desperate straits, desperately wants to care for and protect her son and her mother. But in a foreign, depraved world of relentless barbarity and cruelty, she cannot save them from misery and save their lives. She will be consumed by grief and remorse for the momentous losses and also by self-blame and guilt for the misunderstandings that brought about those losses. She will hold herself culpable. Her flaws are

not the flaw of hubris that inevitably dooms the protagonists in Greek tragedies, but they are tragic flaws nevertheless. The outcomes of her choices were truly tragic, but so were her choices.

In tragic choices, the stakes are not just high stakes but high moral stakes. Tragic choices devolve from conflicts between fundamental moral values, none of which can be renounced. Calabresi and Bobbitt recognize the essential moral nature of tragic choices: Tragic choices involve “humanistic moral values which prize life and well-being,” and when a tragic choice about allocating scarce resources is successful, it “does not appear to implicate moral contradictions” because it averts “morally debasing outcomes” (1978, 18). Two implications follow from the moral nature of a tragic choice. One is that because moral decisions must be rational decisions, tragic choices must not be beyond reason. Tragic choices have goals. The goals of a tragic choice, set out in the epigraph to this article, are to limit tragedy as much as possible and to manage ineliminable tragic destruction of fundamental moral values in the least offensive way. Calabresi and Bobbitt do not explain what “the least offensive way” means, but it is plausible to surmise that properly managing the destruction of fundamental moral values has both a substantive and a procedural dimension. The substantive constraint prohibits both outcomes that “appear to implicate moral contradictions” because they are “morally debasing” (1978, 18) and outcomes that are arbitrary or discriminatory. The procedural requirement mandates a process that fits the nature and context of the particular tragic choice that must be made. Reason can guide the design of an appropriate decision-making process as well as the selection of a regrettable but defensible outcome.

The other implication of the moral nature of a tragic choice is that when none of the conflicting fundamental values can be abandoned, a tragic choice must in some way retain fidelity to the values lost or left unsatisfied. As Calabresi and Bobbitt recognize, tragic choices only “appear” to remove underlying moral contradictions. For the inescapable, singular tragic personal choices of Sophie, Jillian Searle, and Olga Lengyel, fidelity to forgone motherhood is expressed by unending regret, accompanied by varying forms of remorse and guilt. Those emotions are affirmations of the moral residues of their choices. For Sophie and Olga Lengyel there is no salvation; for Jillian Searle there is solace.

Those two implications also hold for tragic social choices. Making tragic social choices in the least offensive way requires that those choices emanate from a rational decision-making process, and the operation of

compromise in that process retains fidelity to all the conflicting fundamental values. In policymaking at a given time, the mixture of methods for making a choice is a compromise that minimizes the tragic outcome of not being able to satisfy all the conflicting fundamental values by satisfying each proportionately to its importance in the current circumstances. In policymaking over time, compromise takes the form of cycling through conflicting fundamental values by giving each alternate primacy. With rational processes for the twofold operation of compromise at a time and compromise over time, tragic choices about allocating kidneys for transplantation are not beyond reason.

### Approaches to Allocating Kidneys for Transplantation

According to statistics provided by the National Kidney Foundation, as of April 29, 2013, 95,903 people in the United States were waiting for a kidney transplant (National Kidney Foundation 2013). In 2012, 16,812 kidney transplants were performed in the United States, of which 11,043 came from deceased donors and 5,769 from living donors (National Kidney Foundation 2013). So almost 80,000 people now on the list, with more continually added, must wait, many for a long time, and some will die while they are waiting. With the opt-in donation policy in the United States, kidneys from deceased persons may be used for transplantation only if that person explicitly consented, for example, by completing a donor card or signing a driver's license. Sometimes, however, family members are, in practice, allowed to override that consent. Donations from living donors modestly reduce the discrepancy between the need for and the availability of kidneys. Living donations can be directed to a specific recipient, for example, a family member or friend, or nondirected, in which case the recipient is determined based on medical compatibility with a patient in need (United Network for Organ Sharing 2013). The analysis in this article pertains only to the tragic choice that society has to make about designing a system for allocating kidneys from deceased donors.

Allocating kidneys from deceased donors for transplantation is the process of determining which patients will be put on the waiting list for a transplant and the sequence in which kidneys that become available will be offered to the candidates on that waiting list. Different



organ allocation systems have different goals. The goal of the liver and lung allocation systems is to minimize death on the waiting list. The lung allocation system also strives to maximize survival in the first year after transplant. The kidney allocation system affirms and degrades, in different ways, to different degrees, and at different times, the values of equality and efficiency.

When kidney transplantation was being introduced and its success needed to be proved, the obstacle that had to be overcome was the body's rejection of a foreign kidney. To reduce the risk of having transplanted kidneys rejected, tissue-type testing was used to assess how closely a candidate "matched" a donated kidney, and matching continues to be used in allocation decisions. With the development of antirejection drugs, however, the importance of matching decreased, and considerations of fairness became salient. For more than twenty years, kidneys have been allocated primarily on the basis of first-come, first-served, a familiar and simple way of according equal respect to persons in distributing scarce goods. For almost a decade, the Kidney Transplantation Committee (KTC) of the Organ Procurement and Transplantation Network (OPTN) has been developing recommendations for revising the current allocation system. OPTN is operated by the United Network for Organ Sharing (UNOS), which is a private, nonprofit organization under contract with the federal government.

### *The Current System*

The current kidney allocation system assigns points that recognize relevant medical and moral features of candidates to rank-order those on the waiting list. Everyone cumulatively receives one point for each year on the waiting list. Points are assigned to compensate candidates who are highly sensitized, that is, candidates who are substantially more likely to reject a kidney or for whom a long time may be needed to find a suitable donor, and to match candidates and donors in a way that is likely to enhance the success of a transplant. Highly sensitized candidates are assigned four points. The process of matching kidneys and candidates to predict the likelihood of kidney survival compares the human lymphocyte antigens of the donor and the candidate (HLA matching). Each person has three pairs of these antigens—A, B, and DR—so the maximum match or mismatch is six. The fewer mismatches

there are, the greater the likelihood of the kidney's survival is, so having zero mismatches is best. The extent to which the A, B, and DR antigens affect kidney survival varies, however, with the DR antigen having the strongest influence. Candidates receive one extra point for one DR HLA mismatch and two extra points for a zero DR HLA mismatch. Relatively few candidates get two points; more candidates get one point. Candidates who have been living donors are rewarded with four extra points, but they are rare. Overall, time on the waiting list is the major determinant of priority for a transplant.

The current approach has two perceived weaknesses that have prompted proposals for improving it. One is that it does not seek to optimize the length of the kidney's and the candidate's survival by matching the donated kidney's likely longevity and the recipient's likely longevity. A kidney capable of functioning for decades could, for example, be allocated to an elderly candidate who has only a few years to live. The other weakness is that it does not minimize death on the waiting list because it does not recognize that different candidates have different prospects of surviving the wait for a transplant.

The current system does not promote the value of efficiency—getting the most posttransplant life-years for kidneys and recipients from a scarce resource—and it does not recognize the value of rescuing lives. The value of equality, in the temporal form of first-come, first-served, dominates the current system.

### *The Original 20/80 Proposal*

The Kidney Transplantation Committee's initial proposal for revising the current allocation system, which was released for responses on February 16, 2011 (OPTN 2011), introduced two changes, one major and one minor. The major change would be to combine two different methods for matching kidneys and candidates—survival matching and age matching—that are designed to increase the longevity of both the kidneys and the recipients. A kidney donor profile index was created to assess the quality of a donated kidney and, on that basis, to estimate how long the kidney would be likely to function after transplant. An estimate of the length of candidates' posttransplant survival also was created based on four factors: age, length of time on dialysis, any prior organ transplant, and diabetes status. The highest-quality kidneys currently

comprise 20 percent of the pool of donated kidneys. Survival matching would offer the 20 percent of kidneys with the longest expected length of function to the 20 percent of candidates who have the longest expected length of life. Age matching would be used to allocate the remaining 80 percent of kidneys, which would be offered to candidates who are between fifteen years older and fifteen years younger than the donor.

The minor change would be in how the waiting time would be calculated in rank-ordering the candidates within the survival-matching and age-matching categories. In the current system, waiting time is calculated primarily from when a candidate is placed on the list. In this proposal, the calculation of waiting time would be backdated to the most recent start of chronic maintenance dialysis if the candidate had been listed after this date, and if the candidate previously had had a kidney transplant, the waiting time would be calculated from the most recent initiation of dialysis. Points also would start to accrue if the GFR (glomerular filtration rate), a measure of kidney function, fell below 20. Currently, a significant number of candidates who have the advantages of timely access to care and ready connections to the kidney transplantation system can start accumulating points early and thereby improve their priority, even to the point of having a transplant before they start dialysis. With the changes in the calculation of waiting time, that possibility would still exist but would be less likely.

Whereas equality is the dominant value in the current allocation system, the combination of survival matching and age matching makes efficiency—correlating the projected longevity of the kidneys and the candidates—the dominant value in the original 20/80 proposal. The changes in calculating the waiting time, however, support equality by removing an unfair disadvantage and precluding an unfair advantage.

### *The Amended 20/80 Proposal*

The original 20/80 proposal's dramatic switch in values did not last long. It succumbed, nine months after it was released, to the concern expressed by the Office of General Counsel and the Office of Civil Rights in the U.S. Department of Health and Human Services that age matching contravenes the requirements of the 1975 Age Discrimination Act (KTC 2011a, 2011b, 3). The 20/80 proposal, as subsequently amended and released for public comments on September 21, 2012 (KTC 2012, 22),

retains the 20 percent survival matching and allocates the remaining 80 percent of kidneys on the basis of modifying waiting time to dialysis time or  $\text{GFR} < 20$ . The amended 20/80 proposal modestly promotes the value of efficiency and preserves the strong commitment to temporal equality in the form of first-come, first-served.

### *Equal Opportunity Supplemented by Fair Innings (EOFI)*

Independently of the work of the Kidney Transplantation Committee, L.F. Ross and colleagues proposed an approach (2012) to allocating kidneys that uses age to enhance equality and efficiency concurrently without, they claim, discriminating on the basis of age. The two components of their approach operate sequentially. The first step is equal opportunity (EO), which is designed to give candidates of all ages an equal chance of receiving a kidney. The second step is fair innings (FI), which allocates the higher-quality kidneys to the younger candidates who are worse off because they developed end-stage renal disease (ESRD) at an early age and consequently have had fewer years of healthy life. Age groups are created for candidates, and age ranges are created for donors. To give each candidate an equal opportunity to receive a kidney, the number of kidneys allocated to each age group is proportional to the number of candidates in that age group. Then, starting with the kidneys in the youngest donor age range and moving through the consecutive donor age ranges to the kidneys in the oldest age range, kidneys are distributed across the candidate age groups, starting with the candidates in the youngest age group and moving through the consecutive age groups to the candidates in the oldest age group. Within the candidate age groups, kidneys are allocated to particular individuals primarily on the basis of their waiting time on dialysis.

Unlike the two independent components of both the original and the amended 20/80 proposals, the EO and FI components are integrated. Embedding the FI component within the EO component produces two different kinds of equality—statistical, not temporal, equal opportunity to receive a transplant and rectificatory equal opportunity to have a normal life span. Moreover, integrating EO and FI produces a synergy of equality and efficiency because redressing the disadvantage of the younger candidates concurrently aligns the expected life spans of

the candidates and the kidneys. The EOFI proposal strongly promotes equality and efficiency.

In all these approaches, the value of efficiency is understood in the same way: extending the length of survival of both candidate and kidney. The value of equality, however, is understood in different ways and instantiated by different methods. The diverse conceptions and methods of equality generate disparate approaches to making tragic choices about allocating kidneys.

### Making Tragic Choices

Kidney transplantation extends the lives of recipients and vastly improves their quality of life, thereby engaging what Calabresi and Bobbitt call “the principal humanistic value at stake . . . in every tragic situation, life, or its correlative, well-being” (1978, 23). Because kidneys from deceased (and living) donors are scarce, kidney transplantation also engages the fundamental values of equality and efficiency. The societal decision to restrict the procurement of kidneys from deceased donors to those who signed a donor card, that is, to adopt an opting-in policy, is a tragic choice that substantially contributes to the scarcity of a resource that alleviates suffering and postpones death. The ensuing societal choices about how kidneys from deceased donors will be allocated are tragic choices that determine whose suffering will be abated and whose life will be extended.

Calabresi and Bobbitt distinguish those two independent but related tragic choices. How much of a scarce good there will be is a “first-order determination”; who will get the scarce good is a “second-order determination.” The scarcity of kidneys for transplantation results from a panoply of first-order social determinations that have been made about the medical, institutional, and financial resources that are available for organ procurement and transplantation and the policies that control and limit the donation of kidneys. Those choices manifest a diversity of fundamental values. Prominent among those values is individual free choice, which is the basis of an opting-in procurement system, but also prevails in the offer-and-acceptance practice of allocating kidneys. When a kidney becomes available, it is offered to the eligible candidate on the waiting list, who then has the option of accepting it or declining it and waiting for a higher-quality kidney. Which candidate ultimately gets

to make that choice is the result of second-order policy determinations of which various methods are used to allocate kidneys and how various ways are used to combine those methods.

Procedural and substantive values infuse both methods of making tragic choices and approaches to deciding what methods should be used and how those methods should be combined. Different methods, as Calabresi and Bobbitt recognize, have different strengths and different weaknesses. A pure lottery, for example, is objective, certain, simple, clear, and completely egalitarian. A political agency that is responsible to its constituents is centralized and distanced, whereas an agency or parajury that is not responsible to its constituents is decentralized, hence more attuned to the values of a local region. Moreover, different procedures can impose various costs. A method that seems arbitrary and capricious because it does not explain decisions creates anxiety and frustration. Uncertainty about how and why decisions are made also can compel anxious, vulnerable claimants to reveal intimate, hopefully persuasive, details about their lives. Methods are selected and amalgamated in ways that promote the substantive values deemed most important. In addition, the procedural values displayed in the process of designing methods into an approach for allocating kidneys—openness, transparency, and honesty—contribute strongly to fostering and sustaining the public trust that such a tragic choice vitally needs.

Ultimately, however, the respective importance of the substantive values of equality and efficiency in allocating kidneys must be settled. Tragedy is to be limited as much as possible, but tragedy can only be limited, not eliminated. And often tragic choices will not remain stable. Fundamental values that have been displaced or only partially satisfied will not remain that way forever, and fundamental values that have been prized cannot long escape being relegated. So how is the dynamic nature of tragedy handled?

By cycling, Calabresi and Bobbitt explain. One form of cycling is shifting back and forth between second-order and first-order determinations to reduce tragedy to a socially tolerable level. This strategy exploits the interdependence of first-order determinations and second-order determinations: when the number of people who can get a scarce fundamental good becomes drastically low or the distribution of a scarce fundamental good becomes blatantly inequitable, pressure builds to increase the supply of that scarce good, and yielding to that pressure reduces the tragedy to an endurable magnitude. Another form of cycling operates within

second-order determinations by shifting among methods of allocation that accord different priorities to fundamental values.

From their historical survey of how the United States, England, and Italy have made tragic choices, Calabresi and Bobbitt concluded that the “most subtle” of the methods adopted by the three countries to avoid tragic results is the “cycle strategy”: the constant replacement of methodology, methods, and mixtures of methods. Cycle strategy is inevitable because “it accepts the fact that society faces the paradox of being forced to choose among competing values in a general context in which none can, for long, be abandoned” (1978, 195–96). Calabresi and Bobbitt believe that the cycle strategy allows society to “limit the destructive impact of tragic choices by choosing to mix approaches over time” and thereby to reaffirm values that have been endangered (1978, 196). Not only does the cycle strategy preserve fundamental values; the forthright admission that the cycle strategy is being used promotes the procedural value of honesty.

## Methodologies

Because kidneys for transplantation are a scarce resource that can prolong life and reduce suffering, potential recipients must be scrupulously treated with fairness, and kidneys must be used as productively as possible. How can equality and efficiency be promoted and reconciled? Three methodologies—optimization, balancing, and compromise—offer different procedures and different answers.

### *Optimization*

Optimization satisfies values to the maximum extent possible, but when two values conflict, it is not possible to maximize the satisfaction of both values simultaneously. Some approaches to allocating kidneys would optimize one value. A pure lottery, for example, would optimize equality, but to the exclusion of efficiency. Alternatively, using only survival matching to maximize the prospective longevity of kidney and patient would optimize efficiency to the exclusion of equality. Because it relies heavily on waiting time, the current allocation system comes close to optimizing equality. The original 20/80 proposal came close to optimizing efficiency. Most approaches to allocating kidneys reject the extreme

of optimizing one value, or coming close to optimizing one value, in favor of striving to “balance” equality and efficiency.

### *Balancing*

Balancing is the preferred, virtually unanimous, way of resolving the conflict between equality and efficiency. It appears in the title of an article, “Rational Rationing or Discrimination: Balancing Equity and Efficiency Considerations in Kidney Allocation” (Ladin and Hanto 2011), for example, and it occurs in a critical review of approaches to allocation: “The concepts of efficiency and equity are nebulous constructs that require consensus definition in the context of organ allocation before development of successful strategies to balance them can be devised” (Gill 2012, 1974). How is balancing supposed to do the practical work consigned to it?

In the law, the blindfolded Lady Justice holding the scales of justice is the symbol of balancing. The attraction of this metaphor is the comforting impression that balancing delivers a determinate correct answer, and Lady Justice’s blindfold emphasizes the objectivity and impartiality of the decision making. Unfortunately, however, the metaphor of the scales is mistaken, unhelpful, and misleading.

The scales metaphor is mistaken because its balancing process does not produce a balanced outcome. Competing considerations are put on the scales to weigh their support for the two sides of a case. One scale goes down, and the other goes up. Guilty or not guilty. For allocating kidneys, it would be equality or efficiency, all one value or the other. In the scales metaphor, balancing collapses into optimizing, which is precisely what it is supposed to avoid.

The metaphor is unhelpful because the process of balancing is mysterious. How is balancing supposed to work? How are the elements put on the scales supposed to be weighed relative to each other? Physical scales realistically, and Lady Justice’s scales metaphorically, use gravitational weight, but that does not exist in law or ethics.

Finally, the metaphor is misleading because it portrays balancing as a one-time, independent, isolated event that provides a determinate, final, correct answer to a problem. Once the correct answer is found, the problem has been solved, so the only thing to do is move on to another problem. With balancing, there is no residue. The simple balancing



metaphor misrepresents the complex, dynamic challenge that allocating kidneys for transplantation poses, just as much as it misrepresents the complicated intricacies of legal decision making.

So what does balancing do? Balancing can alternatively be understood as a substantive criterion for the acceptability of a decision about how a conflict between values should be resolved. A strong version of the balancing criterion would require that the competing values be accorded equal importance. A weak version of the balancing criterion would allow the importance accorded to the competing values to be unequal as long as the importance of each value is reasonably acceptable. Either way, the same problems recur. There is no process for producing an outcome in which conflicting values have equal or reasonable importance. Nor are there any substantive criteria for ascertaining whether conflicting values have equal or reasonable importance. In the current allocation system, for example, nine points are assigned for need or equity: one for each year of waiting, four for being highly sensitized, and four for being a living donor. Three points are assigned for efficiency: one for one DR HLA mismatch and two for a zero DR HLA mismatch. Does this assignment of points accord equal importance or reasonably acceptable importance to equality and efficiency? If so, why?

The extent to which values are satisfied can be globally judged; for instance, equality and efficiency are roughly equal in this proposal or efficiency is hardly satisfied at all in that proposal. Balancing can be construed to exclude the optimization of one value and to prevent egregious discrepancies between the degrees to which competing values are satisfied. Taken as a substantive criterion for an acceptable resolution of a conflict between values, balancing could reject the current system of allocating kidneys for its neglect of efficiency, and it could reject the original 20/80 proposal for its neglect of equality but deem the amended 20/80 proposal and the EOFI proposals to be acceptable. But beyond protecting relevant values from being completely or strongly disregarded, balancing is no more than a vague, abstract rhetorical device, one that, moreover, neglects residue.

### *Moral Compromise*

Dr. John Friedewald, who chairs the Kidney Transplantation Committee, described the conundrum for its members:

We want to maintain equal access and do better with this pool of kidneys. But by changing allocation slightly and getting 10,000 more life-years lived, what is that worth? Is it worth slightly decreased rates of access for certain groups of people? That's what we go back and forth trying to decide. (Sack 2012)

Given the interminable vacillation, why not search for a compromise? Allocating kidneys has the hallmarks of a moral compromise. Although neither equality nor efficiency can be satisfied fully, neither can be abandoned. Each value must be satisfied partially and proportionately to its importance in the circumstances. We routinely make compromises, including moral compromises, throughout our lives. Why not here?

In his book about compromise, *Splitting the Difference*, Martin Benjamin provides a vivid example of how moral compromise could work in an intensive care unit (ICU) (Benjamin 1990, chap.2). An experienced critical care nurse and the attending physician disagree about whether aggressive treatment should be continued for a young single woman who has suffered severe brain damage. The ICU staff agree on the clinical details of the patient's condition and her extremely poor prognosis, but they disagree on how aggressively she should be treated. Nurse Chapman argues that it is highly unlikely that the patient would want to be kept alive in these circumstances, that continuing the current aggressive treatment is very expensive and not worth the cost given the exceedingly low probability of any significant improvement, and that the treatment is an inefficient use of resources that could be used to provide greater benefits to other patients in the unit. Conversely, Dr. Lehman believes that the patient's young age, the sudden onset of the viral encephalitis that caused the damage, and the patient's previously excellent condition suggest that if anyone could recover, she could, and that recovery is of most benefit to the young. She also appeals to the inherent value of human life and the importance of the medical and nursing professions remaining steadfastly dedicated to preserving and prolonging life. The ICU staff are correspondingly divided and remain so after a meeting of the unit in which they discussed what to do. The status quo—aggressive care—continues, but the issue must be resolved, for the sake of other patients and because the controversy is proving corrosive to the staff's cohesion.

At a second meeting the ICU staff are receptive to a compromise. Their discussion is "marked by mutual respect," and the discussants are marked by humility, born of appreciating that they all have legitimate

reasons for their views. Their differences remain intractable, however, so after having participated in a process of compromise, the staff decide, for the sake of resolving the dispute, “to split the difference.” They agree to continue the aggressive treatment for a specific, limited period, at the end of which they will assess the patient’s condition using criteria they mutually accept, and then the aggressive treatment will continue only if the patient’s condition has improved. Otherwise, they will institute less aggressive treatment and accord more importance to the equitable and efficient use of ICU resources. The agreement is a compromise because both sides act in a way that partially defeats the full satisfaction of their basic obligations as they see them while at the same time still acknowledging the continuing full force of those obligations.

Benjamin’s framing of the problem and the compromise encompasses both the participants’ views of the proper treatment for the patient and their views of how they can, as professionals, manage their disagreements about obligations to patients in a mutually respectful manner. This resolution allows them to maintain amicable relationships and to continue to work together productively and, as well, enables each participant to retain self-respect, dignity, and integrity. In doing so, it embraces a complex array of substantive and procedural values pertaining to the issue at hand, the institutional and social contexts, and individual moral views. Moral conflicts encompass not just discrete substantive issues, in this case whether to continue aggressive treatment for the patient, but also the people who have to resolve the issues, the contexts in which they decide, and the processes they use to arrive at their decisions.

The obligations that attend participating in an ethical decision-making process—respect, tolerance, and the like—and the associated personal obligations conflict with the original operative substantive obligations; otherwise, considering them could not lead to a compromise about continuing the aggressive treatment. Appealing to participatory and personal obligations is relevant to how willing individuals are to compromise with the basic substantive obligations of others when they do not accept either those obligations or the relative weights assigned to those obligations. Recognizing the broad contextual scope of the matter expands the original conflict among basic substantive obligations to include further conflicts with participatory and personal obligations and thereby expands the need for further compromises.

Compromise and balancing have the same foundational structure. Both occur when values, principles, or obligations conflict, and none

of the conflicting values, principles, or obligations can be abandoned or fulfilled only nominally. Beyond imposing that constraint on a resolution of the problem, however, the vacuous notion of balancing has nothing to offer. Compromise aspires to satisfy each of the conflicting values, principles, or obligations partially and proportionately to its importance in the situation. As Benjamin's ICU example illustrates, compromise as a decision-making method involves a process of interactive compromising, whose very outcome is a compromise. The design of the process of compromise is crucial to producing a defensible compromise outcome, one that satisfies the conflicting values partially and proportionately in the prevailing circumstances. Some readers might use the term *balancing* for an approach to resolving ethical conflicts that has the content and import of the approach for which we use the term *compromise*, with its persistent fidelity to all relevant values, residue, and cycling. If so, that difference is terminological, and although we consider *compromise* more perspicuous, using *balancing* instead will not create problems as long as the substantive differences between the positions we call *balancing* and *compromise* remain clear.

Not every process of compromise ends with an outcome that is a compromise, however. In the ICU, for instance, participating in a process of compromise could prompt all parties to reassess their initial positions and modify or change them in ways that make it possible for everybody to agree to a new position that collectively is regarded as superior. In that event, no compromise outcome is needed. But if the disagreement persists, the parties will have to compromise to settle the disagreement, and the acceptability and rationality of that outcome will derive from the process of compromise. Because the parties have to agree to a compromise, they all have the power to ensure that their position is represented reasonably in a compromise outcome. If they are not satisfied, they can continue to press their case or adhere to their initial positions. That is how a process of compromise fosters an outcome that fulfills the competing values, principles, or obligations partially and proportionately to the importance that their advocates argued them to have in the situation. In addition, the participatory values displayed in a process of compromise enhance the legitimacy, rationality, and acceptability of the outcome.

Calabresi and Bobbitt acknowledge the place of compromise in designing an approach to making tragic choices when they characterize the melding of disparate methods "as a compromise between basic approaches usually entailing in modified versions some of the shortcomings

(and concomitant powers) of each” (1978, 146). Mixing different methods is guided by how the powers and shortcomings of the methods contribute to partially and proportionately satisfying the values that conflict in the circumstances. That is one kind of compromise. Partially and proportionately satisfying values that conflict by cycling through them over time is another kind of compromise.

### *Cycling*

The example of a single parent coping with the demands of caring for a child and working at a job shows how compromise can extend over time. A single mother might decide that because she has not played with her son much this week, she will leave work early, pick him up at day care, and take him to the park. Earlier in the week the demands of her job prevailed, but now it is time to give priority to her son. Subsequently, her job will reclaim priority, only to be curtailed again by the mother’s love and devotion. That temporally extended compromise will continue, persistently and perhaps haphazardly, for some time in the conjoined lives of mother and son. Over that time, cycling between the inevitable and irreducible obligations of being a parent and having a job leaves a residue of unfulfilled obligations in the mother. But it is the best she can do.

Residue is the acknowledgment that a partially or wholly unsatisfied moral claim continues unabated. Cycling is driven by the residue of moral compromise. Cycling through values in successive policies for allocating kidneys is that kind of compromise: oscillating between the conflicting values of equality and efficiency, satisfying one as much as possible and proportionately to its importance in the immediate circumstances to the sacrifice of the other, then subsequently redeeming the other value when the circumstances are propitious. Compromise does not renounce, recast, or diminish values, and consequently it does not remove the conflicts between values or the dissatisfaction of not being able to satisfy them fully.

The unsatisfied moral claim is the residue proper, but it can be accompanied by feelings of regret, remorse, and guilt, as well as derivative feelings such as anger at a person or an institution that unnecessarily constrained the full satisfaction of a claim. Given that compromise is a considered decision about the full array of apposite claims and

constraints in a situation, nothing more can reasonably be expected, so remorse and guilt are inappropriate. Guilt, in particular, can be a useless, destructive emotion because it freezes a person myopically in the present, thereby blocking the positive self-appraisal and hope needed for a forward-looking exploration of constructive possibilities and improvement. Regret does not have to accompany residue, but it can be an appropriate accompaniment, and it typically is helpful because it promotes residue's important contribution to moral life. By keeping people attuned to the full panoply of moral claims on them, residue provides an ongoing motivation to scrutinize those claims and to find ways of removing constraints to their satisfaction. In doing that, residue fosters ethical sensitivity and spurs moral development and maturity.

Whether that progress occurs, however, depends on where the residue is directed. The residue of the tragic choices of Sophie and Jillian Searle seems focused backward on the past ineradicable event. However understandable that orientation is, it often is destructive. And neither mother has to be looking backward. Sophie could have helped orphaned survivors of concentration camps, and Jillian Searle similarly might have helped other children who survived the tsunami. In contrast, the residue of the single mother's continuous compromising seems focused on the unfolding malleable future. Like the ongoing struggle of the single parent, and for the same reason, the tragic choices of a society can extend over time, and the moral culture of a society can orient residue backward in recrimination or forward in hope, with the determination to secure improvement.

Balancing entirely misses moral residue. Because balancing is an independent, one-time, completed affair, it does not recognize either the empirical reality of residue or the moral salience of residue. Consequently, balancing does not keep people attuned to the residues of their decisions and thus does not promote moral learning and maturity. Nor can balancing account for the impact of moral residue in the history of allocating kidneys for transplantation.

Past and proposed changes in the approaches used to allocate kidneys exemplify compromise as cycling. Neither equality nor efficiency can be renounced, but their strengths wax and wane reciprocally. When kidney transplantation was emerging and being tested, the overriding, if not exclusive, values were effectiveness and efficiency. With the introduction of immunosuppressive drugs that reduced the risk of rejection, equality became a serious moral concern. In the 1980s, allocation substantially

emphasized equality for patients with special needs (Starzl et al. 1987); by one assessment, roughly “three-fourths of the weight was given to equity, only one-fourth to predictors of good medical outcome” (Veatch 2000, 285). In the early 1990s, the priorities were reversed, assigning two-thirds of the points to medical benefit or efficiency. Subsequently, with the introduction of the current system of allocating kidneys primarily on the basis of first-come, first-served, equality again became the dominant value.

Cycling continued dramatically with the rescue of the value of efficiency in the original 20/80 proposal. Both its components promote efficiency. The highest-quality kidneys are allocated to the candidates with the longest potential longevity, and age matching for the remaining kidneys improves efficiency by making the potential longevity of both the kidney and the recipient roughly commensurate. But the original 20/80 proposal succumbed to the allegation of age discrimination.

The amended 20/80 proposal retains the allocation of the highest-quality kidneys to the candidates with the longest prospective longevity and allocates the remaining kidneys on the basis of waiting time. Cycling still occurs but is substantially checked because efficiency is only partially reclaimed and remains decidedly subordinate to equality.

The Equal Opportunity Fair Innings (EOFI) proposal perpetuates the commitment to equality and manifests cycling by reaffirming the suppressed value of efficiency. It accomplishes that feat by transforming the value of equality. The current first-come, first-served conception of equality is replaced with a combination of age-based equal opportunity (EO) and rectification of age-based inequality (FI). Both age-based conceptions of equality do double duty by simultaneously promoting equality and efficiency. Whereas the original and amended 20/80 proposals segregate equality and efficiency in discrete components of the proposals, each of EOFI’s two age-based conceptions of equality melds satisfaction of the value of efficiency with satisfaction of the value of equality. EO enhances efficiency because it matches the potential longevity of kidneys with the potential longevity of recipients more commensurately. FI enhances equality and efficiency concurrently because kidneys with the greatest potential longevity are allocated first to the youngest candidates and then successively to increasingly older candidates. Cycling is more prominent in the EOFI proposal than the amended 20/80 proposal because, despite being derivative from equality, efficiency is restored more

robustly and because cycling also occurs with respect to the value of equality.

Recognizing the two forms of compromise—compromise between equality and efficiency in an approach to allocating kidneys and compromise through cycling between equality and efficiency over successive approaches to allocating kidneys—contributes to a clearer, more expansive view of the state of affairs regarding the allocation of kidneys that is badly needed in the protracted effort to revise the current system. Where, then, does the understanding of allocating kidneys as a tragic choice lead? Which proposed mixture of methods for allocating kidneys “most limits tragedy” and manages the “irreducible minimum” of tragedy “in the least offensive way”?

### An Assessment of Approaches to Allocating Kidneys for Transplantation

The value of efficiency serves the goal of limiting tragedy. The more years of life after transplantation that can be produced, the less suffering there will be and the fewer years of life will be lost. The value of equality serves the goal of managing inescapable tragedy in the least offensive way, that is, by deciding in the fairest possible way who suffers and who dies. The moral challenge for policymaking is to design a mixture of methods that facilitates both values effectively, judiciously, and responsibly.

The current system promotes equality and neglects efficiency. The absence of a compromise between those two values is the source of the concerted effort to revise it. It has another problem, however. The kind of equality promoted by the current system—first-come, first-served—is understandable because it is common in our lives and easy to implement. But as practical and familiar as this temporal form of equality is, it does not fit the allocation of kidneys. Queuing is a fair, objective way of distributing some scarce goods, for example, lining up to buy tickets to a popular entertainment. Queuing allows people to choose whether the effort required to obtain a scarce good and the probable success of obtaining it are worth it. Queuing is attractive because it is a measure of the subjective value of a scarce good and because the order of a queue is the result of a free, informed choice. But people do not choose whether and when they get end-stage renal disease (ESRD), and given the superiority of transplantation to dialysis, people do not choose to have a kidney



transplant. Getting ESRD is a natural lottery with only losers. People with ESRD do not freely join a transplant queue; people with ESRD are put on a transplant queue by others. In extreme situations such as famine, food can be dropped from an airplane or handed out from the back of a truck to those who have lined up. Tragic choices about who will eat and who will starve to death are dictated by urgency and desperation. Of necessity, food goes to the savvy, the swift, and the strong. The allocation of kidneys should not be predicated on misconceived assumptions about choice or necessity. People with ESRD are put on a queue because making them queue is an easy, simple, transparent, familiar method for allocating scarce goods. Queuing is an acceptable method for allocating scarce quotidian goods. With ESRD, however, temporal sequentiality is temporal arbitrariness. Dr. Alan Leichtman, who was “helping to craft the [revised allocation] policy” in 2007, appreciates that point: “Waiting time is arbitrary. It seems like a real shame that we’re not being better stewards of the organs” (Meckler 2007, A1). Putting people with ESRD on a queue does not respond to the relevant differences and magnitudes of their misfortunes, but doing just that is essential to managing this tragedy “in the least offensive way.”

The original 20/80 proposal is a reversal of the current system because it promotes efficiency and neglects equality. It is not itself a compromise between equality and efficiency, but it could have been a dramatic component of a process of compromise as cycling through the two values over time. In that enlarged perspective the original 20/80 proposal, directly following the current first-come, first-served system, would have completed a cycle that gives roughly equal importance to equality and efficiency over the cycle.

Calabresi and Bobbitt would understand the demise of the original 20/80 proposal, however, because they emphasize that the emergence and fate of any approach to making tragic choices depend on the nature and fundamental values of the society making the choice. The steadily increasing number of older people in the United States, a cherished tradition of constitutionally proclaimed and protected individual rights, a robust ethos of prohibiting and rectifying discrimination, and a ready penchant for litigation are formidable obstacles to age-based categorizations anywhere.

By retaining survival matching for 20 percent of kidneys and reverting to allocating 80 percent of kidneys on the basis of first-come, first-served, the amended 20/80 proposal modestly endorses efficiency,

perhaps sufficiently to be a substantive compromise between equality and efficiency and to contribute to the process of compromise as cycling. Nevertheless, the temporal method of equality it perpetuates, albeit workable and clear, remains impervious to the distinctively tragic nature of this choice.

The EOFI proposal promotes two different forms of equality and concurrently and concordantly fosters efficiency strongly enough to compete with the amended 20/80 proposal to become the successor to the current first-come, first-served approach in the process of cycling. The FI component especially befits the nature of the required tragic choice. Although the loss of any life can be tragic, the death of a child from leukemia seems more tragic than the death of a nonagenarian who dies from cardiac failure. Similarly, succumbing to ESRD at a young age is more tragic than succumbing to it at a much older age. By giving priority to more tragic tragedies, FI limits the tragedy of kidney scarcity, as does EOFI's production of efficiency. In addition, the robust statistical equality of the EO component deals with the "irreducible minimum" of tragedy in "the least offensive way." Only a pure lottery, as might be used in drafting soldiers to fight in a war, would be a less offensive way of responding to inevitable tragedy. By simultaneously affirming the relevant forms of equality and restoring efficiency, EOFI minimizes the need for compromise between these fundamental values. With its complementary, apposite forms of equality and its synergy of equality and efficiency, EOFI best fulfills the two criteria of limiting tragedy and dealing with tragedy in the least offensive manner.

But how does the EOFI proposal fare with respect to the charge of age discrimination that scuttled the original 20/80 proposal? Ross and colleagues hold that the FI component is "a nondiscriminatory use of age, provided that the number of kidneys allocated to each age group is held constant . . . because it treats individuals equally at different life stages"; that is, it is a form of prudential life-span equity (2012, 2118). They also point out that their EOFI proposal promotes efficiency not by allocating more than an equal share of kidneys to younger candidates but by allocating higher-quality kidneys to younger candidates, which uses age as a proxy for quality (2012, 2120). These are explanations of why and how they treat younger candidates differently. Rather than being a matter of simply treating people differently, discrimination is a matter of treating people differently when there is no good reason for doing so. Because there are good reasons for treating younger candidates differently

in the EOFI proposal, it does not discriminate against older candidates. Nevertheless, EOFI is as vulnerable to legal action as the original 20/80 proposal, and so is any other reasonable proposal for improving the allocation of kidneys. In this regard, the struggle to revise the current system of allocating kidneys is likely to expose the real fundamental value of society: not prolonging lives, not alleviating suffering, and not recompensing the most vulnerable, but legally preserving and protecting individual rights.

Procedural values also are relevant to assessing approaches to allocating kidneys. An allocation system must maintain public trust and confidence, and to do that it has to be simple and transparent. It is no accident that methods of allocating kidneys are presented as “algorithms.” The procedures for allocating kidneys have to be, and be perceived as, intelligible, objective, reliable, and immune to manipulation in order for the public to have faith in their legitimacy and fairness. The current system and the original and amended 20/80 proposals are simple and easy to understand. The EOFI proposal is more complex but not unduly so. The notion of fair innings is a comprehensible and appealing response, medically and morally, to the plight of younger candidates, and the nature of and reason for the equal opportunity component can be readily explained. Given its many virtues, EOFI should not be rejected because it is allegedly too arcane.

Moreover, public trust and confidence depend on the process from which an allocation system emanates. The public dissemination of the revisions to the current allocation system proposed by the Kidney Transplantation Committee (KTC) and reports of the meetings of the KTC on the Organ Procurement and Transplantation Network website, along with calls for public comments, are commendable. In addition, the KTC has “implemented a detailed communications strategy which included a media webinar, tailored presentations for both professional and lay audiences, and documents to address frequently asked questions” (KTC 2012, 22). That “communications strategy” presents information about what the KTC is doing and how it is doing it. What is crucially missing, however, is an explanation of *why* the KTC is doing what it is doing. That omission is dismayingly evident in the KTC’s insouciant rejection of the EOFI’s “theoretical method for allocating kidneys” (KTC 2012, 22). Its curt summary of the EOFI proposal attributes the sole goal of providing “an equal chance of getting a kidney for all candidates” to

the proposal, recognizing only the EO component and ignoring the FI component entirely. It then criticizes the proposal for not taking account of “other factors affecting equality such as access challenges due to geography, blood type, or degree of sensitization,” which the KTC’s amended 20/80 proposal does (KTC 2012, 22).

The KTC’s process of revising the system for allocating kidneys is designed to find a practical medical approach to making transplantation more efficient without violating carefully selected forms of equality. The KTC’s orientation is displayed in the design of its composition. Of its twenty-eight members, twenty are physicians from hospitals or medical centers. Four of the remaining eight members work in transplantation. Two others are from organ donation and transplantation organizations, and of the two general public members, one is a doctor. An approach to allocating kidneys certainly has to be practical and grounded in extensive medical expertise and empirical research. But social choices about allocating kidneys are paradigmatic tragic choices, as discomfiting as that realization is, and must be made by a process that is cognizant of and responsive to their essential nature. A process of compromise requires a more diverse and representative group of participants who are committed and empowered to defend substantive values and positions, sensitive to procedural values, and willing to make concessions that are necessary for a compromise outcome. Consultation likely would suffice for balancing. With compromise, however, consultation is no substitute for participation.

## Conclusion

The tragic choices of a society affirm some fundamental values and degrade others. Designing an approach to allocating kidneys for transplantation implicates tragic choices about the fundamental values of life and death, well-being and suffering, and it requires a tragic choice between the fundamental values of equality and efficiency. Neither equality nor efficiency can be abandoned, yet both cannot be fully satisfied. So compromise is occasioned. But partially satisfying a fundamental value leaves a moral residue that preserves fidelity to the diminished value and eventually prompts the redemption of that value. Tragedy is resilient. Whatever tragic choice is made at one time must be a provisional accommodation, not a final resolution. Over time, tragic choices

cycle between conflicting fundamental values in a dynamic process of compromise, restoring those that hitherto have been degraded, and limiting the degradation of those that hitherto have been protected. The history of allocating kidneys for transplantation is a history of compromising in the face of the relentless tenacity of tragedy. Just as compromise is a rational, responsible way for a single parent to manage both caring for a child and working, so, too, is compromise a rational, responsible way for society to adjust the conflicting values of equality and efficiency at one time and over time in making tragic choices about allocating kidneys.

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