



Robert Veatch's transplantation ethics: obtaining and allocating organs from deceased persons

James F. Childress¹

Accepted: 18 April 2022 / Published online: 10 June 2022
© The Author(s), under exclusive licence to Springer Nature B.V. 2022

Abstract

This essay appreciatively and critically engages the late Robert Veatch's extensive and important contributions to transplantation ethics, in the context of his overall ethical theory and his methods for resolving conflicts among ethical principles. It focuses mainly on ways to obtain and allocate organs from deceased persons, with particular attention to express donation, mandated choice, and presumed consent/routine salvaging in organ procurement and to conflicts between medical utility and egalitarian justice in organ allocation. It concludes by examining the unclear relations between Veatch's ideal moral theory and his nonideal moral theory, especially in organ allocation.

Keywords Transplantation ethics · Organ donation · Organ allocation · Presumed consent · Ideal and nonideal theory

Introduction

With the death of Robert M. Veatch in November 2020, bioethics sadly lost one of its most distinguished and prolific contributors as well as a generous, stimulating colleague whose interactions and friendship will be sorely missed. Depending on how the lines are drawn, he could be considered either one of the “pioneers” in bioethics or one of the early “settlers” of the field. Situated at two of the earliest and most important US centers in bioethics—the Hastings Center (originally named the Institute of Society, Ethics, and the Life Sciences) and the Kennedy Institute of Ethics—Veatch made regular, major, singular contributions to theory and method in bioethics and to a number of substantive bioethical areas, including organ transplantation.

Veatch's work in transplantation ethics was both scholarly and practical, and much of his scholarship was designed to inform public policies and practices. He

✉ James F. Childress
jfc7c@virginia.edu

¹ University of Virginia, Charlottesville, VA, USA

also actively participated in institutional and public roles in setting policies and shaping practices, which in turn informed and enriched his scholarship. For over twenty years, he served on the Board of the Washington Regional Transplant Consortium. He was also very active in the United Network for Organ Sharing (UNOS). In addition to serving on its Living Donor Committee and Vascular Composite Allograft Committee, he served on its Ethics Committee multiple terms for a total of fifteen years, the longest service of any member, and ended his last term in 2020. Particularly important for this essay was his role as chair of the UNOS Ethics Committee's Subcommittee which produced an influential and enduring report on "General Principles for Allocating Human Organs," for which Veatch was the primary drafter. He testified before congressional and other committees on ethical issues in obtaining and allocating organs, and he held several informal and formal advisory and consulting roles on transplantation ethics at the Georgetown University Medical Center, the North American Transplant Coordinators Organization, and other institutions.¹ The president and CEO of one Organ Procurement Organization (OPO) told me by email that he had been working with Dr. Veatch to ensure that his OPO was "growing smartly and within sound ethical standards" and that he would now "miss those conversations greatly."

Transplantation Ethics is one the most significant and enduring books among the many Veatch published. I wrote a highly positive blurb for the first edition: "Without question, the best and most important book on this topic. It provides a well-informed, carefully argued, insightful, and comprehensive perspective on the wide range of ethics issues that arise in organ transplantation. I enthusiastically recommend this book" [1]. This glowing endorsement also holds for the second edition for which Veatch enlisted as co-author Lainie F. Ross, physician, philosopher, bioethicist, who is also a prolific and insightful author on ethics in organ transplantation [2].² The second edition displays the consensus reached by Veatch and Ross on most ethical issues in transplantation along with an internal debate in Chapter 18 about the major issue on which they could not reach agreement— "Voluntary Risks and Allocation: Does the Alcoholic Deserve a New Liver?" [2]. While I will concentrate on this book, I will also attend to many of Veatch's other writings on transplantation ethics over the years.

On rereading these works for this essay, I reiterate but also expand my earlier praise for *Transplantation Ethics* by stressing that Veatch's work in this area is very sophisticated, crystal clear, and passionate in a controlled way. His scholarship is marked by deep and wide grounding in the relevant literature—ethical, scientific, clinical, policy, legal, and so forth—and by careful and rigorous analyses and assessments of different positions in the literature. His writings also manifest deep

¹ This information about Veatch's different roles and activities in organ transplantation comes largely from *Transplantation Ethics* [1, pp. xvi–xvii, 306n2; 2, pp. xix–xx, 302n2] and UNOS' "In Memoriam: Robert Veatch, Ph.D." [3].

² Even though Veatch co-authored the second edition of *Transplantation Ethics* with Lainie Ross, and the second edition thus represents their shared ideas, this essay will refer to these as Veatch's ideas for economy of writing.

respect and civility toward critics and opposing views. It was a sheer joy to reread *Transplantation Ethics*, along with his other works on transplantation ethics. As a way of paying homage to Veatch's important contributions, I now want to critically engage his views.

In reviewing Veatch's extensive work in this area, I was struck by the continuity in his thought over time. Of course, there were changes, especially in the direction of more nuanced formulations in light of developments in transplantation, policies, and practices, but there is a core of undisturbed continuity. Some critics may diagnose this as a symptom of rigidity, while some defenders may celebrate Veatch's consistency and constancy. Both judgments may be correct on different topics in transplantation ethics. Sometimes, I will argue, his categorizations, for instance, of models of organ transfer, are insufficiently flexible and adaptable. In addition, Veatch failed to adequately address the relation between his ethical theory (both general and specifically in transplantation ethics) and public policy. We will turn to this at the end, following an examination of his views on organ allocation, to consider the relation between—to use Rawlsian language—Veatch's ideal theory and his nonideal theory.

Both editions of *Transplantation Ethics* exhibit the same tripartite structure: (1) defining death, (2) procuring organs, and (3) allocating organs. My essay focuses on the second and third part of this structure, leaving the first part, defining death, for another essayist. Within the second part, I will concentrate on obtaining organs from deceased persons, rather than from living donors. I will start by examining the general ethical theory and method back of and crucial for understanding and assessing Veatch's work on transplantation ethics.

Theory and method: principles and conflicts

In 1981, Veatch published *A Theory of Medical Ethics* [4]. Over against the “chaos” of “unsystematic, unreflective, ethical stances, or traditions,” it sought to provide “some ordering... some systematic structuring” through an ethical theory [4, p. 5], which Veatch characterizes as follows:

An ethical theory is a complex, integrated approach, articulating an ethical framework coherently and systematically. ... The components of a complete theory of ethics will answer such questions as what moral rules apply to specific ethical cases, what ethical principles stand behind the rules, how seriously the rules should be taken, and what constitutes the fundamental meaning and justification of the ethical principles. [4, pp. 17, 33]

Veatch continued theory building for bioethics as a whole in four editions of *The Basics of Bioethics* as well as in other writings [5]. In addition, as we will see later, his discussion of organ transplantation ethics incorporated both his general ethical theory and more specific theories and frameworks, including “A General Moral Theory of Organ Allocation” [2].

The elements of Veatch's ethical theory most important for this essay are the principles he employs and the processes he uses to connect these principles to concrete

situations and to resolve any conflicts that arise. With modest variations in language and formulations, *A Theory of Medical Ethics* and the four editions of *The Basics of Bioethics* propose several independent ethical principles for medical ethics and bioethics. These principles, which identify right-making characteristics of human action, are both consequentialist and non-consequentialist or deontological in nature. Consequentialist principles, as the phrase suggests, focus on maximizing good consequences, while deontological principles identify features of human action that are duty-based and thus right-making independently of the action's consequences. The consequentialist principle of beneficence (often coupled with nonmaleficence) may target individuals, as in the Hippocratic tradition, or the society, as in appeals to utility. Several non-consequentialist principles spotlight duties to individuals, which Veatch groups under the broad rubric of respect for persons—these are autonomy, fidelity or keeping promises, honesty or veracity, and avoiding killing. Justice is a separate non-consequentialist principle, focused on social relations and policies. All of these principles come into play in analyzing ethical issues in obtaining and allocating organs for transplantation.

Veatch's ethical principles generally overlap with several other approaches in the bioethics literature, even when the clusters of moral concern are arranged under different organizing categories.³ Equally—or perhaps more—important for my analysis and assessment of Veatch's transplantation ethics is his method for resolving conflicts among principles.

Resolving conflicts among principles requires attention to their weight or strength. Principles can be viewed as (1) absolute, (2) rank-ordered, (3) *prima facie*, or (4) relative (i.e., so-called rules of thumb). It is difficult to imagine a framework with more than one absolute ethical principle because a conflict between two absolute principles would create incoherence, and yet no single principle is sufficient to capture all relevant ethical concerns, even though utility is often proposed as a candidate. Serious counterexamples also threaten a framework that employs a rank order by regarding some principle(s) as absolute relative to some other principle(s). A framework of *prima facie* principles usually involves balancing, but there are concerns about the role of intuitive judgments in this process. An approach that recognizes only rules of thumb effectively reduces principles to merely suggestive guidelines, thereby losing the prescriptivity expected in ethical principles.

Veatch's approach includes both balancing and rank ordering [4, 5, 10, 11]. He first balances the nonconsequentialist principles that fall under respect for persons (autonomy, veracity, fidelity, avoiding killing) and justice, and balances consequence-maximizing principles (beneficence and nonmaleficence) with each other. Then, after these separate balancing processes, he employs rank ordering, which, following John Rawls, he calls serial or lexical ordering (as in a dictionary's lexicographical ordering) [4]. This means that one principle or set of principles must be "fully satisfied" before the next principle can be brought into play [4]. Veatch lexically ranks non-consequentialist principles over consequence-maximizing ones.

³ For discussions of overlapping and distinctive principles, see several of Veatch's works [4–7] and works by Beauchamp and Childress [8, 9].

The consequentialist principle of beneficence remains important and after the non-consequentialist principles are fully satisfied, it can generate obligations [4]. For both organ procurement and organ allocation, Veatch holds that deontological or non-consequentialist principles “have priority over consequences” [2].

The rationale for this lexical ordering is unclear and seems problematic in some of the conflicts considered below. Overall, the sharp distinction between consequentialist and non-consequentialist considerations is not as defensible or as illuminating as Veatch supposes [9]. The assignment of absolute priority to some principle(s), whether against all other principles or only against some other principles, teeters under counterexamples, for example, in conflicts between medical utility and equity in organ allocation [9]. I will first consider what Veatch's ethical theory implies in policies to obtain organs from deceased persons.

Obtaining organs for transplantation

In a panel at one of several congressional hearings in 1983 that led up to the National Organ Transplant Act of 1984, Alexander Capron focused on “Ethical and Legal Issues in Organ Replacement,” Robert Veatch reviewed “Bioethical and Religious Issues Surrounding Organ Procurement,” and I examined “The Gift of Life: Ethical Problems and Policies in Obtaining Organs for Transplantation” [12]. Congressman Albert Gore Jr. (D-TN), who chaired the subcommittee, sought to sharpen the differences between Veatch's and my testimonies, particularly regarding opt-in systems and opt-out systems. I responded:

We [Veatch and I] probably don't disagree as much as it first appeared because we both agree on the ranking of the systems, with the Uniform Anatomical Gift Act at the top, as the [ethically] preferable system; then a system of forced decision [often called mandated choice], and then a system of presumed consent. Where we differ, I think is in our assessment of how soon, if ever, we might need to move away from the Uniform Anatomical Gift Act to one of the other systems. It may in part have to do with a judgment about need and a judgment about effectiveness. I think we do perhaps disagree at one point, though. I understood Professor Veatch to suggest that the religious traditions have more unanimity or uniformity of disagreement with a policy of presumed consent than I think is actually the case. [12, pp. 371–372]

In *Transplantation Ethics*, Veatch identifies three different models: donation, routine salvaging, and sales. Sometimes he draws the boundaries around these models too sharply. It may be possible to mix elements of these different models to produce more effective and efficient systems of organ procurement while simultaneously respecting persons and their autonomy and satisfying other non-consequentialist principles. For example, in contrast to Veatch, it may be possible and ethically

acceptable to provide modest financial incentives (so-called “rewarded gifting”) for post-mortem donation without abandoning the gift model for the market model.⁴

The Uniform Anatomical Gift Act in the United States builds on express, explicit donation, consent, or authorization by the decedent while alive and competent, through such mechanisms as a donor card or registry. In absence of a decedent’s documented wishes, the next-of-kin may decide whether to donate the decedent’s organs. Because this system fails to meet the need for transplantable organs, questions frequently arise about how to make it more effective and efficient, within ethical boundaries, and, if it cannot be adequately improved, whether there are promising and ethically acceptable alternatives. While conceding that the donation model “is probably not the most efficient way” of obtaining organs, Veatch held that it is ethically preferable for non-consequentialist reasons [2].

Mandated choice/routine inquiry with required response

Among possible ways to improve first-person organ donation decisions, Veatch vigorously supported mandated choice or what he often called routine inquiry with required response. He proposed such a policy in 1976 in the first edition of his important *Death, Dying, and the Biological Revolution: Our Last Quest for Responsibility* [14]. And his support continued in the second edition of that work [15], in both editions of *Transplantation Ethics* [1, 2], and in other writings. While granting that “routine salvaging without explicit consent” would “probably” be more efficient than mandated choice, he strongly affirmed the latter because it would better respect autonomy and avoid dishonesty and deception [2].

A policy of routine inquiry or required request has been adopted to ensure that the next-of-kin or other surrogate of a patient who has died or is imminently dying in hospitals under circumstances where his or her organs might be usable is offered the opportunity for organ donation when the decedent did not make or record his or her own choice. Generally, the hospital contacts an Organ Procurement Organization (OPO) whose trained representative makes the inquiry/request. Not only is this too little too late, in Veatch’s view, it is really directed at the wrong decisionmaker [2].

By contrast, Veatch proposed to direct routine inquiry with required response at living individuals when they engage in state-mandated activities such as renewing

⁴ Space limitations prevent the development of this point here. Rather than arguing that we should adopt “rewarded gifting,” I only want to suggest that Veatch’s rigid categories sometimes prevent him from grasping the complexity and richness of current or proposed policies and practices in organ procurement. He treats “rewarded gifting” in the chapter on “Markets for Organs,” under “Variations on the Market Model: ‘Rewarded Gifting’” [2]. However, depending on how it is conceived and implemented, “rewarded gifting” can easily and accurately be described as a “variation on the donation model.” It is necessary to distinguish *systems* for the transfer of organs (donation/gift versus sales/purchases) from the *motivations* of individual participants in these systems. Participants in any system of post-mortem organ transfer may act on a variety of motives, including but not limited to altruism. Our ordinary experiences of giving gifts and making donations are sufficient to establish that our motives are often mixed in those practices. The offer of rewards, including modest financial rewards, may provide incentives for donation without undermining the donation system or transmuting it into a market. I develop these points more fully elsewhere [13, pp. 186–193].

their driver's license or filling out their annual income tax forms. This may be particularly important when inertia, lack of thought, limited resolve, or limited opportunity are primary obstacles to first-person donor registration. This approach also fits well with Veatch's conception of the individual as, ethically speaking, the primary decisionmaker for organ donation: "systematic and routine inquiry made to individuals while alive and competent may be more morally defensible and perhaps even more efficient" than routine inquiry of the family when the individual is dying or has just died [2]. According to Veatch, routine inquiry of the family of a dead or dying person is "at best...the second alternative for decision making in a liberal society" [2].

Against those who worry about "an offensive intrusion by the state into private matters," Veatch views routine inquiry with required response as "little to ask for what could have a significant lifesaving impact." He contends that our obligation to the community is broad enough and strong enough to warrant this intrusion [2]. As long as the intrusion is minor, and does not involve penalties, such as denial of a driver's license to an individual who does not respond, a mandated choice policy is not inevitably coercive or, if modestly coercive, not unjustifiably so.

It would be helpful to have more empirical evidence than we do about the probable effects of a policy of mandated choice on rates of first-person deceased organ donation. Survey evidence of public support for a policy of mandated choice does not provide proof that individuals would say "yes" if they were required to respond to a routine inquiry about post-mortem organ donation [13]. Moreover, a law requiring a choice, but unaccompanied by extensive and enhanced public education and reduction of public mistrust or distrust, would probably be ineffective and perhaps even counterproductive. Public mistrust and distrust are important, particularly because potential donor registrants often fear being declared dead prematurely or not receiving maximum treatment to save their lives if they are on record as organ donors.⁵ Where such fears are strong, even if not well-founded, people's reluctance to register as organ donors may not indicate their actual opposition to deceased organ donation. However, their "no" would effectively block a possible familial decision to donate their organs after their deaths. Hence, a policy of mandated choice could actually decrease the supply of transplantable organs and could even fail to accomplish Veatch's goal of maximally respecting and protecting individual autonomy [13, 17].

One possible way to blunt the potential negative effect of "no" decisions is to record "yes" decisions in a donor registry but not to record "no" decisions in a non-donor registry. Such a policy is ethically unacceptable because it fails to respect respondents' choices and undoubtedly misleads many respondents about the effect of their "no" decision. Hence, there must be a way to record when individuals respond "no" or "undecided" [13]. Another possibility is to allow and even encourage individuals to designate a surrogate to make a decision about organ donation after their deaths [13, 18]. Placing post-mortem decisions about organ donation in

⁵ For a discussion of several public opinion polls in the United States on organ donation, see [13, 16, 17].

trusted hands could increase the individual's sense of security, as often occurs now in advance directives for decisions about care at the end of life.

Unfortunately, many proponents of mandated choice, including Veatch, assume highly individualistic, rationalistic, formalistic, and legalistic versions of autonomous choices. They fail to appreciate wide variations in how people exercise their autonomy, for instance, not only through formal first-person donor registration but also through informally leaving the donation decision to their family or through not blocking their family's decision by saying "no." Such actions can express personal autonomy, even in the absence of a formal document. In light of uncertainty about whether mandated choice would be effective overall, along with persistent, if exaggerated, concerns about governmental intrusion and coercion, there appears to be insufficient reason for the United States to adopt it as a policy. Seeking to obtain, through a forced decision, individuals' declarations of what they want to happen to their organs after death reflects an excessively narrow, rationalistic, formalistic approach to the exercise of and respect for autonomous choices. Moreover, as previously noted, this may not even accurately register what many individuals actually want to happen with their organs after their deaths; it may only reflect their fears about what will happen to them while alive if they are on record as organ donors.

Opt-out policies: presumed consent or routine procurement without explicit consent

The first edition of *Transplantation Ethics* identified "the core ethical controversy" in obtaining transplantable organs from deceased persons as whether organs may be "routinely salvaged" without individual consent (a form of "taking") or whether they must be "donated" (a form of "giving") by the decedent while alive or by a surrogate after his or her death [1]. But matters may be more complex than this framing of the controversy suggests.

Different moral frameworks can support opt-out laws for deceased organ transfer/procurement.⁶

Moral framework I

This moral framework holds that the state or society has dispositional authority over dead persons' organs. It supports legislation to authorize what is often labeled *routine removal* or *routine salvaging*. While in this moral framework states are not required to grant individuals and families rights to opt out, they generally do so to avoid or reduce conflicts. Moreover, these systems are not morally obligated to promote extensive public education or to adopt clear, easy, non-burdensome opt-out procedures, but practical reasons and concerns may lead them to do so.

⁶ Much of this presentation of these moral frameworks derives from *Public Bioethics* [13].

Moral framework II

This moral framework recognizes that individuals have authority to dispose of their dead bodies and parts, subject to certain limits, and that the next-of-kin is the default decision maker. In this framework, individuals while alive may authorize transfer of their organs after their deaths through express or explicit consent, donation, or authorization or through what is variously called tacit, silent, or presumed consent, in which the individual's lack of explicit dissent is construed as consent. Such tacit, silent, or presumed consent can be ethically valid if, and only if, individuals have adequate understanding of the options along with access to clear, easy, reliable, and non-burdensome ways to opt out. An ethically acceptable opt-out system, based on the individual's primary right to control what happens to his or her bodily parts after death, must contain these conditions. This is often labeled *presumed consent*.

For Veatch, both systems are ethically problematic because they involve routine procurement without explicit consent. He implacably opposed a system based on the second moral framework, but he was more willing, though still reluctant, to consider a system based on the first moral framework. Both violate the principle of respect for autonomy so central to liberal political philosophy, but the presumed-consent model, expressed in the second moral framework, has an additional moral flaw: It is "dishonest" and "deceptive" in claiming a non-existent connection with respect for autonomy through "presumed consent" [2]. Veatch concedes that routine salvaging would be "probably more efficient" than express donation in obtaining needed organs for transplantation, but efficiency is not a sufficient reason to adopt a policy that violates core deontological principles [2].

Most routine salvaging laws around the world, Veatch stresses, are not officially couched in the language of presumed consent; rather they simply authorize the taking of organs without explicit consent. This is particularly evident in opt-out laws in Europe; there are exceptions in some jurisdictions in Central and South America and in Scandinavia [2]. Nevertheless, Veatch believes that these laws cannot, in fact, be accurately and legitimately couched in the language of presumed consent.

To presume consent is to make an empirical claim. It is to claim that people *would consent* if asked, or, perhaps more precisely, that they would consent to a policy of taking organs without explicit permission. The reasoning behind true presumed consent laws is that it is legitimate to take organs without explicit consent because those from whom the organs are taken would have agreed if they had been asked when they were competent to respond. [2]

Such claims of hypothetical consent are "dishonest." They would be wrong "at least 25 percent of the time" [2]. Moreover, "discomfort" and "embarrassment" lead people to characterize laws that authorize routine organ removal without express consent as "presumed consent." As a result, they dress routine salvaging "in the flimsy outer garb of the consent doctrine" [2]. So-called "presumed consent" is at best an "ill-formed notion" and at worst "an outright deception" [2]. If one favors routine salvaging, it would be better to argue for it directly on grounds of efficiency, in order to avoid the "dishonesty," "deception," and "moral affront" required to promote a

putatively consent-based policy that actually violates respect for persons and their autonomy.

Nevertheless, a fundamental question remains—what kind of consent do we need, from whom, for what? The model of informed consent developed for therapy and participation in research is not the only one. In contrast to Veatch, I believe that, in principle, a system of routine procurement without express consent can be developed that incorporates silent, tacit, or presumed consent and that is not dishonest or deceptive. Two key components are vigorous public education and clear, easy, reliable, and non-burdensome ways for people to register their objections or dissent. In principle, reliance on tacit or silent consent in certain contexts, including organ donation, is not objectionable. It can be real consent, not merely hypothetical consent, in carefully defined social practices.

While this is possible in principle, there is no strong argument to pursue such a policy in the United States at this time, in part because the aforementioned factors that would probably derail mandated choice would also undermine presumed consent: Hence, it would probably be ineffective and possibly counterproductive. Even if it could be adopted across the US, which is politically unlikely, and even if we could build in and implement all the conditions required for ethically valid silent or tacit consent, the system would probably reduce rather than increase the supply of transplantable organs. The risk is that a significant proportion of the US population would opt out and, in doing so, would block opportunities for family members to donate and thereby significantly reduce the number of organs donated for transplantation.⁷ Many fear being on record as organ donors, whether actively (through opting in) or passively (through not opting out), even if they are not opposed to post-mortem organ donation by a family member. In short, pursuit of presumed consent in the US would not be justifiable on consequentialist grounds [13, 17].

Allocating organs

Moral theory of organ allocation

Transplantation Ethics devotes a chapter to “A General Moral Theory of Organ Allocation” [2]. This chapter offers a “systematic organ allocation theory,” which, Veatch stresses, depends upon a “more general theory of ethics” [2]. Substantively, Veatch’s theories are all “grounded in the common moral premises of the tradition of Western liberal political philosophy,” a tradition that includes both utility/

⁷ In a 2019 US survey, 56.3% of respondents indicated support (“strongly support” or “somewhat support”) for a policy of presumed consent, an increase of 5.2 percentage points from 2012. However, in 2019, 34.4% indicated they would opt out under such a policy, up from 23.4% in 2012. Opting out would block post-mortem familial organ donation. For survey data from 2019, see “National Survey of Organ Donation Attitudes and Practices, 2019” [19]. For a summary and interpretation of survey data from 2005 and 2012, see Childress, *Public Bioethics* [13]. Many of the same questions were used across these surveys (2005, 2012, and 2019) to allow comparisons of trends at different times.

efficiency and justice/equity as well as other moral principles for structuring policies for allocating organs [2].

Veatch's work has significantly influenced debates about frameworks of organ allocation. And yet it has also encountered some serious limits and limitations, mainly because it adamantly insists on a lexical order of non-consequentialist principles over consequentialist principles—specifically, the absolute priority of egalitarian justice over medical utility in organ allocation. Before we consider how Veatch handles unavoidable conflicts between egalitarian justice and medical utility, we need to briefly sketch his conception of these two complex principles.

Veatch's core idea of justice recognizes “the fundamental equality of persons” [20, 21]. The egalitarian or “pure” principle of justice requires providing people “an opportunity for equality of well-being” and, within health care, “opportunities for equality of health” [20]. In contrast to some egalitarians who make an exception to requirements of equality in order to accommodate the needs of the worst off, Veatch builds the needs of the worst off into his conception. A serious challenge—the so-called “bottomless pit” problem—is that this would lead to investing resources, including organs, in those who have little chance of benefitting. In transplantation this would waste organs. Veatch rejects this charge by stressing limits on “worst off,” for instance, insisting that this does not require offering a transplant to a patient for whom it will do no good [20]. But this remains a serious challenge, especially in comparing the probable positive outcomes among different transplant candidates, including the worst off.

In holding that egalitarian justice requires equal *opportunities* for health, Veatch stresses that people who squander their opportunities, for example, by abusing alcohol or drugs that cause end-stage liver failure, do not have equal claims in justice for a liver transplant [2]. In such cases, other considerations might warrant equal priority, including compassion to those in need and the difficulty of determining the voluntariness of harmful actions or their actual role in end-stage organ failure in particular cases. Against Veatch, Lainie Ross, the co-author of the second edition of *Transplantation Ethics*, argues that justice requires “treat[ing] all patients according to need, regardless of how the need came about” even if we could resolve uncertainty about causation in particular cases [2].

The principle of beneficence combined with nonmaleficence—together constituting the principle of utility—requires maximizing good consequences. Transplantation often produces net positive medical and social effects, when their benefits and their harms, burdens, and costs are all balanced. In the allocation of organs, judgments of medical utility attend to probable positive medical outcomes among patients needing a transplant, such as patient survival, years of life, and quality-adjusted life years, minus probable negative outcomes, such as side effects. Comparing patients needing transplants in terms of their probable overall medical utility considers factors that predict better and worse outcomes, such as tissue match, Panel Reactive Antibodies (PRA), age, other medical conditions, and the like, which need to be incorporated into point systems.

Not surprisingly, given his overall ethical theory, Veatch rejects trade-offs between egalitarian justice and medical utility. His “preference” is never to permit “mere utility to offset nonconsequentialist ethical considerations such as justice”

[20]. This means that “no amount of medical utility” justifies overriding the egalitarian claim of justice that supports “a policy of allocating scarce medical resources such as kidneys on the basis of who is worst-off” [20].

In a debate with Veatch in the early 1990s, I argued that when there are conflicts between justice/fairness and medical utility in setting organ allocation criteria, it is “not possible to indicate in advance exactly which principle should have priority” [22]. Hence, I argued, balancing is required for particular policies. Veatch vigorously responded: “I want to go on record that I oppose this strategy as being terribly dangerous and contrary to our common moral sense” [20]. He condemned this balancing strategy as “dangerous” because “logically” it opens the door to “sacrifices” of other rights, perhaps even to such evils as unconsented-to Nazi-like medical experiments [20]. This invocation of the Nazi analogy is inappropriate when assessing organ allocation policies that seek to meet patients’ needs by considering both medical utility (degrees of medical need, probability of successful outcomes) and justice/fairness for all when there are simply not enough organs to go around.

Veatch’s own “preference is for an ethic that gives justice priority over utility, focusing on making those who are worst off among us more equal insofar as possible—that is, on giving the sickest the opportunity to recover their health, even if that means a less efficient system for allocating organs” [2]. This is not ethically acceptable to many who instead support a system that either assigns priority to medical utility or, alternatively, assigns equal weights to medical utility and egalitarian justice.

“Political compromise”: ideal theory versus nonideal theory

Veatch viewed “political compromise” as inevitable in a pluralistic, democratic society where people have different “preferences” about the respective weights of medical utility and egalitarian justice: “A good case can be made using democratic political theory that, although some would prefer utility and others justice, the appropriate political compromise is to give them equal weight in organ allocation” [2]. In accepting this “political compromise” for public policy formation, he also promoted, as did the national Task Force on Organ Transplantation, greater public participation in the process of setting organ allocation criteria [23]. The context and expression of this “political compromise” include US federal legislation and regulation, particularly the National Organ Transplant Act (NOTA) and the OPTN Final Rule.

Veatch himself contributed to this “political compromise.” As chair of a subcommittee on “General Principles of Organ Allocation” for the UNOS Ethics Committee in the early 1990s, Veatch took the lead in drafting an influential report which identified justice and utility as equally weighty principles that need to be balanced for “equitable” organ allocation [24, 25].⁸ Despite Veatch’s language of “political

⁸ In 1991, the Ethics Committee of the Organ Procurement and Transplantation Network (OPTN), which the United Network for Organ Sharing (UNOS) operates under a contract with and under the oversight of the federal government, approved a report on principles of organ and tissue allocation, which had been prepared by a subcommittee chaired by Robert Veatch who was also its primary drafter [2, 24, 25]. In 2010, a revised version was approved by the Board of Directors of the OPTN [25]. It underwent further review and update in 2015 and is available as a “White Paper” on the OPTN website [25].

compromise,” this is also a moral compromise and a compromise in moral theory, as is clear from his strong claims about the priority of justice/equity over utility/efficiency in his normative theory of organ allocation.

John Rawls' distinction between *ideal theory* and *nonideal theory* in *A Theory of Justice* [26] can help us sort out some critical issues.⁹ Sorely missing from Veatch's account is a serious examination of the relation between his *ideal* general moral theory of organ allocation (in which egalitarian justice has absolute lexical priority over medical utility) and his *nonideal* moral theory (in which these have equal weight). While the tensions and conflicts are evident, Veatch apparently still wanted his ideal theory to provide more than a blanket indictment of nonideal allocation decisions. However, we need to know more about his method for connecting ideal theory and nonideal theory and for supplying concrete guidance when his ideal theory cannot be realized. Instead, apart from mentioning some possible metrics [2], *Transplantation Ethics* mainly provides a series of rich and illuminating analyses of difficult problems in organ allocation, such as the role of geography, age, and the like in setting allocation formulae. It presents careful arguments from the standpoints of utility (efficiency) and justice (equity), but these arguments individually and collectively do not display a clear, coherent method for resolving the conflicts. In contrast to his ideal theory's lexical order, Veatch appears to engage in balancing—a process his ideal theory repudiated in conflicts between medical utility and egalitarian justice.

Veatch concedes that it simply may not be possible to realize his ideal moral theory in the real world of organ allocation policy in the United States. His ideal theory's absolute prioritization of egalitarian justice over medical utility seems to be—in Veatch's own words—“utopian” [2]. An organ allocation formula or point system can “satisfy fully” the non-consequentialist principles grouped under respect for persons, such as respecting autonomy and avoiding killing, before turning to consequence-maximizing principles, but it appears “impossible” to “satisfy fully” either egalitarian justice (equity) or utility (efficiency).

Some of Veatch's language suggests that he could say that his ideal moral theory is “ethically preferable” but that, under various circumstances, a nonideal moral theory, which views medical utility and justice as equally weighty and then balances them for particular policies, expresses what is “ethically acceptable.” He prepared the way for such an approach by stressing that there are several right-making characteristics including both medical utility and justice and that “a policy that is just or fair may turn out not to be exactly the policy that is ethically right, all things considered” [20].

Armed with this distinction between justice and rightness, Veatch admits that the sacrifice of justice could be justified under some circumstances, that is, it could be “right,” but it should not be called “just” [20]. As a requirement of honesty, he insists that we should clearly state that “we are *sacrificing justice* in order to make the system more efficient or utility maximizing” [20] (emphasis added). This sharply

⁹ There is debate among philosophers about how best to interpret Rawls' distinction and its implications [27, 28].

contrasts with approaches that recognize various theories of justice, including utilitarian, libertarian, and communitarian as well as egalitarian ones [8].

Clearly, we need to know more about Veatch's conception of the distinctions and relations between his ideal and nonideal theories and about his methodology for connecting them in public policy. This is especially important if ideal theory is expected to provide more than an indiscriminate criticism of nonideal theory for falling short of the ideal. What does the ideal theory contribute when it cannot be fully realized? Does it aid in making judgments—and if so, exactly how—about the appropriate balance of medical utility and equity in specific organ allocation point systems? How, if at all, does ideal theory help us identify which “compromises” are ethically acceptable, even if not ethically ideal? Should our judgments in nonideal theory be based on which proposed organ allocation formula most approximates the ideal theory or would move in the direction of the ideal theory over time?

As rich and as illuminating as Veatch's various arguments are about particular allocation policies, his general practical guidance is limited because of a lack of clarity and detail about the relation between ideal theory and nonideal theory. This is all underdeveloped and undertheorized. We would have benefited greatly from Veatch's closer attention to these matters. It is sad and unfortunate that we cannot have this further conversation on this occasion of honoring Robert Veatch for his remarkable and enduring contributions to bioethics in general and to transplantation ethics in particular. Thank you, Bob!

References

1. Veatch, Robert M. 2000. *Transplantation ethics*. Washington, DC: Georgetown University Press.
2. Veatch, Robert M., and Lainie F. Ross. 2015. *Transplantation ethics*, 2nd ed. Washington, DC: Georgetown University Press.
3. United Network for Organ Sharing. 2020. In Memoriam: Robert Veatch, Ph.D. *UNOS News*, December 23, 2020. <https://unos.org/news/in-memoriam-robert-veatch>. Accessed September 2, 2021.
4. Veatch, Robert M. 1981. *A theory of medical ethics*. New York: Basic Books.
5. Veatch, Robert M., and Laura K. Guidry-Grimes. 2020. *The basics of bioethics*, 4th ed. New York: Routledge.
6. Veatch, Robert M. 2020. Reconciling lists of principles in bioethics. *Journal of Medicine and Philosophy* 45: 540–559.
7. Veatch, Robert M. 2007. How many principles for bioethics? In *Principles of health care ethics*, 2nd ed., ed. Richard E. Ashcroft, Angus Dawson, Heather Draper, and John R. McMillan, 43–50. West Sussex: John Wiley.
8. Beauchamp, Tom L., and James F. Childress. 2019. *Principles of biomedical ethics*, 8th ed. New York: Oxford University Press.
9. Beauchamp, Tom L., and James F. Childress. 2020. Response to commentaries. *Journal of Medicine and Philosophy* 45: 560–579.
10. Veatch, Robert M. 2003. Revisiting *A Theory of Medical Ethics*: Main themes and anticipated changes. In *The story of bioethics: From seminal works to contemporary explorations*, ed. Jennifer K. Walter and Eran P. Klein, 67–89. Washington, DC: Georgetown University Press.
11. Veatch, Robert M. 1995. Resolving conflict among principles: Ranking, balancing, and specifying. *Kennedy Institute of Ethics Journal* 5: 199–218.
12. US House of Representatives. *Organ transplants: Hearings before the Subcommittee on Investigations and Oversight of the Committee of Science and Technology*. 98th Congress, 1st Session. Washington, DC: US Government Printing Office.

13. Childress, James F. 2020. *Public bioethics: Principles and problems*. New York: Oxford University Press.
14. Veatch, Robert M. 1976. *Death, dying, and the biological revolution: Our last quest for responsibility*. New Haven: Yale University Press.
15. Veatch, Robert M. 1989. *Death, dying, and the biological revolution: Our last quest for responsibility*. Rev. New Haven: Yale University Press.
16. Childress, James F. 1997. *Practical reasoning in bioethics*. Bloomington: Indiana University Press.
17. Childress, James F., and Catharyn T. Liverman, eds. 2006. *Organ donation: Opportunities for action*. Washington, DC: National Academies Press.
18. Areen, Judith. 1988. A scarcity of organs. *Journal of Legal Education* 38: 555–565.
19. Health Resources and Services Administration. 2020. *2019 National survey of organ donation attitudes and practices: Report of findings*. Rockville, MD: US Department of Health and Human Services. <https://www.organdonor.gov/sites/default/files/organ-donor/professional/grants-research/nso-dap-organ-donation-survey-2019.pdf>.
20. Veatch, Robert M. 1991. Equality, justice, and rightness in allocating health care: A response to James Childress. In *A time to be born and a time to die: The ethics of choice*, ed. Barry S. Kogan, 205–216. New York: Aldine De Gruyter.
21. Veatch, Robert M. 1986. *The foundations of justice: Why the retarded and the rest of us have equal claims to equality*. New York: Oxford University Press.
22. Childress, James F. 1991. Fairness in the allocation and delivery of health care: The case of organ transplantation. In *A time to be born and a time to die: The ethics of choice*, ed. Barry S. Kogan, 179–204. New York: Aldine De Gruyter.
23. Task Force on Organ Transplantation. 1986. *Organ transplantation: Issues and recommendations*. Washington, DC: United States Department of Health and Human Services.
24. Burdick, James F., Jeremiah G. Turcotte, and Robert M. Veatch. 1992. Principles of organ and tissue allocation and donation by living donors. *Transplantation Proceedings*. 24 (5): 2226–2235.
25. Organ Procurement and Transplantation Network. 2015. Ethical principles in the allocation of human organs. <https://optn.transplant.hrsa.gov/resources/ethics/ethical-principles-in-the-allocation-of-human-organs>. Accessed September 2, 2021.
26. Rawls, John. 1971. *A theory of justice*. Cambridge: Harvard University Press.
27. Simmons, A. John. 2010. Ideal and nonideal theory. *Philosophy and Public Affairs* 38: 5–36.
28. Valentini, Laura. 2012. Ideal versus non-ideal theory: A conceptual map. *Philosophy Compass* 7: 654–664.

Publisher's Note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.