

GIVING UNTIL IT HURTS: PRISONERS ARE NOT THE ANSWER TO THE NATIONAL ORGAN SHORTAGE*

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This Note argues that prisoners, whether executed or living, should not become organ donors. The introduction acknowledges the shortage of transplantable organs in the United States and the steps that have been taken to ameliorate this crisis. Part I discusses the procurement of organs from executed prisoners, beginning with a brief examination of China, a country where this type of procurement is routinely practiced. Part I also examines organ procurement legislation pertaining to executed prisoners. Finally, Part I asserts the reasons that prisoners should not become donors, including the dead donor rule, the ban against physicians as executioners, the Oath of Hippocrates, the risk of transmissible diseases, and the negative perception that would result if organ procurement was tied to executions. Part II of this Note discusses prisoners donating their organs in return for mitigated sentences. Part II then argues that this practice should not be adopted because of the lack of informed consent and voluntary choice. Finally, Part III of this Note introduces potential solutions to the national shortage of transplantable organs. Specifically, this Part discusses the possibility of maintaining a voluntary system, moving to a presumed consent system, and using financial inducements to create a larger supply of transplantable organs.

INTRODUCTION

The need for organs is far greater than the available supply. In 1999, the total number of organs recovered for donation by the United Network for Organ Sharing (UNOS)¹ was 10,538.² However, the UNOS national patient waiting list for organ transplants increased to seven times the amount recovered by the year 2000.³ “The gap between need and supply of organs also reflects the fact that while the number of transplants each year has been increasing, the number of waiting list registrations has been growing twice as fast.”⁴ Although startling,

* This Note was selected by the *Indiana Law Review* Volume 34 Board of Editors as the 2001 Outstanding Note.

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1. WILLIAM CURRAN ET AL., *HEALTH CARE LAW AND ETHICS* 767 (Epstein et al. eds., 5th ed. 1998). “UNOS is a membership organization that includes the [sixty-nine] organ procurement organizations throughout the country, as well as transplant surgery centers, medical laboratories that perform tests for organ matching, volunteer and advocacy groups, donors and donor families, transplant recipients and patients awaiting a transplant.”

2. United Network for Organ Sharing, *Critical Data: U.S. Facts About Transplantation*, http://www.unos.org/Newsroom/critdata_main.htm (n.d.) (basing this statistic on the UNOS Scientific Registry data as of June 10, 2000).

3. *Id.* (showing that the waiting list totaled 71,366 as of August 26, 2000).

4. CURRAN ET AL., *supra* note 1, at 721 (“While the number of waiting list registrations rose from 16,000 to 50,000 between 1988 and 1996, the number of transplants rose from 12,800 to

these figures underestimate the problem.

Many individuals in need of a new organ are never placed on a local, regional, or national waiting list.⁵ Transplant centers take into account many factors before assigning an individual to a waiting list. For instance, the centers consider the likelihood that the transplant surgery will go well, the length of time that the recipient will benefit from the transplant, and the quality of life that the recipient will experience post-transplant.⁶ Moreover, experts predict that “dozens of people probably die annually because they don’t have enough money for the operations or because they are considered too old to be worthy candidates.”⁷

More organ donors must be located to balance the disheartening figures of organ recovery and discontinue the ranking system inherent in the waiting list process. “The only solution to the ever widening gap between the number of organs available for transplantation and the number of patients waiting is to substantially increase the number of suitable organ donors identified and recovered.”⁸ Furthermore, a larger pool of organs would assure every individual in need a spot on a waiting list.

Recovering a larger number of organs, nonetheless, is an extremely difficult task under the present national system. Volunteerism is the current method used by the United States to recover transplantable organs. It is the belief of some transplant centers, however, that “relying on people’s altruism is naïve.”⁹ One transplant center director said, “[t]here’s an attitude of ‘Why should I help anybody else?’ And even worse than that, they’re suspicious of those who do.”¹⁰ Because of the belief that volunteerism is an insufficient means for closing the gap between organ need and supply, the national campaign to recover more organs has triggered inquiries into a variety of irrational, unworkable organ procurement methods.

The United States is not the only nation faced with an organ shortage and irrational proposed remedies. Australia is suffering from a national organ

20,200.”). See also Gloria Taylor & James Wolf, SCI. MUSEUM OF VA., *Organ/Tissue Donation and Transplantation*, <http://www.smv.org/prog/B2Kprimorgtrans.htm> (last updated July 15, 1999) (stating that the number of persons in need of an organ transplant has increased more than 100% since 1990).

5. CURRAN ET AL., *supra* note 1, at 720.

6. *Id.* at 767. See also Delthia Ricks, *Dying Woman’s Dream: Making Transplant List; The Sanford Woman’s Plight Illustrates How Some People Who Need Life-Saving Help Never Make the Cut*, ORLANDO SENTINEL, June 29, 1995, at A1 (noting that a UNOS spokeswoman suggested that medical and psychological tests need to be administered and the amount of family support considered when deciding who makes it onto a waiting list).

7. Ricks, *supra* note 6, at A1.

8. Taylor & Wolf, *supra* note 4.

9. Marcia Mattson, *Looking for Ways to Increase Organ Donation*, FLA. TIMES-UNION, May 9, 2000, at C1 (quoting Thomas Peters, director of the Jacksonville Transplant Center, who stated that some individuals view organ retrieval as an act of punishment).

10. *Id.* (quoting Thomas Peters).

shortage and has recently been exposed to some illogical ideas intended to increase the number of donors. The Australian government, for example, was recently faced with opposition to its introduction of “mandatory seat belt laws due to the detrimental effect it would have on the transplant front.”¹¹ This example shows that at least some individuals, who are involved in a national campaign to recover more transplantable organs for their country, only think of the innocent lives that could be saved, rather than other adverse effects of their efforts. Although a larger number of donors must be immediately located in the United States, utilizing prisoners, similar to opposing mandatory seat belt laws, is an irrational, unworkable proposal.

It is undisputed that the national search for more organ donors is a necessary and worthy cause. “The science and technology surrounding organ recovery and transplantation have advanced rapidly since its early development in the 1950s. No longer considered experimental, transplantation saves lives.”¹² State governments first addressed the need for organ donors when they approved the Uniform Anatomical Gift Act (UAGA) of 1968, which was designed to standardize the process of organ donation and removal.¹³ This Act did not generate the expected results; therefore, the UAGA was amended in 1987 to increase the number of potential donors.¹⁴ The federal government joined the campaign in 1984 by passing the National Organ Transplant Act (NOTA).¹⁵ The

11. Troy R. Jensen, *Organ Procurement: Various Legal Systems and Their Effectiveness*, 22 HOUS. J. INT’L L. 555, 577 (2000).

12. Taylor & Wolf, *supra* note 4.

13. Laura-Hill M. Patton, *A Call for Common Sense: Organ Donation and the Executed Prisoner*, 3 VA. J. SOC. POL’Y & L. 387, 389 (1996).

The 1968 UAGA provided that individuals at least eighteen years of age could make or refuse to make anatomical gifts at death. If the decedent had neither made a gift nor indicated any opposition to making a gift, the decedent’s family could authorize a gift on behalf of the decedent. The UAGA provided that gifts not revoked by the donor during life were irrevocable after death, and the execution of the donor’s wishes did not require the consent of the donor’s family. Furthermore, the UAGA provided that if the gift was made through a will or other document, the gift became effective upon the donor’s death without being subject to the probate process.

Andrew C. MacDonald, *Organ Donation: The Time Has Come to Refocus the Ethical Spotlight*, 8 STAN. L. & POL’Y REV. 177, 178 (1997).

14. MacDonald, *supra* note 13, at 178 (stating that the UAGA of 1987 added tools designed to guide the implementation and execution of the law by requiring hospitals to make a routine inquiry on whether an admitted patient wants to donate).

15. *Id.*

NOTA created the Division of Organ Transplant (DOT) as a division of the Department of Health and Human Services. DOT is responsible for administering NOTA, coordinating organ procurement activities, and encouraging donation. DOT is also responsible for the Organ Procurement and Transplantation Network (OPTN), the Scientific Registry, and grants to Organ Procurement Organizations (OPOs). OPOs are private health care institutions that receive federal grants for participating in organ

effectiveness of the UAGA, however, has recently been under fire as a result of “the current scarcity of human organs available for transplant.”¹⁶ Thus, other avenues, including the use of condemned prisoners as organ donors, are being proposed to solve this countrywide problem.

In some societies, the use of prisoners as organ donors might be considered beneficial. “The human body has approximately thirty transplantable parts.”¹⁷ Prisoners, as living donors, could donate non-vital organs, whereas executed prisoners could be used to provide vital as well as non-vital organs.¹⁸ This information tends to suggest that the organs of prisoners, whether dead or alive, could be used to save many lives. Unfortunately, in our society numerous barriers exist that prohibit the use of these organs for the purpose of donation.

Prisoner’s organs cannot be utilized because of legal, medical, and ethical barriers. The UNOS Ethics Committee “opposes any strategy or proposed statute regarding organ donation from condemned prisoners until all of the potential

transplant programs.

The OPTN established by NOTA was designed to create a national waiting list and a computerized method of matching organs with people on that list. The job of setting up and operating the OPTN was contracted out to the United Network for Organ Sharing (UNOS).

Id. at 178-79.

16. Patton, *supra* note 13, at 390. *See also* *Fixit; A Single Organ Donor Can Save Many Other Lives*, MINNEAPOLIS STAR TRIB., Jan. 12, 1997, at 9E (stating that “[a] name is added to the national waiting list every [eighteen] minutes”); Lisa R. Kory, *Altruism Should Prompt Organ Donation*, PLAIN DEALER (Cleveland, OH), June 16, 1999, at 8B (stating that “[e]ach day [ten] Americans waiting for organ donations die”); Mattson, *supra* note 9 (stating that “[e]very day, [thirteen] people die waiting for an organ”); Ricks, *supra* note 6 (estimating that each year 2000 Americans die while waiting for organ donations); Taylor & Wolf, *supra* note 4 (stating that “[f]or every patient who undergoes a successful transplant, two new patients begin their wait for an organ transplant”); Elizabeth Zubritsky, *Thousands Await Life-Saving Organs*, CHAPEL HILL HERALD, Apr. 25, 1995, at 1 (reporting that “nearly 3000 patients died while waiting for transplants [in 1994]”).

17. Gloria J. Banks, *Legal & Ethical Safeguards: Protection of Society’s Most Vulnerable Participants in a Commercialized Organ Transplantation System*, 21 AM. J.L. & MED. 45, 46 (1995). *See also id.* at 46 n.12 (citing Lloyd R. Cohen, *Increasing the Supply of Transplant Organs: The Virtues of a Futures Market*, 58 GEO. WASH. L. REV. 1, 3 (1989) (noting that there are at least twenty-five transplantable parts including the inner ear, a variety of glands (pancreas, pituitary, thyroid, parathyroid, and adrenal), blood vessels, tendons, cartilage, muscles (including the heart), testicles, ovaries, fallopian tubes, nerves, skin, fat, bone marrow, blood, livers, kidneys and corneas)).

18. Banks, *supra* note 17, at 53 (noting that vital organs consist primarily of organs that are irreplaceable and essential in preserving the life of the donor such as the heart, lungs, liver, pancreas, stomach and kidneys, whereas non-vital organs are those which can be removed from the donor without causing death due to their absence, such as one of two kidneys and a dissected portion of a functioning liver).

ethical concerns have been satisfactorily addressed.”¹⁹ When reaching its decision, the Committee considered the effects of such a law and determined that only a small number of organs would be recovered, and donation rates would most likely decrease as a result of the stigma attached to donation.²⁰ A beneficial way to understand why proposals of this practice should be immediately abandoned in the United States is to discuss another country that has shaped its existence.

I. ORGAN PROCUREMENT FROM EXECUTED PRISONERS

A. China's Practice

In China, organs from executed prisoners are habitually removed, resulting in tens of thousands of harvested organs.²¹ The Chinese government, however, has repeatedly denied such a widespread practice stating that it occurs “‘only in rare instances’ and ‘with the consent of the person’ to be executed.”²² Chinese law allows the procurement to occur, but only if the prisoner’s body is not claimed; if the prisoner has consented to the organ removal; or, if the prisoner’s family has given consent.²³ The facts, nevertheless, support a tainted system.

The Chinese government does not abide by its rigid law concerning the procurement of organs from executed prisoners. Organ procurement, for instance, is conducted with the acquiescence of Chinese government officials; organs are rarely obtained with the consent of the prisoner; and families are rarely informed that the prisoner’s organs will be removed.²⁴ Furthermore, China’s procurement of organs from executed prisoners is motivated by greed.²⁵ Although life-necessary organs cannot be sold in the United States,²⁶ organs in China are given to the individuals willing to pay the highest prices.²⁷ For example, between 2000 and 3000 organs are obtained from Chinese prisoners per

19. United Network for Organ Sharing, *UNOS Ethics Committee: Ethics of Organ Donation from Condemned Prisoners*, at <http://www.unos.org/resources/bioethics%5Fwhitepapers%5Fconvictdonors.htm> (n.d.).

20. *See id.*

21. Dan Burton, Editorial, *Outraged at China's Sale of Organs*, INDIANAPOLIS STAR, June 29, 1998, at A5.

22. Cesar Chelala, *Prospect of Discussions on Prisoners' Organs for Sale in China*, 350 LANCET 1307, 1307 (1997).

23. Patton, *supra* note 13, at 425 (citing Allison K. Owen, *Death Row Inmates or Organ Donors: China's Source of Body Organs for Medical Transplantation*, 5 IND. INT'L & COMP. L. REV. 495, 499-502 (1995)).

24. Chelala, *supra* note 22; Patton, *supra* note 13, at 425.

25. Burton, *supra* note 21, at A5 (noting that “[d]esperate people throughout Asia are being charged \$40,000 or more for organs”).

26. *See* CURRAN ET AL., *supra* note 1, at 722.

27. *See* Chelala, *supra* note 22.

year, and those organs are usually offered for around \$30,000 each.²⁸ China's practice, moreover, is unlikely to end.

Two examples suggest that the Chinese government may not intend to take any steps to discontinue the procurement of organs from executed prisoners. First, China's means of execution is still a gunshot to the head,²⁹ which conveniently allows this practice to continue. A gunshot to the head is "conducive to transplants because it does not contaminate the prisoners' organs with poisonous chemicals, as lethal injections do, or directly affect the circulatory system. . . ."³⁰ Second, it has been implied that this practice has sharply increased the number of executed convicts in China.³¹ "Even more disturbing is the fact that as the traffic in prisoners' organs has grown, so has the number of executions. Between 1988 and 1996, the number of kidneys transplanted in China rose fourfold. Between 1990 and 1996, the number of executions grew by 600 percent."³² Thus, there is an understandable anxiety among the Chinese that the procurement of the prisoners' organs is not an "unanticipated benefit."³³ Instead, this practice appears to be the main reason for the execution. The United States, consequently, should not adopt this practice.

China's system of procurement from executed prisoners is unethical, illegal, and morally revolting. Although this system has been attacked as violating human rights policies and the international standards of medical ethics,³⁴ this is only the outer core of its problems. If the United States were to implement such a system, the sale of organs would become a normal practice, the number of executions would rise without justification, and the organs of executed prisoners would be taken without consent. For these reasons, as well as the others discussed later in this Note, China's practice of organ procurement from executed prisoners cannot be adopted by the United States.

B. Origin in the United States

State legislators have proposed using prisoners as organ donors, particularly

28. *Id.*; Burton, *supra* note 21, A5 (stating that "[i]n 1996 alone, China earned almost \$100 million in hard currency from organ sales"); Christine Gorman, *Body Parts for Sale: An FBI Sting Operation Uncovers What Chinese Activists Say is a Grisly Trade: Human Organs for Cash*, TIME, Mar. 9, 1998, at 76 (stating that after an execution in China "[d]octors at military hospitals . . . transplant the organs into wealthy foreigners willing to pay anywhere from \$10,000 to \$40,000 for the operation").

29. Thomas Fuller, *Transplant Lifeline to Death Row: Organs of Executed Convicts in China Sold to Malaysians*, GUARDIAN (London), June 16, 2000, at 2.

30. *Id.*

31. See Chelala, *supra* note 22, at 1307; Gorman, *supra* note 28, at 76 (stating that "[s]ome activists fear that Chinese officials may have broadened the kinds of crimes punishable by death in order to line their own pockets").

32. Burton, *supra* note 21, at A5.

33. Patton, *supra* note 13, at 426.

34. Chelala, *supra* note 22, at 1307.

death row inmates. A Florida state legislator offered the most recent proposal. In 2000, state Representative William F. Andrews introduced Florida House Bill 999.³⁵ The original version of the bill entitled, “An Act Relating to Anatomical Gifts by Capital Defendants,” would have authorized death row prisoners to donate their organs upon execution.³⁶ Criticism to the bill, however, came from a variety of organ procurement organizations. Opposition, for example, came from the general counsel for Lifelink, a Tampa organ procurement organization, who cited medical, scientific and constitutional objections.³⁷ Representative Andrews subsequently revamped that version of the bill because “a host of ethical and scientific issues” had to be resolved before it could become law.³⁸ The bill presently states that “convicts will be given the opportunity to decide whether they want their organs to be donated, should they die in prison.”³⁹ The Florida House Crime and Punishment Committee approved the modified measure, yet the bill has to pass three more committees before it hits the House floor for a full vote.⁴⁰

Florida is not the only state that has considered this avenue to increase donation rates. Almost two decades ago, the California state legislature nearly faced a similar suggestion. “In 1984, a member of the California state judiciary committee prepared to introduce Senate Bill 1968, which would have provided for organ donation by condemned prisoners.”⁴¹ This bill, nonetheless, was never proposed as a result of California’s reluctance to execute its prisoners as well as the low percentage of organs that the proponent thought could be procured from this class.⁴² Then, in 1987, “in Kansas, state Representative Martha Jenkins introduced House Bill 2062, which . . . provided for organ donation by the condemned [prisoner],” but it did not prove to be a successful plan.⁴³ A similar proposal was also unsuccessful in Indiana. In that state, “representative Padfield introduced a resolution in 1995 urging Indiana’s Legislative Council to consider

35. Jeff Testerman, *Organs of Condemned Sought for Transplant*, ST. PETERSBURG TIMES, Mar. 26, 2000, at 1B; see also Mattson, *supra* note 9, at C1.

36. Testerman, *supra* note 35, at 1B.

37. *Id.*

38. *Id.* See also H.R. 999, 2000 Leg., 102d Reg. Sess. (Fla. 2000) (showing the original version of House Bill 999 that died in committee); S.B. 1970, 2000 Leg., 102d Reg. Sess. (Fla. 2000) (showing that a bill similar to the original House Bill 999 died on calendar).

39. Gwyneth K. Shaw, *Prisoners as Donors Could Flop; If a Death-Row Inmate Is Executed, There Is No Way To Keep the Heart Beating and Harvest Body Organs*, ORLANDO SENTINEL, Apr. 5, 2000, at D1. See also Mattson, *supra* note 9, at C1 (stating that the bill “would simply require the Department of Corrections to give donor cards to every prisoner”).

40. *Florida: Bill Allows Inmates To Donate Organs Upon Death*, American Health Line, Apr. 5, 2000.

41. Patton, *supra* note 13, at 432 (citing JACK KEVORKIAN, *PRESCRIPTION: MEDICINE* 163 (1991)).

42. *Id.*

43. *Id.* at 433.

organ removal from condemned prisoners.”⁴⁴ Furthermore, the former Attorney General of Texas, Jim Mattox, considered a similar proposal, yet no such law ever passed in that state.⁴⁵

Finally, in 1996, two states, Arizona and Georgia, considered the issue of executed prisoners as organ donors. Arizona state Representative Bill McGibben proposed a measure that would allow condemned inmates a choice between lethal injection or having their organs harvested for transplant.⁴⁶ McGibben argued, “if these guys can do something positive for society on their way out, why not?”⁴⁷ Despite his efforts, “the bill failed to pass out of committee.”⁴⁸ In Georgia, state Representative Teper proposed another bill, which provided the condemned prisoner with a choice between death by electrocution or guillotine.⁴⁹ This bill would have allowed those who chose death by guillotine to be organ donors; however, it did not succeed.⁵⁰ Representative Teper, in addition to that proposed bill, submitted a stay of execution for Georgia death row inmate Larry Lonchar. Lonchar, who was slated to die by electrocution, as required under Georgia law, stated that “he would like to donate his organs if an alternative method of execution would be allowed.”⁵¹ Ironically, Lonchar specifically requested to donate his kidney to the detective who supervised his investigation.⁵² Lonchar’s request, while raising many ethical and practical concerns, ultimately failed.⁵³ Electrocution remains the only method of execution in Georgia.⁵⁴ There are numerous reasons as to why these respective bills failed to become law. These reasons will be discussed in the remainder of this section and will give further support to the argument that legislation proposing the use of executed

44. *Id.* at 431-32; *see also id.* at 432 n.210 (recounting a telephone interview with Padfield in 1995 in which Padfield stated that Indiana’s Interim Committee on Criminal Justice convened without informing him and summarily rejected his proposed legislation without hearing any testimony); *id.* (citing 1995 Ind. Act 41) (calling “for a study of execution methods that do not destroy human organs”).

45. *Id.* at 433.

46. Pamela Manson, *Donor Group: Inmate Organs Unsuitable*, ARIZ. REPUBLIC, Jan. 12, 1996, at B1; Patton, *supra* note 13, at 432 n.213 (citing 1996 Ariz. Sess. Laws 2271 and 2007, which proposed an amendment to Arizona’s Constitution to provide for organ donation by the executed prisoner).

47. Patton, *supra* note 13, at 432.

48. *Id.*

49. *Id.* at 432 n.211 (citing 1996 Ga. Law 1274).

50. *See id.*

51. Marla Jo Brickman, *As Execution Nears, Donor Chance Fading; Death Row Inmate Doesn’t Want Wish to Result in Delay*, ATLANTA J. & CONST., June 20, 1995, at 4B.

52. Mark Curriden, *Inmate’s Last Wish Is to Donate Kidney; His Quest Opens Debate over Ethics of Harvesting Executed Convicts’ Organs*, 82 A.B.A. J. 26, 26 (1996).

53. *See generally* Angela Carson, *Lonchar v. Thomas: Protecting the Great Writ*, 13 GA. ST. U. L. REV. 809 (1997).

54. Patton, *supra* note 13, at 432 n.211 (citing H.B. 1113 (Ga. 1996)) (calling for execution by lethal injection and was later withdrawn from committee).

prisoners as organ donors should not be adopted.

C. Problems with Procurement from Executed Prisoners

Some cadaveric organs are not capable of being procured for transplantation because of the method of death. “Many potential organ donors are victims of accidents and violent crimes that result in some type of head injury.”⁵⁵ Public policy, moreover, directed to reduce these very accidents and crimes has resulted in a decrease in the number of cadaveric organs available for donation.

The number of persons who die in a way that leaves their organs suitable for transplantation is being reduced by the enactment of laws requiring seat belts or motorcycle helmets, the use of air bags in automobiles, gun control legislation, and the stricter enforcement of laws that prohibit driving under the influence of alcohol.⁵⁶

Although these laws are necessary for public welfare and safety, they put more pressure on the use of controversial classes of individuals as cadaveric donors such as anencephalic children⁵⁷ and executed prisoners.

Executed prisoners, however, are one class of potential cadaveric donors that cannot be utilized because their organs would be destroyed during the act of execution.⁵⁸ Execution destroys organs.⁵⁹ Although many barriers prohibit the use of prisoners as cadaveric organ donors,⁶⁰ the main barrier is that organ procurement centers would not be able to locate “cadavers that [had] fresh organs which [could] be used by the intended donee” from this population.⁶¹ First, the organs of executed prisoners would not be “fresh” because of the amount of time that transpires before the pronouncement of death.⁶² Second, even if that time frame could somehow be reduced, the organs would still not be useful to the intended donee because the various methods of execution in the United States, including lethal injection, electrocution, gas, hanging, and firing squad, all

55. Taylor & Wolf, *supra* note 4 (noting that patients who become brain dead from bleeding within the brain, patients who suffer strokes, patients who have primary brain tumors with no metastasis, patients with anoxic brain injury, patients who overdose on drugs, patients who die from smoke inhalation, patients who drown, or patients who go into cardiac arrest are potential donors).

56. CURRAN ET AL., *supra* note 1, at 721.

57. *In re Baby K*, 16 F.3d 590, 592 (4th Cir. 1994). Anencephaly is “a congenital malformation in which a major portion of the brain, skull, and scalp are missing.” These children only have a brain stem, will never be conscious, and normally die within a few days after birth. *See id.*

58. Rorie Sherman, “*Dr. Death*” Visits the Condemned, NAT’L L.J., Nov. 8, 1993, at 11 (noting that one of Dr. Jack Kevorkian’s objectives is to extract reusable organs of death row inmates before execution damages them).

59. *Id.*

60. *See Banks, supra* note 17, at 58.

61. *Id.*

62. Patton, *supra* note 13, at 401.

damage organs and render them useless for transplantation purposes.⁶³ No method of execution exists that would allow the procurement of prisoners' organs for transplantation.⁶⁴ Moreover, adding another method of execution to this nation's impressive list would not solve the national organ shortage.

Organ procurement should not become a new means of execution. "The death penalty is highly problematic morally, legally, and socially in those states that allow it; it would become even more so if it also served as a method of organ procurement."⁶⁵ Three major arguments block the adoption of organ procurement as a new method of execution. The dead donor rule would have to be modified, physicians would have to stand in the executioner's shoes, and the Oath of Hippocrates would have to be ignored.

1. *The Dead Donor Rule, Physicians as Executioners, and the Oath of Hippocrates.*—The act of organ donation as a means of execution is a very contentious proposal, especially within the medical community. The present means of execution available in the United States leave the prisoners' organs useless for transplantation purposes.⁶⁶ Organ donation as a means of executing prisoners, therefore, would be the only possible way to procure prisoners' organs for transplantation.⁶⁷ This means of execution, however, ignores the dead donor rule, which is "the ethical and legal rule that requires that donors not be killed in order to obtain their organs."⁶⁸

The dead donor rule is based on society's respect for human life.⁶⁹ "According to the law of every state, organs necessary for life (e.g., the heart or an entire liver) cannot be removed from a person for transplantation unless the

63. *Id.*

64. See Testerman, *supra* note 35, at 1B.

65. John A. Robertson, *The Dead Donor Rule*, 29 HASTINGS CENTER REP., Nov. 1, 1999, at 6.

66. See discussion *supra* Part I.C.

67. Execution by organ retrieval would be performed as follows:

The condemned prisoner would request this method five to seven days before the execution date. At the time selected for execution, the prisoner would be taken from death row to the prison hospital and strapped on a gurney as in preparation for execution by lethal injection. Witnesses to the execution, including the victim's family, could view the insertion of intravenous lines and administration of anesthetic outside of the operating room. When the prisoner became unconscious, he would be moved to an operating room where the transplant team would then remove all his organs. When organ removal was completed, ventilatory or other mechanical assistance would be terminated, as occurs in retrieval from brain-dead, heart-beating cadavers. Death would be pronounced as having occurred either at the time that the heart and lungs were removed, or when mechanical assistance was terminated. The retrieved organs would then be distributed to consenting recipients in accordance with existing rules for distributing organs.

Robertson, *supra* note 65, at 6.

68. *Id.*

69. *Id.*

person is dead”⁷⁰ Therefore, the rule protects the interests of living persons; it provides assurances to living persons that having their organs removed will not shorten their lives; and it preserves the value of respect for life. The act of organ procurement as a means of execution would require a modification of the dead donor rule. Although the proponents of such a modification argue that the benefits from relaxing the rule in the case of executed prisoners outweigh the loss of respect for human life, they ignore the fact that a very small number of organs would be procured as a result of this extremely controversial modification.⁷¹ There are approximately fifty executions each year;⁷² therefore, the number of lives saved would be very small. Modifications of the rule would also result in other difficulties.

A relaxation of the dead donor rule would “require a concomitant relaxation in prohibitions against physicians killing.”⁷³ Physicians would have to participate in the organ procurement from executed prisoners given the complex medical nature of this proposed procedure.⁷⁴ However, this proposal is tainted with one major problem. Physicians, according to the American Medical Association (AMA), are prohibited from participating in executions.

From a utilitarian standpoint this would make sense; the anesthetizing of the condemned and the recovery of organs in the usual manner would produce optimum organs for transplantation. However, the cross-clamping the aorta and the ensuing cardiectomy, followed by the disconnection of the ventilator, create an unacceptable situation for the organ recovery team. It clearly places the organ recovery team in the role of executioner.⁷⁵

“To be used for transplant to needy patients, the organs of condemned criminals would have to be removed under anesthesia prior to formal execution, in effect making physicians executioners—something organ recovery physicians won’t countenance.”⁷⁶

Additionally, if the dead donor rule were modified, the Oath of Hippocrates

70. CURRAN ET AL., *supra* note 1, at 731 (giving IND. CODE ANN. § 29-2-16-2 (1998) as an example). The Uniform Declaration of Death Act (UDDA) reads: “An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead.” James M. DuBois, *Non-Heart-Beating Organ Donation: A Defense of the Required Determination of Death*, 27 J.L. MED. & ETHICS 126 & n.2 (1999) (citing the PRESIDENT’S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *DEFINING DEATH: MEDICAL, LEGAL, AND ETHICAL ISSUES IN THE DETERMINATION OF DEATH* 73 (1981)).

71. See Robertson, *supra* note 65, at 6.

72. *Id.*

73. *Id.*

74. See Patton, *supra* note 13, at 403.

75. United Network for Organ Sharing, *supra* note 19.

76. Bette-Jane Crigger, *An Eye For an Eye; Donation of Death Row Inmates’ Organs*, 19 HASTINGS CENTER REP., Mar. 1989, at 3 (reporting Georgia’s bill was unsuccessful).

would have to be ignored. The Hippocratic Oath asserts that physicians should “[f]irst, do no harm.”⁷⁷ The Oath further declares, “I will . . . abstain from whatever is deleterious,” and “give no deadly medicine to any one if asked, nor suggest any such counsel”⁷⁸ Physicians are healers. The AMA, therefore, has constantly refused to give support to physicians participating in capital punishment because it is contrary to the Oath.⁷⁹ The AMA also believes that physician participation breaches society’s trust in the medical profession.⁸⁰ It believes that society would become doubtful of physician’s motives if they were to participate in capital punishment, and the trust between doctor and patient would be lost. Consequently, the AMA as well as other organizations take the position that such participation is unethical and grounds for sanctions.⁸¹ Although it can be argued that the AMA ambiguously defined the word “participation” in its resolution,⁸² it seems logical that an individual who actually causes the death of another by organ procurement is “participating.” Society’s interest in protecting the health of the individual is best served when physicians do not participate in executions. The health of the individual would be threatened if the organs of such a high-risk class were used for transplantation.

2. *High-Risk Group.*—Infectious diseases exist and continue to spread in correctional facilities.⁸³ Nearly all prisoners on death row have been involved in some type of risky activity, which has contaminated their organs with transmissible diseases. First, correctional facilities include a high concentration

77. Joel D. Kallich & Jon F. Merz, *The Transplant Imperative: Protecting Living Donors from the Pressure to Donate*, 20 IOWA J. CORP. L. 139, 139 (1994) (quoting STEDMAN’S MEDICAL DICTIONARY 716-17 (25th ed. 1990)).

78. The Oath of Hippocrates, at <http://www.humanities.ccny.cuny.edu/history/reader/hippoath.htm>.

79. David J. Rothman, *Physicians and the Death Penalty*, 4 J.L. & POL’Y 151, 153 n.3 (1995) (citing Sheryl Stolberg, *Doctor’s Dilemma: Physicians Attending Executions? Increasingly, Many Are Wrestling with Their Consciences—And Saying No*, L.A. TIMES, Apr. 5, 1994, at E1 (stating that “the AMA [has] concluded that doctors should have no role in executions other than to arrive afterward to certify that an inmate is dead”)).

80. Stacy A. Ragon, *A Doctor’s Dilemma: Resolving the Conflict Between Physician Participation in Executions and the AMA’s Code of Medical Ethics*, 20 U. DAYTON L. REV. 975, 998 (1995).

81. *Id.* at 991 (stating that the American College of Physicians, Physicians for Human Rights, the American Nurses Association, the American Public Health Association, the Society for Correctional Physicians, the National Commission on Correctional Health Care, and the World Medical Association join the AMA in its position).

82. Patton, *supra* note 13, at 394 (arguing that the resolution passed by the AMA against physician participation in executions left physicians free to define the word participation themselves).

83. D. Stuart Sowder, *AIDS in Prison: Judicial Indifference to the AIDS Epidemic in Correctional Facilities Threatens the Constitutionality of Incarceration*, 37 N.Y.L. SCH. L. REV. 663, 663 (1992).

of individuals with histories of illegal intravenous drug use.⁸⁴ Mandatory sentencing in drug offenses, for instance, has resulted in an extremely high percentage of drug offenders in the federal system.⁸⁵ Moreover, this high-risk activity does not stop once the drug offenders are incarcerated. A woman imprisoned at the California Institute for Women (CIW) reported that “there’s more dope in [CIW] than on the street.”⁸⁶ This activity of drug abuse within prison walls is able to continue with the help of drug smugglers, including visitors and prison guards.⁸⁷ Second, unsafe sexual practices also result in the transmission of diseases between inmates. “[B]oth consensual and coerced homosexual contact is a common occurrence in most, if not all, correctional facilities.”⁸⁸ Third, tattooing is another way prisoners’ organs could become contaminated. When multiple prisoners receive tattoos from the same unsterilized needle, there is an increased risk that those prisoners will acquire a transmissible disease. Prisoners’ organs are likely to be infected with tuberculosis, HIV, or hepatitis as a result of participating in any or all of these high-risk activities. Therefore, most prisoners are of no use to organ procurement centers or intended donees.⁸⁹ Federal organizations recognize that prisoners are a high-risk group and advise against using them as donors.

The Food and Drug Administration’s (FDA) Center for Biologics Evaluation and Research has advised blood and plasma centers not to accept prison inmates as donors.⁹⁰ The FDA reviewed a series of reports by the U.S. Department of Justice, the National Center for Disease Control and Prevention, and others, which found that the high-risk behavior of inmates “correlates with a high rate of infection among inmates and incoming prisoners with bloodborne transmissible agents, such as HIV and hepatitis viruses.”⁹¹ The FDA also forbids the use of prisoners as cadaveric organ donors because of this risk of transmitted diseases.⁹² An FDA spokesman said that “the reason for the FDA’s ban is that inmates often engage in high-risk activity, including intravenous drug use. ‘We have an overlapping system of safeguards. Even though the tests are good, they are not 100 percent accurate. We have to be certain.’”⁹³ Legislators should take

84. *Id.* at 666.

85. *Id.* at 667 (referring to a study conducted in San Diego, New York, Philadelphia, and Washington, D.C. that “reported that seventy percent of all arrestees had tested positive for the presence of one or more intravenous drugs in their bloodstream at the time of their arrests”).

86. *Id.*

87. *Id.* at 668.

88. *Id.*

89. See United Network for Organ Sharing, *supra* note 19.

90. *Blood Donor Criteria Revised to Exclude Prisoners; High Prevalence of Inmates Engaged in High-Risk Behavior for Blood-Borne Diseases*, 29 FDA CONSUMER 4 (1995).

91. *Id.*

92. Testerman, *supra* note 35, at 1B.

93. Twila Decker, *From Prison Cell, A Gift of Freedom*, ST. PETERSBURG TIMES, May 31, 2000, at 1D. See also Jeffrey A. Lowell, *Prisoner Organ Donation Is a Bad Idea*, ST. LOUIS POST-DISPATCH, Feb. 24, 1998, at B7 (stating that “no blood tests rule out the presence or absence of

the advice of the experienced individuals who make up the FDA rather than proposing organ donation laws based on little, if any, medical knowledge. Studies show, moreover, that most prisoners have transmissible diseases.

In reference to inmates, the National Commission on Acquired Immune Deficiency Syndrome has stated that “no other institution in this society has a higher concentration of people at substantial risk of HIV infection.”⁹⁴ A study conducted by the National Institute of Justice showed that the incidence rate of AIDS cases for the general public was 14.65 cases per 100,000 people compared to 202 cases per 100,000 in federal and state correctional facilities.⁹⁵ Prisoners who contract transmissible diseases, moreover, cannot donate their organs. The prevalence of HIV on death row makes prisoners’ organs only a minimal help to the national disaster, if any help at all. Florida’s Representative Suzanne Kosmas stated, “I just question the public policy reason for starting with those whose organs would be in the highest-risk end.”⁹⁶ The reality is that an organ infected with a transmissible disease could go undetected and be transplanted into an innocent individual. The organs of executed prisoners involve too great a risk. Moreover, the coupling of executions and organ removal could lead to a negative perception by society.

3. *Minorities and the Discriminatory Application of the Death Penalty.*—An organ procurement policy for prisoners condemned to death will result in a negative perception of organ donation.⁹⁷ The national system, which is based on altruism, will be tainted if associated with the controversy over capital punishment. This negative perception will most likely lead to a decrease in organ donation rates, especially among minorities.⁹⁸ “Any notion that particular groups of people [are] receiving increased numbers of death sentences to provide organs for the rest of society would clearly make it difficult to attempt to obtain consent for altruistic donation from these groups.”⁹⁹ Statistics show, moreover, that the death penalty is applied inequitably among racial and ethnic groups.¹⁰⁰

The death penalty is used to discriminate against African-Americans. “The data indicate that blacks are five times more likely to be sentenced to death than whites convicted of similar crimes. . . .”¹⁰¹ The federal death penalty represents the “most arbitrary and racially discriminatory use of the death penalty in the nation.”¹⁰² For example, Janet Reno, the Attorney General for the Clinton

these viruses with 100 percent certainty. Transplant recipients on immunosuppressive medications are particularly susceptible to these potentially fatal viruses.”).

94. Sowder, *supra* note 83, at 666.

95. *Id.* at 668.

96. *Florida: Bill Allows Inmates to Donate Organs Upon Death*, *supra* note 40.

97. *See* Patton, *supra* note 13, at 411.

98. *See* United Network for Organ Sharing, *supra* note 19.

99. *Id.*

100. *Id.*

101. *Id.* *See also* DAVID COLE, NO EQUAL JUSTICE: RACE AND CLASS IN THE AMERICAN CRIMINAL JUSTICE SYSTEM (1999) (discussing the discriminatory application of the death penalty).

102. Stephen B. Bright, *The Politics of Crime and the Death Penalty: Not “Soft on Crime,”*

Administration, approved ten death penalty prosecutions, all of which were against African-Americans, between her appointment in 1993 and 1995.¹⁰³ The discriminatory application of the death penalty, coupled with a law allowing organ procurement upon execution, would have tragic effects. African-Americans would continue to receive a disproportionate number of death sentences thereby providing organs for the rest of society. Consequently, African Americans, who are already hesitant to donate, would be less likely to donate their organs.

African-Americans are hesitant to donate because they have a negative view of the medical profession.¹⁰⁴ The Tuskegee Syphilis Study is one reason that African-Americans have a negative view of the medical community in general, and organ donation specifically.¹⁰⁵ This study began as an effort by the U.S. Public Health Service to control widespread cases of syphilis with mostly poor, uneducated, black sharecroppers in Tuskegee, Alabama.¹⁰⁶ It later became an experiment that left hundreds of black men intentionally untreated for their syphilis for nearly forty years.¹⁰⁷ The experiment continued even after penicillin was found to be a safe and effective cure.¹⁰⁸ According to Michael Taylor, “[t]he men were never told they were not receiving treatment and never given a full explanation of the meaning of syphilis and its deadly effects. And through it all, no one from the U.S. Public Health Services was held accountable.”¹⁰⁹ The Tuskegee Syphilis Study continues to influence the amount of trust that African-Americans give to organ procurement organizations. Moreover, if another negative perception were added to this inherent distrust, African Americans’ donation rates would be almost nonexistent.

The negative perception of organ procurement would most likely have the effect of wiping out every potential African-American donor.¹¹⁰ The Tuskegee

but Hard on the Bill of Rights, 39 ST. LOUIS L.J. 479, 480 n.6 (1995). See also *id.* at 481 (stating that of the first thirty-seven federal death penalty prosecutions, all but four were against members of a minority group).

103. *Id.* at 481 (stating that the racial disparity in federal death penalty prosecutions are even greater than in Alabama, Georgia, Mississippi, Texas, or any other state).

104. See CURRAN ET AL., *supra* note 1, at 782 (stating that most organs do not come from African-American donors).

105. See *id.*

106. Michael Taylor, *From Our Spirit: A Column for African-Americans: Righting the Wrongs of Tuskegee*, at <http://www.apla.org/apla/9705/spirit.html> (n.d.); University of Virginia Health System, *The Troubling Legacy of the Tuskegee Syphilis Study*, at <http://www.med.virginia.edu/hs-library/historical/apology/index.html> (last modified June 12, 2000).

107. Taylor, *supra* note 106.

108. *Id.*

109. *Id.*

110. “Minorities comprise 25 percent of the population and they also make up 25 percent of the donating population. ‘The problem is that when you look at the waiting list, they make up about one half of the list . . .’” *Selling African Americans on Organ Donation*, at <http://www.healthatoz.com/atoz/HealthUpdate/alert02232000.html>.

Syphilis Study “continues to cast a long shadow over the relationship between African Americans and the bio-medical professions; it is argued that the Study is a significant factor in the low participation of African Americans in . . . organ donation efforts”¹¹¹ African-Americans already distrust the medical community, and a law calling for inmate organ removal would cause African-Americans to distrust the medical community even more. Consequently, African-American organ donors would not exist. African-Americans, however, are not the only group to view the bio-medical community negatively.

The stigma attached to organ donation as a result of its association with capital punishment would also result in fewer donations by Caucasian-Americans. Although the death penalty is applied with equal force among Caucasian-Americans, they too have a reason to question the motives of bio-medical professionals. “The Clinton administration revealed that hundreds of persons had been involuntarily, and in some cases unknowingly, subjected to research in which they were exposed to radiation and other harmful substances.”¹¹² Thus, the distrust of medical professionals by Caucasian-Americans, like that of African-Americans, would be even greater if executions were linked to organ procurement, and fewer of those individuals would consider donation. Caucasians’ threshold for trusting the medical community may also be raised to an unattainable standard, and organ donation would suffer a distressing blow. Executed prisoners, therefore, should not be used as cadaveric organ donors.

Organ donation and the death penalty is a very risky union:

The purpose and effect of capital punishment is to end the life of a person who has himself taken life. Trying at the same time to preserve other lives through execution by organ retrieval only confuses the situation. It is best for organ transplantation and capital punishment to go their separate ways.¹¹³

Enacting a law that permits procurement of organs from executed prisoners will cause many potential donors, whether African-American or Caucasian-American, to rethink their decisions because of an inherent lack of trust in the medical profession. Donors will question the motives of the organ procurement team, believing their lives might be shortened in order to save another human being. This proposal, moreover, would not remedy the national organ shortage. George B. Markle, IV, a New Mexico surgeon, has deemed organ donation by executed prisoners pointless. “There are simply too few condemned prisoners, and fewer still executions, for this source to make up the shortfall in organs for transplantations.”¹¹⁴

111. *A Request for Redress of the Wrongs of Tuskegee*, at <http://www.med.virginia.edu/hs-library/historical/apology/report.html> (n.d.) (featuring an abstract of the Syphilis Study Legacy Committee Final Report of May 20, 1996).

112. CURRAN ET AL., *supra* note 1, at 277.

113. Robertson, *supra* note 65.

114. Crigger, *supra* note 76, at 3.

II. ORGAN DONATION IN EXCHANGE FOR A MITIGATED SENTENCE

A. *Origin in the United States*

At least one state legislator has proposed that death row inmates should be able to donate their non-vital organs in exchange for lighter sentences. Missouri State Representative Chuck Graham introduced a bill entitled “Life for a Life” in 1998, which targeted death row inmates.¹¹⁵ This bill proposed that prisoners on death row should be permitted to donate a kidney or bone marrow in exchange for a sentence of life without parole.¹¹⁶ Graham did not seem to be concerned with the small amount of healthy, non-vital organs that could be retrieved from this high-risk group.¹¹⁷ He stated, “if [prisoners] can save [three] innocent lives through this program then they are making society better.”¹¹⁸

A prisoner on Missouri’s death row found this exchange tempting. In 1998, Milton V. Griffen, who was sentenced to be executed on March 25, 1998 for fatally stabbing a man in 1980,¹¹⁹ stated that he was willing to “swap a kidney or some bone marrow to save his neck” under this controversial proposal.¹²⁰ Griffen further expressed his wish to “give back to the community” by becoming an organ donor.¹²¹ Griffen was not permitted to participate in the exchange, however, because Graham’s proposed bill violated federal law. The “Life for a Life” bill promoted the practice of selling organs to buy more time. Buying or selling organs is illegal in the United States,¹²² and Graham’s bill, though not promoting monetary exchanges, defied legislative intent. “Although the ‘letter of the law’ may not be violated in this bill, clearly the spirit is violated.”¹²³ Until the federal law is amended, organ donation must be altruistic. There cannot be any benefit to the donor, monetary or otherwise.¹²⁴ Even if the federal law were to allow incentives, live donation by death row inmates in exchange for life without parole would violate the prisoners’ rights, as discussed in the remainder of this section.

115. See Gorman, *supra* note 28, at 76.

116. *Id.*; Lowell, *supra* note 93, at B7.

117. See discussion *supra* Part I.C.2.

118. *Newsfront*: (MSNBC cable broadcast, Mar. 21, 1998) [hereinafter *Newsfront*].

119. *Killer Offers Organ to Get Off Death Row*, L.A. TIMES, Mar. 16, 1998, at A15.

120. *Id.*

121. *Id.*

122. Jensen, *supra* note 11, at 570. Proponents of the voluntary organ donation system claim that it is unethical and immoral to profit from the sale of human organs; the existence of a market in human body parts cheapens life; the practice of selling organs is similar to selling one’s self into slavery; and human organs simply fall into a category of something that cannot be sold. *Id.* at 572.

123. Lowell, *supra* note 93, at B7.

124. See *id.*

B. Problems with Procurement from Prisoners as Live Donors

Individual rights become the central issue of live organ donation. Environmental pressures to utilize living donors are increasing¹²⁵ because of the fixed number of cadaveric organs that are procured¹²⁶ and the increasing number of people placed on various waiting lists.¹²⁷ It has been argued that the “[p]rotection of the rights and health of the living person who is asked to donate an organ largely has been ignored by those who focus on the promotion of transplantation as a panacea for organ failure.”¹²⁸ It follows that the health and rights of prisoners could be disregarded to an even greater extent. Consequently, balancing the harms and the benefits of live prisoner donation involves much more care than ordinary live donor situations.

Live organ donation “is apparently based on a utilitarian balance of benefit to the recipient versus harm to the donor,”¹²⁹ but when prisoners are asked to donate in exchange for mitigated sentences, the balance becomes skewed. The benefits of the exchange would seem to greatly outweigh any potential harm for three main reasons. First, the exchange implies a benefit *to the donor* much greater than the potential harm. In the United States, an organ donor cannot receive a secondary gain.¹³⁰ Second, the small amount of information given to prisoners concerning live donation would make the potential harm seem very minimal. Third, the coercive nature of the exchange would eliminate any voluntary choice. Issues of family pressure, undue influence and property interest exist in this framework, but they will not be discussed in this Note.¹³¹ The first argument against live organ donation in exchange for a mitigated sentence is the lack of informed consent.

1. *Informed Consent.*—Prisoners cannot exchange an organ for a mitigated sentence because their consent would not be informed. “The most common controversy involving competent, live human organ donors centers on whether the donor’s consent to donate is voluntary and informed.”¹³² Every competent adult has a fundamental right to refuse unwanted medical treatment.¹³³

125. See Kallich & Merz, *supra* note 77, at 143.

126. See *id.* at 142-43 (noting that the fixed number of cadaveric donors may be a result of the declining number of donors from automobile fatalities, the increased prevalence of diseases that preclude use in transplants, and the reorganization of organ procurement activities from entrepreneurial activities to federally regulated enterprises); see also *supra* Part I.C.

127. See Kallich & Merz, *supra* note 77, at 143; see also *supra* text accompanying notes 1-15.

128. See Kallich & Merz, *supra* note 77, at 143.

129. Howard S. Schwartz, *Bioethical and Legal Considerations in Increasing the Supply of Transplantable Organs: From UAGA to “Baby Fae,”* 10 AM. J.L. & MED. 397, 427 (1985).

130. Lowell, *supra* note 93, at B7.

131. See generally Banks, *supra* note 17.

132. Banks, *supra* note 17, at 57; see also *id.* at 57 n.291 (citing *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 317 P.2d 170 (Cal. Dist. Ct. App. 1957) and *Natanson v. Kline*, 350 P.2d 1093, 1106 (Kan. 1960) as starting the era of informed consent doctrine).

133. See *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 269 (1990). “[N]o right is held

Therefore, “‘ideas of self-preservation, self-determination, and self-fulfillment are jeopardized when consent to a medical procedure is either uninformed, involuntary, or absent.’”¹³⁴ Knowledge of the risks involved is extremely important because the living organ donor has absolutely no medical need for the procedure and could be inflicted with serious health problems.¹³⁵ The knowledge prisoners receive, therefore, must be examined carefully to eliminate the possibility of misrepresentation.

Health care providers might be inclined to misrepresent risks to prisoners. The doctrine of informed consent requires that the physician and donor discuss the risks associated with the removal of the donor’s organs.¹³⁶ There are four requirements of informed consent:

Plaintiffs in informed consent claims generally will be required to prove that (1) the medical procedure carried a specific risk that was not disclosed, (2) that the reasonably prudent physician would have disclosed that risk to the patient, (3) that the undisclosed risk materialized, and (4) that the failure to disclose the information caused the patient’s injury.¹³⁷

Moreover, “[h]ealth care providers who misrepresent the risks associated with treatments could be held liable for fraud or misrepresentation.”¹³⁸ Physicians may misrepresent the risk because they believe that the convicted prisoner’s life is less important than the lives of the individuals waiting for transplants. However, the law does not allow this type of activity even if motivated to save an innocent life. Furthermore, prisoners are used for experimentation and research.¹³⁹ Organ donation is the next logical step.

Prisoners have been particularly targeted for experimentation and research purposes. “Scientists have sought to expand the knowledge of human biology, illness, and treatment, often at the expense of the least fortunate in society: slaves, the poor, criminals, and other institutionalized persons.”¹⁴⁰ Medical researchers, moreover, have a tendency to not disclose all of the potential risks

more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others. . . .” *Id.* (quoting *Union Pac. R. Co. v. Botsford*, 141 U.S. 250, 251 (1891)).

134. Banks *supra* note 17, at 57 (quoting Armand Arabian, *Informed Consent: From the Ambivalence of Arato to the Thunder of Thor*, 10 ISSUES L. & MED. 261 (1994)).

135. *See id.* at 85; Kallich & Merz, *supra* note 77, at 146 (discussing the risks of donating solid organs).

136. *See* Kallich & Merz, *supra* note 77, at 144; Anthony Szczygiel, *Beyond Informed Consent*, 21 OHIO N.U.L. REV. 171, 191 (1994) (stating that “[a] meaningful consent requires that the patient have some understanding of what she is agreeing to and how that course of treatment compares to alternative therapies and to non-treatment”).

137. CURRAN ET AL., *supra* note 1, at 227.

138. *Id.* at 228.

139. *See id.* at 201.

140. *Id.* at 276.

involved. "The reluctance of well-informed patients to participate in risky experiments might lead researchers either to conceal the experiment or to use patients from vulnerable or socially disadvantaged groups."¹⁴¹ A good example of information being concealed in an experiment involving a vulnerable group is the Tuskegee Syphilis Study.¹⁴² Prisoners, moreover, are another example of a vulnerable group used by researchers.

Prisoners have been particularly targeted for research studies because they "have long been conveniently immobile, docile, and hence ideal subjects. . . ."¹⁴³ For this same reason, they are being considered for organ donation. Many prisoners, faced with the option to donate their organs or die, are probably neither educated enough to know about their right to informed consent nor unwilling to choose the option of donation in exchange for a lighter sentence. Thus, physicians may not consider their fiduciary duties to disclose the risks as severely as their duties to other classes of living donors, especially when this vulnerable group could save innocent lives. Because a donor's consent is not informed if any crucial information is lacking or misrepresented, a physician, acting alone, cannot choose to remove non-vital organs from convicted prisoners in order to save innocent lives. A prisoner given the option of donating an organ for a mitigated sentence can neither give consent that is informed nor make a choice that is free of coercion.

2. *Coercion*.—The practice of live donation in exchange for a mitigated sentence necessarily involves coercion. Typically, live organ donation within families is welcomed.¹⁴⁴ However, most living donors are subjected to pressures from family members asking them to part with a kidney or a piece of liver.¹⁴⁵ Physicians, who verify that a family member could die without the donation, can also coerce donors in this context.¹⁴⁶ Both of these pressures can be classified as "subtle or not so subtle."¹⁴⁷ The pressure from family members can be compared to the coercion prisoners feel when forced to choose between live donation and death.

In *McFall v. Shimp*,¹⁴⁸ a Pennsylvania court refused to force a defendant to submit to an involuntary bone marrow transplant. In *McFall*, a transplant was necessary to save the life of the defendant's cousin, and the defendant was the only suitable donor.¹⁴⁹ The defendant refused to submit to the necessary

141. *Id.*

142. *See supra* discussion, Part I.C.3.

143. CURRAN ET AL., *supra* note 1, at 279.

144. *See id.* at 722.

145. *See id.* (stating that when donating occurs within the family there are concerns about coercion).

146. *See* Lawse v. Univ. of Iowa Hosps., 434 N.W.2d 895, 897 (Iowa Ct. App. 1988) (living donor was advised that his brother would die without a kidney transplant and the donor then consented to donate one of his kidneys).

147. Kallich & Merz, *supra* note 77, at 143.

148. 10 Pa. D. & C.3d 90 (Pa. C. 1978).

149. *Id.* at 92.

transplant, and his cousin filed suit.¹⁵⁰ The court did not compel the defendant to donate his bone marrow recognizing his constitutional right to refuse medical treatment and to maintain bodily integrity.¹⁵¹ The court reasoned:

For our law to *compel* defendant to submit to an intrusion of his body would change every concept and principle upon which our society is founded. To do so would defeat the sanctity of the individual, and would impose a rule which would know no limits, and one could not imagine where the line would be drawn.¹⁵²

Giving a prisoner the option to choose live donation or a death sentence compels a prisoner to submit to an intrusion of his body. A choice between death and life is not free of coercion. As the *McFall* court held, this coercion “would know no limits,” and would lead to a country that condones involuntary bodily invasions of prisoners for the benefit of an individual organ donor.¹⁵³

Live donations that do not involve family members, however, are discouraged by transplant centers.¹⁵⁴ Cases of stranger-to-stranger live donations do exist, yet they are very rare.¹⁵⁵ Unrelated transplants are beneficial because they broaden the pool of potential live donors and free up cadaveric donors for others on the waiting list.¹⁵⁶ However, medical professionals are hesitant to use the organs of unrelated donors even if it is the donor’s wish to donate for two main reasons. First, is “the decreased likelihood of a good match” when using an unrelated donor.¹⁵⁷ Second, “experience indicates that individuals who write to a transplant center in order to donate a kidney to a prospective recipient to whom they are not connected by any kind of emotional tie are frequently pathologic by psychiatric criteria.”¹⁵⁸ Additionally, there are also concerns about hidden payments when the donation is extra-familial.¹⁵⁹ Prisoner-to-stranger donations implicate even further coercion than stranger-to-stranger donations. “Legal ethicists object to inmates’ making organ donations while they’re alive to non-relatives because they believe it is impossible to obtain voluntary consent in a prison setting—especially among death row prisoners who hope their

150. *Id.* at 90.

151. *Id.* at 91.

152. *Id.* (emphasis in original).

153. *See id.*

154. *See* CURRAN ET AL., *supra* note 1, at 722.

155. *Virginian Ken Schuler Gives Liver to Stranger*, at http://www.unos.org/Newsroom/archive_story_19990820_schuler.htm (Aug. 20, 1999).

156. *Id.*

157. Schwartz, *supra* note 129, at 429. *See also* Banks, *supra* note 17, at 56 n.93 (noting that an organ transplant between genetic human twins, called an isograft, has been recognized as the most promising and successful tissue match for transplant procedures, resulting in a success rate over ninety percent).

158. Schwartz, *supra* note 129, at 429.

159. *See* CURRAN ET AL., *supra* note 1, at 722.

benevolence might win them pardons”¹⁶⁰ The prisoner’s benevolence, furthermore, will definitely win them pardons if a law allowing mitigated sentences in exchange for organs is passed.

A choice between death and donation can never be free of coercion.¹⁶¹ If prisoners are given the option to be living donors in exchange for mitigated sentences, they will be unable to make truly informed decisions or decisions that are free of coercion. “According to Sigrid Fry, the inherently coercive [prison] environment makes it ‘doubtful that prisoners can ever give truly voluntary consent’ to donate their organs”¹⁶² Moreover, when a mitigated sentence is added to this inherently coercive environment, the potential for a free decision is lessened if not destroyed. “Obviously a person condemned to death cannot consider organ or bone marrow donation as a coercion-free option. Even a death row inmate should have the option of refusing an invasive surgical procedure—although unlikely, given the alternative.”¹⁶³ The coercion implicit in Graham’s “Life for a Life” bill, “I’ll save you, if you spare me,”¹⁶⁴ is a very real and necessary obstacle in the way of passing such a law. Prisoners, like all other individuals, must have control over whether to donate their organs. Public opinion also supports the idea of bodily integrity.

3. *Public Opinion.*—Public opinion does not support a bill allowing prisoners to choose live donation in exchange for mitigated sentences. Although it has been argued that the idea of prisoners as live donors is much more popular than that of procuring prisoners’ organs after execution,¹⁶⁵ the type of live donation that involves a mitigated sentence is not. A survey administered by the *Orlando Sentinel Tribune* in 1998 revealed that twenty-six of the 617 readers questioned thought prisoners should be allowed to trade their organs for a lighter sentence and seventy-four percent thought prisoners should not be given this option.¹⁶⁶ One man interviewed about this proposal said that “this choice is unethical coherence, of course you will give up an organ instead of lethal injection.”¹⁶⁷ Another interviewee stated that “the prisons should be a place to go serve punishment and the prisoners should not be able to donate parts of their bodies.”¹⁶⁸ Some believe allowing prisoners to donate would establish “‘another vested interest in capital punishment,’ perhaps prompting judges and juries to

160. Sherman, *supra* note 58, at 11.

161. See Lowell, *supra* note 93, at B7.

162. Patton, *supra* note 13, at 417-18 (quoting Sigrid Fry, Note, *Experimentation on Prisoner’s Remains*, 24 AM. CRIM. L. REV. 165 (1986)).

163. United Network for Organ Sharing, *supra* note 19.

164. Lowell, *supra* note 93, at B7.

165. Patton, *supra* note 13, at 430 n.204. See also Robertson, *supra* note 65 (noting that Texas and other capital punishment states permit condemned prisoners to become live donors as long as the prisoners freely consent).

166. *Callers Reject Organ-Transplant Idea*, ORLANDO SENTINEL, Mar. 31, 1998, at E4.

167. *Newsfront*, *supra* note 118.

168. *All Things Considered* (NPR radio broadcast, Mar. 20, 1998).

impose the death sentence more readily.”¹⁶⁹ A proposal involving prisoners and mitigated sentences is not popular with the public. Yet, they might condone other more practical solutions to this problem.

III. POTENTIAL SOLUTIONS

A. *Voluntary System*

A voluntary system could be successfully implemented to solve this national crisis. “The current organ donation system in America is premised upon an ‘encouraged volunteerism’ basis, which recognizes that organ donation is legally permissible where the organ donor has freely (without coercion or undue influence) agreed to donate an organ for transplantation”¹⁷⁰ In this type of organ donation system, the donor is usually deceased. Although actual volunteerism is questionable when organs are removed from executed prisoners, the average American can voluntarily commit to this altruistic act. If more individuals were made aware of the organ shortage, educated on the availability of donor cards, and informed of the ability to tell their family of their wishes to donate, a larger pool of organ donors could be uncovered. The UNOS is leading this crusade.

The goal of the UNOS is to “[i]ncrease the public’s knowledge about the need for donors, and families will make more organs available.”¹⁷¹ In addition to the UNOS, other organizations have sought to increase education and public awareness of organ donation in furtherance of the voluntary system.¹⁷² Moreover, Jeffrey A. Lowell has argued that the representatives who have proposed the bills calling for prisoners to become donors “should lead by example: They should volunteer to be organ donors, sign the donor cards on the back of their drivers licenses, and share their wishes to be a donor with their families. Then, take the same message to their constituents.”¹⁷³ The reality, however, is that “[m]ore than [seventy-five] percent of potential organ donors do not donate.”¹⁷⁴

The voluntary system has many critics. The failure of potential donors to sign written directives; the inability of emergency and hospital personnel to locate existing donor cards; the failure of hospital personnel to approach families to request donation when the decedent does not have a donor card; the refusal of some families to give consent; and the failure of medical examiners to release bodies for organ recovery¹⁷⁵ are all major flaws of the voluntary system, and

169. Crigger, *supra* note 76, at 3.

170. Banks, *supra* note 17, at 64-65.

171. Mattson, *supra* note 9, at C1.

172. See *Organ Transplants: HHS, UNOS Announce First Substantial Increase in Organ Donations Since 1995*, Health Care Daily Rep. (BNA) (Apr. 19, 1999).

173. Lowell, *supra* note 93, at B7.

174. *Id.*

175. See MacDonald, *supra* note 13, at 180.

prove that other avenues must be considered. “Although the altruistic characteristic of voluntary donation laws is appealing, such laws have failed to reduce the organ deficit and are much less efficient than presumed consent in providing needed organs.”¹⁷⁶

B. Presumed Consent

“Under [the] ‘presumed consent’ approach, the law would shift the presumption that people do not want to donate their organs in the absence of explicit consent to a presumption that people do want to donate their organs in the absence of an explicit refusal.”¹⁷⁷ Only those individuals who do *not* want to donate are required to document their intentions in a presumed consent system.¹⁷⁸ “[P]resumed consent countries are more successful at augmenting organ supplies than countries relying on altruism.”¹⁷⁹ The intent to donate in a voluntary system can be manifested by either a donor card signed by the decedent or by a family member executing the decedent’s wishes.¹⁸⁰ Presumed consent for cadaveric organ donation offers advantages. For example, presumed consent does not harm individual liberty because donors are given the opportunity to opt-out. Also, the transplant is more likely to be successful because organs can be removed more quickly without contacting the donor’s family. Furthermore, presumed consent leads to an increased organ supply, resulting in more tissue matches.¹⁸¹

Many states allow medical examiners to remove corneas during autopsies. In *State v. Powell*¹⁸² and *Brotherton v. Cleveland*,¹⁸³ for example, the decedents’ corneas were removed without consent and used as anatomical gifts during statutorily required autopsies. These cases held that medical examiners can presume consent in these jurisdictions.¹⁸⁴ The medical examiners, however, cannot take the corneas without making a reasonable effort to ascertain a family’s objection.¹⁸⁵ These state statutes have many justifiable reasons, including: removing the corneas of a decedent during an autopsy results in a minimal intrusion into the person’s body; most families give consent when asked for permission; there is a small impact on the appearance of the deceased; and important health benefits are gained from corneal transplants.¹⁸⁶ A system of presumed consent to the removal of visceral organs would be the next logical

176. Jensen, *supra* note 11, at 570.

177. CURRAN ET AL., *supra* note 1, at 751.

178. MacDonald, *supra* note 13, at 181.

179. Jensen, *supra* note 11, at 565.

180. MacDonald, *supra* note 13, at 178.

181. Jensen, *supra* note 11, at 566-67.

182. 497 So. 2d 1188 (Fla. 1986).

183. 923 F.2d 477 (6th Cir. 1991).

184. CURRAN ET AL., *supra* note 1, at 749-50.

185. *Id.* at 750-51.

186. David Orentlicher, course handout in *Bioethics and the Law*, Fall 2000-2001, Indiana University School of Law—Indianapolis (on file with author).

step.

Some states have enacted statutes allowing the removal of visceral organs during autopsies.¹⁸⁷ However, these statutes have not been employed as much as those allowing the removal of corneas. “Medical examiners are reluctant to remove visceral organs for transplantation without the family’s permission.”¹⁸⁸ Although this system could be successful if implemented by professionals other than medical examiners during autopsies, critics support their argument with data from countries that utilize this practice.

Presumed consent has been employed in several European countries.¹⁸⁹ Austria and Belgium have found this system effective; however, the presumed consent system has not been successful in most of Europe, nor in Brazil.¹⁹⁰ Physicians, for example, usually ask the family for consent before the organs are removed for transplantation.¹⁹¹ “A system that has repeatedly failed in several countries is unlikely to succeed anywhere else. More consideration and study should be given to market driven alternatives.”¹⁹²

C. Financial Inducement

“Another obvious way to increase the supply of transplantable organs is with financial inducement.”¹⁹³ Financial incentives would primarily be for the families of decedents and could include such benefits as estate tax deductions, funeral expense allowances, and college education benefits.¹⁹⁴ A market system, in which human organs would be treated as a commodity, is another example of a financial inducement.¹⁹⁵ A posthumous system is the most supported financial inducement system; yet, both would increase the availability of organs.¹⁹⁶ Although federal law currently prohibits payment for organs,¹⁹⁷ some individuals are beginning to question its rationale.¹⁹⁸ Pennsylvania, for example, is one of the first states to challenge this controversial prohibition.

Pennsylvania is testing the federal law that makes it illegal to buy or sell

187. See CURRAN ET AL., *supra* note 1, at 749-50.

188. *Id.* at 751.

189. *Id.*

190. See Jensen, *supra* note 11, at 572-73.

191. See CURRAN ET AL., *supra* note 1, at 751.

192. Jensen, *supra* note 11, at 583.

193. CURRAN ET AL., *supra* note 1, at 756.

194. MacDonald, *supra* note 13, at 182.

195. *Id.*

196. *Id.*

197. Banks, *supra* note 17, at 74 (citing 42 U.S.C. § 274 (e) (1994), which provides that “it is ‘unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce.’”)

198. See *supra* note 122 and accompanying text.

organs.¹⁹⁹ Pennsylvania “dropped a plan to reimburse organ-donor families up to \$300 in funeral expenses, but now [is] considering covering up to \$3,000 in ‘incidental expenses’ such as food, lodging and transportation to help promote organ donation.”²⁰⁰ It dropped the funeral expense plan to reimburse donor families fearing that the plan might violate federal law; however, Pennsylvania’s new plan is exempt from federal law because the plan only defrays incidental expenses.²⁰¹ Many individuals support Pennsylvania in its fight to end the prohibition against buying and selling organs.

Thomas Peters is one of those individuals who support financial inducements. Peters, a clinical professor of transplant surgery at the University of Florida and director of the Jacksonville, Florida transplant center said that “a financial award would be a token of acknowledgment for serving society, akin to the funds the family of deceased military personnel receive, or the money older Americans receive after paying into Social Security during their careers. New federal laws may allow for pilot projects in financial incentives.”²⁰²

Proponents of financial inducement are subjected to a vast amount of criticism. First, opponents argue that organ sales will undermine altruistic attitudes.²⁰³ Proponents contend, however, that “altruism in society is not based on what kind of organ donation system we have.”²⁰⁴ The lack of altruism is a very unsubstantial reason to prohibit a system that increases the organ supply. “Food, water, shelter, and medical care, which are all necessary for human survival, are allocated on a market system. Why then should the harvest of organs, which also provides life to those in need, be any different?”²⁰⁵ Second, “[o]pponents also worry that organ sales ‘commodify’ the body.”²⁰⁶ There is also concern that desperate individuals will take unacceptable risks for pay.²⁰⁷ Proponents counter that society already commodifies people “paying them for the fruits of their mind.”²⁰⁸ Additionally, proponents argue that this proposal may be structured such that organs are taken only after death and payment made to the decedent’s heirs.²⁰⁹ Third, opponents are concerned that wealthy individuals will be able to obtain organs more easily than poor individuals.²¹⁰ However, public assistance programs could be implemented to avoid exploitation of the poor.²¹¹ Permitting sales only to the UNOS, which, in turn, allocates the organs according

199. See Mattson, *supra* note 9, at C1.

200. *Id.*

201. See *id.*

202. *Id.*

203. See CURRAN ET AL., *supra* note 1, at 757.

204. *Id.*

205. Jensen, *supra* note 11, at 580.

206. CURRAN ET AL., *supra* note 1, at 757.

207. See *id.*

208. *Id.*

209. *Id.*

210. See *id.* at 758.

211. See Jensen, *supra* note 11, at 579.

to its usual criteria, could also eliminate this concern.²¹² Fourth, critics argue that the cost of transplantation would increase, and the quality of donated organs would decrease.²¹³ The critics, however, fail to point to any empirical evidence that the cost of transplantation will go up and seem to ignore the fact that all organs are screened for quality before transplantation. Finally, opponents can argue that incentives would alienate families that might otherwise have approved of donating their loved one's organs.²¹⁴ However, those families could donate the money to a charity.²¹⁵ "The arguments made by the critics of a market system are not strong enough to justify the failure to seriously consider a market system."²¹⁶

Financial inducement should be seriously examined. "A market system with just enough incentive to override the prevailing concerns that deter people from becoming donors may very well eradicate the organ deficit."²¹⁷ Financial inducement might be capable of succeeding where altruism has failed.

Although it is impossible to assert with certainty the exact guidelines by which such a system would best function, it is reasonable to suggest that the theories should be more vigorously debated and tested. Once implemented, the market system could be improved and fine-tuned until it operates efficiently without favoring the wealthy or encouraging violations of human rights.²¹⁸

The federal ban on the selling and buying of human organs might be a barrier in the way of saving many innocent lives, and the rationale for that law is not convincing. The various proposals attempting to further organ donation, however, have to convince their critics.

Altruism, a humane system supported by most Americans, has not been successful. Systems which include financial inducement and presumed consent deserve serious consideration. Although prisoners are not the answer to the national organ shortage, the time has come to face the imperfect nation in which we live and employ a solution that is workable, instead of likeable.

212. See CURRAN ET AL., *supra* note 1, at 758.

213. Jensen, *supra* note 11, at 579.

214. See MacDonald, *supra* note 13, at 182.

215. See Mattson, *supra* note 9, at C1.

216. Jensen, *supra* note 11, at 583.

217. *Id.* at 578.

218. *Id.* at 583.