

JUSTICE FOR JAILBIRDS: SUMMONING BIOETHICAL LIBERATION FOR DEATH ROW AND REINVENTING INDIANA’S HOUSE BILL 41

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I. INTRODUCTION

Somewhere in our country a young child is dying in a hospital bed. Wires cover her body and the monotonous pang of a heart monitor fills the air. Next door, a young man hobbles out of bed. He makes it far enough to look out of his room's window. Each day, for each of these patients, is a gift—for each day is not a given. Each patient faces a similar fate. Living on the organ waiting list has its travails. It is unlikely that either patient will ever be a recipient.

And yet still, somewhere else in our country, two men are exact biological matches for these two patients. They want to donate. They have the medical requisites. However, they are disallowed from doing so. They cannot save the lives of these two patients. This story's conclusion is an unfortunate one, for at the end, both the patients and the willing donors die.

Should the patients' lives have been saved? Should the men have been allowed to donate? This cold injustice has happened and will continue to happen. However, what if you were told that these two men, the potential donors, were death row inmates? Would that change the injustice of the story? Would that change the weight of the patients' needs? Would that change the value of a decision to donate?

This is the battle that Indiana's legislative system needs to fight. We need to change the ending to this story. And we can. We can allow death row inmates to donate their organs. By allowing this, not only could we proactively combat the organ shortage but we could also preserve the biological autonomy of those condemned to die.

A. The History of Organ Donation

Organ donation may seem like a phenomenon brought on only by the recent breakthroughs of the medical community within the last few decades. However, organ donation and transplantation date back to the 18th century when researchers experimented with transplantation on both

humans and animals.¹ Since then, the evolution of medicine has come a long way. Now more and more tissues and organs are available to be recycled to save lives.

Anatomically, the organs and tissues available to be used in transplantations are numerous. Currently, “[t]he human body has approximately twenty-five transplantable parts, including the heart, nerves, skin, bone marrow, the liver, kidneys, corneas, glands, blood vessels, and tendons.”² And yet, just because the body has so many different parts that can be donated, does not necessarily mean that, by default, these organs are in fact given to those in need. Nonetheless, science has progressed to allow for this possibility. As such, the organ donation process has become quite simplistic. Transplantation surgeries are now more common than ever before.

In 1869 the first skin transplant was performed.³ Years later, doctors were able to successfully transplant a cornea.⁴ Even later, the first successful transplant of a kidney was performed in 1954.⁵ This was an immense breakthrough. The transplantation of an entire organ, like a kidney, meant that more vital and complex parts of the human body had the potential to be recycled as long as they remained functional.

Biological science was making leaps and bounds in the mid 1900s with these new technologies that allowed people to both donate and to receive life-saving organs and parts.

¹ *History, Organ Procurement and Transplantation Network*, U.S. DEPT. OF HEALTH AND HUMAN SERV., <http://optn.transplant.hrsa.gov/learn/about-transplantation/history/> [<http://perma.cc/7B44-9Q5X>] (last visited Nov. 20, 2015).

² Laura-Hill M. Patton, *A Call for Common Sense: Organ Donation and the Executed Prisoner*, 3 VA. J. SOC. POL’Y & L. 387, 388 (1996) (citing to Lloyd R. Cohen, *Increasing the Supply of Transplant Organs: The Virtues of a Futures Market*, 58 GEO. WASH. L. REV. 1, 3 (1989)).

³ *Timeline of Historical Events Significant Milestones in Organ Donation and Transplantation*, ORGANDONOR.GOV, <http://www.organdonor.gov/legislation/timeline.html> [<http://perma.cc/9CHV-MLHA>] (last visited Oct. 7, 2015).

⁴ *Id.*

⁵ *History*, UNITED NETWORK FOR ORGAN SHARING, <https://www.unos.org/transplantation/history/> [<http://perma.cc/48KJ-QA8H>] (last visited Oct. 7, 2015).

Thus, due to the increase in the use of these procedures, “the National Organ Transplant Association (NOTA) [in 1984], called for an Organ Procurement and Transplantation Network (OPTN).”⁶ OPTN was to be managed by a private, non-profit group.⁷ Doctors and patients alike could rely on this independent governing body to facilitate each of their needs. Organ donation, in practice and in procedure, was rapidly evolving and becoming a highly regulated and structured endeavor.

Nearly forty years after the first organ transplantation surgery, the first living-donor and living-recipient organ donation procedure was performed in 1998.⁸ By 2001, there were more living donors than deceased: 6,528 living donors as compared to 6,081 deceased donors.⁹ This accomplishment allowed the surplus living donors to achieve a valuable position in the organ donation hierarchy.

After successes in dead-donor operations, doctors began conducting procedures involving more essential, non-self-renewing organs.¹⁰ In one documented case involving a living donor, “Dr. Joseph E. Murray successfully transplanted a healthy kidney from Ronald Herrick to Mr. Herrick's identical twin Richard, who had been diagnosed with end-stage kidney failure.”¹¹ Richard lived many years longer following the life-saving transplant, before suffering a heart attack and dying.¹²

After Dr. Murray's successful kidney transplant procedure, the realm of biological science and operative medicine had been forever changed. To keep pace with the growing evolution of organ transplantation, even more regulation was needed. Today, the Uniform Anatomical Gift

⁶ *Id.*

⁷ *Id.*

⁸ *Id.*

⁹ *Id.*

¹⁰ Kelly Ann Keller, *The Bed of Life: A Discussion of Organ Donation, Its Legal and Scientific History, and A Recommended “Opt-Out” Solution to Organ Scarcity*, 32 STETSON L. REV. 855, 865-66 (2003).

¹¹ *Id.*

¹² *Id.*

Act (UAGA), the United Network for Organ Sharing (UNOS), and the National Organ Transplant Act (NOTA) all serve as entities that regulate various transplant and donation procedures, established to coordinate and regulate organ transplantation.

The UAGA was established in 1968.¹³ This Act established protocol that allowed for donation via documented gifts.¹⁴ The Act “deemed a person's legal consent to donate before death sufficient under the law”¹⁵ Thus, UAGA allowed the law to catch up with science.

However, despite the breakthroughs in science and the legal underpinnings that proved to be quite simple, a deficit was created. As of January 31, 2016, there were 121,579 individuals waiting for an organ transplant.¹⁶

Someone is added to the organ wait list every 10 minutes.¹⁷ And, although seventy-nine people receive organ transplants each day,¹⁸ on average, it is estimated that twenty-two people die waiting for an organ everyday.¹⁹

For those lucky enough to be placed on a waiting list, the process is highly and thoroughly systematic. Through the UNOS Organ Center, organ donors are matched to waiting recipients all day, every day throughout the year.²⁰ “When an organ becomes available, the local organ procurement

¹³ *Selected Statutory and Regulatory History of Organ Transplantation*, ORGANDONOR.GOV, <http://www.organdonor.gov/legislation/legislationhistory.html> [http://perma.cc/5Q2M-9PJ2] (last visited Nov. 16, 2015).

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Data*, ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK, <http://optn.transplant.hrsa.gov/converge/data/> [https://perma.cc/RX7E-NLLS] (last visited Jan. 31, 2016).

¹⁷ *The Need is Real: Data*, ORGANDONOR.GOV, <http://www.organdonor.gov/about/data.html> [http://perma.cc/8PDC-2NDB] (last visited Nov. 16, 2015).

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ UNITED NETWORK FOR ORGAN SHARING, <https://www.unos.org> [http://perma.cc/P359-AMZA] (last visited Oct. 8, 2015).

organization (OPO) sends medical and genetic information to UNOS.”²¹ UNOS then generates a list of potential recipients.²² The organ is first offered to the candidate who is the best match.²³ Organs are distributed locally first, and if no match is found, they are offered regionally and then nationally.²⁴

Though there are thousands on the waiting list, many of those people could be helped or saved by just a few donors. “Experts say that the organs from one [person] can save or help as many as [fifty] people.”²⁵ With a few simple steps, it’s easy to become a donor. All it takes is signing up for a state’s donor registry. Even when updating one’s identification at the DMV, a simple “yes” answer would allow an individual to become a donor. However, despite the seemingly simple processes, not all people are given the right to donate in its entirety.

II. ORGAN DONATION IN PRISON SYSTEMS

A. Rights of Regular Inmates

Many are unaware that even in light of the huge demand for organs and tissues, not all people are afforded the right to donate. Many cannot participate in live donations and even more striking, others may not be allowed to donate upon death. These people are our nation’s death-row prisoners.

Many states oppose the idea of allowing condemned prisoner organ donation considering the high-risk population

²¹ *Organ Transplantation*, CLEVELAND CLINIC: TREATMENT AND PROCEDURES, https://my.clevelandclinic.org/health/treatments_and_procedures/hic_Organ_Donation_and_Transplantation [<https://perma.cc/5KVP-BT5V>] (last visited Nov. 24, 2015).

²² *Id.*

²³ *How Organs Are Matched*, UNITED NETWORK FOR ORGAN SHARING, <https://www.unos.org/transplantation/matching-organs/> [<http://perma.cc/3URR-F84Y>] (last visited Oct. 8, 2015).

²⁴ *Id.*

²⁵ *Organ Donation*, U.S. NAT’L LIBR. OF MED., <http://www.nlm.nih.gov/medlineplus/organdonation.html> [<http://perma.cc/UG3Z-7KGK>] (last updated Oct. 2, 2015).

that comprises prisons in the United States.²⁶ Since the 1990s, health-related risks have prevented inmates from being able to donate their organs.²⁷

However, in Arizona's Maricopa County, as of 2007, there is a program to allow inmates to donate only certain organs.²⁸ Nevertheless, for death row inmates, the official position of UNOS currently is that until the ethical and legal barriers of condemned prisoner organ donation are overcome, no support can be lent to the movement.²⁹

And yet, in spite of UNOS's stance, Arizona's prison organ donation program has proven to be quite effective.³⁰ In Arizona, when criminals are booked into prison, they are given the opportunity to register to be an organ donor.³¹

²⁶ See Lawrence O. Gostin, *Prisoners Shouldn't Be Allowed to Donate Their Organs*, N.Y. TIMES (April 26, 2013, 1:18 PM), <http://www.nytimes.com/roomfordebate/2013/04/25/should-prisoners-be-allowed-to-donate-their-organs/prisoners-shouldnt-be-allowed-to-donate-their-organs> [<https://perma.cc/JPE3-DHRY>].

²⁷ Martha F. Rogers et al., *Guidelines for Preventing Transmission of Human Immunodeficiency Virus Through Transplantation of Human Tissue and Organs*, CDC (May 20, 1994), <http://www.cdc.gov/mmwr/preview/mmwrhtml/00031670.htm> [<http://perma.cc/W2CY-HJTA>].

²⁸ Shannon Ross, *With Organ Donations, Let Prisoners Give Life to Others*, N.Y. TIMES (Apr. 25, 2013), <http://www.nytimes.com/roomfordebate/2013/04/25/should-prisoners-be-allowed-to-donate-their-organs/with-organ-donations-let-prisoners-give-life-to-others> [<http://perma.cc/38BK-4TUG>]. See also Joe Arpaio, *Arpaio's 'I Do' Program (Inmates Willing to Donate Their Organs) Has Them Joining National Drive*, MARICOPA COUNTY NEWS RELEASE (Apr. 29, 2015) available at <http://www.mcso.org/MultiMedia/PressRelease/Organ%20Donor.pdf> [<https://perma.cc/78VH-9G34>].

²⁹ *The Ethics of Organ Donation from Condemned Prisoners*, U.S. DEP'T OF HEALTH & HUMAN SERV., <http://optn.transplant.hrsa.gov/resources/ethics/the-ethics-of-organ-donation-from-condemned-prisoners/> [<http://perma.cc/5GWH-3VG5>] (last visited Oct. 8, 2015).

³⁰ Arpaio, *supra* note 28.

³¹ Kate Bennion, *Kidneys from Felons? Prisoner Organ Donation Spurs Debate*, DESERET NEWS (April 24, 2013, 11:05 AM), <http://www.deseretnews.com/article/865578852/Kidneys-from-felons-Prisoner-organ-donation-spurs-debate.html?pg=all> [<http://perma.cc/B2N4-4QHM>].

Somewhere between frisking and fingerprinting, those who opt in are given access to the state donor registry site . . . As of [January] 28 of [2013], the office has registered 14,124 inmates for the state organ donor program. Those booked into the county jail are pre-sentence and pre-trial detainees or sentenced to a year or less. If they [a]re released, they are no longer considered by the organ registry to be at high risk for health complications – and remain on the state organ donor registry.³²

One must keep in mind though, that the various programs that are offered to allow inmates to donate their organs are conditioned upon death within the prison system. Many politicians, lawmakers, and ethicists struggle in grappling with the idea of allowing *living* prisoners to donate non-vital organs like kidneys. The potential risks of coercion, undue persuasion, or even compensation for a decreased prison sentence are worrisome.

As an example, “[i]n January 2011, Mississippi Governor Haley Barbour freed two sisters from life sentences . . . on the condition that one donate a kidney to the other.”³³ Governor Barbour granted parole to Gladys Scott on the condition that she become a donor for her sister, Jamie Scott, who needed a kidney transplant in order to survive without the imposition of dialysis treatment.³⁴ Barbour claimed that his reasoning was based in part on the financial burden of Jamie Scott’s kidney dialysis treatment on the state.³⁵ Despite the arguably unethical underpinnings of these orders, one must ask how this can be tolerated over death row organ donation, where there may be no coercion or unethical persuasion at play.

Similar to Governor Barbour’s order, other state legislators have proposed bills that would shorten sentences

³² *Id.*

³³ Arthur Caplan, *The Use of Prisoners as Sources of Organs – An Ethically Dubious Practice*, 11 AM. J. OF BIOETHICS 1, 1 (2011), available at http://dihealtheconomist.com/media/caplan_prisoners_organs.pdf [https://perma.cc/TP72-XUZB].

³⁴ *Id.*

³⁵ *Id.*

for inmates who choose to donate organs.³⁶ In 2007, a law was proposed in South Carolina that would shorten prison sentences in exchange for kidney or bone marrow donation.³⁷ Further, South Carolina “State Senator Ralph Anderson proposed bills that would release prisoners [sixty] days early”³⁸ One bill gave early release for those who donated bone marrow and the other gave “good-behavior credit of up to 180 days, ‘to any inmate who perform[ed] a particularly meritorious or humanitarian act [] includ[ing] living kidney donation.’”³⁹

Regulations such as these are completely unethical because they function as bribes. These ethical pitfalls are not givens, and they are not necessarily fundamental to how death row inmate donation could work. Realistically, for condemned prisoners, unlike regular inmates, there is no incentive to be had. And so, without any indication of incentivized conditions, even those who wish to be wholly and truly altruistic nonetheless cannot.

B. Rights of Death Row Inmates

Utah, in 2013, became the first state to allow any inmate to donate his organs if he were to die while incarcerated.⁴⁰ This law, while a major breakthrough in the realm of bioethics and the law, still leaves much to be done in other states to follow suit. Although strides such as Utah’s law have been made to allow prisoners to donate, death row inmates in Indiana, and across the nation, are still disallowed access to one of life’s most noble deeds. They are denied the right to donate organs, whether during their lives or upon their deaths.

This issue has spurred debate over what rights death row inmates actually possess. Some believe that due to their incarceration, prisoners have no rights—not even to their

³⁶ *Id.*

³⁷ *Id.* at 1-2.

³⁸ *Id.* at 1.

³⁹ *Id.* at 2 (citation omitted).

⁴⁰ Utah Code Ann. 1953 § 64-13-44 (2013).

bodies. Others believe that allowing our nation's worst criminals to become organ donors, would detract from the retributive nature of the death penalty itself. In other words, if death is the punishment, any act of altruism or act of purification (in this case organ donation) would seemingly purge the sentence of its inherent severity.

Others may believe the stigma of inmate-donated organs cannot be overcome, or that organs acquired from prisoners are too risky. That is, there may be too many health concerns. And yet, despite these concerns, many states have proposed legislation to allow death row inmates to donate their organs. However, these bills have not survived the wide criticism they encounter.

In 2000, Florida State Representative William F. Andrews introduced Florida House Bill 999 entitled "An Act Relating to Anatomical Gifts by Capital Defendants."⁴¹ This bill, like many of its predecessors and progeny, would have permitted condemned prisoners to donate their organs following their executions.⁴² However, this bill saw huge opposition from all facets of the community.⁴³

In 1984, California tried to pass a similar bill, which would have provided for organ donation from death row inmates.⁴⁴ However, this bill failed to be introduced due to huge opposition and distaste for the idea.⁴⁵

Arizona also tried to allow death row inmates to donate their organs.⁴⁶ There, Representative Bill McGibbon proposed a system that would allow inmates to have a choice in the method of execution—one where their organs could be harvested and another where a lethal injection was used.⁴⁷ However, like the others, the bill did not pass.⁴⁸

⁴¹ Whitney Hinkle, *Giving Until It Hurts: Prisoners Are Not the Answer to the National Organ Shortage*, IND. L. REV. 593, 599 (2002).

⁴² *Id.*

⁴³ *Id.*

⁴⁴ Patton, *supra* note 2, at 432.

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ Hinkle, *supra* note 41, at 600.

⁴⁸ *Id.*

Concerning Indiana most, though, is the case that began the state's legislative drive to allow death row inmates to donate their organs.⁴⁹ Gregory Scott Johnson, a death row inmate who catalyzed the controversy, was sent to prison and sentenced to death for the murder of an 82-year-old woman.⁵⁰ On May 25, 2005, the headline of an article in the *Indianapolis Star* read: "[s]tate executes killer who wanted to donate liver."⁵¹ Johnson had fervently petitioned for clemency in order to become an organ donor.⁵² On the Tuesday before Johnson's execution, Governor Mitch Daniels rejected Johnson's plea for clemency, which was to determine if he could donate a portion of his liver to his dying sister.⁵³ The Indiana Parole Board did not believe that Johnson truly wanted to help his sister.⁵⁴ Then, just twelve hours before Johnson was scheduled to die, Governor Mitch Daniels denied a final clemency plea stating that he "found no reasonable grounds to spare Johnson's life."⁵⁵

One of the reasons that the Indiana Parole Board denied Johnson's request was due in part to the response from the greater Indiana physician network.⁵⁶ The network advised the Parole Board "that they did not want to jeopardize [the transplant center's] compliance with guidelines set by the United Network for Organ Sharing, which has a 'clear position against allowing condemned prisoners to donate organs.'"⁵⁷

Further, Governor Daniels was informed by the medical community that Johnson, regardless of his status as a

⁴⁹ Johnson v. State, 584 N.E.2d 1092 (Ind. 1992).

⁵⁰ *Id.* at 1096-97.

⁵¹ Vic Ryckaert & Kevin Corcoran, *State Executes Killer Who Wanted to Donate Liver; Gregory Scott Johnson is 3rd Inmate Indiana Has Put to Death This Year*, INDIANAPOLIS STAR (May 25, 2005) available at <http://www.clarkprosecutor.org/html/death/US/johnson970.htm> [http://perma.cc/HWM8-8EVN].

⁵² *Id.*

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.*

condemned prisoner, was an unsuitable donor.⁵⁸ The doctors stated that there was “the presence of a hepatitis B antibody in Johnson’s system.”⁵⁹ This antibody, in addition to Johnson’s obesity, rendered him an unsuitable donor.⁶⁰

Despite its setbacks and final result, this case raised the question in Indiana concerning the morality of condemned prisoner organ donation. Had Johnson been a suitable candidate, would it have been likely that he would have been granted a stay in order to harvest a portion of his liver to save his dying sister? Based on the medical community’s outcry and their strict deference to the standards set by UNOS, it is unlikely. Further, judging from other states’ failures in their bill passage initiatives, it is unlikely that a stay for Johnson would have been granted.

In fact, prior to Johnson’s execution, a bill was proposed by Indiana State Representative Jon Padfield that would have allowed Johnson to donate.⁶¹ “[R]epresentative Padfield introduced a resolution in 1995 urging Indiana’s Legislative Council to [create a committee to] consider organ [extraction] from condemned prisoners.”⁶² The bill called “for a study of execution methods that do not destroy human organs.”⁶³ The bill did not pass.⁶⁴

Since then, no bill in Indiana has had full support from the legal, political, or medical community—the kind of support required to prevail. It would appear then that Indiana’s status is much like that of other states across the country. It will not be until key bioethical dilemmas and legal hurdles are overcome that the state will be able to pursue a bill like this again. Until a Padfield-like bill is passed, our nation’s organ shortage may only grow larger as this population of willing donors is continually denied access to saving lives.

⁵⁸ *Id.*

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ H. Res. 41, 109th Leg., 1st Sess. (Ind. 1995) *reprinted in* State of Indiana, JOURNAL OF THE HOUSE OF REPRESENTATIVES, 109TH GENERAL ASSEMBLY, FIRST REGULAR SESSION, at 1111 (1995).

⁶² Hinkle, *supra* note 41 at 599-600 (citation omitted).

⁶³ *Id.* at 600 n.44.

⁶⁴ *Id.* at 599.

III. CHALLENGES OF PASSING A BILL

A. *Stigma*

The first place to start in gaining speed with a bill allowing for condemned prisoner organ donation would be to overcome the stigma attached to prisoners—and even more so, to death row prisoners. There is no question that incarcerated individuals are stigmatized, that is, they are stereotyped and deemed to be members of an overall distasteful group. Studies have shown that the public's thoughts and perceptions regarding inmates are generally quite negative.⁶⁵ It is not hard to imagine then, given that inmates exist as reflections of society's stigma, that there would be some hesitation with combining a part of an inmate's body with the body of a non-criminal member of society. This is all to say that some individuals may not like the idea of having a criminal's organs used within the organ transplantation network. It could be that many do not value the lives of inmates and view organ donation as a perversion of the qualities of retributive justice.⁶⁶ Given the past acts of these condemned prisoners, most of whom are guilty of society's most heinous crimes, many may feel repulsed by the idea of the potential to somehow be biologically "linked" to them. As Dr. David Orentlicher, professor of law at Robert H. McKinney School of Law states in a piece done by the New York Times, "People might say, 'Gosh I'm walking around with the organ of a murderer,' — that is, some individuals

⁶⁵ Kelly Moore, et. al., *Jail Inmates' Perceived and Anticipated Stigma: Implication for Post-release Functioning*, 12 SELF AND IDENTITY: THE J. OF THE INT'L SOC'Y FOR SELF AND IDENTITY, 527-28 (2013) available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4103667/pdf/nihms-596010.pdf> [https://perma.cc/5QFW-PAGK].

⁶⁶ Rabbi Geoffrey A. Mitelman, *Retributive Justice and Restorative Justice*, HUFFINGTON POST (May 4, 2011) http://www.huffingtonpost.com/rabbi-geoffrey-a-mitelman/retributive-justice-and-r_b_857219.html [perma.cc/RW3F-A93Q].

may be wary of such a connection, no matter how attenuated, to a condemned prisoner.⁶⁷ However, this hypothetical associative stigma should not stand in the way of saving other lives.

Instead, stigma should be bypassed entirely. Christian Longo, a man serving his sentence on death row claims, “to be able to save so many lives, that means a lot to me [],”⁶⁸ For many, this outlook is difficult to understand in light of Longo’s history.⁶⁹ Longo was sentenced to die after being found guilty of killing his wife and children and throwing their bodies into an Oregon waterway in December 2011.⁷⁰ In an article discussing Longo’s drive to donate, the author acknowledges that this sentiment is

hard to hear from a man who went back to work at his job at a local Starbucks outlet in the days after the murders before fleeing to Mexico, where he told people he was a New York Times reporter, went swimming and snorkeling, and struck up a brief romance with a woman, according to court records. When he was caught, he denied the killings.⁷¹

But what if this man’s organs could save more lives than he took? Perhaps then, justice would still have been served. The horrible histories of condemned prisoners like Longo surely can be cast aside when it comes to donating valuable

⁶⁷ Brandi Grissom, *Considering Death Row for Organs*, THE N. Y. TIMES (SEPT. 8, 2012), <http://www.nytimes.com/2012/09/09/us/considering-the-ethics-of-organ-donations-from-death-row.html> [perma.cc/B9RD-7L7U].

⁶⁸ JoNel Aleccia, *Killer’s Quest: Allow Organ Donation After Execution*, NBCNEWS.COM (April 21, 2011, 9:33 AM), http://www.nbcnews.com/id/42667886/ns/health-health_care/t/killers-quest-allow-organ-donation-after-execution/#.VFJMnYvF91Y [http://perma.cc/4YQW-P4DQ].

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ *Id.*

and necessary organs. It is not about the pasts of the donors, but rather, the futures of the recipients.

While the criminal histories of these potential donors may be a huge stigma to overcome, others may believe that prisoners are “dirty”—that their organs would not be as good as another person’s organs, due to illness or disease.⁷² This particular sentiment is not without merit. In 2011-12, about 4 in 10 prisoners (41%) . . . reported having a current chronic condition.”⁷³

However, other populations around the nation have much higher rates of conditions including infectious diseases in relation to size. These populations include New York City, Miami, and Washington D.C.⁷⁴ And yet, these populations are not scrutinized or barred from organ donation. Furthering this logic, the difference between receiving an organ from a young man who had been a methamphetamine addict for ten years versus an inmate who has no access to drugs and is in a more controlled environment is politically negligible, but medically immense. How can a meth addict be allowed to donate his corneas, skin, and bone marrow, while the prisoner cannot? The reason likely does not rest purely with stigma but with the concerns held by the medical community.

Therefore, the hurdles posed by the medical community are the biggest obstacles to overcome if Indiana is ever going to be able to pass a bill like House Bill 41, as Padfield tried to do. First, we must start with the role of physicians in executions and organ extraction.

⁷² Marcus Berzofsky, et. al, *Medical Problems of State and Federal Prisoners and Jail Inmates, 2011-2012*, BUREAU OF JUSTICE STATISTICS, <http://www.bjs.gov/index.cfm?ty=pbdetail&iid=5219> [<http://perma.cc/CX28-ZRYK>] (last revised Feb. 5, 2015).

⁷³ *Id.* at 11.

⁷⁴ *HIV Surveillance Report, 2008*, CTRS. FOR DISEASE CONTROL AND PREVENTION (June 2010), http://www.cdc.gov/hiv/pdf/statistics_2008_hiv_surveillance_report_vol_20.pdf [perma.cc/82R8-NZP5].

B. A Physician's Role

The tangled web that is the death penalty, and a physician's role within it, must be unraveled if organ donation from condemned prisoners is ever to be allowed. Physicians paired with the lethal injection process equates to a huge ethical challenge.

Historically, Dr. Jack Kevorkian favored the lethal injection because he initially believed that it would allow inmates to donate their organs.⁷⁵ He would later champion the idea of physician-assisted suicide. He believed that "only the highest degree of technical competence should be relied upon to insure trouble-free lethal injection, to avert unnecessary suffering, and, even more important, to minimize the potential danger of inadvertent suffocation of the condemned."⁷⁶ In other words, he believed that lethal injections should be performed by medical professionals.

Politicians must have the support from the medical community, and the legal community must have the authority from those medical boards that stand to make and analyze policy in order to gain any ground in passing a bill. However, the American Medical Association's Medical Code of Ethics states that physicians should not participate in capital punishment and executions.⁷⁷

Physician involvement in capital punishment is ethically banned because it violates the ethical foundations of the profession as a whole. The World Medical Association has condemned physician participation in prison executions.⁷⁸

⁷⁵ Deborah W. Denno, *The Lethal Injection Quandary: How Medicine Has Dismantled the Death Penalty*, 76 FORDHAM L. REV. 49, 84 (2007).

⁷⁶ *Id.*, at 85 (quoting JACK KEVORKIAN, PRESCRIPTION: MEDICINE, THE GOODNESS OF PLANNED DEATH 17-99 (1991))

⁷⁷ Opinion 2.06-Capital Punishment, AM. MED. ASS'N, *available at* <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion206.page?> [<http://perma.cc/A6XB-B3UX>].

⁷⁸ *WMA Resolution to Reaffirm the WMA's Prohibition of Physician Participation in Capital Punishment*, WORLD MED. ASS'N (Oct. 2012), <http://www.wma.net/en/30publications/10policies/c23/> [<https://perma.cc/GX5M-9H66>] [hereinafter *WMA Resolution*].

Further, it has been said that, “[d]octors are not executioners. Inflicting death is antithetical to their ancient creed.”⁷⁹

Although physician participation in some instances may arguably reduce pain in the execution procedure, there are other reasons some may cite to disallow physician participation. For example, physicians’ presence during executions may serve only to “feign the appearance of humanity.”⁸⁰ The presence of a physician could be a way of showing compassion during a gruesome act. Second, the physician may provide a false showing of medical legitimacy.⁸¹ Third, the physician would act on behalf of the state as an executioner.⁸² “In return for possible reduction of pain, the physician, in effect, acts under the control of the state, doing harm,” a seemingly deliberate violation of the World Medical Association’s prohibition.⁸³

Mirroring those three reasons to disallow physician participation, the medical ethics community blatantly condemns physician participation in lethal injection execution; further, two states even statutorily forbid doctors from participating in such executions.⁸⁴

Despite the numerous concerns, ethicists must understand that, “since the inception of capital punishment, physicians have aided in the execution process.”⁸⁵ Still today, doctors may be used to ensure adequate measures are taken, and that the execution procedures go according to plan. Ultimately it may be determined “that a physician’s

⁷⁹ *Medical Ethics and Physician Involvement*, HUMAN RIGHTS WATCH (2014) available at <https://www.hrw.org/reports/1994/usdp/8.htm> [perma.cc/S9FS-HFHD] (quoting Kim Thorburn, *Doctors and Executions*, 7 AM. J. OF DERMATOPATHOLOGY (1985)).

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² *Id.*

⁸³ *WMA Resolution*, *supra* note 78.

⁸⁴ KY. REV. STAT. ANN. § 431.220(3) (2015); 725 ILL. COMP. STAT. 5/119-5(d-5) (2015).

⁸⁵ Stacy Ragnon, *A Doctor’s Dilemma: Resolving the Conflict Between Physician Participation in Execution and the AMA’s Code of Medical Ethics*, 20 U. DAYTON L. REV. 975, 976 (1995).

presence is necessary [for] a responsible execution, [so] physician participation will not be barred.”⁸⁶

However, physicians who decide to participate in the lethal injection process face harsh consequences like license revocation or other severe consequences.⁸⁷ Despite these consequences, those physicians who choose to violate the creed and the call to the profession should not face legal consequences if those actions were to ensure that an execution was performed responsibly and successfully.

C. The Lethal Injection Process

Lethal injection is the primary method of execution used in all United States jurisdictions that still retain the death penalty. Indiana is among those states.⁸⁸ However, that was not always the case. The United States Supreme Court held in *Furman v. Georgia* that the statutory imposition of the death penalty in sentencing was unconstitutional because it violated the cruel and unusual punishment clauses of the Eighth and Fourteenth Amendments.⁸⁹ However, Indiana, only one year later, in 1973, “enacted a new death penalty sentencing statute to replace the statute struck down by the U.S. Supreme Court in *Furman*.”⁹⁰

In *Baze v. Rees*, the United States Supreme Court upheld the protocol of injecting the three drug cocktail (the lethal injection) in executions as used by the State of Kentucky.⁹¹ The Court held that there was no evidence to show that Kentucky’s lethal injection procedure was “objectively intolerable” and therefore the procedure did not violate the Eighth Amendment.⁹²

⁸⁶ *Id.* (quoting 58 Fed. Reg. 4898 (Jan. 19, 1993)).

⁸⁷ *Id.*

⁸⁸ IND. CODE § 35-38-6-1-(1) (2015); IND. CODE § 35-50-2-9 (2015).

⁸⁹ *Furman v. Georgia*, 408 U.S. 238, 286 (1972).

⁹⁰ *Death Penalty Facts*, INDIANA PUBLIC DEFENDER COUNCIL 1, http://www.in.gov/ipdc/public/dp_links/indianadpfactsheet.pdf [<http://perma.cc/6MDY-GDUB>] (last updated July 8, 2015).

⁹¹ *Baze v. Rees*, 553 U.S. 35 (2008).

⁹² *Id.*, at 62-63.

Today in Indiana, the condemned are imprisoned until their execution day arrives. Upon execution, the lethal injection is the method used.⁹³

Of the states that use lethal injection as the primary means for execution, the overwhelming majority of them “essentially [use] the same three-drug cocktail: 1) sodium thiopental; 2) pancuronium bromide; and 3) potassium chloride.”⁹⁴ Sodium thiopental is used to anesthetize patients, inducing an unconscious state.⁹⁵ Once unconscious, mechanical ventilation is required.⁹⁶ In clinical doses sodium thiopental acts quickly and lasts for a short time only; “however, when used in a massive or superclinical dose, as is the case in an execution, it is capable of reliably produc[ing] prolonged and deep unconsciousness.”⁹⁷

Pancuronium bromide is the next drug injected. Pancuronium bromide is a neuromuscular blocking agent.⁹⁸ In effect, pancuronium bromide stops respiration and ceases involuntary muscle movement. Because these drugs have such severe effects, ensuring appropriate dosages, standards, and methods are of the utmost importance. One mistake could have disastrous effects.

The final drug injected is potassium chloride which is used to stop the heart from beating.⁹⁹ This is the most important step in the procedure. Not only does this drug lead to cardiac failure, but this is the point at which donation from prisoners becomes much harder. Most organ procurement is

⁹³ Ind. Code § 35-38-6-1.

⁹⁴ Jerry Merrill, *The Past, Present, & Future of Lethal Injection: Baze v. Rees' Effect on the Death Penalty*, 77 UMKC L. Rev. 161, 162 (2008).

⁹⁵ *Id.* at 162; *See also* Brief of American Society of Anesthesiologists as Amicus Curiae Supporting Neither Party, *Baze v. Rees*, 128 S. Ct. 1520 (2008) (No. 07-5439), *available at* <https://www.law.berkeley.edu/clinics/dpclinic/LethalInjection/LI/documents/bazebriefs/ASA.pdf> [https://perma.cc/59DR-8RH5].

⁹⁶ Merrill, *supra* note 94, at 162.

⁹⁷ *Id.* at 163 (citing Brief of American Society of Anesthesiologists as Amicus Curiae Supporting Neither Party, *supra* note 95, at 5).

⁹⁸ *Id.*

⁹⁹ *Id.*

performed following brain death, not cardiac death. Therefore, “donation from death row inmates will not be like a typical brain-death donation and thus will have to be a case of controlled DCD (donation after cardiac death).”¹⁰⁰ Because the heart has stopped beating in cases of DCD, the organs do not get oxygen, meaning there may be a shorter period of time for procurement before the organs become unusable.

As such, the procedure to procure organs becomes exceedingly more challenging in the execution setting due to the execution methods used. However, just because the setting is different, does not mean that the tissues sought are somehow different. Procedures and methods can change.

D. Jury Deliberations

Another substantial hurdle in gaining support for a bill to allow for death row organ donation is the risk that juries and judges may be more inclined to hand out death sentences. That is, jurors may believe that criminals should pay back society for their wrongs by giving up their organs (or so the logic would go). Juries do not always make decisions based purely on the evidence presented; other variables and stereotypes interfere with jury verdicts as it is. Concerns regarding higher incidences of death sentences rest on this basic assumption.

Furman v. Georgia originally addressed the issue of inappropriate death sentences due to bias and prejudice.¹⁰¹ There, the Court was concerned that death sentences could be imposed at the unfettered discretion of judges and of jurors – that “people die dependent on the whim of one man or of [twelve].”¹⁰² Sometimes jury decision-making may not focus entirely on the evidence presented at trial. Jurors are not immune from internal psychological impulses no matter how

¹⁰⁰ Shu Lin, Lauren Rich, Jay Pal & Robert Sade, *Prisoners on Death Row Should be Accepted as Organ Donors* (July 3, 2012), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3388804/> [<http://perma.cc/S4MN-TFHQ>].

¹⁰¹ *Furman v. Georgia*, 408 U.S. 238 (1972).

¹⁰² *Id.* at 253.

obviously prejudicial these impulses are. It is hard to determine whether organ donation would be analogous to considerations of race, previous convictions, or confidence of a defendant, in jury decision-making paradigms, but it is a genuine concern held by the legal community.¹⁰³

Before the year 2002, a jury's sentence in death penalty cases in Indiana was nothing more than a nonbinding recommendation to the court. In *Ring v. Arizona*, the United States Supreme Court held that a judge, even in determining appropriate sentencing, could not conduct a factual inquiry to find for the presence or absence of aggravating factors that would lead to the imposition of the death penalty; a jury, by the mandate of the Sixth Amendment must engage in that type of determination.¹⁰⁴ Because of the Supreme Court's holding in that case, "the 2002 General Assembly amended our death penalty statute to provide that if a jury unanimously reaches a recommendation, the trial court must 'sentence accordingly.'" ¹⁰⁵

Though the standard for the death penalty is set quite high, unanimous decisions can still be born of both conscious and unconscious bias. Stereotypes of groups of people necessarily inform these biases because they "operate as source[s] of expectancies about what a group as a whole is like . . . as well as about what attributes individual group members are likely to possess. . . ." ¹⁰⁶ That is, jurors may see a defendant as a member of a group and then apply characteristics to that defendant based on that group's purported stereotype. Stereotypes can affect a "perceiver's attention to, encoding of, inferences about, and judgments

¹⁰³ Dennis J. Devine, et al., *Jury Decision Making: 45 Years of Empirical Research on Deliberating Groups*, 7 PSYCHOLOGY, PUB. POL. & L. 622 (2001).

¹⁰⁴ *Ring v. Arizona*, 536 U.S. 584, 609 (2002).

¹⁰⁵ *Death Penalty Facts*, *supra* note 90, at 3.

¹⁰⁶ Nancy King, *Postconviction Review of Jury Discrimination: Measuring the Effects of Juror Race on Jury Decisions*, 92 MICH. L. REV. 63, 77 (1993); David Hamilton et al., *Stereotype-Based Expectancies: Effects on Information-Processing and Social Behavior*, 46 J. SOC. ISSUES, 35, 43 (1990).

based on that information.”¹⁰⁷ Resulting cognitions reflect the previous patterns of information received.¹⁰⁸ In other words, confirmation bias acts to bring what people see and hear (i.e. what the jurors would see and hear) in line with what people believe or what society has conditioned them to believe about something or someone. This opens the door to bias.

In *Turner v. Murray*, the United States Supreme Court determined that juror latitude mixed with prejudice may prove to be too risky a combination to leave unbridled.¹⁰⁹ In its opinion, the Court stated that “the range of discretion entrusted to a jury in a capital sentencing hearing [poses] a unique opportunity for racial prejudice to operate but remain undetected”¹¹⁰ Thus, the Court determined that “a capital defendant accused of an interracial crime is entitled to have prospective jurors informed of the race of the victim and questioned on the issue of racial bias.”¹¹¹ Theoretically, this line of questioning would serve to detect hidden biases present within the juror pool.

Though evidence points to several accounts of juror decision-making that seem hardly ethical—decisions and sentences based on faulty cognition, racial prejudice, and psychological pull,—we may be able to rule out this hurdle in the realm of death row organ procurement fairly quickly. Just as our legislature should not make laws that seek to pierce through unconscious motives—mostly because this would be impossible and because it would be difficult to exact within a statute—laws surrounding the death penalty and organ donation would be unable to circumvent any prejudice that already exists in relation to the death penalty overall.

It is not the same to say that jurors are more likely to hand down the death penalty for African American men as it is to say that if someone *does not* believe in the death penalty suddenly he or she *will* if death row prisoners were allowed to donate their organs. Further, it is not as if the government would force these inmates to donate. Moreover, if juror

¹⁰⁷ King, *supra* note 106, at 77.

¹⁰⁸ *Id.*

¹⁰⁹ *Turner v. Murray*, 476 U.S. 28 (1986).

¹¹⁰ *Id.* at 35.

¹¹¹ *Id.* at 36-37.

prejudice were a true concern in death penalty cases (where statutorily an inmate could donate), those jurors that would foreseeably pose problems to the defendant's case could be weeded out just like any other.

IV. PADFIELD AND HOUSE BILL 41 – A HISTORY OF PUSHING FOR PROCUREMENT

All legal, ethical, and medical reasons aside, Indiana's Representative Padfield had the right idea. Condemned prisoner donation, while not the end of the organ shortage, is surely a step in the right direction. A bill like House Bill 41, would not be without at least some support from constituents of the state. As an example, in an ongoing internet poll on a webpage seeking to gauge opinions on controversial and popular issues, (as of November 17, 2015), 60% of web participants agreed with Padfield; that is, that prisoners should be allowed to donate organs.¹¹² As stated by a condemned prisoner, mimicking one side of the spectrum of sentiments felt by the community, "[w]hy go out and waste your organs when you have the potential to go out and save six to [twelve] lives?"¹¹³

A. What Happened?

The Padfield Bill did not pass. It was likely due to the immense stigma (yet likely undisclosed and unvoiced) attached to this topic, the distaste for subtracting from retributive justice, and the impossible battle lawmakers and the medical community would face in establishing protocol. The fight to get these kinds of bills passed is still alive as is the fervor with which proponents of it fight. Christian Longo still fights for his right to donate, and, similarly, up until his execution, Gregory Johnson fought for his ability to donate as well.

¹¹² *Should Death Row Inmates Donate Their Organs*, DEBATE.ORG, <http://www.debate.org/opinions/should-death-row-inmates-donate-their-organs> [<http://perma.cc/QZ32-FD5P>] (last visited Nov. 17, 2015).

¹¹³ Aleccia, *supra* note 68.

B. No Legislation Since Bill 41 in Indiana

Legislation of this kind will likely not be brought back to the table in Indiana until there is clear evidence that a number of things can change. The method of execution would have to change. Though, as aforementioned, donation after cardiac death can be a viable way to harvest healthy organs, the lethal injection process and the hurdles regarding its implementation are too strong to overcome. It is likely that in order for organs to be viable following execution, procedures must preserve the integrity of the organs. Tackling a method of execution, however, should not be the first order of business. Rather, the role of physicians would have to change.

V. OVERCOMING CHALLENGES*A. Changing the Role of Physicians in Executions*

In order to procure organs from executed prisoners, a physician must be present. Though it may seem macabre and somewhat voodoo, physicians and death are not strangers. In fact, Dr. Joseph Guillotin was a French physician who developed a method of execution – the guillotine.¹¹⁴ He believed executions by this method would relieve pain in death; he later faced many critical responses following this invention.¹¹⁵ Further, by 1982, there was clear evidence of physician involvement in executions within the United States.¹¹⁶ Condemned prisoner Charles Brooks was set to be executed in 1982 by lethal injection.¹¹⁷ Dr. Ralph Gray participated in the injection in a limited capacity. “He []

¹¹⁴ *Medical Ethics and Physician Involvement*, *supra* note 79.

¹¹⁵ *Id.* at 5.

¹¹⁶ *Id.*

¹¹⁷ *Id.*; See also Robert Reinhold, *Technician Executes Murderer in Texas by Lethal Injection*, N.Y. TIMES (Dec. 7, 1982), <http://www.nytimes.com/1982/12/07/us/technician-executes-murderer-in-texas-by-lethal-injection.html> [<https://perma.cc/5KJF-56UF>].

examine[d] the prisoner to make sure his veins were large enough to accept the needle”¹¹⁸ After the injection, Dr. Gray was ultimately the one to pronounce Brooks dead.¹¹⁹

In that case, the physician, Dr. Gray, did everything but inject the drugs. Dr. Gray monitored the inmate, assisted the executioner, pronounced death, and oversaw the general sequence of events. This, by some standards, could be seen as a physician-assisted execution.

It is hard to grasp that there is room for physician-assisted suicide, but not physician-assisted organ procurement in executions. Is there really a difference? Many U.S. physicians get requests for assisted death and assisted suicide, and of these physicians receiving requests, roughly six percent have accepted on at least one occasion.¹²⁰

1. Exploring the Case of Brittany Maynard

Recently in the news was the case of Brittany Maynard, a woman diagnosed with a terminal form of brain cancer.¹²¹ At only twenty-nine years of age, Brittany made the decision to end her life.¹²² Facing the prospect of terrible side effects from radiation, and the symptoms of the brain cancer itself, Maynard and her husband journeyed to Oregon in search of the death with dignity law.¹²³

¹¹⁸ Tamar Lewin, *Execution by Injection: A Dilemma for Prison Doctors*, N.Y. TIMES (Dec. 12, 1982), <http://www.nytimes.com/1982/12/12/weekinreview/execution-by-injection-a-dilemma-for-prison-doctors.html> [https://perma.cc/L47N-UWJ7].

¹¹⁹ Patton, *supra* note 2, at 392.

¹²⁰ Diane E. Meier, et al., *A National Survey of Physician-Assisted Suicide and Euthanasia in the United States*, 338 NEW ENG. J. MED. 1193 (1998), available at <http://www.nejm.org/doi/full/10.1056/NEJM199804233381706> [http://perma.cc/BFG9-YDDU].

¹²¹ Brittany Maynard, *My Right to Death With Dignity at 29*, CNN NEWS, <http://www.cnn.com/2014/10/07/opinion/maynard-assisted-suicide-cancer-dignity/> [http://perma.cc/U98C-BTKB] (last updated Nov. 2, 2014 10:44 PM).

¹²² *Id.*

¹²³ *Id.*

Oregon, in 1994 passed a one-of-a-kind law that allowed terminally ill patients to access physician assisted suicide.¹²⁴ In effect, the law allowed competent, adult patients to receive a physician-authorized prescription for drugs that would result in death.¹²⁵ The law was greeted with scorn and apprehension from many across the nation and especially in Oregon. The law barely passed: “[t]he statewide vote was 51% in favor and 49% opposed [in 1994].”¹²⁶ Even after its initial passage, the bill’s enforcement was enjoined, only later to wind up as a hot topic in the United States Supreme Court. The Court held that there was a distinction “between ‘physician-assisted suicide’ and withdrawal of life support or the ‘double effect’ of aggressive palliative care.”¹²⁷ In essence, the Court did not see Oregon’s law as a constitutional issue, but rather one of politics. Thus, the law took full effect in 1997.¹²⁸

Maynard took advantage of the passage of this law and moved from California to Oregon to seek death with dignity.¹²⁹ She passed away after taking her prescribed medication in late 2014.¹³⁰

Many, like Maynard, have done the same since Oregon’s law has gone into effect. “More than 750 people in Oregon used the law to die as of Dec[ember] 31, 2013 . . . Only six were younger than 35, like Maynard.”¹³¹

¹²⁴ OR. REV. STAT. §§ 127.800-127.897 (2015); *see also* PATRICK DUNN ET AL., THE OREGON DEATH WITH DIGNITY ACT: A GUIDEBOOK FOR HEALTHCARE PROFESSIONALS 4 (2008), *available at* <https://www.ohsu.edu/xd/education/continuing-education/center-for-ethics/ethics-outreach/upload/Oregon-Death-with-Dignity-Act-Guidebook.pdf> [<http://perma.cc/R8PT-RW7E>].

¹²⁵ DUNN ET AL., *supra* note 124.

¹²⁶ *Id.* at Appendix A.

¹²⁷ *Id.* Appendix A, at 113.

¹²⁸ *Id.*

¹²⁹ *Death With Dignity Advocate Brittany Maynard Ends Her Life*, CBS NEWS (Nov. 2, 2014, 10:22 PM), <http://www.cbsnews.com/news/death-with-dignity-advocate-brittany-maynard-ends-her-life/> [<http://perma.cc/88FA-JUZP>].

¹³⁰ *Id.*

¹³¹ *Id.*

2. Oregon's Death with Dignity Act and the Hippocratic Oath

Following the widespread recognition of Maynard's case, a documentary, that was unveiled in 2011, rose in popularity. It was entitled: "How to Die in Oregon."¹³²

This documentary explores real life responses to Oregon's 'Death with Dignity Act,' the first law in the U.S. to allow physicians to prescribe lethal doses of drugs to the terminally ill. A middle-aged woman with terminal liver cancer, prepares to take her own life, while another cancer patient decides to suffer through his illness even though death is just as certain for him. Others grapple with choosing their own course of action, and one man decides to hold a 'death party.'¹³³

The film explores the problems patients encounter when their decision ultimately is to die. For the most part, the film highlights the relief each patient feels for having the opportunity to assert his or her "right to die" under the Oregon law. While it is most difficult for the family members who must sit idly by and watch helplessly, the film truly hones in on the power the patient holds in determining his fate.

There are two interesting components of the film that must be addressed, especially in relation to the issue of death row organ procurement and the involvement of the medical community. There is no doubt that Oregon's medical community has established many protocols, rules, and guidelines to traverse the confusing realm of its law. As such,

¹³² HOW TO DIE IN OREGON (2011), *available at* <http://www.imdb.com/title/tt1715802/> [<http://perma.cc/AY9Y-LCY4>] (last visited Oct. 11, 2015).

¹³³ *How to Die in Oregon*, MOVIE FONE, <http://www.moviefone.com/movie/how-to-die-in-oregon/10054198/main> [<http://perma.cc/V7PW-MRMZ>] (last visited Nov. 17, 2015).

medical ethicists and legal scholars are especially interested in the safeguards and methods employed in carrying out this law. However, though the statute was passed, and though the procedures have been tried, verified, and found to be adequate, there are potential problems with the processes instituted before the patient ingests the lethal medication.

Indiana residents, as viewers and as members of a population somewhat detached from this Oregon law, must assume that the real-life accounts portrayed in the film are the actual and true ways that the right to die law is carried out. Building on this assumption, the analysis of risk can begin.

In the film, a volunteer arrives at the patient's home and speaks with him before the medication is taken.¹³⁴ The volunteer tells the patient how to crush the pills, how much water to mix in, what it will taste like, and how long it will take for him to die.¹³⁵ Additionally, the volunteer asks the patient two questions: first, the patient is informed that he has the right to change his mind and if he would like to presently do so; second, the patient is asked if he knows what the medication will do.¹³⁶

To a politician and to a potential patient, these questions may seem adequate—they probe competency and underscore the possibility for liability. However, once in the position of comparing this process with that of the potential criteria for death row organ procurement, one must employ a deeper, more microscopic analysis.

A large potential problem with this procedure is that a volunteer, not a physician or a nurse, is present during the ingestion of the drugs and is present for the death. A volunteer is the one who asks these questions in an effort to categorically determine understanding and competency. Why is a volunteer the judge of the mental health and competency of a patient prior to the time of death? Why is a volunteer the one overseeing the process? Granted, the volunteers are likely adequately trained before engaging in this process, but the risk is ultimately too high regarding

¹³⁴ HOW TO DIE IN OREGON (Peter D. Richardson, 2011).

¹³⁵ *Id.*

¹³⁶ *Id.*

liability and bioethics to allow anyone other than a medically trained and licensed professional to oversee this process. The potential for mistakes, the questions that could be posed and then incorrectly or ignorantly answered, and the way in which the patient takes the drug, are all potentially catastrophically harmful situations. What would happen if two gulps into the drug cocktail the patient changes his or her mind? How would a volunteer be equipped to handle such a hazardous situation? Realistically, the patient's physician should be there.

Secondly, that there are so few questions posed moments before the medication is to be ingested raises serious concerns regarding willingness, competency, safety, and liability. These questions only seek to uncover whether the person knows he will die upon taking the drug, and whether he wants to change his mind. This could be troublesome. Would the fact that others (for example, family members and friends of the patient) are present for these questions change the answer? Would the patient feel compelled to say that he did not want to change his mind? How could a person asking these questions gauge competency invariably? There is no battery of questions, no history of psychological screenings, and no tests – it is just too easy.

The process of end-of-life decision-making does not square with that of the lethal injection. Each offers the same result: death. And yet, one offers physician-prescriptive help to achieve the result while the other doesn't. One is established with relatively relaxed bioethical safeguards while the other has heightened ones. As such, Oregon's death with dignity law ties a close knot to the ethics behind organ donation of death row inmates and parallels some key concerns, especially regarding physician involvement.

The same concerns held by the medical community when physicians participate in the lethal injection process are highlighted in right to die laws. Doctors may not inflict death—to do so would be “antithetical to their ancient creed.”¹³⁷ This argument is used to prevent physicians from

¹³⁷ *Medical Ethics and Physician Involvement*, *supra* note 79 (quoting Kim Thorburn, *Doctors and Executions*, 7 AM. J. OF DERMATOPATHOLOGY (1985)).

meddling in the lethal injection process. It is used to prevent physicians from developing ways to procure organs during the “death process,” and it is used to disallow a method of execution that would necessarily entail organ harvest. And yet, this argument is cast aside when it comes to Oregon’s death with dignity law.

It seems contrived that our medical community and political infrastructure could pick and choose when to employ this reasoning. Many may view the difference between physician involvement in lethal injections versus their involvement with right to die patients as an informed consent issue. Right to die patients must be deemed competent, and must jump through several hoops before being able to be prescribed the lethal medication. On the other hand, those inmates who must face death do not get the luxury of informed consent for any portion of the process. The State decides.

The physician involvement distinction is negligible. Despite the fact that there is finer print and more safeguards to acquire informed consent in right to die cases, there could never, ever be such a strict and humanitarian standard for executions. Courts, juries, politics, and state governments, in essence, act as the informed consent counselors.

Just because one form of doctor-induced death operates on a different set of standards does not mean that by default medical rules and ethics apply more so to that one. The Hippocratic oath and a doctor’s involvement in death in the most general sense must be a level platform if a medical ethics argument is to be used to prevent incarcerated organ donations. To apply the oath in only some cases would take the vigor out of the standards themselves.

In addition to the informed consent and medical standards parallel, residents of Indiana should consider right to die laws and ask what the true difference is between physician-prescribed death and physician-assisted death.

As stated before, one of the ways to overcome challenges in passing a bill to allow for organ procurement from death row inmates would be to rewrite the role of physician involvement in executions—to either write them out of the process completely, or more effectively, to allow them to participate in organ extraction during a brain death execution as opposed to a cardiac death execution. Here,

dissidents claim that to allow a doctor to do this allows him to be the executioner himself. One would have to ask then, what was the role of the physician who prescribed Brittany Maynard her lethal prescription? Using that logic, is he not the executioner as well? A key question as posed by Dr. David Waisel, an anesthesiologist with the Mayo Clinic is: “whether the physician is acting as a tool of the individual to minimize suffering and to further the individual's goals or whether the physician is acting as a tool of the government to ensure a successful execution.”¹³⁸ If an inmate wishes to donate his organs, in theory, a physician conducting the procurement would be ensuring that this inmate's wishes are carried out and that his goals are attained, rather than acting as the “hand of death” on behalf of the State. In other words, the goal of the doctor providing comfort and the goal of the State in executing a criminal have aligned¹³⁹ in a seemingly perverse way.

It is hard to draw the line that physician participation in death is fine for patients in Oregon, but is inexcusable in the eyes of the medical community for condemned inmates.

First, patients who seek Oregon's death with dignity law are invoking their right to their own health autonomy. Physicians who assist these patients, in effect are respecting the patient's autonomy. The argument put forth by proponents of the right to die is that, “[c]ompetent people should have the right to choose the timing and manner of death.”¹⁴⁰ Physicians tout the importance of respecting this right; competent individuals must never be deprived of their personal and patient autonomy.¹⁴¹ However, condemned

¹³⁸ David Waisel, *Physician Participation in Capital Punishment*, 82 MAYO CLINIC

PROCEEDINGS 1073, 1076-77 (2007) (discussing the nature of physician involvement in executions).

¹³⁹ *Id.* at 1077

¹⁴⁰ Helene Starks et al., *Physician Aid-in-Dying*, ETHICS IN MED. U. WASH. SCH. MED. (2013), <https://depts.washington.edu/bioethx/topics/pad.html> [<http://perma.cc/V7JY-C88V>].

¹⁴¹ *Declaration of Lisbon on the Rights of the Patient*, WORLD MED. ASS'N., (reaffirmed April 2015) *available at* <http://www.wma.net/en/30publications/10policies/14/> [perma.cc/YMV5-ZLBL]. The third patient

inmates are denied the right to autonomy in their end of life choices altogether. The denial of this right is stretched to bar choices about the fate of their own organs. Nonetheless, respect for autonomy cannot be the end-all be-all of physician involvement arguments.

Second, there is no distinction between active and passive death either in executions or in physician-prescriptive death.¹⁴² Brittany Maynard's doctor in Oregon prescribed her medication to take.¹⁴³ There is nothing passive about this kind of death. The medication was deliberately requested and prescribed. Similarly, in executions, the method is not passive; it is active. The injections are deliberately administered. Therefore, in a very crass sense, an active "killing" exists on both sides of the spectrum; yet, one is tolerated, and the other is not.

In *Washington v. Glucksberg*, the United States Supreme Court found that the right to assisted suicide was "not a fundamental liberty interest that is protected by the Due Process Clause."¹⁴⁴ Further, the Supreme Court in *Vacco v. Quill*, held that a New York law prohibiting "assist[ed] suicide [did] not violate the Equal Protection Clause."¹⁴⁵ This in effect left it up to each state to decide whether or not to legalize physician-assisted suicide.¹⁴⁶ Thus, courts have continually recognized both liberal interpretations of right to die laws while still limiting the enforceability of such broad life-ending rights.

Oregon's right to die law raises serious questions about the integrity of medical ethics. While many may not want to agree, the circumstances facing the physicians who choose to participate in patients' right to die plans, are the same

right listed, "right to self-determination," states: "the patient has the right to self determination, to make free decisions regarding himself/herself."

¹⁴² *Id.*

¹⁴³ Lindsey Bever, *Cancer Patient Brittany Maynard, 29, Has Scheduled Her Death for Nov. 1*, WASH. POST (Oct. 8, 2014), <https://www.washingtonpost.com/news/morning-mix/wp/2014/10/08/terminally-ill-brittany-maynard-29-has-scheduled-her-death-for-nov-1/> [https://perma.cc/3REF-YUQC].

¹⁴⁴ *Washington v. Glucksberg*, 521 U.S. 702 (1997).

¹⁴⁵ *Vacco v. Quill*, 521 U.S. 793 (1997).

¹⁴⁶ *Id.*

circumstances that physicians would be facing in organ extraction executions. The point is this: wavering medical ethics provide no true guiding light to overcoming serious challenges in not only condemned prisoner organ procurement, but in all facets of medical decision-making. Therefore, physicians can and should be involved in the execution process.

If the legal and medical community cannot come together as they did in establishing Oregon's death with dignity law, perhaps the Indiana community can still achieve medical reform to allow for death row organ procurement nonetheless. Physicians may not even need to be the ones to do the lethal injection at all. In turn, this would purge them of any ties to the actual death, rendering them capable of procuring the inmate's organs thereafter.

Prisons commonly hold required trainings prior to the execution date where participants are educated regarding the process and their responsibilities. As an example highlighted by the state of Kentucky, there, the prison implements training sessions regarding the lethal injection process to those individuals who play integral roles.¹⁴⁷ Among those involved in the training are EMT'S.¹⁴⁸ Allowing EMTs or any other health professional to administer an IV (the channel for lethal injection drugs) would overcome the ethical dilemma raised by physician participation. The physician may be in attendance to pronounce death but not to administer the process that ultimately results in death. The physician could then extract organs. Here physicians would be fulfilling their roles as caregivers as they would be extracting and procuring organs on behalf of the transplant recipients.

B. Changing the Nature of Lethal Injection

In addition to renegotiating the role of physicians and the staff used for executions, the method of execution could be

¹⁴⁷ *Baze v. Rees*, 553 U.S. 35, 118 (2008).

¹⁴⁸ *Id.*

altered. The lethal injection may not be the best model for organ procurement purposes. In the clinical setting, organ transplantation surgeries are typically performed on patients whose hearts are still beating, but who have reached brain dead status.¹⁴⁹ The goal in harvesting organs from executed prisoners would in theory be to mimic a clinical transplantation as much as possible. Therefore, achieving brain death would be ideal in order to procure organs while the person's heart still beats. To this end, the introduction of anesthesia in "excessive amounts" would lead to death with a still-beating heart in a seemingly simpler process.¹⁵⁰

This could be the new lethal injection process. Doctors perform organ procurement operations on brain dead, yet heart-beating patients all the time. Unlike donation upon cardiac death, brain death donations may yield far greater results due to the fact that the heart is still beating and is still able to provide oxygenated blood to all tissues.

Changing the lethal injection would not destroy a flawless process. The injection has faced its fair share of problems. Botched executions are not entirely uncommon. On January 9, 2014, Michael Wilson was executed in Oklahoma by lethal injection.¹⁵¹ As the drugs were introduced, Wilson remarked, "I feel my whole body burning."¹⁵² He was dead shortly after uttering this sentiment.¹⁵³ The pain he felt during the lethal

¹⁴⁹ D.W. McKeown, et. al., *Management of the Heartbeating Brain – Dead Organ Donor*, 108 BRITISH J. ANAESTHESIA 96 (2012) available at http://bj.a.oxfordjournals.org/content/108/suppl_1/i96.full.pdf+html [<https://perma.cc/6BCV-2QM9>].

¹⁵⁰ Paul Kempen, *Lethal Injection, Anesthesia, Medicine and Organ Donation – Ethical and Clinical Consideration Regarding the Pending Supreme Court Case: Baze v. Rees*, 2 OPEN ANESTHESIOLOGY J. 7-9 (2008) <http://benthamopen.com/contents/pdf/TOATJ/TOATJ-2-7.pdf> [<http://perma.cc/YHK7-XMR8>].

¹⁵¹ Graham Lee Brewer, *Condemned Man's Last Words Lead to Questions About Lethal Injection 'Cocktail' in Oklahoma, U.S.*, THE OKLAHOMAN (Feb. 9, 2014), <http://newsok.com/article/3932043> [<http://perma.cc/V3AP-GUVH>].

¹⁵² *Id.*

¹⁵³ *Id.*

injection raised serious concerns regarding the safety and effectiveness of the chemicals used in the process.¹⁵⁴

In a separate instance, Clayton Lockett, after the drug cocktail was administered, moaned and jerked on the gurney.¹⁵⁵ Edith Shoals, who was present as a victim advocate described the scene as “like a horror movie . . . he kept trying to talk.”¹⁵⁶ Debate spurred on whether to take Lockett to a hospital or not, but Lockett died soon after.¹⁵⁷ Nothing went according to plan.

Additionally, in 2009, Ohio attempted to execute a man named Romell Broom.¹⁵⁸ Officials could not find a vein to insert the IV; instead records indicate that officials stuck him eighteen times until the governor finally terminated their efforts.¹⁵⁹

Other instances perpetuate the need for change in lethal injection procedure. In light of the need for organs, and in light of the rights denied to death row inmates, this change could and should incorporate medical techniques that not only allow for a more humane death, but also for a death that would be conducive to organ procurement.

The problems with lethal injection procedure will not fix themselves. And, like any medical complication, medical adjustments, not political ones, will be the best corrective action. The lethal injection is dangerous as it is. If the process of death went from cardiac death to brain death,

¹⁵⁴ *Id.*

¹⁵⁵ *Scene at Botched Oklahoma Execution of Clayton Lockett Was a ‘Bloody Mess,’* THEGUARDIAN.COM, <http://www.theguardian.com/world/2014/dec/13/botched-oklahoma-execution-clayton-lockett-bloody-mess> [<http://perma.cc/H4MH-6JJT>] (last visited Nov. 18, 2015).

¹⁵⁶ *Id.*

¹⁵⁷ *Id.*

¹⁵⁸ Tracy Connor, *Top Court Will Hear Romell Broom’s Execution Do-Over Appeal*, NBC NEWS (June 3, 2014), <http://www.nbcnews.com/storyline/lethal-injection/top-court-will-hear-romell-brooms-execution-do-over-appeal-n121366> [<http://perma.cc/4J5D-656P>].

¹⁵⁹ *Id.*

many of these botched injections would not have happened. Rather, the patients would have eventually “overdosed” on anesthesia¹⁶⁰—a relatively peaceful and pain free process.

Further, allowing for physician involvement would accomplish two things. First, if a medical complication were to arise during the execution, the physician would be there to make the right call. There would be no lengthy debate on whether hospitalization was or was not necessary as was the case for Lockett’s execution.

Second, the physician could be there to do the organ procurement. This would not only ensure that the organ extraction was done in a timely manner, but that it was done with the kind of precision that is required.

Adjusting simple techniques and restructuring the staffing procedure for executions may provide room to overcome bioethical challenges. Performing organ procurement as a means of execution—that is, brain death executions versus cardiac death executions—would not only overcome problems associated with the adverse biological effects of the lethal injection, but would also allow other trained personnel (other than licensed physicians) to be a part of the execution process, circumventing any potential issues that may arise from medical ethics communities regarding physician-involved executions.

C. Bill Reintroduction is a Necessity

Indiana has the potential to turn the dial in advancing the evolution of the field of bioethics and to set precedent in the law. Just as Oregon made waves in instituting the Death with Dignity Act, so too can the state of Indiana make waves. Passing a bill to allow for organ procurement from death row inmates will not cure the organ deficit, nor will it change stigma and opposition from certain members of society, but just as Oregon’s Act was intended to grant justice to those who had no other recourse, a bill to allow death row inmates

¹⁶⁰ Kempen, *supra* note 150.

to donate organs would grant justice to those also without recourse. Those inmates condemned to die would have the opportunity to reach for atonement and reveal their humanity – a final act of selflessness and autonomy while incarcerated.

Ultimately, in truth, the number of organs that would end up viable and transplantable may be miniscule. Nonetheless, there is something much greater at play. Denying these people—because yes, inmates are people—the right to donate, infringes on a basic tenant of personal autonomy that not even a death sentence can remove. These prisoners seek, in their final hour, to have one last attempt to overcome their pasts. Whether to atone or to demonstrate a manifestation of their own humanity, these prisoners continue to pursue organ donation.

In light of Oregon's new law, in light of the measures attainable to overcome bioethical barriers, and in light of the methods with which organ procurement within the execution process are possible, there is no reason why another bill like House Bill 41 could not be reintroduced and passed.

Stigma will not perish, nor will resentment from victims' families and other members of the community. Yet, despite trepidation from all fronts of opposition, a new bill should and must be reintroduced. To continue to deny organ transplants to the dying and to deny organ donation to the almost dead seems too great a burden for our state to bear—killing two by denying rights to one.

It is time to re-think the system. It is broken and it can be reworked. In his concurrence in *Cruzan v. Director, Missouri Department of Health*, Justice Scalia highlighted the liberty interests at stake in end-of-life decision-making, writing that “[t]he text of the Due Process Clause does not protect individuals against deprivations of liberty . . . [i]t protects them against deprivations of liberty ‘without due process of law.’”¹⁶¹ While the *Cruzan* case does not delve into the realm of incarcerated individuals, the holding marks an important concept that must be actualized. All people hold the biological

¹⁶¹ *Cruzan v. Director, Mo. Dep’t of Health*, 497 U.S. 261, 293 (1990).

rights to do with their bodies what they wish. Under the strength and steadfastness of the law, due process should adequately protect this right, because all people deserve, at the end of their lives, to be the apex of authority for the liberties of their bodies—for in death, everyone is a vulnerable prisoner.