

Target Article

The Use of Prisoners as Sources of Organs—An Ethically Dubious Practice

Arthur Caplan, University of Pennsylvania

The movement to try to close the ever-widening gap between demand and supply of organs has recently arrived at the prison gate. While there is enthusiasm for using executed prisoners as sources of organs, there are both practical barriers and moral concerns that make it unlikely that proposals to use prisoners will or should gain traction. Prisoners are generally not healthy enough to be a safe source of organs, execution makes the procurement of viable organs difficult, and organ donation post-execution ties the medical profession too closely to the act of execution.

Keywords: cadaver donation, compensation for donation, organ donation, prisoners, redemption, retribution

STRATEGIES FOR FINDING MORE ORGAN DONORS

The push to find more organs to transplant has led to some very novel ideas. Some cities have decided to send out specially equipped “donor” ambulances to follow regular ambulances. When someone dies outside of a hospital and is pronounced dead by the first ambulance team, a second team can be called in from the trailing donor ambulance, try to get consent from any available family member to attach the corpse to life support, and then transport the body back to a place capable of carrying out procurement. Initially this strategy will only be used when a newly dead person is known to be an organ donor by an advance directive or other means, but the plan is to eventually extend the effort to all newly deceased persons who die outside a hospital, using surrogate consent (New York Organ Donor Network 2010). Still others have proposed routinely offering kidney donation to anyone undergoing elective surgery (Testa et al. 2009). And some procurement teams argue that advance directives regarding termination of life support should never interfere with the possibility of donation (DeVita and Caplan 2007).

The movement to try to close the ever-widening gap between demand and supply of organs by creative strategies has recently arrived at the prison gate. While there is some enthusiasm for using prisoners as sources of organs, there are both practical barriers and moral concerns that make it likely that the use of prisoners will not contribute in any significant way to relieving the problem of organ shortage.

Calls for the Use of Organs From Executed Prisoners

There has been a renewed interest in the use of organs from death-row inmates, as reflected in an editorial in the *New York Times* written by a death-row inmate, Christian Longo

(2011). He wrote that he was in prison in Oregon as a consequence of having killed his wife and three children. He said he had reached the point where he wished not to make any further appeals of his conviction. What he hopes is that after he is put to death he can donate his organs. But prison authorities have rejected his request.

Longo says there are others on death row who want to donate after execution. He has started a movement to insure he and they have the chance to exercise what he claims is his right to donate: “I am seeking nothing but the right to determine what happens to my body once the state has carried out its sentence” (Longo 2011).

Longo has attracted some support for his idea of using executed prisoners as sources of organs (Wood 2011). Longo’s idea is not original. Efforts to obtain organs from executed prisoners have attracted attention for many years (Patton 1995; Bartz 2005).

Use of Living Prisoners as Organ Sources in Exchange for Parole or Reduction in Sentence

In January 2011, Mississippi Governor Haley Barbour freed two sisters from life sentences in jail for an \$11 armed robbery on the condition that one donate a kidney to the other. Given the offer of parole, Gladys Scott agreed to be a donor for her sister Jamie, who requires dialysis. Barbour was not apparently convinced of the sisters’ innocence or meritorious conduct while serving their sentences in prison. He said a key reason for his decision to order the sisters’ release was that Jamie Scott’s kidney dialysis and treatment was a financial burden on the state of Mississippi (Williams 2011).

In 2007 a state legislator in South Carolina proposed a law to shorten prison sentences in exchange for kidney or bone-marrow donation. State Senator Ralph Anderson proposed bills that would release prisoners 60 days early

for donating bone marrow and another that would give good-behavior credit of up to 180 days to “any inmate who performs a particularly meritorious or humanitarian act,” which Anderson said would include living kidney donation (O’Reilly 2007).

So, do either of these strategies to seek organs from prisoners, dead or living, pass muster either practically or ethically?

OBSTACLES TO CADAVER DONATION BY EXECUTED PRISONERS: PRACTICAL AND MORAL

The Number of Potential Organ Donors Is Very Small

The practice of capital punishment remains ethically controversial. A tiny minority of the world’s nations still retain this form of punishment. Some countries that permit capital punishment have not executed any prisoner for many years.

The majority of all executions in the world happen in China, with approximately 5000 per year. Iran, with about 400 per year, is the second highest executioner. No other countries regularly execute more than 100 people per year. The only other countries that regularly execute more than 10 people per year are Iraq, Saudi Arabia, the United States, and Yemen.

As of February 2011 there were 60 federal prisoners in the United States on death row (<http://www.deathpenaltyinfo.org/federal-death-row-prisoners>). Since the reinstatement of the federal death penalty in 1988, 68 defendants have been sentenced to death. Three have been executed. Six had their death sentence removed.

Thirty-four states permit the death penalty for nonfederal crimes. In 2010, there were 46 executions, down from a peak of 98 in 1999. That number may well decline in the future due to problems raised concerning the manner in which executions are currently conducted.

Many challenges and appeals have been mounted in recent years to execution, protesting the mode of execution used as cruel. This has led to court-ordered stays of all executions in some states. Other states may abandon capital punishment in light of difficulties in obtaining drugs that courts deem necessary for humane execution (Belluck 2011). So the pool of potential candidates may grow even smaller in the future.

Not only are the numbers of potential donors small, but many prisoners would not be eligible to serve as donors due to age, ill health, obesity, or communicable disease. The average time between sentencing and any execution is 10.6 years (*Baltimore Sun* 2011). This means that executed prisoners are often in their fifties or older, greatly reducing their potential to serve as sources of organs. Inmates engage in drug-related and sexual risk behaviors, and the transmission of HIV, hepatitis, and sexually transmitted diseases occurs at high rates in correctional facilities. The prevalence of HIV and other infectious diseases, whether acquired prior to or during imprisonment, is much higher among inmates than among those in the general commu-

nity. The burden of disease among inmates is also disproportionately high (Hammett 2006; Kuehn 2010). Those in prison for long periods of time are more likely to become infected with communicable diseases that would either disqualify them as donors or make their organs a high risk for recipients.

Even if one presumes the willingness of all those sentenced to death in the United States to donate, the actual number of executions diminishes the maximum pool of possible donees to roughly 40 to 50 persons per year. That number is declining. Presuming some of those on death row would not be willing to be donors and that others would be medically ineligible due to age or ill health, the use of prisoners as cadaver organ donors cannot yield anything more than a tiny number of organs for those in need.

Ethical opposition to capital punishment is strong and further compromises proposals to use executed prisoners as sources.

Efforts to abolish capital punishment remain vigorous in the United States and around the world. In the United States, fears of false conviction reinforce efforts to do away with the death penalty. The Innocence Project reports 267 post-conviction exonerations in the United States using DNA evidence since 1989. Of these, 17 were prisoners on death row (http://www.innocenceproject.org/Content/Facts_on_PostConviction_DNA_Exonerations.php).

Critics of the practice may see linking organ procurement to execution as increasing the image or social acceptability of capital punishment. The introduction of organ procurement into executions also raises concerns that prosecutors, judges, or juries may be more likely to insist on the death penalty, knowing that lives might be saved.

Opponents of the use of executed prisoners are likely to be very concerned about the impact of legalization in the United States on other nations, since such a move may make it more difficult to condemn controversial international practices involving the execution of persons in order to obtain their organs. Allegations persist of the involuntary and brutal execution and then immediate harvesting of “prisoners” in China (Matas and Kilgour 2010).

Some of those executed may have been imprisoned for religious or political activities (Matas and Kilgour 2010). Any legitimization of the use of executed prisoners in the United States may make it more difficult to protest cruel and unjust execution practices in other nations.

Yet another moral problem confronting the use of executed prisoners is the role that physicians and health care workers ought play with respect to executions (Caplan 2007). Many maintain that physicians should play no role whatsoever in the process, and some include in this even the pronouncement of death at an execution. This is the position of many national medical associations (American College of Physicians [ACP] 1994; American Medical Association [AMA] 2010; World Medical Association [WMA] 2005). It is not clear whether the professional groups that condemn physician or health care worker involvement with executions would deem it ethical to be involved with organ procurement after an execution has been completed. It is

clear that they would not condone any change in the practice of execution in order to achieve procurement (ACP 1994; AMA 2010; WMA 2005).

Putting aside the controversy over the morality of the practice and the permissibility of health care workers involvement with executions, the use of prisoners as cadaver donors is made even more difficult by the complexity, practical and moral, of procurement in the setting of an execution.

Cadaver Donation Would Be Difficult to Achieve Using Executed Prisoners

A large number of methods of execution including electrocution, hanging, and firing squad make organ procurement impossible. However, nearly all executions in the United States are by lethal injection.

Typically, three drugs are used in lethal injection: sodium thiopental is used to induce unconsciousness; pancuronium bromide (Pavulon) is used to cause muscle paralysis and respiratory arrest; and these are followed by potassium chloride to stop the heart. In the past 3 years, two states have used a single-drug execution protocol using only sodium thiopental. The only American company that made this drug stopped manufacturing it due to its use in executions, leading to shortages that have delayed executions.

The primary obstacle to utilizing organs from executed prisoners is that the prisoners do not die on life support. This means that donation must be accomplished using protocols developed from donation after cardiac determination of death without life support. Prisoners would be treated as if they were controlled DCDD (donation after cardiac determination of death) donors. This category refers to patients in intensive care units with nonsurvivable injuries who have treatment withdrawn and a transplant team present to immediately try to retrieve organs after monitored cardiac arrest has occurred.

Hearts cannot be used after a non-life-support death. If the liver, kidneys, or lungs are felt to be suitable for transplantation, the donor in a hospital setting is taken directly to an operating room after cardiac arrest, and, after a waiting period of up to 5 minutes depending on the protocol in place at the hospital, a rapid retrieval operation is performed. The outcomes for kidneys post DCDD procurement seem comparable to those obtained from persons who die on life support. Outcomes for livers and lungs are less certain.

Part of the problem in trying to carry out DCDD recovery from executed prisoners is the extent to which the legal and practical requirements of the execution would diminish the likelihood of successful DCDD procurement. Executions take place in prisons, not hospitals. Most executions involve at least 10 to 15 minutes of examination prior to a final pronouncement of death (<http://www.txexecutions.org>). If the usual DCDD protocols involving additional waiting time post death to insure death has occurred were to be applied and if, since most prisons lack a facility where DCDD procurement could safely be done, bodies will likely have to be moved to another location, the time involved could well

make DCDD procurement impossible. Given these practical challenges, it is likely that only kidneys may be safely used.

This scenario also presumes medical teams would be willing to be involved in the requisite proceedings. The ethics of involvement in monitoring a patient post execution, the use of interventions to preserve organs either prior to, during, or right after the execution, and participating in the movement of the body from the execution chamber to a surgical suite raise issues of complicity with the execution that may violate professional norms. Moreover, the number of physicians and nurses willing to be publicly associated with these activities, given that executions are witnessed events, is likely to prove extraordinarily small. Potential recipients may not be willing to accept organs from executed prisoners, knowing the risks involved (Halpern et al. 2008), or simply out of ethical concerns that they do not want organs from a person executed for terrible crimes.

Could Organ Removal Be Used as the Mode of Execution?

It might be possible to shift the location of executions into hospitals or clinics in order to increase the chance of a successful procurement of more organs. Prisoners might be anesthetized and have their organs removed by a medical team before they are dead. I have dubbed the notion of execution by means of the removal of the heart or other vital organs the "Mayan protocol" after the Mayan practice of human sacrifice by removing a beating heart during certain religious rituals (Wood 2008). It is, however, morally repugnant to involve physicians as executioners or to shift the setting of punishment from prison to hospital. Involvement in causing death in any way is a direct violation of the "dead donor" rule, which has long been maintained as a bright line between death and donation in order to insure public trust and support for cadaver donation (DeVita and Caplan 2007). This principle would even restrict efforts to maximize the likelihood of procurement by the use of drugs and cold perfusion as steps prior to execution.

Donation Undercuts the Morality of Execution

The point of capital punishment is to achieve retribution for terrible crimes. It is also, proponents argue, a deterrent. If either justification is to hold, then is organ donation likely to be compatible with these reasons?

Retribution may be made far more difficult to achieve as families and friends of victims watch as executed perpetrators are lauded in their final days by possible recipients and the media for their altruism in saving lives. Some may find redemption acceptable (Wang and Wang 2010) if it saves lives, but given the horrific nature of the crimes that lead to execution, relatives and friends of victims are not likely to be among them.

Consider Christian Longo, the prisoner behind the movement to permit organ donation post-execution. What were his specific crimes? He killed his wife MaryJane, 34, and children Zachery, 4, Sadie, 3, and Madison, 2. Longo

strangled MaryJane and Madison, stuffed their bodies in suitcases, and threw them in a bay. Then he drove Zachery and Sadie to a nearby bridge, tied rocks to their legs, and tossed them into the water to drown. He said he did it because his family was hindering his lifestyle. After the murders he fled to Mexico, where he engaged in a variety of cons and swindles until he was caught. In prison he has made money by writing explicit sex letters to gay men, who pay him for the raw prose (Smith 2011).

Longo now seeks redemption through being an organ donor. If the moral basis for his execution is retribution for his horrific acts, then how is any redemptive gesture on his part consistent with the retributive intent of capital execution (Hill 2009)?

Similarly, the deterrent effect of execution may wane if social good is seen as issuing from the practice. While the needs of those awaiting transplants are real, the aim of the penal system is not to serve medical needs but to achieve justice for those wronged and their families and friends, as well as to deter future crimes. Mitigating the horror of execution by permitting organ donation is not consistent with the deterrent purpose of execution.

Giving the state a motivation to execute beyond retribution or deterrence may be seen as inconsistent with protecting prisoners' rights. Creating the possibility of organ donation may provide an incentive to prisoners or their legal teams to prematurely abandon efforts to appeal death-penalty decisions, particularly if prisoners believe they may be able to expiate their crime and be remembered in a positive manner as a result of donation.

Nor is it true, contrary to Longo's claim (Longo 2011), that being an organ donor is a right. Organ donation is a gift that neither organ procurement agencies nor anyone else is bound to accept. Even freed felons lose their right to vote, to be a party in most lawsuits, to hold public office, and to bear arms, and they suffer restrictions on travel overseas. Why permit prisoners the chance to make posthumous gifts of their bodies if their punishment is in part based on both retribution and their loss of standing within society (Hill 2009)?

The practical and ethical problems facing the use of executed prisoners as donors are overwhelming. Despite ongoing interest in their use, there is absolutely no possibility of this strategy moving forward.

DONATIONS FROM LIVING PRISONERS

Practical Obstacles

In 2008 there were about one and a half million persons in federal and state prisons and another 785,000 in local jails in the United States at some point during the year (Sabol 2009). This large population might be available to provide kidneys and perhaps portions of liver to those in need of these types of transplants.

There are prisoners willing to consider donation, especially to family members. In the past a few prisoners have done so. And prison officials in many states are willing to consider these requests on a case-by-case basis (<http://www.tdcj.state.tx.us/policy/policy-home.htm>).

The primary practical problem facing living prisoner donation is the ill health and high rate of infectious disease among prisoners (Hinkle 2002). In the case of the sisters in Mississippi where the governor granted parole on condition of sister-to-sister donation, no donation took place. The would-be donor was too obese to be able to safely donate. The risk factors for prisoners are significant enough that they require special consent requirements to be used in approaching potential recipients to inform them of the dangers of accepting a kidney or lobe of liver from this source (Singer et al. 2008; Halpern et al. 2008; Kucirka et al. 2009).

Ethical Concerns Over Use of Living Prisoners

The issue of living donation from prisoners is made morally complex when various incentives or rewards such as parole, reduction in sentence, or the extension of privileges are associated with making an organ available. Federal law prohibits making organs available for "valuable consideration" (NOTA 1984). Arguably, giving a prisoner parole or a reduction in sentence on condition of giving a kidney to another is a form of valuable compensation. That is how various national (UNOS [United Network for Organ Sharing] Ethics Committee 2009) and international groups (Zhiyong 2007) interpret policies that reward prisoners who give up organs for rewards.

In addition to worries about compensation, the question of free choice clouds the issue of prisoner consent (WMA 2005). Many maintain that prisoners cannot consent freely, given the nature of the environment in which they live. The vulnerability of prisoners in terms of coercion and manipulation is explicitly acknowledged in their categorization as a special population for whom informed consent may be compromised in regulations governing prisoner participation in research (National Institutes of Health [NIH] 2011). The ability to comprehend the facts about donation and to make a voluntary choice must be carefully weighed on a case-by-case basis if voluntary consent is to remain a key component for obtaining organs from all living persons.

In most programs for living donors a donor advocate is appointed, a psychological assessment is undertaken, and the donee is made aware that he or she may change his or her mind about donation at any time prior to the actual act. These steps would have to be in place for a vulnerable population such as prisoners, and those carrying them out ought not have a connection to the corrections system, to minimize any possibility of coercion or manipulation.

The arguments against allowing prisoners to donate organs—kidney, liver, or bone marrow—while alive are not as persuasive as the practical and ethical issues raised by cadaver donation from executed prisoners. Still, as the case in Mississippi shows, a decision to commute a sentence conditioned on making an organ available for reasons of cost may well backfire. A high degree of ill health among prisoners, alongside issues around the acceptability of compensation, and the problematic nature of consent by those who are incarcerated make this practice one that needs to be carefully regulated and assessed on a case-by-case basis. Direct

promises of reward will have to be replaced by a willingness to consider generous acts as a part of parole decisions without any guarantees. As such, while lives may be saved, living prisoners are not likely to provide a significant source of organs for those in need. ■

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