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ORGAN TRANSPLANTS FOR PRISONERS: THE INCOMPATIBILITY OF INCARCERATION AND HEALTH CARE

I. INTRODUCTION

Death row. In 1996, Horacio Alberto Reyes-Camerena was sentenced to death for the murder of an 18-year-old woman whom he stabbed to death.¹ A lengthy Oregon State appeals process for death row inmates has kept him alive to date.² His kidneys are failing as he awaits his execution.³ In 2003, a prison physician concluded that Camerena was a good candidate for a kidney transplant due to his end-stage kidney failure.⁴ The State of Oregon denied his request.⁵

Life-in-Prison. In 1967, James Earl Ray was sentenced to 99 years in a Tennessee state prison for the assassination of Rev. Martin Luther King, Jr.⁶ While incarcerated, Ray was attacked and repeatedly stabbed 22 times by a fellow inmate.⁷ He developed cirrhosis of the liver as a result of a blood

¹ DAVID L. HUDSON, PRISONERS' RIGHTS 60 (Allan Marzilli, ed., 2007).

² Bryan Robinson, *Death-Row Inmate Seeks Organ Transplant*, ABC NEWS (May 28, 2012), <http://abcnews.go.com/US/story?id=90611>.

³ *Id.*

⁴ HUDSON, *supra* note 1, at 60.

⁵ ON MORAL MEDICINE: THEOLOGICAL PERSPECTIVES IN MEDICAL ETHICS 437 (M. Therese Lysaught et al. eds., 3rd ed. 2012).

⁶ Jessica Wright, Comment, *Medically Necessary Organ Transplants for Prisoners: Who Is Responsible for Payment?*, 39 B.C. L. REV. 1251 (1998).

⁷ *Id.*

transfusion following the attack.⁸ Prison physicians concluded that Ray needed a liver transplant and was subsequently placed on the organ waiting list.⁹ The State of Tennessee requires postoperative care to be financed by the prisoner-patient.¹⁰ Ray was unable to raise the requisite funds to finance the transplant operation.¹¹ He died of liver failure.¹²

14-Years-in-Prison. In 2002, an unknown California inmate who was serving a 14-year sentence for an armed robbery conviction, was given a heart transplant due to a viral illness contracted prior to his incarceration.¹³ The transplant cost the State of California \$1 million.¹⁴ The inmate was still serving his sentence while undergoing postoperative care.¹⁵ The inmate died less than a year after his transplant.¹⁶ His death was attributed to the inmate being “less than a model patient.”¹⁷

The Eighth Amendment requires the government to provide prisoners with adequate medical care.¹⁸ Medical services offered to prisoners range from routine medical visits and checkups to resource intensive specialty care for chronic and terminal illnesses. Specialty care includes the treatment of infectious diseases, chronic illnesses, mental health care, end-of-life care, and also organ failure. Unfortunately, the examples above highlight the multitude of barriers prisoners often experience when requiring medically necessary organ transplants. In each of these cases, the treating physician’s recommendation for organ transplantation was rendered independent of the severity of the crime or the

⁸ *Autopsy Confirms Ray Died of Liver Failure*, CNN, April 24, 1998, <http://www.cnn.com/US/9804/24/ray.autopsy.pm/> [hereinafter CNN Ray].

⁹ Wright, *supra* note 6, at 1251.

¹⁰ *Id.*

¹¹ *Id.*

¹² CNN Ray, *supra* note 8.

¹³ *Prisoner Gets \$1M Heart Transplant*, CBSNEWS.COM (January 31, 2002), <http://www.cbsnews.com/news/prisoner-gets-1m-heart-transplant/>.

¹⁴ *Id.*

¹⁵ Kate Douglas, Comment, *Prison Inmates Are Constitutionally Entitled to Organ Transplants-So Now What?*, 49 ST. LOUIS U. L.J. 539-40 (2005).

¹⁶ *Id.* at 540.

¹⁷ *Id.* at 540.

¹⁸ *Estelle v. Gamble*, 429 U.S. 97, 103 (1976); *Brown v. Plata*, 131 S.Ct. 1910, 1928 (2011) (“Prisoners retain the essence of human dignity inherent in all persons. Respect for that dignity animates the Eighth Amendment prohibition against cruel and unusual punishment... A prison that deprives prisoners basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society.”).

length of sentence. And in each of these cases, despite the medical advice of the treating physician, the prisoner-patient was denied an organ or given inadequate postoperative care post-surgery.

Supreme Court jurisprudence applying the Eighth Amendment to questions of medical care states that prison officials are to give great deference to the treating physician's recommendation.¹⁹ However, medical judgment has been far from controlling when determining the scope of medical care provided a prisoner with a serious medical need. Public opposition, resource allocation, and costs, all contribute to a prison health care system not providing the same level of care to non-incarcerated individuals. As a result, a treating physician's medical judgment, professional medical ethics, and the law have been routinely circumvented and many prisoners are left to suffer and/or die while incarcerated.

Organ transplants for prisoners largely depend on society's commitments to prisoners' health and health care.²⁰ Prisoners should have equal access to organs for transplantation because humanity and justice demand compassion.²¹ Anything to the contrary offends the principle that all people have the right to be treated with humanity and respect for their inherent dignity. The Eighth Amendment demands that policies be developed to ensure prisoners are protected from extraneous factors impeding their access to organs.²² Moreover, they should be secured access to organs for transplantation under the same criteria that non-incarcerated individuals operate within. Policy makers weigh public need and public opinion in developing and implementing solutions.²³ Therefore, there must be a cultural shift in the current way

¹⁹ Marc J. Posner, Comment, *The Estelle Medical Professional Judgment Standard: The Right of Those in State Custody to Receive High-Cost Medical Treatments*, 18 AM. J.L. & MED. 347, 351 (1992) ("Once the doctor has become involved in the treatment process (by actually prescribing treatment or by the state's attempt to influence the doctor before she prescribes), the two-pronged Estelle test gives great deference to the doctor's medical opinions.")

²⁰ Jeffrey Kahn, *Ethical Issues in Dialysis: The Ethics of Organ Transplantation for Prisoners*, in SEMINARS IN DIALYSIS, 365-366 (Allen Spital, ed. 2003). ("Questions immediately emerge about how to justify the use of scarce organs for prisoners when law-abiding citizens are waiting. The answer to whether and why we ought to perform organ transplants for prisoners lies in how we understand society's commitments to prisoners' health and health care, and whether being incarcerated changes the priority of a patient waiting for a transplant.")

²¹ N.N. Dubler & B. Heyman, *End-of-Life Care in Prisons and Jails, in Clinical Practice*, in CORRECTIONAL MEDICINE 364 (M. Puisis, ed., 1998). ("[P]unishment and care are generally incompatible. Even if retribution is justifiable, dying alone, in pain, without comfort, exceeds the boundaries of the permissible for the vast majority of inmates...simple humanity and primitive justice demand compassion.")

²² E. Bernadette McKinney, J.D., Ph.D. et al., *Offender Organ Transplants: Law, Ethics, Economics, and Health Policy*, 9 HOUS. J. HEALTH L. & POL'Y 39, 68-69 (2008).

²³ Id. at 61. ("Policy makers weigh public need and public opinion in developing and implementing solutions to perceived problems.")

prisoners and their rights are perceived for any new policies to come to fruition. Part II explores the current organ transplant and allocation process in the United States, the aging prison population, and prevailing societal attitudes towards prison health care and organ transplants. Part III explores the legal rights of prisoners to organ transplants. In particular, it explores the origins of the ban on “cruel and unusual punishment” and Eighth Amendment jurisprudence developing the concept and its application to prisoner medical care. This section also highlights the current OPTN/UNOS allocation policies for prisoners as organ recipients and various international law covenants and treaties on the subject. Part IV seeks to apply the Eighth Amendment right to adequate health care to the issue of organ transplantation for prisoners. Moreover, it seeks to dispel the many prevailing arguments against prisoner transplantation, including the issues of costs and scarcity. Finally, it explores the tension between professional medical ethics and the realities of incarceration.

II. BACKGROUND

Understanding the issue of organ transplants in prisoners necessitates an understanding of the organ transplant process and allocation system, the make-up of the United States prison population, ethical dilemmas, and the social and political attitudes towards their medical treatment.

A. Organ Transplantation in the United States

The idea of organ transplantation has been around since the time of the Ancient Greeks but attempts at transplantation were unsuccessful for thousands of years.²⁴ The first successful organ transplant did not occur until 1954 in the United States; a kidney transplant from a donor to his identical twin brother.²⁵ The successful procedure was hailed as one of the greatest achievements in modern surgery.²⁶ However, fierce political and philosophical debate on a multitude of unique issues followed.

²⁴ STEVE FARBER & HARLAN ABRAHAMS, ON THE LIST: FIXING AMERICA'S FAILING ORGAN TRANSPLANT SYSTEM 17-18 (2009).

²⁵ DAVID HAMILTON, A HISTORY OF ORGAN TRANSPLANTATION 426, (2012).

²⁶ *Health Technology Achievements*, NATIONALACADEMIES.ORG, http://www.nationalacademies.org/greatachievements/ga_16_3.html (last visited November 30, 2013).

Debates stemming from resource allocation to organ property rights began dominating the public discourse regarding transplants.²⁷ The realities of a severely limited supply and a growing demand spawned a legitimate fear of the potential lengths and abuses to which society could go in procuring such a valuable commodity. These included fears of a burgeoning black market for organs²⁸, recipient discrimination²⁹, and illegal procurement methods such as murder, theft, and organ harvesting.³⁰

i. National Organ Transplantation Act (NOTA)

Today, organ transplantation is no longer considered an experimental treatment.³¹ It is a common, acceptable, and successful treatment option for end-stage organ failure.³² In 2012, there were 28,053 life-saving organ transplants from 14,015 donors (living and deceased).³³ This is largely attributable to cultural acceptance, medical advances, and legal and political evolution. Organ transplants are one of the most regulated areas of health care today.³⁴

Congress, mindful of the potential abuses in organ procurement and inequities in organ distribution, passed the National Organ Transplantation Act (NOTA) in 1984.³⁵ NOTA included language that made it a crime for “any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce.”³⁶ It also provided a much-needed framework for the transfer, allocation, and transplantation

²⁷ Gwen Mayes, *Buying and Selling Organs for Transplantation in the US: National Organ Transplant Act of 1984 (NOTA) Bans Buying and Selling*, MEDSCAPE.ORG, http://www.medscape.org/viewarticle/465200_2.

²⁸ Larry Rohter, *THE ORGAN TRADE: A Global Black Market; Tracking the Sale of a Kidney On a Path of Poverty and Hope*, N.Y. TIMES, May 23, 2004, <http://www.nytimes.com/2004/05/23/world/organ-trade-global-black-market-tracking-sale-kidney-path-poverty-hope.html>.

²⁹ Charles T. Carlstrom & Christy D. Rollow, *The Rationing of Transplantable Organs: A Troubled Lineup*, 17 CATO J. 163 (2007), available at <http://object.cato.org/sites/cato.org/files/serials/files/cato-journal/1997/11/cj17n2-3.pdf>.

³⁰ Rohter, *supra* note 28.

³¹ Dulcinea A. Grantham, Comment, *Transforming Transplantation: The Effect of the Health and Human Services Final Rule on the Organ Allocation System*, 35 U.S.F. L. REV. 751, 751 (2001) (“Organ transplantation, once a risky and uncommon procedure, is now a routine medical procedure with a relatively high success rate.”).

³² Douglas, *supra* note 15, at 542.

³³ 2012 Annual Report, UNITED NETWORK FOR ORGAN SHARING 4 (Feb. 2013), <http://www.unos.org/docs/AnnualReport2012.pdf> [hereinafter UNOS Annual Report].

³⁴ *Legislation and Policy*, ORGANDONOR.GOV, <http://www.organdonor.gov/legislation> (last visited Nov. 20, 2013).

³⁵ Mayes, *supra* note 27, at 2.

³⁶ National Organ Transplant Act, 42 U.S.C.A. § 274(e) (2006).

of organs within the federal system. To this end, the Act established the Organ Procurement and Transplantation Network (OPTN) to maintain a national registry for organ matching.³⁷ The Act called for the OPTN Network to be managed and operated by a private, non-profit organization under federal contract.³⁸ Congress purposely chose the OPTN Network to be managed by a private organization to protect the organ allocation system from potential political interference.³⁹

ii. United Network for Organ Sharing (UNOS)

The United Network for Organ Sharing (UNOS) is a nonprofit organization authorized by NOTA and contracted with the federal government to manage the OPTN Network.⁴⁰ UNOS's responsibilities include maintaining a list of individuals waiting for transplants, operating a system for matching donated organs with individuals on the waiting list, establishing medical criteria for allocating organs, collecting and analyzing data on organs donated and transplanted, and implementing methods to increase supply.⁴¹ UNOS is also involved in most other aspects of the organ transplant process: requiring specific credentials of transplant surgeons and physicians, providing assistance to patients, monitoring transplant program compliance, and providing education to the public and health care professionals.⁴²

Every transplant program, procurement organization, and tissue-typing laboratory in the United States participates in UNOS.⁴³ UNOS coordinates organ transplant efforts with 58 "organ procurement organizations" (OPOs) and 250 transplant centers—medical facilities that maintain organ transplantation

³⁷ Id. at § 372.

³⁸ Id. at § 274(e).

³⁹ Wright, *supra* note 6, at 1255. ("Because UNOS is an independent, non-profit agency, its operations and policies are to some measure insulated from the political process.")

⁴⁰ *About Us*, UNITED NETWORK FOR ORGAN SHARING, <http://www.unos.org/about/index/.php> (last visited Nov. 30, 2013).

⁴¹ RANDALL B. WILLIAMSON, ORGAN TRANSPLANT PROGRAMS: FEDERAL AGENCIES HAVE ACTED TO IMPROVE OVERSIGHT, BUT IMPLEMENTATION ISSUES REMAIN 9-11 (Apr. 28, 2008).

⁴² Id. at 10.

⁴³ Id. at 9.

programs.⁴⁴ Members also include professional scientific and medical organizations and individuals interested in organ donation or transplantations.⁴⁵

iii. The Waiting List

28,053 organ transplants were performed in 2012,⁴⁶ however, over 120,000 patients remain on the waiting list.⁴⁷ The swelling demand for organs continue to exceed the available supply. Thousands of people, including those incarcerated, die each year while waiting for a suitable organ to become available.⁴⁸

a. Waiting List Eligibility: Transplant Centers

For most transplant candidates, including prisoners, the first step to receive an organ transplant is to get on the OPTN/UNOS transplant waiting list.⁴⁹ This is a computer database that contains medical information on every person waiting for any type of organ transplant in the United States.⁵⁰ A physician must give a patient a referral to be seen by a “transplant center” (also referred to as a “transplant hospital”) for an evaluation.⁵¹ Over 250 transplant centers exist in the United States.⁵² The medical staff at the transplant center determines whether the patient is an eligible candidate for entry onto the waiting list.⁵³ The primary objective of the evaluation is to determine whether an organ transplant is medically necessary and likely to succeed.⁵⁴ The evaluation usually consists of (but not limited to): blood & tissue

⁴⁴ *Talking About Transplantation: What Every Patient Needs to Know*, UNITED NETWORK FOR ORGAN SHARING 10 (Feb. 2013), <http://www.unos.org/docs/WEPNTK.pdf>. [hereinafter UNOS What Every Patient Needs to Know].

⁴⁵ Williamson, *supra* note 41, at 9.

⁴⁶ UNOS Annual Report, *supra* note 33, at 4.

⁴⁷ UNITED NETWORK OF ORGAN SHARING, <http://www.unos.org> (last visited Nov. 30, 2013).

⁴⁸ Legislation & Policy, *supra* note 34. (“[A]n average of 18 people die each day waiting for transplants that can’t take place because of the shortage of donated organs.”)

⁴⁹ *The National Waiting List*, TRANSPLANTLIVING.ORG, <http://www.transplantliving.org/before-the-transplant/getting-on-the-list/the-national-waiting-list/> (last visited Nov. 30, 2013) [hereinafter Transplant Living: National Waiting List].

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² UNOS What Every Patient Needs to Know, *supra* note 44, at 10.

⁵³ The National Waiting List, *supra* note 49.

⁵⁴ UNOS What Every Patient Needs to Know, *supra* note 44, at 11.

typing, dental exams, chest x-rays, cardiac & pulmonary work-up, infectious disease testing, gender-specific testing, and a psychological evaluation.⁵⁵

Non-medical factors are also generally evaluated to determine the probability of a good outcome post-organ surgery prior to wait list entry.⁵⁶ OPTN/UNOS recognizes that life expectancy, behavior/character flaws, likelihood of compliance with medical advice, repeat transplantation, and the availability of alternative therapies, can influence eligibility determinations.⁵⁷ However, UNOS stresses that such non-medical factors are to be applied broadly and universally—not directed to any particular class of individuals.⁵⁸

The patient's ability to pay is often a controlling factor either by express policies at the transplant center or by limiting circumstance.⁵⁹ Although every transplant center operates within a broad UNOS framework of rules, they each have certain discretion to apply their own criteria.⁶⁰ A patient's ability to pay is a legal and accepted criterion.⁶¹ Many transplant centers expressly require a patient to demonstrate an ability to pay for the transplant operation.⁶² Other transplant centers, such as the University of Michigan Transplant Center, try work with the patient to help provide some financial assistance or help navigate governmental assistance.⁶³ Well-to-do patients are better positioned to explore various transplant centers and find centers with policies favorable to their situation.⁶⁴ Lower-income individuals

⁵⁵ Id. at 12.

⁵⁶ OPTN/UNOS Ethics Committee General Considerations in Assessment for Transplant Candidacy, ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK, <http://optn.transplant.hrsa.gov/resources/bioethics.asp?index=5> (last visited Nov. 30, 2013). (“There is general agreement that non-medical transplant candidate criteria need to be evaluated. The legitimate substance of such an evaluation could cover a very wide range of topics.”)

⁵⁷ Id.

⁵⁸ Id. (“To the greatest extent possible, any acceptance criteria should be broad and universal...because we are serving individual human beings with highly complex medical situations, a process of individual evaluation must be maintained within the broad parameters.”)

⁵⁹ Joy Victory, *Need an Organ? It Helps to Be Rich*, ABC NEWS (June 26, 2006), <http://abcnews.go.com/Health/story?id=1514702&page=2>.

⁶⁰ Id. at 1. (“Each center sets its own criteria, which often include the patient's ability to pay.”)

⁶¹ Id.

⁶² Gina Kolata, *Getting on a Transplant List is the First of Many Hurdles*, N.Y. TIMES, June 10, 1995, <http://www.nytimes.com/1995/06/10/sports/getting-on-a-transplant-list-is-the-first-of-many-hurdles.html>.

⁶³ Victory, *supra* note 59, at 2.

⁶⁴ Id. at 1. (“Centers have different practices. And if you're a well-to-do patient, you can shop around to centers. But if you don't have any money, you will go wherever is closest, and their policies are what you are stuck with.”)

may not have the ability or resources to “shop” transplant facilities and are often pinned to policies at transplant centers conveniently located.⁶⁵

Many prisoners, on the other hand, do not have present financial capacity to fund such procedures. They often have their livelihoods stripped when entering the prison system and are at the mercy of the government to provide medical services on their behalf. However, the government does not always intervene. For example, James Earl Ray was medically qualified for a liver transplant but because he could not finance the operation, he was denied the organ transplant.⁶⁶ The state refused to pay.⁶⁷

b. Transplant Eligibility: Wait Times

The waiting list is not the typical waiting list found at the DMV or at the local deli. It is not a list where a patient simply waits his or her turn and is called on by order of placement on the list. There is no number or rank. The waiting list is a large pool of patients in a database containing the medical information of every person in the United States who is seeking an organ for transplantation.⁶⁸ Each candidate’s medical prognosis and situation is unique, therefore, waiting times can vary and is dependent on a number of factors.⁶⁹

Some general principles guide the distribution of organs. A patient’s medical urgency, blood tissue, size, time on the waiting list, age, and geographic proximity to the donor are taken into consideration.⁷⁰ However, specifics on transplant eligibility and wait times vary by organ.⁷¹ UNOS has developed specific policies and guidance for each individual organ, taking into consideration a patient’s unique medical needs.⁷² For example, patients with kidney/renal failure can typically maintain dialysis treatments for a period of time before a kidney becomes available; priority for patients in need of livers

⁶⁵ Id.

⁶⁶ Wright, *supra* note 6, at 1251.

⁶⁷ Id.

⁶⁸ Transplant Living: National Waiting List, *supra* note 49.

⁶⁹ *Organ Type and Waiting Time*, TRANSPLANTLIVING.ORG, <http://www.transplantliving.org/before-the-transplant/about-organ-allocation/waiting-for-an-organ/> (last visited Nov. 30, 2013). [hereinafter *Transplant Living: Organ Type and Waiting Time*].

⁷⁰ Id.

⁷¹ Id.

⁷² UNOS What Every Patient Needs to Know, *supra* note 44, at 10.

often depend on their “Model for End-Stage Liver Disease” (MELD) score that measure the degree of medical urgency coupled with geography; priority for patients in need of hearts often depend on the geography of the donor and the patient coupled with medical urgency.⁷³

1. Discrimination

In 1995, baseball Hall-of-Famer, Mickey Mantle was diagnosed with end-stage liver disease due to liver cancer complicated by alcoholism.⁷⁴ He was placed on the transplant waiting list for only two days before he underwent a liver transplant procedure.⁷⁵ The average waiting time for a liver transplant at the time was 67 days.⁷⁶ Mantle died two months after his transplant surgery from liver cancer.⁷⁷ UNOS policies vehemently prohibit discrimination or favoritism of transplant recipients.⁷⁸ “Candidates for transplantation shall not differ on the basis of a candidate’s citizenship or residency status in the United States...[a]llocation shall not be influenced by favoritism or discrimination based on political influence, national origin, race, sex, religion, or financial status.”⁷⁹ However, cases like Mantle’s raise public distrust and questions about the discrepancy in access to organs between the well-to-do, famous, and the poor.

iv. Costs of Organ Transplantation

Organ transplant procedures are among the most expensive medical procedures available. High costs are primarily incurred for the procurement of the organ itself, the relative difficulty of the procedure, and the skill level required of the surgeon.⁸⁰ Overall transplant costs include the initial evaluation,

⁷³ Transplant Living: Organ Type and Waiting Time, *supra* note 69.

⁷⁴ Kolata, *supra* note 62.

⁷⁵ *Id.*

⁷⁶ Carlstrom & Rollow, *supra* note 29, at 163.

⁷⁷ *Id.*

⁷⁸ *Policies and Bylaws §6.2.1*, UNITED NETWORK FOR ORGAN SHARING, http://www.unos.org/About/policy_policies.htm (last visited Nov. 30, 2013).

⁷⁹ *Id.*

⁸⁰ *Organ Transplantation: The Process*, ORGANDONOR.GOV, <http://organdonor.gov/about/transplantationprocess.html> (last visited Nov. 30, 2013). (“Costs include laboratory tests, organ procurement, transplant surgeons and other operating room personnel, in-hospital stays, transportation to and from the transplant hospital for surgery and for checkups, rehabilitation, including physical or occupational

surgery, postoperative care, tests and medication.⁸¹ The costs vary for each patient based on the patient's individual medical needs and the type of organ needed for transplant.⁸² Transplant costs also vary due to limited supplies of available organs. For example, a kidney transplant is among the least expensive organ transplant due to the relatively higher volume of supply compared to other organs.⁸³ The average cost of a kidney transplant is \$260,000 where a heart transplant averages around \$1 million.⁸⁴

Transplant centers have the discretion to first establish a patient's ability to pay for the transplant procedure prior entry on the organ waiting list.⁸⁵ A patient's ability to pay depends on the scope of their health insurance coverage (private or public) or ability to pay out-of-pocket.⁸⁶ If a patient does have medical insurance, coverage for an organ transplant can sometimes depend on whether states recognize an organ transplant as an "essential health benefit."⁸⁷ The Patient Protection and Affordable Care Act (PPACA) requires all health plans to cover "essential health benefits" which must include items and services within at least the following ten categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services.⁸⁸ However, whether a transplant is covered largely depends on what the state considers an essential health benefit.⁸⁹ States are guided by a

therapy; and medications, including immunosuppressive or anti-rejection drugs which may cost up to \$2,500 per month.")

⁸¹ *Id.*

⁸² UNOS What Every Patient Needs to Know, *supra* note 44, at 30. (Chart of estimated costs per organ)

⁸³ *Financing a Transplant*, TRANSPLANTLIVING.ORG, <http://www.transplantliving.org/before-the-transplant/financing-a-transplant/the-costs/> (last visited, Nov. 20, 2013).

⁸⁴ *Id.*

⁸⁵ *Victory*, *supra* note 59.

⁸⁶ RW Evans, Abstract, *Organ transplantation costs, insurance coverage, and reimbursement*, BATTELLE SEATTLE RESEARCH CENTER (1990), available at <http://www.ncbi.nlm.nih.gov/pubmed/2103158>.

⁸⁷ *Current Policy Issues*, AMERICAN KIDNEY FUND, <http://www.kidneyfund.org/advocacy/policy-and-issues/policy-issues.html> (last visited Nov. 30, 2013). [hereinafter American Kidney Fund Policy Issues].

⁸⁸ *What Does Marketplace Health Insurance Cover*, HEALTHCARE.GOV, <https://www.healthcare.gov/what-does-marketplace-health-insurance-cover/> (last visited Dec 1, 2013).

⁸⁹ American Kidney Fund Policy Issues, *supra* note 87. ("CMS outlined an approach that would give each State the flexibility to define its essential health benefits package through the selection of an existing benchmark plan, rather than prescribe a specific list of items and services that all health plans must provide.")

benchmarking plan rather than a specific list of items and services when prescribing what is mandatorily covered.⁹⁰

Federal insurance programs, including Medicare and Medicaid have covered end-stage renal disease and certain transplant procedures for over four decades.⁹¹ In 1972, Medicare was amended to cover people with end-stage renal disease regardless of their age.⁹² Notably, Medicaid—a cooperative program between states and the federal government—funds only certain health care expenses for low-income or disabled persons.⁹³ The states have discretion to develop eligibility and coverage criteria.⁹⁴ Medicare currently covers organ transplants under certain circumstances in approved facilities: heart, lung, kidney, pancreas, intestine, and liver.⁹⁵ Medicare transplant coverage includes: diagnostics, immunosuppressive drugs, follow-up care, and the procurement of organs and tissues.⁹⁶

a. Costs for Prisoners

Whether a prisoner is covered for organ transplantation often depends on the state system and the policies therein. In federal prisons, the Federal Bureau of Prisons' general policy is not to provide organ transplants for federal inmates unless inconsistent with evolving community standards or the Medical Director makes an exception.⁹⁷ The determination is usually made on a case-by-case basis and is based

⁹⁰ Id.

⁹¹ *Timeline of Historical Events*, ORGANDONOR.GOV, <http://organdonor.gov/legislation/timeline.html> (last visited Dec. 1, 2013).

⁹² H. Bradley Southern, Comment, *Medicare's End-Stage Renal Disease Program: Its Development and Implications for Health Care Policy*, 26 HARV. J. ON LEGIS. 225, 226 (1989).

⁹³ Melissa Wong, Comment, *Coverage for Kidneys: The Intersection of Insurance and Organ Transplantation*, 16 CONN. INS. L.J. 535, 546 (2010) (“Medicaid is a cooperative program between the federal government and individual states to fund certain health care expenses for low-income or disabled persons who qualify.”)

⁹⁴ Id. at 546. (“While the federal government may set broad policies and ensure state compliance with the Medicaid statute, it is up to the states to develop state eligibility and coverage criteria subject to federal approval and reimbursement.”)

⁹⁵ *Your Medicare Coverage: Transplants*, MEDICARE.GOV, <http://www.medicare.gov/coverage/transplants-adults.html> (last visited Nov. 25, 2013).

⁹⁶ Id.

⁹⁷ Press Release, Federal Bureau of Prisons, Statement of the Federal Bureau of Prisons, (Nov. 18, 1998), available at http://www.bop.gov/news/press/press_releases/ipaorg.jsp.

on factors including, the preservation of life, prevention of irreparable harm, or whether the procedure is experimental.⁹⁸

Some states attempt to address organ transplants for prisoners directly through legislation or regulation. Washington State, for example, offers an “Offender Health Plan” which lists the health services and scope of health coverage available for inmates within the state.⁹⁹ The Offender Health Plan specifically states that organ transplants are not to be funded by the state unless the “Utilization Review Committee” specifically authorizes the individual prisoner/patient for transplant.¹⁰⁰ The Committee looks at alternative methods of securing funding for the organ transplant, such as, private insurance, social service groups, and nonprofit organizations.¹⁰¹ If funding cannot be secured through alternative sources, the Committee has the discretion to pay for or deny the transplant.¹⁰² For the most of the country, no formulaic policies exist as to state-funded organ transplants for the incarcerated—most opting for case-by-case review.¹⁰³

The issue as to whether organ transplants for the incarcerated should be state funded is heavily contested. What follows is the argument that a prisoner’s Eighth Amendment protection against cruel and unusual punishment would be violated if a prisoner/patient could not afford his or her lifesaving procedure. This is explored in-depth within the Constitutional Analysis in Part III.

B. The Aging Prison Population

As the average age of the prison population rises to record levels, the reality faced by the government is that their inmates are becoming old and expensive to care for. Over 1.5 million people are

⁹⁸ Id.

⁹⁹ Washington State Dep’t of Corrections, Offender Health Plan § 3 (Dec. 13, 1996).

¹⁰⁰ Id. § 4.

¹⁰¹ Wright, *supra* note 6, at 1260. (“The Committee will first seek alternative methods of funding, such as private insurance or veterans groups.”)

¹⁰² Id.

¹⁰³ Id. at 1261. (“[I]ndividualized consideration of each inmate’s case...will probably continue to be the predominant method of dealing with the funding question, at least until states see a need to formulate specific, written policies.”)

incarcerated in the United States—among the highest concentration of prisoners in the world.¹⁰⁴ Adding additional strain on the prison system is that over 8% of the total prison population is above the age of 55.¹⁰⁵ The number of prisoners 55 and older is growing at exponential rates compared to the total prison population.¹⁰⁶ The overall prison population has increased 42.1% from 1995 to 2010.¹⁰⁷ The prison population of inmates 55 or older grew a staggering 282% during the same time span.¹⁰⁸ The number of older prisoners is growing at a faster rate than the same age demographic within the general U.S. population.¹⁰⁹ As prisoners age, they are at increasing risk of developing various disabilities and serious illnesses that require resource intensive medical therapies.¹¹⁰

i. Reasons for the Aging Prison Population

There are varied reasons for the dramatic rise in the older inmate population. One of the main factors has been the adoption of “tough on crime” policies implemented by state and federal legislators in an attempt to curb rising crime rates in the 1980s.¹¹¹ The aggressive laws harshened punishments and increased the likelihood and length of prison sentences for criminal activity.

¹⁰⁴ John V. Jacobi, *Prison Health, Public Health: Obligations and Opportunities*, 31 AM. J.L. & MED. 447, 449 (2005) (“Prison and jail populations increased more than four-fold from 1980 to 2003, from about 500,000 in 1980 to over 2,000,000 in 2003. The rate of incarceration in the United States grew to 726 persons per 100,000 by 2004, far outstripping the imprisonment rates in every other country in the world for which such statistics are maintained.”)

¹⁰⁵ OLD BEHIND BARS, HUMAN RIGHTS WATCH 6 (January 2012), *available at* http://www.hrw.org/sites/default/files/reports/usprisons0112webwcover_0_0.pdf. (“8 percent of sentenced state and federal prisoners are age 55 or older, more than doubling from 3 percent in 1995.”) [hereinafter HRW Old Behind Bars].

¹⁰⁶ *Id.* at 19. (“In the last fifteen years, the number of men and women age 55 years or older in US prisons has grown markedly, and at an increasingly rapid pace. In 1995, there were 32,600. By 2010, there were 124,400.”)

¹⁰⁷ *Id.* at 20. (“The number of prisoners age 55 or older grew at a much faster rate than the total prison population, growing by 282 percent compared to a 42.1 percent increase in the prison population.”)

¹⁰⁸ *Id.*

¹⁰⁹ *Id.* (“The number of older prisoners is growing faster than the number of older persons in the US population, as is evident from the growth in incarceration rates relative to population.”)

¹¹⁰ *Id.* at 43. (“As persons age, they are at increasing risk of developing various illnesses and disabilities.”)

¹¹¹ Felicia Cohn, *The Ethics of End-of-Life Care for Prison Inmates*, 27 J.L. MED. & ETHICS 252, 253 (1999) (“This increase can be attributed to several policy trends of the 1980s. These include limits on judicial discretion in sentencing and releases, restrictions on community-based intermediate sanctions, “get-tough-on-crime” campaigns, “three-strikes-and-you-are-out” legislation, and state and federal laws mandating longer sentences for drug-related criminal convictions.”)

Tough-on-crime policies have contributed dramatically to the overcrowded prison system.¹¹² “Three-strikes” laws sent many repeat felony offenders to serve life sentences; “truth in sentencing” laws made it much more difficult for a prisoner to be released on parole without serving at least 85% of his or her sentence; and the establishment of mandatory minimum sentences and increased life-without-parole sentences.¹¹³ Federal prisoners serving life-sentences have no prospect of release in their lifetime because the federal system does not have parole.¹¹⁴ In state systems where parole is offered, many states have adopted harsher parole revocation policies that have returned high percentages of released offenders back to prison for parole violations.¹¹⁵ These policies have led to an irreversible overcrowded prison environment and an increased financial burden on federal and state governments to provide care for them.

Crime rates have declined since tough-on-crime laws began to be passed.¹¹⁶ However, it is debated as to whether these “front-end” tough-on-crime policies are directly attributable to the reduction in crime rates or attributed to other variables and societal trends.¹¹⁷

ii. Costs of Incarcerating the Elderly

The government spends over \$60 billion a year on its prison system.¹¹⁸ Anywhere from 9-30% of prison budgets are spent on inmate health care.¹¹⁹ The average costs for housing aging prisoners is up to

¹¹² Id.

¹¹³ HRW Old Behind Bars, *supra* note 106, at 24. (“State and federal legislators adopted laws that increased the likelihood and length of prison sentences, including by establishing mandatory minimum sentences and three strikes laws, and by increasing the number of crimes punished with life and life- without-parole sentences. In addition to these “front end” policy changes, the legislators sought to increase the amount of time prisoners would serve in prison before release, for example by establishing truth-in-sentencing conditions that require 85 percent or more of a prison sentence be served before the inmate becomes eligible for release, and by making some crimes ineligible for parole. Harsh parole revocation policies were also adopted that returned high percentages of released offenders to prison for technical parole violations.”)

¹¹⁴ Id. at 36.

¹¹⁵ Id. at 24.

¹¹⁶ Id. (“These sentencing and release policies help explain why the US prison population has grown six-fold since 1980, despite declining crime rates.”)

¹¹⁷ Anthony Nagorski, Comment, *Arguments Against the Use of Recidivist Statutes That Contain Mandatory Minimum Sentences*, 5 U. ST. THOMAS J.L. & PUB. POL’Y 214, 227 (2010) (“[L]ower rates could be attributed to the enactment of any number of new criminal statutes or deterrence methods, not necessarily due to the Three Strikes laws.”)

¹¹⁸ Aging Inmate Committee, *Aging Inmates: Correctional Issues and Initiatives*, Md. B.J., November/December 2011, at 22. (“States spend over \$60 billion per year to incarcerate their inmates.”)

¹¹⁹ Phil Schaanman et al, *Opportunities for Cost Savings in Corrections Without Sacrificing Service Quality: Inmate Health Care*, URBAN INSTITUTE 3 (February 2013), available at <http://www.urban.org/UploadedPDF/412754->

three times higher than housing younger inmates.¹²⁰ The prison environment is often less conducive to healthy living. Prisoners tend to “age” much more rapidly than those similarly aged outside the prison system.¹²¹ Aging prisoners typically have serious health conditions, including, physiological and psychological health conditions, associated with people at least a decade older.¹²² Moreover, the common services for treating the elderly outside of prison—the need for walkers, wheelchairs, hearing aids, and daily assistance such as going to the toilet and eating—are also necessary for many aging inmates.¹²³

iii. Methods for Addressing Increased Costs

Prisoners are entitled under the Eighth Amendment to receive health care to at a level comparable to the care they could receive if not incarcerated.¹²⁴ As prison populations rapidly rise and grow older, the costs of addressing their health care will continue to rise.¹²⁵ Some states and the federal government have instituted cost saving methods to deal with this quandary.¹²⁶

In 2014, Medicaid will expand the potential of medical coverage for inmates.¹²⁷ Any inmate with an income below 133% of the federal poverty line will become Medicaid eligible for treatment services *outside* the prison.¹²⁸ The cost-saving potential for states is great since many inmates will qualify.¹²⁹

[Inmate-Health-Care.pdf](#). (“Typically 9 to 30 percent of corrections costs go to inmate health care. This amounts to hundreds of millions of dollars nationally.”)

¹²⁰ HRW Old Behind Bars, *supra* note 106, at 72. (“Older prisoners are at least two to three times as expensive to incarcerate as younger prisoners, primarily because of their greater medical needs.”)

¹²¹ *Id.* at 17. (“[I]ncarcerated men and women typically have physiological and mental health conditions that are associated with people at least a decade older in the community.”)

¹²² *Id.*

¹²³ *Id.* at 4. (“Prisons in the United States contain an ever growing number of aging men and women who cannot readily climb stairs, haul themselves to the top bunk, or walk long distances to meals or the pill line... who need wheelchairs, walkers, canes, portable oxygen, and hearing aids; who cannot get dressed, go to the bathroom, or bathe without help.”)

¹²⁴ Shaenman et al, *supra* note 119, at 3. (“Prisons and jails are required to provide health care to inmates at a level comparable to the care they could receive in the community if not incarcerated. It is considered an Eighth Amendment issue regarding cruel and unusual punishment.”)

¹²⁵ Carrie Abner, *Graying Prisons*, THE COUNCIL OF STATE GOVERNMENTS 11 (December 2006), *available at* <http://www.csg.org/knowledgecenter/docs/sn0611GrayingPrisons.pdf>. (“As America’s prisoners continue to grow older and sicker, the costs to states will continue to rise.”)

¹²⁶ *Id.*

¹²⁷ HRW OLD BEHIND BARS, *supra* note 106, at 79. (“In 2014, anyone with an income below 133 percent of the federal poverty line will become Medicaid eligible, which probably includes most inmates since they have little or no income.”)

¹²⁸ *Id.*

¹²⁹ *Id.*

However, the cost savings would be minimized due to costs of transporting prisoners to and from outside medical facilities safely and securely.¹³⁰

The Federal Bureau of Prisons and some states have expanded medical and age criteria to increase eligibility for an early “compassionate release” program (or “medical parole”).¹³¹ Prisoners released under this program could be eligible for Medicare, Social Security, or veterans’ benefits, relieving a portion of the states’ financial burden for their care.¹³² Although the federal compassionate release program has been around since 1984, the program is whittled in bureaucracy, controversy, and implemented inconsistently.¹³³ Only two-dozen prisoners are released each year on compassionate grounds.¹³⁴ And nearly 1 in 8 prisoners die while awaiting a decision.¹³⁵

C. Common Public Attitudes of Transplants for the Incarcerated

The term “waiting list” alone makes it clear that organs are a precious and rare commodity. There are many more people on the waiting list than there are available organs. And many die each year while waiting for an organ to become available. This phenomenon creates a logical tension among awaiting recipients regarding eligibility hierarchy. Media reports of Raj Rajaratnam, a wealthy white-collar convict serving 11 years in federal prison for insider trading, attempting to secure a kidney transplant,¹³⁶ and the unidentified California inmate who obtained a \$1 million heart transplant but died a year later,¹³⁷ sparked intense public backlash. Some prisoners report that they receive better and more

¹³⁰ Id. (“While Medicaid may help states defray some of the costs associated with hospital care provided outside the prison system, it will do nothing to relieve states of the considerable costs of transporting incarcerated men and women to and from outside service providers, nor will it help with the costs of providing officers to guard offenders while they are receiving community-based treatment.”)

¹³¹ Richard A. Serrano, *Government Explores Early Release For More Aging Prisoners*, L.A. Times, Nov. 13 2013, <http://articles.latimes.com/2013/nov/12/nation/la-na-prisoners-release-20131113>.

¹³² Abner, *supra* note 125, at 11. (“Proponents for this approach argue that once released, inmates may be eligible for Medicare, Social Security or veterans benefits, relieving a portion of the states’ financial burden for their care.”)

¹³³ Serrano, *supra* note 131. (“[T]he release program has been bogged down in bureaucracy and that wardens and judges remain reluctant to free inmates.”)

¹³⁴ Id.

¹³⁵ Id.

¹³⁶ Aaron Smith, *Rajaratnam's kidney transplant could cost taxpayers \$300,000*, CNN MONEY (Oct. 21, 2011, 5:12 PM), http://money.cnn.com/2011/10/21/news/companies/rajaratnam_kidney_taxpayer/.

¹³⁷ Douglas, *supra* note 15, at 539.

available medical care in prison than they do outside prison walls.¹³⁸ There is an inherent sense of injustice when criminals secure scarce resources and available public finances from law-abiding citizens.

On the other side of the debate is the argument that only “objective medical judgment” should guide eligibility decisions for securing organs. Non-medical factors, including criminal records or incarceration status, should not be considered. If such factors control eligibility, this could open up a litany of factors that may prevent certain social or economic classes from securing lifesaving transplant procedures. Fundamental human rights and civil rights dictate that one’s social status should not be a controlling factor in medical decisions. Due to a prisoner’s loss of freedom, the government has the responsibility to make sure their prisoners are not suffering while under their control. As wards of the state, a prisoner is under the complete control and dominion of the state—analogous to the parent/child relationship.¹³⁹ Prisoners cannot independently secure medical services; they are reliant on the system and its practitioners. If correctional facilities fail to provide proper medical care, incarcerations could equate to a death sentence.¹⁴⁰

III. LEGAL ANALYSIS

Every prisoner in the United States has an Eighth Amendment right to adequate health care.¹⁴¹ It is considered “cruel and unusual punishment” for the government to ignore or interfere with this right – especially interfering with a physician’s prescribed treatment for a prisoner with a serious condition.¹⁴²

¹³⁸ Smith, *supra* note 136. (“Ex-prisoner, Levine, states, “I tell people that I had better medical care in prison,” he said. “Going to prison probably did save my life.”)

¹³⁹ McKinney, et al, *supra* note 22, at 64. (“Offenders become wards of the state and must depend on the state the same as a child in the state’s custody.”)

¹⁴⁰ Id. at 65. (“The courts recognize the ethical problems associated with punishing a person by taking away his or her liberty and denying him basic necessities of life. If correctional facilities fail to provide proper medical care, every incarceration could become a death sentence.”)

¹⁴¹ Estelle, 429 U.S. at 97. See, e.g., Posner, *supra* note 19, at 349. (“[I]n Estelle v. Gamble, the Supreme Court held that the Eighth Amendment required the federal government and, through the Fourteenth Amendment, the states to provide medical care to prisoners.”)

¹⁴² Plata, 131 U.S. at 1928. (“Prisoners retain the essence of human dignity inherent in all persons. Respect for that dignity animates the Eighth Amendment prohibition against cruel and unusual punishment... A prison that deprives prisoners basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society.”)

However, despite Constitutional protections and evolving ethical and moral standards, the law is often ignored.

A. Constitutional Analysis

Prisoners are stripped of some of their constitutional rights while incarcerated. However, their right to humane treatment endures regardless of their incarceration status and their Eighth Amendment right against cruel and unusual punishment, which includes the right to receive adequate medical treatment, attaches.

i. Eighth Amendment: Cruel and Unusual Punishment

The phrase “cruel and unusual punishment” first appeared in the English Bill of Rights of 1689: “Nor Cruel and Unusual Punishments Inflicted.”¹⁴³ In the United States, the Eighth Amendment of the U.S. Constitution embodies “cruel and unusual punishment”: “Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.”¹⁴⁴ Early court cases limited Eighth Amendment protections due to the “hands-off doctrine.”¹⁴⁵ According to the doctrine, the court lacked any jurisdiction to supervise the internal management of the criminal justice system.¹⁴⁶ Any issues relating to the supervision of prisoners and internal prison affairs were beyond judicial review.¹⁴⁷ The judiciary has evolved from the “hands-off doctrine.”¹⁴⁸ It no longer precludes judicial review of constitutional infringements on prisoners’ rights.¹⁴⁹

¹⁴³ *Gregg v. Georgia*, 428 U.S. 153, 169 (1976).

¹⁴⁴ U.S. CONST. amend. XII.

¹⁴⁵ Michael Cameron Friedman, Note, *Cruel and Unusual Punishment in the Provision of Prison Medical Care: Challenging the Deliberate Indifference Standard*, 45 VAND. L. REV. 921, 927 (1992) (“Before the 1960s, courts generally employed the hands-off doctrine, deferring to decisions made by prison administrators.”)

¹⁴⁶ *Wagner v. Ragen*, 213 F.2d 294, 295 (7th Cir. 1954). (“[P]rison officials are vested with wide discretion in safeguarding prisoners committed to their custody. Discipline reasonably maintained in State prisons is not under the supervisory direction of federal courts.”)

¹⁴⁷ *Id.*

¹⁴⁸ Friedman, *supra* note 145, at 928. (“Since the erosion of the hands-off doctrine, however, courts have shown much less deference to prison administrators in matters unrelated to prison discipline or security. Courts today do not hesitate to intervene to protect prisoners’ fundamental constitutional rights.”)

¹⁴⁹ *Id.*

In addition to the hands off doctrine, early Eighth Amendment cases focused primarily on determining whether existing execution methods were “inherently cruel” to pass constitutional muster.¹⁵⁰ However, in 1910, the Supreme Court in *Weems v. United States* recognized the need for the Eighth Amendment to have wider application than its narrow interpretation.¹⁵¹ The Court began to reject the proposition that the Eighth Amendment only reaches punishments that are inhuman and barbarous. Rather, the *Weems* Court maintained that the Constitution is not “fastened to the obsolete but may acquire meaning as public opinion becomes enlightened by a human justice.”¹⁵²

In 1958, the Supreme Court in *Trop v. Dulles*, in dicta, observed the concept of expanding Eighth Amendment application to the proportionality of punishments and substantive limits.¹⁵³ The *Trop* Court dispelled any suggestion that a punishment must produce physical or mental suffering for the Eighth Amendment protection to attach.¹⁵⁴ Rather, Justice Warren suggested that “the [Eighth] Amendment must draw its meaning from the evolving standards of decency that mark the progress of a maturing society.”¹⁵⁵ The Court began to focus less on whether physical and mental mistreatment existed but whether a punishment was “degrading to human dignity.”¹⁵⁶

a. Deliberate Indifference Standard: *Estelle v. Gamble*

¹⁵⁰ William H. Danne, *Prison Conditions as Amounting to Cruel and Unusual Punishment*, 51 A.L.R.3d 111 (1973). (“The earliest, and still most frequently resorted to, test for determining whether a punishment is cruel and unusual is an essentially subjective one which is grounded upon the concept that some punishments are so inherently cruel that no offense against society can justify them.”)

¹⁵¹ *Weems v. United States*, 217 U.S. 349 (1910).

¹⁵² *Id.* at 378. (“The clause of the Constitution, in the opinion of the learned commentators, may be therefore progressive, and is not fastened to the obsolete, but may acquire meaning as public opinion becomes enlightened by a humane justice.”)

¹⁵³ *Trop v. Dulles*, 356 U.S. 86, 100 (1958).

¹⁵⁴ Danne, *supra* note 150. (“In reasoning that the penalty of expatriation is violative of the Eighth Amendment precisely because of the fear and mental distress it causes, however, the Supreme Court, in *Trop v Dulles* (1958) 356 US 86, 2 L Ed 2d 630, 78 S Ct 590, would appear to have dispelled once and for all any suggestion that a punishment must produce physical suffering in order to be characterized as cruel and unusual.”)

¹⁵⁵ *Trop*, 356 U.S. at 100-01 (1958).

¹⁵⁶ *Furman v. Georgia*, 408 U.S. 238, 271 (1972). (“The primary principle is that a punishment must not be so severe as to be degrading to the dignity of human beings. Pain, certainly, may be a factor in the judgment. The infliction of an extremely severe punishment will often entail physical suffering. *See Weems v. United States*, 217 U.S., at 366, 30 S.Ct., at 549.11 Yet the Framers also knew ‘that there could be exercises of cruelty by laws other than those which inflicted bodily pain or mutilation.’ *Id.*, at 372, 30 S.Ct., at 551. Even though ‘(t)here may be involved no physical mistreatment, no primitive torture,’ *Trop v. Dulles*, *supra*, 356 U.S. at 101, 78 S.Ct., at 598, severe mental pain may be inherent in the infliction of a particular punishment. *See Weems v. United States*, *supra*, 217 U.S., at 366, 30 S.Ct., at 549.”)

In 1976, the Supreme Court in *Estelle v. Gamble* extended Eighth Amendment protections to a prisoner's right to adequate health care.¹⁵⁷ *Estelle* challenged the old tradition of the 'hands-off' doctrine of courts deferring to prison administrators' their actions.¹⁵⁸ *Estelle v. Gamble* involved a state prisoner seeking treatment for back injuries sustained during an accident that occurred while he was doing prison work.¹⁵⁹ He sought treatment for his injuries and was seen by medical personnel multiple times, however, he sued alleging that his medical treatment was inadequate.¹⁶⁰ The Court, while rejecting his particular claim, recognized for the first time that the Eighth Amendment afforded prisoners the right to adequate health care.¹⁶¹

The *Estelle* Court implemented a decision-making test to field Eighth Amendment "cruel and unusual punishment" questions as to whether a prisoner received unconstitutional health care.¹⁶² Also known as the "deliberate indifference standard," it requires that the complainant show the physician or prison official displayed deliberate indifference to the serious medical needs of the prisoner and failed to respond.¹⁶³ The Court in *Wilson v. Seiter*, refined the deliberate indifference standard in two prongs – both of which must be met for a prisoner to succeed in an Eighth Amendment claim of inadequate health care.¹⁶⁴ (1) The complaining party must be able to demonstrate a "serious medical need" (objective), and (2) the defendant/government must have actual knowledge or awareness of the complaining party's

¹⁵⁷ *Estelle*, 429 U.S. at 97 (1976).

¹⁵⁸ Brittany Bondurant, Comment, *The Privatization of Prisons and Prisoner Healthcare: Addressing the Extent of Prisoners' Right to Healthcare*, 39 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 407, 414 (2013). ("Estelle was instrumental in challenging the old tradition of the 'hands-off' doctrine, in which courts deferred to prison administrators' internal actions and decisions within prison facilities.")

¹⁵⁹ *Estelle*, 429 U.S. at 288-89.

¹⁶⁰ *Id.*

¹⁶¹ *Id.* at 103. ("[T]hese elementary principles establish the government's obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical torture or a lingering death.")

¹⁶² *Id.* at 104. ("[A] prisoner must allege acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs. It is only such indifference that can offend "evolving standards of decency" in violation of the Eighth Amendment.")

¹⁶³ Bondurant, *supra* note 158, at 414. ("The Court established the 'deliberate indifference' standard, which requires that the complainant show the physician or prison official displayed deliberate indifference to the needs of the prisoner and failed to respond to medical needs that were sufficiently serious.")

¹⁶⁴ *Id.* at 414-15.

serious medical need, and acts or omissions that indicate a failure to avert, or to take serious steps to avert, a serious risk of harm to the offender (subjective).¹⁶⁵ In other words, if a correctional official knew or should have known about a prisoner's serious medical needs, and either, disregards it, interferes with treatment, or provides care below the standard of care, that could constitute a violation of the prisoner's Eighth Amendment rights.

b. Evolution of the Deliberate Indifference Standard

Post *Estelle* cases broadened the scope of the deliberate indifference standard and in some cases narrowed it.

1. Difference in Medical Opinion

In *Estelle*, the prisoner claimed that the treating physician acted with deliberate indifference in the treatment of his back injury by failing to order additional diagnostics for his lower back.¹⁶⁶ The Court noted that the mere disagreement with the medical judgment of the treating physician did not constitute a deliberate indifference.¹⁶⁷ A difference of opinion arising between medical professionals or between the inmate and the prison health care provider is also not necessarily a deliberate indifference.¹⁶⁸

2. Requests for Experimental Treatment

Cases involving a refusal of a prisoner's request for "experimental treatment" have also been held to not qualify as a deliberate indifference.¹⁶⁹ In *Hawley v. Evans*, an HIV patient was seeking a drug that at the time was deemed "experimental" in the treatment against HIV/AIDS.¹⁷⁰ The Court denied his

¹⁶⁵ *Id.*

¹⁶⁶ *Estelle*, 29 U.S. at 101.

¹⁶⁷ Douglas, *supra* note 6, at 549-50. ("Although some courts still speak of medical judgment, many cases instead refer to this concept as a "difference of opinion." Where a decision concerning treatment or medication manifests nothing more than a difference of medical opinion, the courts have consistently held that this difference of opinion does not constitute deliberate indifference. Closer examination of post-*Estelle* cases reveal two occasions in which a difference of opinion may arise.")

¹⁶⁸ *Id.* at 550.

¹⁶⁹ *Id.* at 551. ("Cases involving experimental treatment most frequently involve a prisoner's request for cutting-edge medication.⁸⁸ When faced with such a demand, courts have held that refusal to provide prisoners with experimental treatment does not rise to the level of a constitutional violation.")

¹⁷⁰ *Hawley v. Evans*, 716 F. Supp. 601 (N.D. Ga. 1989).

request holding that the drug [at the time] was experimental and that the Eighth Amendment does not extend to experimental treatments.¹⁷¹ In *Harris v. Thigpen*, the court ruled that prisoners are not entitled to “state of the art” treatment but only reasonable care according to the community standard.¹⁷²

3. Providing Easier and Less Efficacious Treatment

Cases where prison officials choose to provide “easier and less efficacious treatment” than other available options, constituted a deliberate indifference.¹⁷³ In *Williams v. Vincent*, the case involved where a prisoner’s ear was severed in a prison fight.¹⁷⁴ Rather than attempting to repair and reattach the ear, the physician threw away the severed ear and stitched up the stump.¹⁷⁵ The court held that the physician displayed deliberate indifference to the prisoner’s serious medical need by providing “easier and less efficacious treatment” rather than attempting to reattach the ear.¹⁷⁶

4. Medical Decisions Based on Costs

The Supreme Court has not yet spoken directly to the issue of considering costs in a prisoners’ medical treatment.¹⁷⁷ The *Estelle* Court did not mention costs when articulating the deliberate indifference standard.¹⁷⁸ However, the majority of lower court decisions at issue have interpreted *Estelle* as to not allow the government to consider costs to allow a prisoners’ medical treatment to fall below a

¹⁷¹ Id. at 603. (“As long as Georgia’s prison system is abiding by reasonable medical practices, the issue of whether to permit a prisoner to be treated with experimental drugs (many of which have not been approved by the FDA) is the “exclusive prerogative” of the state of Georgia.”)

¹⁷² MICHAEL WELCH, *IRONIES OF IMPRISONMENT* 249 (Jerry Westby, ed., 2004) (citing *Harris v. Thigpen*, 941 F.2d 1495 (11th Cir. 1991)).

¹⁷³ JOSEPH ANTHONY MELUSKY & KEITH A. PESTO, *CRUEL AND UNUSUAL PUNISHMENT: RIGHTS AND LIBERTIES UNDER THE LAW* 165 (2003). (Deliberate indifference included “a prison doctor’s choice of the easier and less efficacious treatment of throwing away the prisoner’s ear and stitching the stump rather than treating the prisoner after an altercation.”)

¹⁷⁴ *Williams v. Vincent*, 508 F.2d 541 (2d Cir. 1974).

¹⁷⁵ Id. at 543. (“Upon being taken to the prison hospital, Williams asked the hospital personnel to try to suture the severed portion of his ear back on. Instead, he alleges, they told him that he did not need his ear, threw it away, and sewed up the stump with ten stitches.”)

¹⁷⁶ Id. at 544.

¹⁷⁷ Wright, *supra* note 6, at 1269. (“In Eighth Amendment jurisprudence, the court balances individual and governmental interest only in the context of discipline and security; the state’s interest in limiting expenditures is not considered.”)

¹⁷⁸ Posner, *supra* note 19, at 353. (“[Estelle] does not seem to take the cost of the treatment into consideration at all.”)

minimally adequate level.¹⁷⁹ This is not to say that economic factors may not be considered in choosing methods that achieve the same objective.¹⁸⁰ However, the costs of protecting a prisoner's constitutional right to adequate health care does not justify a total denial of treatment.¹⁸¹

That the government should be responsible for funding a prisoner's health care, including organ transplant treatments, is supported by many post-Estelle cases. In *Monmouth Cnty. Corr. Institutional Inmates v. Lanzaro*, the court held that "prisons should be and are constitutionally required to provide for [i.e., at the institution's expense] all the serious medical needs of the inmates, whose imposed financial dependency is a result of their incarceration."¹⁸² In *Anacta v. Prison Health Services*, the Eleventh Circuit held that refusing to provide a neurologic evaluation prescribed by a treating physician because the prisoner could not pay for the services constituted a deliberate indifference to a serious medical need.¹⁸³ And in *Martin v. DeBruyn*, the court held that "[a] prison official who withholds necessary medical care, for want of payment, from an inmate who could not pay would violate the inmate's constitutional rights if the inmate's medical needs were serious."¹⁸⁴

c. Deliberate Indifference in Organ Transplant Cases

Applying the deliberate indifference two prong test to a prisoner's need for organ transplants unequivocally attaches a constitutional right to receiving such treatment. The first prong of "demonstrating a serious medical need" is easily met because an organ transplant is usually recommended

¹⁷⁹ *Hamm v. DeKalb Cnty.*, 774 F.2d 1567, 1573 (11th Cir. 1985). ("The state's interest in limiting the cost of detention, for example, ordinarily will justify the state's decision to provide detainees with a reasonable level of food, living space, and medical care. Yet that same objective will justify neither the complete denial of those necessities nor the provision of those necessities below some minimally adequate level. Due process must require states to provide pretrial detainees with some minimal level of these necessities, and the failure to provide that level of necessities violates due process-even though the conditions imposed serve some ordinarily legitimate state objective.")

¹⁸⁰ *Bounds v. Smith*, 430 U.S. 817, 825 (1977). ("This is not to say that economic factors may not be considered, for example, in choosing the methods used to provide meaningful access. But the cost of protecting a constitutional right cannot justify its total denial.")

¹⁸¹ *Id.*

¹⁸² *Monmouth Cnty. Corr. Institutional Inmates v. Lanzaro*, 834 F.2d 326, 345 (3d Cir. 1987)

¹⁸³ *Ancata v. Prison Health Servs., Inc.*, 769 F.2d 700, 704 (11th Cir. 1985) ("The knowledge of the need for medical care and intentional refusal to provide that care has consistently been held to surpass negligence and constitute deliberate indifference.")

¹⁸⁴ *Martin v. DeBruyn*, 880 F. Supp. 610, 615 (N.D. Ind. 1995)

as a “last resort” treatment. In most cases, a person is unable to sustain life with a failing heart, liver, or kidney.

The second prong, finding a deliberate indifference to the inmate’s serious medical condition by failing to provide a prisoner with an organ transplant, can be analogized by the direction in which the courts are moving.¹⁸⁵ In *Fernandez v. United States*, a federal prisoner was in need of a life-saving heart transplant.¹⁸⁶ The prisoner was refused a medical furlough, a reduction in sentence, a parole, and a pardon because he did not meet the Federal Bureau of Prisons’ requirement that a prisoner must demonstrate an ability to pay for the procedure.¹⁸⁷ The Eleventh Circuit held that the enforcement of the Bureau’s guidelines denied the prisoner the opportunity to receive an organ transplant but did not constitute a deliberate indifference to his serious medical needs due to continuing treatment of his illnesses.¹⁸⁸

However, nine years later the Eighth Circuit expressed concern regarding the Bureau’s restrictive policy regarding transplants in a series of cases.¹⁸⁹ In *Barron v. Keohane*, Eighth Circuit Judge Richard Arnold, in dicta, expressed concern over the Bureau’s policy: “[g]iven the Bureau's obligation to provide medical care to prisoners, *see* 18 U.S.C. § 4042, denial of a transplant to an inmate who needs-but cannot pay for-a transplant may raise constitutional concerns.”¹⁹⁰ And again in *Clark v. Hedrick*, in dicta, Judge Arnold stated: “[w]e remind the Bureau of Prisons that its policies in connection with transplants, if applied inflexibly, may raise constitutional questions.”¹⁹¹

d. Deference to Medical Judgment

¹⁸⁵ Douglas, *supra* note 6, at 556. (“Though no published court opinion has expressly held that failure to provide inmates with transplants constitutes deliberate indifference, two recent Eighth Circuit opinions indicate that this is the direction in which the courts are moving.”)

¹⁸⁶ *Fernandez v. United States*, 941 F.2d 1488 (11th Cir. 1991).

¹⁸⁷ *Id.* at 1492-93.

¹⁸⁸ *Id.* at 1493-94. (An inmate's entitlement to medical treatment “reasonably commensurate with modern medical science and of a quality acceptable within prudent professional standards” is undisputed. To establish a valid eighth amendment claim, “a prisoner must allege acts or omissions sufficiently harmful to evidence [the] deliberate indifference [of prison officials] to [his] serious medical needs.”)

¹⁸⁹ Douglas, *supra* note 6, at 556. (“Two recent Eighth Circuit opinions indicate that this is the direction in which the courts are moving.”)

¹⁹⁰ *Barron v. Keohane*, 216 F.3d 692, 693 (8th Cir. 2000).

¹⁹¹ *Clark v. Hedrick*, 233 F.3d 1093, 1094 (8th Cir. 2000).

The right of prisoners to receive organ transplant can also be analogized by the great deference to the medical judgment of the treating physician afforded by *Estelle*.¹⁹² Once a physician has diagnosed an illness as serious and has ordered particular treatment, prison officials cannot violate, ignore, or interfere with the order.¹⁹³ The prisoner's Eighth Amendment protections entitles him or her to receive the treatment the medical professional decides is necessary for the treatment of a serious medical need.¹⁹⁴ This especially applies to decisions not to afford Plaintiff an operation that would render the prisoner-patient's condition irreparable,¹⁹⁵ or cause him or her "unnecessary and wanton infliction of pain."¹⁹⁶ Moreover, if a treating physician's recommendation has not been flatly denied but delayed for non-medical reasons, this constitutes a deliberate indifference.¹⁹⁷

ii. Fourteenth Amendment

The Eighth Amendment's prohibition of the federal government's use of cruel and unusual punishment and the right to health care for the incarcerated is also applied to the states through the Fourteenth Amendment Due Process clause.¹⁹⁸ The Fourteenth Amendment regulates the conduct of the

¹⁹² Posner, *supra* note 19, at 351. ("Once the doctor has become involved in the treatment process [by actually prescribing treatment or by the state's attempt to influence the doctor before she prescribes], the two-pronged Estelle test gives great deference to the doctor's medical opinions.")

¹⁹³ *Id.* at 351-52. ("More significantly, the "deliberate indifference" prong also accords the prescribing doctor's judgment significant weight. Because courts have held that prison officials' intentional interference with prescribed medical treatment constitutes "deliberate indifference," the prisoner is constitutionally entitled to whatever treatment the medical professional decides is necessary. Thus, under the Estelle test, the doctor determines to a large degree the prisoner's constitutional right to receive medical care.")

¹⁹⁴ *Id.*

¹⁹⁵ *Derrickson v. Keve*, 390 F. Supp. 905 (D. Del. 1975). ("[A] decision not to perform a tonsillectomy and submucous resection of nasal septum would mean that prisoner's condition would be irreparable a decision by prison officials never to allow prisoner to elect such surgery, which the prison's own physician had recommended, would be arbitrary, capricious, and cruel, but on the other hand, the authorities had not exceeded their discretion in failing to provide surgery to date.")

¹⁹⁶ *Lanzaro, supra* note 182, at 346.

¹⁹⁷ *Ancata*, 769 F.2d at 704.

¹⁹⁸ *Bondurant, supra* note 158, at 411. ("The Eighth Amendment's prohibition on the federal government's use of cruel and unusual punishment is applied to the states through the Fourteenth Amendment Due Process Clause, which regulates the conduct of the states in accordance with the Constitution.")

states in accordance with the Constitution.¹⁹⁹ Therefore, prisoners may bring Eighth Amendment actions against both federal and state prison authorities.²⁰⁰

B. OPTN/UNOS Policy

The OPTN/UNOS Ethics Committee directly addressed the ethical debate regarding organ transplants for convicted criminals.²⁰¹ In an official opinion paper on the subject, it labeled any type of exclusion of criminals from medical treatment, including an organ transplant procedure, as not ethically legitimate.²⁰² “The UNOS allocation system is based on the principles of equity and medical utility.”²⁰³ Wealth, social status, citizenship, and status as a prisoner are not legitimate factors guiding allocation decisions.²⁰⁴

The OPTN/UNOS Ethics Committee acknowledged that non-medical decisions—prior to a patient’s placement on the waitlist—could be made at the discretion of the transplant team so long as the decisions are based on their relative impact to transplant outcomes.²⁰⁵ However, once a patient is placed on the waitlist, the patient is eligible for the *equitable* allocation of organs.²⁰⁶

C. International Law

Various international treaties and covenants also support the right of medical care for prisoners. The International Covenant on Economic, Social and Cultural Rights recognizes the “right of everyone to

¹⁹⁹ Id.

²⁰⁰ Douglas, *supra* note 15, at 545.

²⁰¹ OPTN/UNOS Ethics Committee Position Statement Regarding Convicted Criminals and Transplant Evaluation, Organ Procurement and Transplant Network, <http://optn.transplant.hrsa.gov/resources/bioethics.asp?index=3> (last visited Nov. 30, 2013). [hereinafter OPTN Inmate Policy].

²⁰² Id. (“Punitive attitudes that completely exclude those convicted of crimes from receiving medical treatment, including an organ transplant are not ethically legitimate.”)

²⁰³ Id.

²⁰⁴ Id.

²⁰⁵ Id. (“Consideration of prisoners as well as others for transplantation includes evaluation of medical and non-medical factors relative to their impact on transplant outcome. Screening for all potential recipients should be done at the candidacy stage and once listed, all candidates should be eligible for equitable allocation of organs.”)

²⁰⁶ Id. (“Screening for all potential recipients should be done at the candidacy stage and once listed, all candidates should be eligible for equitable allocation of organs.”)

the highest attainable standards of health.”²⁰⁷ The United States has not ratified the ICESCR and, therefore, is not legally binding.²⁰⁸ However, because the United States is a signatory, it undertakes a number of legal obligations, including, refraining from undermining the intent and purpose of the treaty.²⁰⁹

The International Covenant on Civil and Political rights, to which the United States is a party, guarantees all persons the right to life, to be free from cruel, inhuman or degrading treatment.²¹⁰ People deprived of their liberty, such as prisoners, must be treated with humanity and with respect and inherent dignity.²¹¹ It specifically requires that governments provide “adequate medical care during detention.”²¹²

The United States is also a party to the Convention Against Torture and other Cruel, Inhuman, or Degrading Treatment or Punishment (CAT).²¹³ The CAT prohibits cruel, inhuman, or degrading treatment.²¹⁴ Failure to provide adequate medical care to prisoners is a violation of the CAT.²¹⁵

IV. ARGUMENT

Whatever ambivalent feelings individuals, communities, or government officials may have about a prisoner’s access to organs, the law is quite clear on the subject. The Constitution, OPTN/UNOS policies, and international law are clear – when based on purely objective medical criteria, a prisoner cannot be interfered with or withheld from receiving a medically necessary organ transplant. In practice, however, the law is often circumvented due to matters such as health care costs, organ scarcity, public opposition, and value for life.

A. Scope of “Adequate” Health Care for Prisoners

²⁰⁷ ICESCR, art. 11.

²⁰⁸ HRW Old Behind Bars, *supra* note 106, at 72.

²⁰⁹ *Id.*

²¹⁰ ICCPR, arts. 6, 7, 10(1).

²¹¹ *Id.*

²¹² *Pinto v. Trinidad and Tobago*, (Communication No. 232/1987) Report of the Human Rights Committee, vol. 2, UN Doc A/45/40, p. 69.

²¹³ HRW Old Behind Bars, *supra* note 106, at 72.

²¹⁴ CAT, art. 16.

²¹⁵ HRW Old Behind Bars, *supra* note 106, at 72.

Estelle v. Gamble effectively entitled prisoners to receive *adequate* medical care.²¹⁶ The irony is that no such right exists for the general public. In fact, many inmates receive better medical care while behind bars than they had as a free member of society.²¹⁷ In exchange, prisoners forfeit many of their core rights and freedoms when incarcerated including their liberties and their right to vote. Although imprisoning those who commit crimes is an effective method to keep the general public safe, in turn, the government has an obligation to treat prisoners safe and humanely as well.²¹⁸

The Supreme Court in *Estelle* did not set an exact scope of the medical treatment that should be afforded to prisoners. The Court merely set the floor that the treatment of prisoners, including their medical care, should not offend “evolving standards of decency”²¹⁹ – which likely includes the provision of health care up to the standards of care for the general public. Organ transplant is often a last resort in treating a patient with end-stage organ failure. These are not simple surgeries nor are organ transplant decisions taken lightly. Organ transplants are complex; they require heightened skill, attention, and expense. Despite these complexities, organ transplantation has become the standard of care and, in most cases, is the treatment of choice for end-stage organ disease.²²⁰ Advances in surgical and organ-preservation techniques, improved immunosuppressive and antiviral regimens, and changes in donor-organ allocation have improved the success rates of solid-organ transplantation.²²¹ Transplantation replaces end-stage disease with a more sustainable disease state and has substantial clinical advantages.²²²

²¹⁶ *Estelle*, 429 U.S. at 97 (1976).

²¹⁷ Smith, *supra* note 136.

²¹⁸ Kahn, *supra* note 20, at 365. (“[B]y using prison as a means of protecting the public, society creates an obligation to keep prisoners safe and treat them humanely, which ought to include health care.”)

²¹⁹ *Estelle*, 429 U.S. at 106.

²²⁰ CHRISTOPHER LAROSA, ET AL., SOLID-ORGAN TRANSPLANTATION IN CHILDHOOD: TRANSITIONING TO ADULT HEALTH CARE 743 (Mar. 7, 2011), *available at* <http://pediatrics.aappublications.org/content/127/4/742.full.pdf>. (“Solid-organ transplantation has become the standard of care and, in most cases, is the treatment of choice for end-stage organ disease. Advances in surgical and organ-preservation techniques, improved immunosuppressive and antiviral regimens, and changes in donor-organ allocation have improved the success rates of solid-organ transplantation. Transplantation, in essence, replaces end-stage disease with a more sustainable chronic disease state, and its consequences have substantial clinical and psychosocial implications.”)

²²¹ *Id.*

²²² *Id.*

Organ transplants are woven into the fabric of available treatment options. As the Eighth Amendment evolves contemporaneously with society, organ transplant treatments are also included.

B. The Truth about Costs to the Taxpayer

Organ transplant procurement and procedures are among the most expensive medical treatments available. An organ transplant procedure can range anywhere from \$200,000 to over \$1,000,000 depending on the organ transplant and the medical needs of the patient.²²³ In the case of the unknown California inmate who received a \$1 million heart transplant, much of the public outcry came as a result of the taxpayers footing the bill. However, arguments over costs for organ transplants are often misguided.

The issue is of “perceived” costs rather than “actual” costs.²²⁴ The government must provide medical care for its incarcerated. Paying for a one-time organ transplant would, in theory, save the government/taxpayer money compared to the annual expense of medically managing a chronically ill prisoner with a failing organ. For example, treating a prisoner serving a life-sentence suffering from end-stage kidney failure with dialysis treatments is estimated to cost over \$120,000 per year for the life of the prisoner-patient.²²⁵ The average cost for a kidney transplant procedure plus immunosuppressant therapy costs just over \$260,000 total.²²⁶ The net-cost savings alone make it economically advantageous for the government to remove any barriers and encourage medically necessary organ transplants as a viable treatment option for their prisoners.

C. Scarcity Debate

²²³ *Financing a Transplant*, *supra* note 83.

²²⁴ Douglas, *supra* note 15, at 565. (“Consequently, another potential solution to the public outcry against prisoner organ transplants may be to educate the public about the actual, rather than the perceived, costs of providing inmates with organ transplants.”)

²²⁵ Robinson, *supra* note 2. (“[Oregon] pays a reported \$121,000 a year to keep [inmate] Reyes-Camarena on dialysis.”)

²²⁶ *Financing a Transplant*, *supra* note 83.

Every 10 minutes someone in the United States is added to the organ waiting list.²²⁷ Each day, an average of 79 people receive an organ transplant.²²⁸ However, 18 people die every day waiting for a transplant. The demand for organs well exceeds the available supply. The scarcity of available organs creates an obvious tension regarding “worthiness” when allocation decisions are being made. A common, yet dangerous, view is that those with more social or societal value are more deserving of organs; prisoners who have committed crimes against society should not be placed above any law-abiding citizen in seeking life-saving treatment. Any policy that assigns a lower priority to prisoners would be based on the dangerous premise that prisoners are less valuable human beings. A precedent would be created within the transplant system that social worth is a legitimate consideration when making organ allocation decisions.²²⁹ The slippery slope arguments that flow from this view are obvious.

Using prejudices as the criteria to which the government decides what medical treatment will be received and to who opens up a litany of opportunity to justify classism—government sanctioned classism. Prisoners may not be the only population whose eligibility gets closely examined.²³⁰ Accepting classism as “official government policy” has implications that stem much further from the prisoner-organ transplant debate. Such a policy has the potential to be applied well beyond just the distribution of organs.

D. Protecting Medical Ethics

The goals of capital punishment are contrary to the goals and aims of medicine and vice-versa.²³¹ Physicians and health care providers in the prison system often experience tension between their oath to

²²⁷ *About Donation & Transplantation*, ORGANDONOR.GOV, <http://organdonor.gov/about/data.html> (last visited Dec. 3, 2013).

²²⁸ *Id.*

²²⁹ Kahn, *supra* note 20, at 366. (“Any policy that would award lower priority to prisoners would be based on some sense that prisoners are less valuable members of society and would introduce the notion of social worth to the entire transplant system.”)

²³⁰ *Id.* (“The truth is that if social worth becomes a criterion for judging who gets transplants first—or maybe who gets them at all—then it is not only prisoners whose eligibility should be examined.”)

²³¹ McKinney et al, *supra* note 22, at 63. (“Much of that negotiating power is taken away from the incarcerated individual. Usually, the offender is offered one treatment option and his or her only choice is to take it or leave it. Furthermore, the goals of incarceration are contrary to the goals of medicine. Health-care providers in the prison context encounter pressures to adopt the goals of incarceration and abandon their professional goals of providing compassionate attention for individual medical needs.”)

treat the individual patient with compassion and attention to their medical needs, and the realities of the patient's incarceration status.

However, a physician has a duty to do all that he or she can for the benefit of the patient. The AMA Code of Ethics suggests that policies that allocate limited resources have the potential to limit a physician's ability to adequately fulfill their obligation to their patients.²³² The treating physician must remain a patient advocate and therefore not partake in any allocation decisions.²³³ Moreover, it is not in the physician's purview to consider non-medical criteria, such as the ability to pay, age, social worth, perceived obstacles to treatment.²³⁴ A physician must not be asked to balance competing non-medical interests of a prisoner seeking an organ transplant; the government and UNOS is charged with making such determinations. While there may be strong and varying opinions on the subject, it is not the role of the physician to interpret or be encouraged by societal values.²³⁵

V. CONCLUSION

Legal and ethical norms support the notion that medically qualified prisoners should be able to obtain organ donations regardless of their incarceration status, how violent the crime, and their ability to pay. However, whether organ transplants for prisoners actually get performed strongly depends on society's commitments to a prisoner's health and health care.²³⁶ A prisoner receiving an organ transplant creates a perceived injustice; murderers, thieves, and rapists could secure a life-saving organ from a law-abiding citizen who is of the same medical need. The scarce donor pool and current donation policies offer no solution to the paradox. However, consider the alternatives. Any policy where medical

²³² *Opinion 2.03, Allocation of Limited Medical Resources*, AMERICAN MEDICAL ASSOCIATION (June 1994), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion203.page?>.

²³³ *Id.*

²³⁴ *Id.* ("In making quality of life judgments, patients should first be prioritized so that death or extremely poor outcomes are avoided; then, patients should be prioritized according to change in quality of life, but only when there are very substantial differences among patients. Non-medical criteria, such as ability to pay, age, social worth, perceived obstacles to treatment, patient contribution to illness, or past use of resources should not be considered.")

²³⁵ John Fung, MD., Op-Ed, *Organ Donation to Prisoners: Ethics and the Law*, ABC NEWS (March 3, 2013), <http://abcnews.go.com/Health/story?id=116967>.

²³⁶ Kahn, *supra* note 20, at 365.

judgment is subordinate to non-medical factors such as societal worth could have damaging effects on society beyond transplant decisions.

The debate and case law regarding prisoner organ transplants have only begun to develop. The number of aging men and women confined in United States prisons will continue to grow. And the connection between the increase of aging inmates and the subsequent increase in the need to treat chronically ill prisoners with organ transplants will continue to become more prevalent absent significant policy changes.