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Prisoners on Death Row Should be Accepted as Organ Donors

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Introduction Robert M. Sade, MD

Ten years ago, Christian Longo had been deeply enmeshed in a career of minor crimes and crushing financial burdens that had led to bankruptcy. He saw only one way out: relieving his family, his wife Mary Jane and their three children, of their dependency on him. He strangled Mary Jane and 2-year old daughter Madison, put them into suitcases and threw them into Yaquina Bay in Newport, Oregon. He stuffed his 3-year old daughter Sadie and 4-year old son Zachery into pillow cases, weighted them down with rocks, and threw them, still alive, into a nearby pond where they drowned.

His crime was discovered when Zachery's body floated to the surface of the pond. He was placed on the FBI's 10 most wanted list, was found two years later living with his girlfriend in Cancun, Mexico, and was arrested, brought back to Oregon, put on trial, found guilty on four counts of murder, and sentenced to death.

Several months ago, he wrote an editorial that was published in the New York Times: "Giving life after death row."¹ The editorial began with these words: "Eight years ago I was sentenced to death for the murders of my wife and three children. I am guilty. I once thought that I could fool others into believing this was not true. Failing that, I tried to convince myself that it didn't matter. But gradually, the enormity of what I did seeped in; that was followed by remorse and then a wish to make amends."

He continued: "There is no way to atone for my crimes, but I believe that a profound benefit to society can come from my circumstances. I have asked to end my remaining appeals, and then donate my organs after my execution to those who need them." He went on to say, "And yet, the prison authority's response to my latest appeal to donate was this: 'The interests of the public and condemned inmates are best served by denying the petition.'"

Longo claimed that half of the other inmates on death row wanted to do the same and that there was no valid reason to prohibit them from donating. The question of who was right,

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the condemned prisoner or the prison parole board., was debated at the Southern Thoracic Surgical Association Annual Meeting in November 2011. by Dr. Shu Lin, who sided with the prisoner, and Dr. Jay Pal on the side of the parole Board.

Shu S. Lin, MD, PhD and Lauren Rich, RN, BSN

Introduction

As a member of the transplant community, I recognize the problem we face with the seemingly insurmountable shortage of donor organs; as a transplant surgeon, I also greatly understand the importance of seizing every appropriate opportunity for patients with end-stage organ failure, by performing one transplant at a time, to better their lives. As such, when it was brought to my attention that prisoners on death row have been vocal about wanting an opportunity to donate their organs after the execution, the question that came to my mind was, why not?

Why Allow Death Row Inmates to Donate?

My rationale for allowing death row inmates to donate their organs is simple and logical. One more organ donor means at least one life, and typically more lives, saved. It is not necessarily, as some medical ethicists such as Arthur Caplan of University of Pennsylvania speculate, an attempt to “close the ever-widening gap between demand and supply of organs” in transplantation.² It is, quite simply, to help individuals suffering from end-stage organ disease. The center of attention, in my mind, should be the patient, and how we, as healthcare providers, can help them. There is no question that, when there is a therapy (i.e., transplantation in this discussion) with known benefits to the patients that we serve, everyone would agree that we should attempt to implement that therapy pending the risks or the drawbacks of that therapy.

An important part of transplantation is organ donation, which is generally governed in the United States by two documents—the National Transplant Act of 1984 and the Uniform Anatomical Gift Act, neither of which explicitly prohibits organ donation by death row inmates. Specifically, the National Transplant Act stipulates that organ donation cannot be made for “valuable considerations,” including that in exchange for any monetary or material benefit or, in the case of prisoners, for a shorter sentence to the donor—which obviously would not be an issue for death row inmates. Furthermore, the Uniform Anatomical Gift Act, which is drafted by the National Conference of Commissioners on Uniform State Laws in the U.S. and governs organ donation for the purpose of transplantation as well as the making of one's cadaver to be an anatomical fit to the study of medicine, states in its Section 5 that all that is required for one to be a donor is some type of a document, such as a donor card or an indication on a driver's license. Therefore, the more critical question in this debate, of whether death row inmates should be allowed to donate their organs for transplantation, is what are the reasons *not* to permit this practice? In the sections to follow, I will outline some of the objections raised against the idea of using death row inmates as donors and discuss why those arguments, with deliberate and informed consideration, are not necessarily valid.

Why Not Allow Donation?

Presumptive arguments have been made in an attempt to answer the question of why death row inmates should not be allowed to donate their organs. Arthur Caplan has articulated some of these points in a recently published article in *The American Journal of Bioethics* [A]. In general, these objections can be categorized into those due to *practical barriers* and those involving *ethical or moral concerns*. It is important to recognize up front that, due to

wide cultural differences, what is being discussed here must be considered in the context of how it would apply in the United States and not in other countries.³

The *practical barriers* include what is believed to be a low yield of transplantable donor organs from these prisoners, the concern over the quality of these donors, the perceived difficulty in carrying out the organ procurement in these executed prisoners, and potential lack of public support or acceptance of capital punishment. However, even opponents of this proposal admit that the practical barrier of not being able to meet the demands of organ donation is irrelevant in this discussion.⁴

The *ethical or moral concerns*, on the other hand, involve two seemingly opposite rationale—the fear of coercion and the intention to preserve the morality of capital punishment. The former insinuates that death row inmates are not being adequately protected, while the latter implies that the rights of these same individuals are given too much protection. Specifically, the idea of preserving the morality of capital punishment stems from the belief that this type of donation is not consistent with the intended justifications of capital punishment, which some argue is to achieve retribution and deterrence in our society. Nonetheless, this line of argument, that donation “undercuts the morality of execution,” is challenged by various philosophy, ethics, and religion experts such as Gardner,⁵ Johnson,⁶ and Murphy.⁷

Practical Barriers

small number of potential organ donors, but huge difference for the transplant recipients: In outlining the potential practical obstacles to organ donation by death row inmates, Caplan first states that, even if death row inmates are allowed to donate their organs, this practice “cannot yield anything more than a tiny number of organs for those in need.” [A] While the accuracy of this statement can be argued, depending on what numbers to use, the point of using consenting death row inmates as organ donors is, again, not to solve the problem of organ shortage but to help those few patients that are in dire need of transplantable organs. If this argument of Caplan is taken seriously and we decide to set a policy not to carry out certain ideas simply because the yield is relatively low, then many of our current practices would have to be re-examined. For example, DCD (donation after cardiac death) transplants, in general, would not make sense, since they provide organs for only a small fraction of patients with end-stage organ failure. Instead, the point of allowing organ donation by death row inmates is to save the lives of few patients, or even that of one single patient, even if it seemingly will not make a dent in the overwhelming shortage of donor organs. The number of patients that are directly helped by allowing death row inmates to donate organs may indeed be relatively small, but the impact of these transplants would certainly be hugely significant for those recipients and their families.

is the quality of donor really a problem?: A knee-jerk response by those who are opposed to the idea of allowing prisoners to become an organ donor, whether they are on death row or not, is that there are concerns over the medical and social history of these individuals. Caplan wrote that many of these prisoners “would not be eligible to serve as donors due to age, ill health, obesity, or communicable disease.”² For those who actually have experience selecting donors and matching available organs to potential recipients, it is well known that what many consider as “marginal” donors have yielded perfectly useable organs for transplantation and that donor variables, based on what is published in the literature, rarely have significant adverse effects on the outcome of transplants. Therefore, to immediately exclude the eligibility of prisoners as donors might mean a few missed opportunities to transplant acceptable organs.

In addition, there is clearly a pre-conceived notion that transmission of diseases—infectious ones, in particular—would be more prevalent if prisoners are permitted to donate their

organs. However, while this concern may at first glance seem legitimate, a more thoughtful assessment of the situation allows one to realize that there would, in fact, be more time for screening death row inmates, as compared to that for screening typical brain-dead donors in the hospital setting; these screening tests might even be repeated or re-examined using different methods. Thus, the rates of disease transmission might actually be lower when death row inmates are the donors because of the possibility of a more thorough and better screening process.

difficulty of cadaveric donation—not a new problem: Because the most common method of execution in the United States uses a three-drug protocol (sodium thiopental to induce unconsciousness, pancuronium bromide to cause muscle paralysis and respiratory arrest, and potassium chloride to achieve cardiac arrest), donation from death row inmates will not be like a typical brain-death donation and thus will have to be a case of controlled DCD (donation after cardiac death). Caplan argues that this type of organ donation process will be less successful in condemned prisoners' cases because of the “legal and practical requirements of the execution.” In essence, he is speculating that the organs harvested from DCD in condemned prisoners would be qualitatively inferior to those harvested from DCD in the current hospital setting. However, if one really thinks through the situations, one will realize that a typical DCD case cannot truly be compared to a DCD that might occur in death row inmates. A DCD in a hospital setting starts with withdrawing the donor from the ventilator, after which some time will pass—during which some degree of hypoxemia will take place—before cardiac arrest is declared, and the procurement process takes place after a waiting period of up to 5 minutes. Caplan compares the 5 minutes of cardiac arrest time, used in a typical protocol at most hospitals, to the 10 to 15 minutes of examination time generally used in making the final pronouncement of death in executed prisoners, and argues that this longer cardiac arrest time will limit the viable organs that can be used for transplantation. While that comparison, at first glance, appears to be logical, what is not accounted for in that argument is the differences in the manner in which cardiac death is achieved in each case—for DCD in the hospital setting, the withdrawal of the ventilator support will invariably involve a period of hypoxemia and, therefore, ischemia to various end organs, whereas DCD in the execution setting will involve more immediate achievement of respiratory and cardiac arrest, thus leading to a comparatively shorter time period of hypoxemia in the pre-cardiac arrest phase of the process. Therefore, one cannot simply assume that fewer organs will be usable or that the quality of those organs will be inferior in the death row inmate DCD setting than that from the hospital DCD setting. Let us assume that, for the sake of argument, Caplan's comparison of cardiac arrest time does have some impact on the quality of the organs, and that these death row inmates are therefore considered to be, what is called, “marginal” donors. Even if the quality of the organs is in question by today's standards, provided certain criteria are met, there is very little evidence that, at least in the lung transplant literature, donor factors play a significant role in the outcome of a transplant. Thus, many of the organs that are considered not transplantable today could, in fact, be safely used in recipients that are chronically or critically ill from end-stage organ failure.

Furthermore, recent technological advances in transplantation might allow us to explore different options to examine whether the organs could ultimately be used clinically. For example, in the case of pulmonary transplantation, an ex vivo lung perfusion (EVLP) apparatus could be used to determine whether the pulmonary function is satisfactory in lungs procured from executed prisoners. Biopsies of the tissue can also be done and analyzed in an unrushed fashion if there are any concerns. All of the known advantages that have been specified for EVLP can obviously be applied in this setting. Similarly, kidney perfusion and liver perfusion, as well as possibly heart perfusion, can also be used, much like in a typical setting today.

respecting the rules of organ donation: In considering a way to potentially increase the chances of successfully procuring more organs from death row inmates, Caplan scathingly asked the question, “Could organ removal be used as the mode of execution?” The obvious answer is no. Those of us who are in the field of transplantation have no interest in making a donor organ procurement process, whether it is from a death row inmate or a non-prisoner, a “Mayan practice” (of human sacrifice by removing a beating heart during religious rituals), as Caplan dubbed it. In our transplant community, there is an understood “dead donor” rule that should undoubtedly be followed, whether it is a procurement from a brain-dead donor or a DCD donor. Out of respect for the donors and their families and friends, this principle of separating death and donation should be observed. Contrary to what Caplan suggested, I believe that abiding by this principle, even in death row inmates, would not jeopardize the success of a donor organ procurement; it is a matter of organizing the appropriate resources and personnel leading to each of the two distinct processes—the declaration of death and the procurement operation. It logically follows that this includes not having a physician that is involved in the execution of the prisoner also participate in the donor organ procurement.

the debate over capital punishment—a separate discussion: Just because there is not a 100% public support, it does not mean that a law or a policy cannot be put into effect. In fact, in the democratic society that we live in, most, if not all, of the policies that are implemented do not have the approval of every single member of the community. Similarly, capital punishment is not something that is accepted by everyone in the United States, as evidenced by the fact that 34 states (plus the U.S. government and the U.S. military) have the death penalty and 16 states (plus the District of Columbia) do not. Of course, the fact that not all fifty states have capital punishment diminishes the number of potential donors that can be identified from death row prisoners, but this number argument is again countered by how even a few more donors can make a significant impact on the lives of those who are in need of transplantable organs.

This debate over capital punishment can extend into the discussion of ethical and moral concerns. In response to Caplan's argument about the donation undercutting the morality of execution, Murphy aptly stated, “if capital punishment is not morally permissible to begin with, there is nothing to undercut” [F].⁷ In other words, if a society or a community, whether it is at the national level or the state level, does not accept capital punishment as an option, then there should be no discussion about allowing death row inmates to donate organs; the only reason to have this discussion is that capital punishment is an accepted option (whether it is by majority democracy or by autocracy) within that society. The debate of whether capital punishment should exist is a completely different discussion than the debate over whether death row inmates should be allowed to donate their organs for transplantation.

Ethical/Moral Concerns

is coercion a real issue in death row inmates donating organs?: One of the more commonly declared concerns when mentioning organ donation from prisoner is the issue of coercion. In outlining her objection to the use of prisoners as donors, Nancy Potter worries that coercion can be “subtle” and that “even without an explicit reward like early parole in exchange for a promise of organ donation, prisoners will understand themselves to be making an implicit exchange for their generosity, and policymakers will take advantage of that unspoken expectation.”⁴ [C] She states that “free and voluntary consent is compromised by the prison environment.” Her argument may certainly be relevant to prisoners not on death row, but it does not seem to apply to the situation with condemned prisoners, as in the case of Christian Longo, who willingly and voluntarily asked to make the donation after the execution. There is already precedence allowing donation by non-death row inmates

(although the arguments for and against this practice are just as heated,⁸ so why not permit it in condemned prisoners who are to be executed, in whom coercion is less of an issue?

Although Christian Longo is not the first condemned prisoner to request organ donation after his execution, his case is one of the more publicized in recent history. He was able to write an editorial in the New York Times, something that most lay people are not able to accomplish. As far as we know, no one approached Longo to see if he would consider donating his organs after the execution; it was he who voluntarily thought of this plan and wrote the article in the New York Times after being denied this option. There were at least 14 other instances where death row inmates or their lawyers attempted to seek their respective opportunities to donate their organs but were denied. Clearly, death row inmates are requesting to donate their organs for transplantation, which seems to indicate their willingness to consent to this process. Those who consider organ donation by death row inmates morally wrong due to some subtle form of coercion that takes away the prisoners' autonomy [C],⁴ in fact, are making a hypocritical argument, since denying the prisoners' requests to donate is in itself an act of taking away their autonomy.

does organ donation by death row inmates undermine moral justifications of capital punishment?: Caplan claims that organ donation by death row inmates would undermine the morality of execution, in that condemned prisoners donating organs is not consistent with the two proposed justifications of capital punishment, that is, (a) to achieve retribution and (b) to serve as a deterrent for the crime committed. Let us examine each of these issues separately and see if the arguments are logical enough to prohibit death row inmates from willingly donate their organs for transplantation.

Caplan sees retribution as one of the first points of capital punishment and fears that 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.”² [A] Indeed, it would seem unfair, at initial glance, that this person who committed such a heinous crime would become a hero of some sort at the end. One potential solution to this dilemma would be to make the donation process by death row inmates completely anonymous.

Nonetheless, as L. Syd M. Johnson accurately points out, if the goal is not to diminish retribution in capital punishment, then the society perhaps should not allow “condemned prisoners to apologize or make amends for their crimes, to perform the simplest unselfish acts of kindness, to seek religion, or experience any form of spiritual growth or awakening.”⁶ [E] Clearly, achieving retribution does not seem to be the most critical justification for capital punishment. Again, the main weakness of this argument, it would seem, is that organ donation under this circumstance is supposedly seen as a heroic act, which contradicts the argument, made by the same ethics experts, that the donation is being forced upon the prisoners as a result of subtle coercion—Is it a willing, altruistic deed, or is it a coerced action? There simply appears to be an inconsistency in the logic behind the arguments made by those who are morally opposed to allowing death row inmates to donate organs.

As far as deterrence is concerned, Caplan expresses his concern that “social good is seen as issuing from the practice [of condemned prisoners donating organs]” [A] and that the ability to deter similar crimes in the future would be reduced. If we take one moment to think about that argument, it would be clear that no crime of that magnitude has probably ever occurred, in which the perpetrator contemplates the benefit to the society, i.e., organ donation, versus the evil deed that he or she is about to commit. Furthermore, as Murphy appropriately implied, if deterrence is such an important goal of capital punishment, then “execution

preceded by extended torture” might be a better deterrent than “execution preceded by imprisonment, and the first option would, by Caplan's definition, be morally superior to the second [F].

Opinion Polls

Clearly, as in Christian Longo's case and others, there are plenty of examples of death row inmates requesting the option to donate their organs for transplantation. In the preceding paragraphs, we have outlined how proponents and opponents of this proposed practice would argue their respective points. Forgetting all that, and never mind what the transplant surgeons or the ethicists think, how does the general public feel about this issue? After all, we live in a society where public acceptance of a policy or a practice is at least somewhat important because of the democracy of our government.

In all five opinion polls that we were able to find related to this topic, there is an overwhelming support for the idea that condemned prisoners should be allowed to donate their organs for transplantation.^{9,10,11,12,13} [Table 1] [H,I,J,K,L]. For example, to the question of “Should death row inmates be permitted to donate organs?” posed on a political forum website, 100% of the voter responded “yes”, although there were very few responders, 19 to be exact, in this poll [H]. In a similarly small survey of 21 voters, over 85% of them responded “yes” to the question, “Should organ donation be allowed on death row?” [I] Interestingly, in this survey, there were more people who were undecided than who answered “no,” which perhaps reflect that uncommitted voters are generally still open-minded about this issue. In a larger scale survey conducted by MSNBC news organization in April of 2011, almost 80% of 86,736 voters responded “yes” to the question, “Should death row inmates be allowed to donate their organs?” [J] Even when the public was asked about a specific situation, as in an Indiana University poll which dealt with the Gregory Scott Johnson case, the majority of the 3370 voters agreed that the state of Indiana should delay his execution to see if he can donate part of his liver to his ailing sister [K]. Finally, in an opinion poll, released in conjunction with the story of Christian Longo, that asked, “Should man who killed wife and two children be allowed to donate his organs?”, nearly 90% of 588 voters responded “yes” to this question [L]. Clearly, the general public seems to see these death row inmates as potentially acceptable donors for those who are in dire need of transplantable organs.

In terms of valued opinions, what might be more important is how the potential transplant recipients feel about receiving an organ of a condemned prisoner. In one public opinion poll, 12 out of 14 voters responded “yes” when asked if they would accept a donor heart from a death row inmate [M].¹⁴ This is a survey from a political forum website and therefore obviously reflects what the general public believes if they were in that situation of being a patient suffering from end-stage heart failure.

To more accurately assess, from the point of view of those who would actually be undergoing the organ transplant, whether death row inmates are indeed acceptable organ donors, we surveyed all of the patients that are on the Duke Lung Transplant Program's active waiting list. We posed the following hypothetical question: “If we knew a donor was disease-free and their lungs were in good condition, would you be willing to accept lungs from a death-row inmate?” Sixteen patients were on the active waiting list at the time of the survey, and 12 of them responded “yes” and 4 responded “no.” One individual that replied “yes” commented that this is an acceptable practice “even if just one person was helped.” Of those who responded “no,” one person stated that the response would have been “yes” if that person's condition was more unstable. Thus, there is an agreement, even among those who are actually on the “receiving” end of the debate, that condemned prisoners are indeed

acceptable donors for organ transplantation. The 75% positive response rate is consistent with all of the other polls mentioned above.

Summary

Provided that there is appropriate screening, there is no medical reason that death row inmates cannot be a suitable donor for organ transplantation. Individuals with criminal records in the past and those with unknown medical and social background are currently not excluded from organ donation, and what used to be considered “marginal” donor organs are now known to contribute safely to helping patients that are suffering from end-stage organ failure. Thus, there should be no logical reason why condemned prisoners, after the execution, cannot donate organs that might be useable and, in some cases, provide one of the rare matches for certain potential recipients. Death row inmates are willingly requesting it, general public supports it, and potential recipients accept it. Should moral objection of a few people prevent the precious opportunities for those who might benefit from receiving those organs? Ultimately, whether people are for or against donation after capital punishment is a reflection on our society and the values of our society—Are we more interested in retribution and deterrence, or in actually helping those who have no other options?

Jay D. Pal, MD, PhD

Introduction

Organ donation is a life-saving treatment for patients who suffer from advanced organ failure. Since the first kidney transplant in 1954, thousands of patients have benefited from the “Gift of Life” that is organ donation. With the exception of living related kidney (and to a much smaller extent, liver) donors, most transplanted organs are obtained from cadaveric donors. As such, organ transplantation remains limited by the number of available donors. Despite the incidence of traumatic death in the U.S.A, only 6,000–8,000 deceased donors are available annually, compared to 112,718 patients currently awaiting transplantation[1, 2].^{15,16} Approximately 18 individuals will die each day while awaiting a suitable organ donor[2].¹⁶ Therefore, many novel attempts have been made to increase the potential donor pool. These have included donor registries, first-person consent, surrogate consent, and the use of prisoners as a source of organs.

There has been renewed interest in the use of condemned prisoners as organ donors, as recently highlighted by a New York Times editorial by Christian Longo[3].¹ Mr. Longo, convicted of murder, awaits the death penalty in Oregon. He states his desire to donate his organs after his execution, and claims that half of the death-row inmates in Oregon share his desire. However, the prison board has denied his petition in the “best interests of the public and condemned inmates.”

Transplant physicians are regularly confronted by the effects of an inadequate donor population on patients awaiting transplantation. However, deeper consideration of the use of prisoners as organ donors raises several concerns. These reservations can be grouped into three categories: Legal, moral/ethical, and logistical. Thoughtful insight into these concerns will provide ample evidence that death row inmates are not suitable organ donors.

Legal Issues

Two basic tenets of organ transplantation as stated by the World Health Organization and the World Medical Association are that vitals organs should only be removed from dead patients, and that living patients should not be killed for or by organ procurement. This “dead-donor” rule has been fundamental in the identification of potential organ donors since the 1950s. Accordingly, the accepted definition of death can be by (1) traditional

cardiopulmonary criteria, which is the cessation of circulatory and respiratory functions; or (2) brain-death criteria, which is the irreversible cessation of brain function including brain-stem activity (Uniform Declaration of Death Act of 1981). Although there have been recent discussion regarding the modification of the dead-donor rule in the case of patients with irrecoverable brain injury with remaining brain-stem activity, the prevailing norm is that potential donors meet the currently accepted definitions of death[4–7].^{17,18,19,20}

The concept of brain death provided the legal justification for organ procurement[8].²¹ More recently, the declaration of brain death has been clarified and standardized[9].²² The primary obstacle for organ donation from executed prisoners is that they do not die (brain-death) on life support, as is typical for most organ donors. The most common method of execution in the United States is a three drug protocol to cause sedation, respiratory and circulatory arrest. After a waiting period of 10–15 minutes, the prisoner is examined for evidence of cardiac activity, and in its absence, declared dead. Any modification of the method of execution to decrease this ischemic time would result in death occurring due to organ procurement, which places the surgeon in the role of executioner.

The second legal question to arise in the use of organs from death row inmates is the ability to consent. The concept of informed consent requires the ability to understand the procedure, as well as the autonomy to make a decision without coercion. While there are some differences between states, all prisoners lose some component of citizenship rights at the time of conviction. Death row inmates, in particular, are expressively stripped of the right to make personal decisions. In most states, the prisoner becomes a ward of the state, or a property of the state, and therefore, the state holds the legal authority to consent for the inmate. In every case regarding prisoner donation of organs, state prison boards have upheld this authority and denied inmate petitions. Furthermore, numerous legal reviews have provided arguments against the legality of organ donation from executed prisoners[10–12].^{23,24,25}

Moral/Ethical Issues

A far more problematic issue in the use of organs from death row inmates is the ethical dilemma of obtaining organs from patients who are being executed. Prisoners are subject to physically and psychologically stressful conditions which undoubtedly affect the decisions they make. Mr. Longo states that he “spend(s) 22 hours a day locked in a 6 foot by 8 foot box on Oregon's death row[3].” The Uniform Anatomical Gift Act requires that all organ donation be provided without coercion. However, prisoners are particularly vulnerable to both direct and implied coercion, by virtue of their incarceration. The National Institute of Health explicitly acknowledges this coercion in its rules regarding prisoner consent: “Prisoners may not be free to make a truly voluntary and uncoerced decision... the regulations require additional safeguards”[13].²⁶

Organ procurement in the setting of such coercion is often cited by bioethicists as a reason to avoid the use of executed prisoners as organ donors[14–16].^{27,28,29} In addition, the American Society of Transplant Surgeons states that the use of organs from executed prisoners is unacceptable and that procurement under these circumstances violates the basic principles of transplantation.

The World Medical Association has issued a similar statement, specifically with regards to organ procurement from executed prisoners in China[17].³⁰ More than 5,000 prisoners are executed in China annually, and organs are harvested for transplantation from suitable prisoners. Prisoners who are destined to become organ donors are executed via a temporal gun shot wound. The prisoners are declared dead secondary to execution, rather than the usual definitions of brain-death or circulatory-death, and transported to a hospital for organ

procurement. This process has been described as “death-row inmates received unfinished execution in the surgery theater at the hospital, and their execution is continued after the firing squad and finished by the transplantation surgeons.[18]”³¹ The process of execution without consent for organ procurement, as well as a lack of confirmation of brain-death, has led to numerous calls for the end of organ procurement from executed prisoners[14,19–22].^{27,32,33,34,35}

Given the numerous outstanding ethical issues regarding organ procurement from executed prisoners, the Organ Procurement and Transplant Network/United Network of Organ Sharing Ethics Committee generated a white paper which concluded: “The UNOS Ethics Committee has raised a small number of the many issues regarding organ donation from condemned prisoners. The Committee opposes any strategy or proposed statute regarding organ donation from condemned prisoners until all of the potential ethical concerns have been satisfactorily addressed.”

Logistical Issues

A third argument against the feasibility of transplanting organs from prisoners is the logistical and practical difficulties in procuring and preserving organs after execution. The most common method of execution in the United States is lethal injection. Prisoners are typically sedated, paralyzed to induce respiratory arrest, then injected with potassium to induce cardiac arrest. After a waiting period of 10–15 minutes, the prisoner is examined for evidence of cardiac activity, and in its absence, declared dead. Since executions are performed in maximum security prisons and not in medical facilities, the prisoner would be dead for an extended period before the donor is transported to a hospital and organ procurement can be performed. Due to this delay, very few organs would be recoverable.

A possible solution would be to move the execution to a facility where organs can be recovered more rapidly, similar to donation after circulatory death (DCD) procedures. But that would require moving an inmate to a hospital prior to execution. The process of moving an inmate to an unsecured location would be difficult, given the uncertainty of the appeals process, protests, demonstrations, security requirements, and potential for escape. Also, many hospitals will likely be resistant to accepting prisoners for execution. Despite the potential financial benefit from providing a location for organ procurement, the public relations impact of becoming a center of execution would be detrimental.

Similarly, to minimize ischemic time from execution to organ procurement, physicians and surgeons would need to be intimately involved in the execution process itself. While most physicians would not consider participating in the execution itself, the procurement procedure in conventional brain-dead donors is deliberately separate from the declaration of death. However, DCD procedures create some ambiguity that many physicians find disturbing. Consider the case of Dr. Hootan Roozrok, the transplant surgeon who was accused of hastening the death of a potential organ donor in order to expedite organ procurement. While he was ultimately acquitted, this case highlights the public misunderstanding of organ procurement and the heightened emotions associated with this process. The processes of death and organ donation must be kept separate, but organ procurement from an executed prisoner makes this distinction difficult. For this reason, the American Medical Association and the American Society of Anesthesiology have both issued position statements precluding members from participating in executions.

Conclusion

While organ donation after prisoner execution will continue to be debated, it is helpful to consider how much benefit may actually be realized. In the first nine months of 2011,

10,558 individuals donated organs in the United States. In contrast, 39 inmates were executed. The average age of executed prisoners is over 50, and many suffer from chronic illnesses such as diabetes and hypertension. By conventional criteria, such as age, medical conditions, and communicable disease, half of these prisoners would not be eligible donors[10]. Therefore, the net increase in donors is less than 1/5 of one percent. And given the DCD nature of these donations (with prolonged ischemic times), only kidneys are likely to be recoverable.

Given the contentious nature of this topic, we must evaluate the legal, moral, and logistical impediments to organ procurement from prisoners for the net gain of only 20 donors per year. Less controversial methods to increase the number of donor organs can be obtained by increasing public awareness of organ donation, creating donor registries, and improving organ yield from the eligible donors.

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