MIND THE GAP – THE PRISONER AS AN ORGAN RECIPIENT: A REVIEW OF THE PRACTICAL BARRIERS BETWEEN PRISONERS AND ORGAN TRANSPLANTS

Jasmine Villanueva-Simms*

“It is said that no one truly knows a nation until one has been inside its jails. A nation should not be judged by how it treats its highest citizens, but its lowest ones.”

– Nelson Mandela

INTRODUCTION

The human body holds more than twenty different transplantable organs, including, the kidneys, heart, lungs, and corneas.1 The first successful kidney transplant was performed in 1954, the first successful liver transplant in 1967, and the first successful intestinal transplant in 1987.2 Since then, the United States has made significant progress in medical advancements to safeguard successful organ transplants.3 Improved surgical techniques, combined with an expertise in immunology and the development of antirejection drugs, have significantly increased the survival rates of organ recipients.4

---

* J.D./Health and Biomedical Law Concentration Candidate, Suffolk University Law School, May 2018; B.S., Florida Gulf Coast University, 2012. Mrs. Villanueva-Simms served as the Editor in Chief for the Journal of Health and Biomedical Law for the 2017-2018 academic year and may be contacted at jvillanueva-simms@suffolk.edu.
4 Id. The first heart transplant recipient lived for eighteen days. See Fred Cate, Human Organ Transplantation: The Role of Law, 20 J. CORP. L. 69 (1994) (describing the survival rate of organ
Unfortunately, scientific developments, and cutting-edge pharmacology, have not yet evolved to where innovation can overcome the practical barriers for one vulnerable population: prisoners.\(^5\)

This Article will discuss the “deliberate indifference standard” articulated by the United States Supreme Court forty-two years ago and how that standard applies to prisoners seeking an organ transplant.\(^6\) Part One of this Article will discuss the Eighth Amendment with regard to the State’s requirement to provide healthcare to prisoners.\(^7\) Part Two will discuss the general application of deliberate indifference.\(^8\) Part Three will discuss how the deliberate indifference standard, among other factors, acts as a practical barrier to prisoners in need of an organ transplant, particularly those incarcerated in the Federal Bureau of Prisons.\(^9\) Finally, Part Four will analyze the ethical debate surrounding organ transplants for prisoners.\(^10\)


\(^7\) See Infra Part I and accompanying text.

\(^8\) See Infra Part II and accompanying text.

\(^9\) See Infra Part III and accompanying text.

\(^10\) See Infra Part IV and accompanying text.
I. EIGHTH AMENDMENT

The defining feature of imprisonment is the restriction of liberty. Generally, prison is a tough place: overcrowding, violence, and limited movement are all part of the daily constraints. Included in these restraints, is the inability to leave a prison facility and seek medical treatment, therefore, prisoners rely on prison authorities to treat medical needs. If prison officials fail to provide medical treatment, those medical needs will not be met. Allowing a prisoner to suffer from a treatable medical condition, when the prisoner cannot address these issues on his or her own due to their confinement, could result in liability for the state under the Eighth Amendment.

The Eighth Amendment of the United States Constitution requires the government provide prisoners with adequate medical care. In Estelle v. Gamble, the

---


13 Estelle, 429 U.S. at 103 (1967) (relying on Eighth Amendment principles requiring prisons to provide healthcare).

14 Id. (“[E]lementary principles establish the government’s obligation to provide medical care for those whom it is punishing by incarceration.”).

15 Estelle, 429 U.S. at 106 (citing U.S. CONST. amend. XIII). “[E]xcessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted”. Id. at 108. The Estelle Court noted that, “[m]edical malpractice does not become a constitutional violation merely because the victim is a prisoner.” See Brittany Bondurant, The Privatization of Prisons and Prisoner Healthcare: Addressing the Extent of Prisoners’ Right to Healthcare, 39 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 407, 408-09 (2013). See also West v. Atkins, 487 U.S. 42, 50 (1988) (holding state action exists where private physician contracts with state to provide care for prisoners).

Supreme Court identified a prison’s deliberate indifference to a prisoner’s medical issues as cruel and unusual punishment. The Court found that prison officials can signal deliberate indifference in two distinctive ways: (1) prior to a prisoner receiving medical care, prison guards manifest deliberate indifference by “intentionally denying or delaying access” to the medical care; and (2) subsequent to a prisoner’s receipt of medical treatment, prison guards manifest deliberate indifference by “intentionally interfering” with the prescribed treatment. Furthermore, prison doctors may show deliberate indifference “in their response to the prisoner’s needs.” While the deliberate indifference standard acts as a barometer for the courts, consideration for a prisoner’s bodily integrity bubbles under the surface in everyday application of deliberate indifference.

“A prison that deprives prisoners basic sustenance, including adequate medical care, is incompatible with concept of human dignity and has no place in civilized society.” Id. at 511. See also Estelle, 429 U.S. at 104 (“[I]t is but just that the public be required to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself.”) (quoting Spicer v. Williamson, 132 S.E. 291, 293 (N.C. 1926)).

Gamble, a prisoner of the Texas Department of Corrections, was injured when, in the process of unloading a truck, he was hurt with a bale of cotton. Estelle, 429 U.S. at 99. After a preliminary check for a hernia, Gamble was sent back to his cell where his pain became so severe, he had to return to the unit hospital. Id. The prison physician diagnosed the injury as lower back strain, provided Gamble a pain reliever and muscle relaxant, and provided him a cell pass. Id. Gamble visited the unit hospital seventeen times in a three-month period with unsuccessful outcomes. Id. at 107. The prison facility cited limited resources due to overcrowding as the reason for the Eighth Amendment violation. Id.

See Estelle, 429 U.S. at 105-106 (finding that prisons can signal deliberate indifference in different ways).

See id. at 104 (showing how prison doctors can also have deliberate indifferences).

 Planned Parenthood v. Casey, 505 U.S. 833 (1992) (“[E]very human being of adult years and sound mind has a right to determine what shall be done with his own body is fundamental in American jurisprudence . . .”). See Hovater v. Robinson, 1 F.3d 1063, 1064-65 (10th Cir. 1993) (“[A]n inmate has a constitutional right to be secure in her bodily integrity and free from attack by prison guards”); Campbell v. Wainwright, 416 F.2d 949 (5th Cir. 1969) (finding a prisoner did not have a constitutional right to donate his kidney); Singletary v. Costello, 665 So. 2d 1099, 1101 (Fla. Dist. Ct. App. 1996) (recognizing the right to refuse medical treatment has not been stripped by prisoner status).
II. DELIBERATE INDIFFERENCE IN EVERY DAY APPLICATION

In *Wilson v. Seiter*, the Court refined the deliberate indifference standard in two parts – both must be met for a prisoner to succeed in an Eighth Amendment claim for inadequate care.\(^{21}\) First, the prisoner must be able to demonstrate a "serious medical need" – an objective consideration.\(^{22}\) Second, the defendant, often the government, must have actual knowledge or awareness of the prisoner’s medical need, and fail to take any serious steps to avert a serious risk of harm to the prisoner – a subjective consideration.\(^{23}\)

A difference of opinion between medical professions or between the prisoner and medical professionals does not necessarily amount to deliberate indifference.\(^{24}\) Neither does denying a prisoner’s request for “experimental treatment.”\(^{25}\)

---

\(^{21}\) Wilson, a prisoner in Ohio, complained that a number of conditions of his confinement constituted cruel and unusual punishment. *Wilson v. Seiter*, 501 U.S. 294, 296 (1991). Wilson alleged the improper conditions included overcrowding, excessive noise, inadequate heating and cooling, and unsanitary dining facilities and food preparation. *Id.* Additionally, Wilson alleged that prisoners were improperly classified, resulting in the presence of physically and mentally ill prisoners in the general dorms which lead to a dangerous and stressful environment.

\(^{22}\) *Id.* at 310 (holding prisoners alleging Eighth Amendment violations are required to show prison officials were deliberately indifferent).

\(^{23}\) *Id.* at 305 (defining the subjective consideration of the deliberate indifference standard).

“Nothing so amorphous as ‘overall conditions’ can rise to the level of cruel and unusual punishment when no specific deprivation of a single human need exists.” *Id.*

\(^{24}\) Hodge v. Coughlin, No. 92 Civ. 0622 (LAP), 1994 WL 519902 (S.D.N.Y. Sept. 22, 1994). In *Hodge*, the prisoner sought a corneal transplant as treatment for an eye infection. *Id.* The court refused to find the prison officials acted with deliberate indifference in respect to the transplant, because several eye specialists had previously determined that a corneal transplant was inappropriate given the prisoner’s medical state. *Id.* at *9-10. The difference in opinion between a prisoner and medical professionals did not constitute deliberate indifference. *Id.; Hampe v. Hogan*, 388 F. Supp. 13, 15 (M.D. Penn. 1974). In *Hampe*, the refusal to grant a prisoner’s request for a sphincter muscle transplant did not constitute a deliberate indifference just because medical professionals disagreed with a treatment plan. See Jessica Wright, *Medically Necessary Organ Transplants for Prisoners: Who is Responsible for Payment?*, 39 B.C. L. REV. 1251 (1998) (explaining that prison doctor’s opinion receives deference).

\(^{25}\) In *Hawley*, a prisoner with HIV was seeking a drug that was “experimental” at the time. Hawley v. Evans, 716 F. Supp. 601 (N.D. Ga. 1989). The court denied the request, finding that the Eighth Amendment does not extend to experimental treatments. *Id.* at 603. See *Hampe*, 388 F. Supp. at 15. (finding the transplant was “still in the extremely early stages of development . . .”); *Hodge*, WL 519902 at *1 (stating the transplant was rarely performed for the prisoner’s diagnosis).
Today, the Eighth Amendment requires prison authorities provide adequate medical care, through "some medical attention" of any kind to generally satisfy their obligation.26 Not all inadequate medical treatment in a prison violates the Eighth Amendment and Courts prefer not to probe into what qualifies as adequate medical treatment.27 "Where a prisoner has received some medical attention and the dispute is over the adequacy of treatment, federal courts are generally reluctant to second guess medical judgments and to constitutionalize claims . . . ."28 Here lies with primary issue with any claim of deliberate indifference in an organ transplant case; whether, in measuring the adequacy of a prisoner's care, the case would survive the pleading stage.29 An early dismissal at the pleading stage means the prisoner would have no opportunity to demonstrate the inadequate treatment was more than an accident, careless, or error.30 Even if the claim survives the pleading stage, most prisoner plaintiffs are pro se litigants,

26 See Westlake v. Lucas, 537 F.2d 857, 860 n.5 (6th Cir. 1976) (finding cause of action warranted for prisoners who needlessly suffer pain when relief is available).
27 See Farmer v. Brennan, 511 U.S. 825, 834 (1994) (distinguishing whether prison officials should have known or actually knew of prisoner's ailments); Estelle, 429 U.S. at 106. The Court's statement that "not . . . every claim by a prisoner that he has not received adequate medical treatment states a violation of the Eighth Amendment," implies that some claims do violate prisoner's constitutional rights. Id. at 105. See also Monmouth Cty. Corr. Inst. Inmates v. Lanzaro, 834 F.2d 326, 347 (3rd Cir. 1987). A serious medical need is "one that is so obvious that a lay person would easily recognize the necessity for a doctor's attention." Id.
28 See United States ex rel. Walker v. Fayette County, 599 F.2d 573, 575 n.2 (3rd Cir. 1979) (citing Westlake, 537 F.2d at 860 n.5).
29 See Westlake, 537 F.2d at 860 n.5 (finding deference given to prisoner's healthcare providers is the primary issue of filing a claim). The typical channel – a motion to dismiss for failure to state a claim or motion for judgment on the pleadings – are often joined in prisoner cases by the initial screening required by the Prison Litigation Reform Act ("PLRA"). 28 U.S.C. § 1915A (2006). The statute requires federal courts screen prisoner complaints sua sponte as soon as practical after docketing, and to dismiss any claims that are frivolous, malicious, or fail to state a claim. Id. Easy screening predates the PLRA, although, Estelle v. Gamble was such a case. Estelle, 429 U.S. at 98 ("The District Court, sua sponte, dismissed the complaint for failure to state a claim").
30 See Estelle, 429 U.S. at 106 (establishing the standard for a complaint to survive a 12(b)(6) motion). If the complaint does not contain enough detail about the health care provider's inadequate care, the claim may be dismissed. See Ashcroft v. Iqbal, 556 U.S. 662 (2009). Similar to Estelle, even if the complaint contains all of the relevant information like details about the allegations, the claim may still be dismissed for failed to state a claim upon which relief could be granted. Estelle, 429 U.S. at 106, 108 n.16. A prisoner then has no opportunity to develop documented support to demonstrate their injuries. Id.
wholly untrained in discovery matters and unable to secure relevant documentation or testimony.\textsuperscript{31} For a prisoner in need of an organ transplant, litigation absorbs precious time while the internal process within prison, organ sharing, and cost, continue to be independent obstacles.

III. DELIBERATE INDIFFERENCE IN ORGAN TRANSPLANTATION

Prisoners largely depend on society's commitment to prisoners' health and health care for organ transplants.\textsuperscript{32} The deliberate indifference two prong test is a simple formula that, when applied, clearly attaches a constitutional right to a prisoner's need for organ transplants. First, "demonstrating a serious medical need" is effortlessly met because in most cases, no one would be able to live without a heart, liver, or kidney.\textsuperscript{33} Second, finding deliberate indifference to a prisoner's medical condition by failing to provide an organ transplant, is directly aligned with recent Eighth Amendment jurisprudence.\textsuperscript{34}

\textsuperscript{31} Some litigants are able to obtain internal policies for the treatment of certain diseases, such as internal policies, or facts surrounding the financial considerations in treating an illness. See Johnson v. Wright, 412 F.3d 398, 406 (2d Cir. 2005). Prisoners may also be denied a preliminary injunction for failing to provide an opinion other than his own. See e.g., Boudreau v. Englander, No. 09-cv-247-SM, 2009 WL 4952490, at *6-7 (D.N.H. Dec. 14, 2009) (finding pro se litigants to be inefficient in fighting for their rights due to training). "For his part, and this is critical, Boudreau did not offer any expert medical opinion evidence tending to question or contradict [Defendant's] professional treatment decision." Id. at *6. "This court lacks the medical training and expertise necessary to determine ... whether the medical judgment exercised by the physicians ... was so substandard as to implicate the Eighth Amendment." Id. at *7.

\textsuperscript{32} See Jeffrey Kahn, Ethical Issues in Dialysis: The Ethics of Organ Transplantation for Prisoners, 16 SEMINARS IN DIALYSIS, 365, 366 (2003) (questioning how to justify use of scarce organs for prisoners). "The answer to whether and why we ought to perform organ transplants for prisoners lies in how we understand society's commitment ... and whether being incarcerated changes the priority of a patient waiting for a transplant." Id. at 366.

\textsuperscript{33} See Banks, supra note 1, at 46 (explaining the ethical issues that comes with organ donation).

\textsuperscript{34} See supra text accompanying note 16-20 (providing prisoner's with necessary organ transplant is an Eight Amendment right).
A. Federal Prisoners

The Federal Bureau of Prisons ("BOP"), is responsible for 183,355 federal prisoners, and provides their own guidelines for considering organ transplants as a treatment option. While anyone in need of an organ transplant has various hurdles to clear, prisoners rely on prison officials to assist in overcoming those hurdles. Each step presents a unique opportunity for violating a prisoner's Eighth Amendment rights and each violation would awaken the right to receive necessary medical care.

The process commences when a Clinical Director at an institution “determines it is medically necessary to evaluate a [prisoner’s] suitability for an organ transplant”. The Clinical Director is solely responsible for arranging an organ transplant specialist or laboratory to conduct a work-up at the institution. After an initial workup, where a specialist determines the prisoner may be a candidate for organ transplantation, the Clinical Directed must then recommend further evaluation. The recommendation only provides, yet another, evaluation at a transplant center in the locality of the institution or a Medical Referral Center. If the transplant center determines the prisoner is a suitable candidate for a transplant, the Clinical Director compiles a complete medical file to send

---

38 Program Statement: Patient Care, supra note 35, at 45.
39 Id. (outlining organ transplant process).
40 Id. (describing requirement for specialist review).
41 Id. (requiring a second layer of review for organ transplants).
to the institution's Medical Director for consideration.\textsuperscript{42} Then, if the Medical Director, who may not be specifically trained in organ transplantation, determines an organ transplant is "medically indicated", the prisoner will be approved for surgery.\textsuperscript{43}

There is a significant problem with the step by step process outlined supra. There are plenty of steps where deliberately ignoring the risk of harm to the prisoner could result from an already frustrating process that could affect the prisoner's right to move forward with the evaluation process.\textsuperscript{44} The process for receiving care in prison is inherently burdensome, where prisoner's rely on the sense of urgency amongst the prison staff to receive medical care.\textsuperscript{45} A prisoner has the responsibility for signing up for Sick Call, which is held Monday, Tuesday, Thursday, and Friday from 07:00 – 07:30 a.m.\textsuperscript{46} Prisoners may not be seen the day they fill out a request for sick call and have to request an actual appointment through their work supervisor.\textsuperscript{47} If a prisoner requires urgent medical care, it is up to the unit officer or detail supervisor to determine if treatment is an

\textsuperscript{42} The medical file includes all pertinent medical, surgical, case management, mental health, and social work information to include for consideration. \textit{Id.}

\textsuperscript{43} \textsc{Program Statement: Patient Care}, supra note 35, at 46; see \textsc{Clinical Director, Federal Bureau of Prisons}, https://www.bop.gov/jobs/positions/index.jsp?p=Clinical%20Director (last visited Apr. 2, 2018) (listing clinical director duties).


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... 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.

\textit{Id.}


\textsuperscript{46} \textsc{Inmate Information Handbook}, supra note 45, at 23 (listing sick call process).

\textsuperscript{47} \textit{Id.} ("You will be assessed and assigned an appointment on that day or a subsequent day.") (emphasis added).
This process is hardly conducive to the needs of a prisoner who may need an organ transplant.

Despite an available process, the Eighth Circuit, in dicta, has openly disapproved of the BOP’s organ transplant policy, “[reminding] the Bureau of Prisons that its policies in connection with transplant, if applied inflexibly, may raise constitutional questions”. The Supreme Court in *Estelle* did not set up an exact scope of the medical treatment that should be afforded to prisoners. The Court simply set the floor for the treatment of prisoners, including medical care, as one that should not offend “evolving standards of decency.” Based on these standards, refusing a prisoner an organ transplant, or refusing appropriate access to an evaluation to determine if an organ transplant is necessary, constitutes deliberate indifference.

**B. United Network for Organ Sharing Policy**

The United Network for Organ Sharing (“UNOS”) Ethics committee addressed the debate on organ transplants for prisoners. In an official paper, the committee stated that any type of exclusion for prisoners for medical treatment, including an organ transplantation, is not ethically appropriate. UNOS is adamant that it bases its allocation

48 *Id.* (detailing urgent and after hours medical care procedures).

49 Clark v. Hendrick, 233 F. 3d 1093, 1094 (8th Cir. 2000). The court’s disapproval in *Clark* was entirely in dicta, where the prisoner seeking a bone marrow transplant for leukemia had bone marrow previously extracted and frozen for a transplant in the future. *Id.* The BOP had determined that the prisoner’s condition had not yet deteriorated to where a transplant was necessary. *Id.* Additionally, the prisoner was receiving appropriate treatment, therefore, the BOP had not acted with deliberate indifference with regard to the prisoner’s care. *Id.*

50 *Estelle*, 429 U.S. at 106 (encouraging society to guide prison medical care).

51 *See Kate Douglas, Prison Inmates are Constitutionally Entitled to Organ Transplants – So What Now?,* 49 ST. LOUIS L.J. 539, 546 (2005) (discussing application of deliberate indifference in organ transplant cases).


53 *Id.* (“Punitive attitudes that completely exclude those convicted of crimes from receiving medical treatment, including an organ transplant are not ethically legitimate.”).
system on the principles of equity and medical utility.\textsuperscript{54} UNOS recognizes an argument, echoing the principles articulated in \textit{Estelle}, that a prisoner has been sentenced to a specific punishment, which does not include an additional punishment with respect to medical services.\textsuperscript{55} Although UNOS recognizes the principles outlined in \textit{Estelle}, they also acknowledge that an individual's status as a prisoner has legitimate medical concerns, such as infectious diseases and character disorders.\textsuperscript{56} Despite this, the Ethics Committee reasons that, "absent any societal imperative," a prisoner should not be precluded from consideration for a transplant.\textsuperscript{57} It is not entirely clear how "societal imperative[s]" and the "legitimate concerns" overlap, or if the overlap is an institutional barrier; that is to be determined by UNOS.\textsuperscript{58} What is clear is that the UNOS statement avoids addressing how an organ transplant for a prisoner would be paid for.\textsuperscript{59}

\textbf{C. Cost}

The high costs associated with an organ transplant procedure for a prisoner should not be a determinant factor.\textsuperscript{60} \textit{Estelle} and its progeny supports that the government

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{54} \textit{Id}. ("Acknowledged are medical and non-medical factors that may influence one's candidacy for transplant however prisoner status is not an absolute contraindication.").
\item \textsuperscript{55} \textit{Id}; \textit{Estelle}, 429 U.S. at 103. \textit{See} 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." \textit{Id}.
\item \textsuperscript{56} \textit{See} \textit{Convicted Criminals and Transplant Evaluation, supra} note 52. In 2015, there were 1,390 prisoners with reported acute cases of Hepatitis A, 3,370 prisoners with Hepatitis B, and 2,436 prisoners with Hepatitis C. \textit{See Data on Common Health Problems, Cdc.gov, https://www.cdc.gov/correctionalhealth/health-data.html} (last updated May 13, 2016). These totals do not include prisoners who entered prison with a Hepatitis diagnosis. \textit{Id}; Owen Murray et al., \textit{Managing Hepatitis C in Our Prisons: Promises and Challenges, Correct Care} 1, 17 (2007).
\item \textsuperscript{57} \textit{See Data on Common Health Problems, supra} note 56. UNOS does not define "social imperative" in its opinion paper. \textit{Id}.
\item \textsuperscript{58} \textit{See} \textit{Douglas, supra note} 51, at 565 (discussing UNOS as responsible for educating the public about prisoners receiving organs).
\item \textsuperscript{59} \textit{See Data on Common Health Problems, supra} note 56, at n.1.
\item \textsuperscript{60} "This is not to say that economic factors may not be considered, for example, in choosing the methods used to provide meaningful access." \textit{Bounds v. Smith}, 430 U.S. 817, 825 (1977). "But the cost of protecting a constitutional right cannot justify its total denial." \textit{Id}.
\end{itemize}
\end{footnotesize}
should be responsible for funding an organ transplant for a prisoner.\footnote{See \textit{Lanzaro}, 834 F.2d at 326; \textit{Ancata} v. Prison Health Servs., Inc., 769 F.2d 700 (11th Cir. 1985).} Prisons are constitutionally required to provide for all serious medical needs of prisoners because their financial reliance is a result of their incarcerated status.\footnote{\textit{Lanzaro}, 834 F.2d 326 at 345.} Denying a prisoner treatment due to the inability to pay constitutes deliberate indifference to a serious medical need and creates liability for the state.\footnote{\textit{Ancata}, 769 F.2d at 704 (finding state action present even if medical employees are not strictly public employees).} “[A] prison official who withholds necessary medical care, for want of payment, from a [prisoner] who could not pay would violate the inmates constitutional rights if the [prisoner’s] medical needs were serious.”\footnote{\textit{Martin} v. Debruyn, 880 F. Supp. 610, 615 (N.D. Ind. 1995).} Whether a prisoner is covered for an organ transplant often depends on the state system and its respective policies where federal prisoners are financially covered if they are approved after the process discussed \textit{supra}.\footnote{See supra text accompanying notes 38-43. \textit{See also PROGRAM STATEMENT: PATIENT CARE, supra note 35, at 46. (“The Bureau will pay medical care and hospitalization costs associated with organ donors. These expenses are limited specifically to those costs directly related to the transplant procedure itself.”).} Many states have attempted to address organ transplants for prisoners by regulating the practice through legislation.\footnote{See infra note 76 (discussing legislation to limit prisoners as organ recipients). Various case law does, however, support the view that prisoners may be charged a co-pay. \textit{City of Revere v. Massachusetts Gen. Hosp.}, 463 U.S. 239, 244; \textit{Bihms v. Klevenhagen}, 928 F. Supp. 717, 718 (S.D. Tex. 1996).} For example, Washington State has an “Offender Health Plan” which lists which health services are available to prisoners within the state.\footnote{WASHINGTON STATE DEP’T OF CORRECTIONS, OFFENDER HEALTH PLAN § 3 (effective date Mar. 16, 2018).} The Plan specifically states that organ transplants are not covered by the state unless the “Utilization Review Committee” authorizes the individual prisoner for a transplant.\footnote{\textit{Id.} § 5.}
methods of funding, the Committee has full discretion to pay for or deny the transplant.\textsuperscript{69} For most states, there are no standard policies as to state-funded organ transplants — most states opt for a case-by-case review.\textsuperscript{70}

This is not to imply that economic factors may not be considered when determining which methods would achieve the same outcome for treatment.\textsuperscript{71} Rather, suggesting that cost is not alone a factor in denying treatment is in response to the Supreme Court's silence on the issue.\textsuperscript{72} The \textit{Estelle} court did not discuss costs when articulating the deliberate indifference standard.\textsuperscript{73} In fact, many lower courts have explicitly rejected the opportunity to decide that financial concerns can influence medical care for prisoners, therefore, the cost for a prisoner's organ transplant cannot be a decisive factor without disturbing the spirit of \textit{Estelle}.\textsuperscript{74}

Deliberate indifference is alive and well in the process for obtaining an organ, the cost, and the unclear UNOS policies, however, the Eighth Amendment provides clear

\begin{itemize}
\item \textsuperscript{69} \textit{Id.}
\item Offenders may require health services for which another entity (for example, county or another state, Labor and Industries, Medicaid, Veteran's Administration) is either is contractually or otherwise legally obligated to assume financial responsibility. . . . Nothing in this document shall obligate \textit{DOC} to assume financial responsibility for health care received by persons prior to or following their status as an offender. . . .
\item \textit{Id.}
\item Wright, supra note 24, at 1261 (describing case-by-case consideration as predominant method of dealing with funding).
\item \textit{Bounds}, 430 U.S. 817 at 825.
\item Wright, supra note 24, at 1269. "In Eighth Amendment jurisprudence, the court balances individual and governmental interest only in the context of discipline and security; the States' interest in limiting expenditures is not considered." \textit{Id.}
\item Posner, supra note 44, at 351 (determining a "serious" condition is constitutionally entitled to receive treatment prescribed by a doctor).
\item See \textit{Lanza}, 834 F.2d at 336 n.17 (rejecting financial consideration in defining constitutional rights). \textit{See also} Hamm v. DeKalb Cnty., 774 F.2d 1567, 1573 (11th Cir. 1985) (denying government to consider costs to allow prisoners' medical treatment fall below a minimum standard).
\end{itemize}
protections for these hurdles.\textsuperscript{75} What the Eighth Amendment cannot protect is public opinion.\textsuperscript{76} As the organ shortage crisis continues, one question remains: If there are not enough organs for everyone in need, why should convicted criminals receive an organ transplant over law abiding citizens?\textsuperscript{77}

IV. ANALYSIS – DEBUNKING THE ETHICAL DEBATE

The fact that a “waiting list” exists indicates that organs are a precious and rare commodity where adding a prisoner to the waiting list creates a logical tension.\textsuperscript{78} This tension is inevitable regarding “worthiness” when allocation decisions are made.\textsuperscript{79} A

\textsuperscript{75} See supra text accompanying notes 11-15 (describing Eighth Amendment protections). See also Estelle, 429 U.S. at 105-106 (recognizing the ethical problems associated with denying a prison basic necessities of life). See also Farmer v. Brennan, 511 U.S. 825, 835-36 (1994) (determining prisoner officials must be aware of the risk of harm to the prisoner).

\textsuperscript{76} Bryan Robinson, Death-Row Privilege: Condemned Prisoner May Get Kidney Transplant While Law-Abiding Citizens Wait, ABC NEWS (May 28, 2002), http://abcnews.go.com/US/story?id=90611&page=1. See Jeremy Olson, Urgency Comes First in Transplant Criteria, OMAHA WORLD-HERALD 1B (Feb. 9, 2003). In 2003, Louisiana introduced a bill in the Legislature that would have prohibited state-funded organ transplants “for people who have exhausted all appeals after a conviction for first-degree murder, punishable by death or a life sentence, and second-degree murder, which carries a mandatory life sentence.” Panel Backs Ban on Inmate Transplants, THE BATON ROUGE ADVOC., June 13, 2003, at 15A. Also in 2003, California introduced legislation that would allow those who signed donor cards to indicate that they wished to exclude prisoners from receiving their donated organs. Bill Allowing Donor Card Signers to Exclude Prisoners from Getting Their Organs Introduced in California, TRANSPLANT NEWS, Jan. 15, 2003, at O. See also Kahn, supra note 32 at 366. “Questions immediately emerge about how to justify the use of scarce organs for prisoners when law-abiding citizens are waiting.” Id. See also McKinney, supra note 44, 68-69 (2008).

\textsuperscript{77} “Around 116,000 people in the United States are currently on the waiting list for a lifesaving organ transplant.” Facts & Myths, AM. TRANSPLANT FOUND., https://www.americantransplantfoundation.org/about-transplant/facts-and-myths/ (last visited Apr. 2, 2018). Another name is added to the waiting list every ten minutes and, on average, twenty people die every day waiting for an organ. Id.

\textsuperscript{78} See David Perry, Should Violent Felons Receive Organ Transplants?, MARKKULA CTR. APPLIED ETHICS (Jan. 31, 2002), https://www.scu.edu/ethics/areas/bioethics/resources/should-violent-felons-receive-organ-transplants/. A convicted felon was given a new heart at Stanford
common opinion is that those with more societal value—law abiding citizens—are more deserving of organs rather than a prisoner who has committed crimes against society. This opinion, while familiar, is dangerous. Denying prisoners medical treatment, including transplants, would treat all prisoners the same based on their status as a prisoner; this mentality would have deprived tuberculosis treatments for Nelson Mandela. Any policy that assigns a lower priority to prisoners would be based on the treacherous principle that prisoners are less valuable human beings. Denying transplants based on one’s status as a prisoner would create a practice of attaching worth as a legitimate consideration when allocating an organ and prisoners may not be the only population whose eligibility is carefully inspected.

Medical Center, costing taxpayers nearly one million dollars. The prisoner had been twice convicted for robbery. Perry states, “I’m not persuaded that the Supreme Court intended to give violent criminals a claim equal to that of the rest of us on highly scarce medical resources like hearts, livers, lungs and kidneys, especially when the decision to save one person’s life with an organ transplant almost inevitably means that someone else will die.”

Id. This is the exact opinion that appropriates sacred resources based on “societal worth” discussed infra p. 17.


See Maurice Bernstein, Christopher Myers, & Laurie Lyckholm, A New Liver for a Prisoner, 32 HASTINGS CTR. REPORT 12, 12-13 (2012). Critics question whether “a robber who takes good care of his elderly parents [is] more immoral than a politician who lies to the public and neglects his family?” W. Victoria Lee, A New Heart, or Liver, For a Convict, 122 THE TECH 1, 5 (Jan. 29, 2003).


Kahn, supra note 32, 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.”

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.” Brandon, supra note 80. Brandon questions, “What about the people who haven’t committed crimes but have done other things people would consider condemnable?” and whether “the wife beater [should] be excluded?”
Although resentment over prisoners receiving an organ is understandable, there was a short time when character did determine who received access to scarce treatment and it was a disaster.\textsuperscript{85} In 1962, Seattle Swedish Hospital established what was later called the “God Committee”\textsuperscript{86} The committee was created to determine which patients would be connected to an “artificial kidney” that would cleanse the blood of toxins that the patient’s failing kidney could no longer filter - dialysis.\textsuperscript{87} The committee consisted of seven citizens who would choose who used to kidney because the decision was not viewed as a “clinical decision” rather, it was a societal one.\textsuperscript{88} The committee’s deliberations, although intended to be rid of a medical driven discussion, was riddled with decisions based on “worthiness”.\textsuperscript{89}

In the first meeting, the committee agreed to reject any patient over forty-five because older patients were statistically more likely to develop medical complications.\textsuperscript{90} The committee also agreed to exclude children because they were concerned that they may be traumatized by the procedure.\textsuperscript{91} In the second meeting, the members decided


\textsuperscript{86} The committee was initially called the Admissions and Policies Committee of the Seattle Artificial Kidney Center at Swedish Hospital. Levine, \textit{supra} note 85. All members of the committee were unpaid and insisted on anonymity. \textit{Id.}

\textsuperscript{87} Each patient was connected to the “kidney” twice a week for 12 hours at a time. \textit{Id.} At the time the artificial kidney was created, nearly 10,000 Americans were dying from renal failure each year. \textit{Id.} The Seattle hospital was the only facility in the country offering dialysis and there were only three treatment slots for every sixty people who required treatment. \textit{Id.}

\textsuperscript{88} The committee was “diverse” consisting of a lawyer, minister, banker, housewife, state government official, labor leader, and surgeon. Satel, \textit{supra} note 85. As a societal decision, the hospital chose to leave the burden of choice to the public. \textit{Id.} The “societal decision” was determined by an all white panel, all were male but one. \textit{Id.}

\textsuperscript{89} \textit{Id.} (discussing the principles considered in deliberations).

\textsuperscript{90} Satel, \textit{supra} note 85.

\textsuperscript{91} \textit{Id.}
they did not want to know the candidates' names, and in their third meeting, the committee evolved into considering other crucial, irrelevant factors. The members created a list of all the factors they would consider in their decision, including age, sex, marital status and number of dependents, income, net worth, and emotional stability.

The committee’s deliberations were secret, however, some reflections remain public:

Housewife: “If we are looking for the men with the highest potential of service to society, then I think we must consider that the chemist and the accountant have the finest educational backgrounds of all five candidates . . .”

Lawyer: “Both these men have made provisions so that their deaths will not force their families to become a burden on society.”

State Official: “But that would seem to be placing a penalty on the very people who have perhaps been most provident . . .”

Minister: “Perhaps one man is more active in church work than another because he belongs to a more active church.”

Labor Leader: “For the children’s sake, we’ve got to reckon with the surviving parent’s opportunity to remarry, and a woman with three children has a better chance to find a new husband than a very young widow with six children.”

It is highly likely that most readers would find at least one comment from the deliberations offensive, or at a minimum, outdated; consider the surgeon’s opinion:

Surgeon: “How do the rest of you feel about Number Three – the small businessman with three children? I am impressed that his doctor took special pains to mention this man is active in church work. This is an indication to me of character and moral strength.”

92 Id.
93 The members also considered the educational background, occupation, past performance and future potential, and references. Id. The more dependents (minor children) an applicant had, the greater the chance they would be chosen. Id.
95 Alexander, supra note 94, at 102 (emphasis added).
Without a doubt, if an application from a prisoner had been placed in front of the committee, they would have been instantly denied. The God Committee’s deliberations were clear, medical salvation was only intended for “socially worthwhile” patients. The God Committee is an example of why denying prisoners an organ transplant based on moral worth is a slippery slope. Based on the committee’s metrics, prisoners would be denied, but so was a housewife due to her inability to financially support a move to Seattle. Most of the patients chosen were financially stable, white and male. In addition to the housewife, a chemist and an accountant were denied treatment and later

96 See id. (explaining the moral considerations within the God Committee’s deliberations). The committee struggled with saving the person who contributes the most to society or the one whose death would impose the greatest burden on society, in the form of children left without care or resources. Id. Arguably, prisoners are not contributing to society – rather, they are paying a debt to society – and are already a “burden” as tax payers carry the responsibility of providing their care. Id.


98 See McKinney, supra note 97, at 110.

As human beings ourselves, we rejected the idea instinctively of classifying other human beings in pigeonholes, but we realized we had to narrow the field somehow. Well, we didn’t know it then, of course, but the very first rule we made—to take only candidates from the state of Washington—actually eliminating our very first candidate. ... Then I raised the question: what do we do if someone of great wealth says to us, “Take my candidate, and I’ll finance your whole program here”?

Id.

99 Id. at 110.

Surgeon: “This patient could not commute for the treatment to Walla Walla, so she would have to find a way to move her family to Seattle.

Banker: Exactly my point. It says here that her husband has no funds to make such a move.

Lawyer: Then you are proposing we eliminate this candidate on the grounds that she could not possibly accept treatment if it were offered?”

Id.

V. CONCLUSION

Physicians should not discriminate on the basis of social worth when evaluating transplant candidates. There is no need to return to the days of character biopsy in determining who receives access to rare treatments. While *Estelle* outlines the civil rights of prisoners with regard to medical care, other powers are shaping the actual delivery of such care. As a result, prisoners are facing an uphill battle to overcome institutional barriers, vague policies, and the court of public opinion to receive life-saving treatment. If history is any indication, it is inherently dangerous to apply "societal worth" to who receives organ transplantations.

---

101 Id. (describing the demographics of patients chosen).
102 Id. See Alexander, supra note 94. The Committee primarily made their choices based on superficial predictions of which patients would be able to adhere to the demands of treatment such as diet, hygiene, and regular attendance at treatment and follow-up appointments and who were most likely to return to a "socially useful role". Id. There is no guarantee that prisoners would be able to attend treatment or regular follow-up appointments. Id.

Dr. Murray: Patients Number One and Number Five can last only a couple more weeks. The others probably can go a bit longer. But for purposes of your selection, all five cases should be considered of equal urgency, because none of them can hold out until another treatment facility becomes available.”

103 *Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients*, 155 ARCHIVES INTERNAL MED. 29, 29-40 (1995).
104 See Alexander, supra note 94, at 115.

The fact is that progress in this world comes about through the existence of crises, not the anticipation of them . . . In theory, I believe that a man's contribution to society should determine our ultimate decision. But I'm not so doggone sure that a great painting or symphony would loom larger in my own mind than the needs of a woman with six children.

Id.