

OFFENDER ORGAN TRANSPLANTS: LAW, ETHICS, ECONOMICS, AND HEALTH POLICY

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“The degree of civilization in a society is revealed by entering its prisons.” FYODOR DOSTOEVSKY, *THE HOUSE OF THE DEAD*.

I. INTRODUCTION

Hundreds of Texas prison inmates suffer from irreversible organ damage.¹ Treatment in the form of organ transplants could extend the lives of some of these offenders. However, a number of conflicting concerns have created barriers to providing Texas offenders with access to transplants. This article examines those concerns from perspectives of attorneys, ethicists, and health policy scholars on the legal and ethical obligations of correctional health policy makers, correctional health-care providers, and prison officials.

In addition, legal issues and trends, prison health policies, economic factors, and ethical considerations associated with providing Texas offenders with organ transplants are assessed in light of the health status of people incarcerated in Texas State correctional facilities, and in the context of other relevant medical and health-care information.

We will show that prevailing legal and ethical norms indicate that organ transplants should be made available to medically-qualified offenders at public expense. We conclude that

¹ See generally, Jacques Baillargeon et al., *End Stage Liver Disease in a State Prison Population*, 17 ANNALS EPIDEMIOLOGY 808 (2007) (examining the prevalence of major acute and chronic conditions in the Texas prison populations) [hereinafter *ESLD*]; Jacques Baillargeon et al., *The Disease Profile of Texas Prison Inmates*, 10 ANNALS EPIDEMIOLOGY 74 (2000) (examining the prevalence, mortality, and clinical characteristics of ESLD in the Texas prison system) [hereinafter *Disease Profile*].

comprehensive policies should be developed to provide a framework for screening, referring, and securing organ transplant services for offenders in need. In addition, avenues should be pursued to reduce the need for organ transplants and to address the end-of-life health-care needs of offenders. Finally, studies are needed to ascertain the knowledge, attitudes, and perceptions of correctional health providers concerning organ transplants for offenders, and to gain insight into the resources required for successful implementation of appropriate policies.

II. THE MEDICAL CONTEXT

Organ transplantation is often the last resort in treating end-stage organ failure.² Although donor organs remain scarce and organ transplants are usually performed in special centers that have the skilled personnel and technology needed to carry out the procedures and care for transplant patients, organ transplantation is considered a standard of care; it is no longer dismissed as experimental or unproven.³

A. Offenders' Needs

The need for transplants in prison may be greater than in the general population because of the age, health history, and racial or ethnic make-up of the prison population. For example, hepatitis C is one of the leading causes of liver damage that results in the need for liver transplants in the U.S.⁴ Its prevalence among the incarcerated

² Owen J. Murray et al., *Managing Hepatitis C in Our Prisons: Promises and Challenges*, CORRECT CARE, (ISSUE 2) 1, 17 (2007) [hereinafter *Managing Hepatitis C*], available at http://www.ncchc.org/pubs/CC/managing_hcv.html.

³ *Id.* Perhaps more compelling evidence of the widespread acceptance of organ transplantation is the fact that Medicare covers treatments and services, including organ transplants, that are "reasonable and necessary" as stated in § 1862(a)(1)(A) of the Social Security Act. See 42 U.S.C.S. § 1395y. Medicare has been willing to cover certain non-renal transplants at certified transplant centers since 1986 (e.g., Medicare certified some transplant centers for heart transplants in 1986, for lung and heart-lung transplants in 1995, for liver transplants in 1990, for intestine transplants in 2001). See Centers for Medicare & Medicaid Services, Medicare-Approved Transplant Centers, <http://www.cms.hhs.gov/ApprovedTransplantCenters/> (last updated Aug. 28, 2008).

⁴ See, e.g., Ctr. for Disease Control and Prevention, *Hepatitis C Frequently Asked Questions for*

population is ten to twenty times higher than in the general population.⁵ An estimated twenty-nine percent of entering adult inmates incarcerated by the Texas Department of Criminal Justice (TDCJ) are infected with the virus.⁶ The disease is most often transmitted through injection drug use, but can be transmitted through tattooing, sharing toothbrushes or razors, and sexual activity.⁷ Before they were tested for the virus, blood products used for therapeutic purposes caused transmission of hepatitis C.⁸ Transmission of the disease requires blood-to-blood contact.⁹ When the patient is also infected with HIV, which is five times more prevalent in the offender population, or hepatitis A or B, damage to the liver progresses more rapidly than otherwise.¹⁰

In the general public, the elderly are most likely to suffer serious morbidity from chronic illnesses. The same is true for people in prison. Because chronic illnesses take time to cause serious organ damage, the more serious symptoms may be considered age-related. Elderly has a different meaning for the prison population. Offenders are often considered geriatric at age fifty or fifty-five, a decade or more earlier than in the general public.¹¹ The fastest growing population in prison is over age sixty.¹² Members of these older groups are more likely than members of younger age groups to suffer from life-threatening illnesses that can be diminished or alleviated through organ transplants.¹³

Because minority groups are overrepresented in the prison

Health Professionals (Oct. 16, 2008),
<http://www.cdc.gov/hepatitis/HCV/HCVfaq.htm#section1>.

⁵ Baillargeon, *supra* note 1, at 808.

⁶ Murray, *supra* note 2, at 1 (referring to a seroprevalence survey of nearly 4,000 adults).

⁷ Doris B. Strader et al., AASLD Practice Guideline: Diagnosis, Management, and Treatment of Hepatitis C, 39 *Hepatology* 1147, 1147-48 (2004).

⁸ *Id.* at 1147.

⁹ *Id.*

¹⁰ Baillargeon, *supra* note 1, at 808.

¹¹ See Mike Mitka, Aging Prisoners Stressing Health Care System, 292 *JAMA* 423, 423 (2004).

¹² Sarah Moore, Old-Timers Doing Time are the Fastest-Growing Group of Texas Inmates, *Beaumont Enterprise*, Jan. 21, 2007,
<http://www.beaumontenterprise.com/news/20024419.html>.

¹³ *Disease Profile*, *supra* note 1, at 78 tbl. 6.

population in Texas,¹⁴ and because the same groups are more likely than others to experience certain organ-destroying disorders (e.g., high blood pressure or diabetes, which can result in the need for dialysis or kidney transplants), offenders incarcerated by the TDCJ may develop end-stage organ failure at a higher rate than occurs in the general public.¹⁵

Hepatitis C, HIV, diabetes, and high blood pressure are chronic illnesses. Serious symptoms of these disorders may take years to develop. Chronic illnesses are the usual causes of end-stage organ failures that result in the need for transplants. Offenders often have histories of inadequate health care prior to incarceration, high risk behaviors, and lack of awareness about how to maintain a healthy lifestyle.¹⁶ This type of personal history, when combined with a long prison sentence, can mean that the offender will develop serious illnesses while incarcerated. Prison sentences in Texas are typically longer than five years.¹⁷

B. Screening for Chronic Diseases

Prisons typically screen for a variety of health problems shortly after the offender enters prison.¹⁸ However, because of costs or other resource limitations, many prison systems do not screen for some serious or potentially serious disorders.¹⁹ Curatives, if available, are expensive, sometimes costing tens of thousands of dollars per person per year. Furthermore, the treatments may be less effective in certain groups and for certain strains of the diseases.²⁰ Correctional officials

¹⁴ See Tex. Dep't. of Crim. Just., Fiscal Year 2007 Statistical Report 8 (2008), <http://www.tdcj.state.tx.us/publications/executive/Fiscal%20Year%202007%20Statistical%20Report.pdf> (last visited July 31, 2008); see also Elizabeth M. Greico & Rachel C. Cassidy, U.S. Census Bureau 2000 Brief: Overview of Race and Hispanic Origin [No. C21 br/01-1], 3 tbl. 1 (2001), http://www.census.gov/prod/2001pubs/cenbr01_1.pdf.

¹⁵ Disease Profile, *supra* note 1, at 78 tbl.5 (showing the most prevalent diseases according to gender and ethnicity in prisons).

¹⁶ See *id.* at 79.

¹⁷ Tex. Dep't of Crim. Just., Fiscal Year 2007 Statistical Report 15 (2008).

¹⁸ Disease Profile, *supra* note 1, at 74-75.

¹⁹ See Baillargeon, *supra* note 1, at 809.

²⁰ Theodore Sy & M. Mazen Jamal, *Epidemiology of Hepatitis C Virus (HCV) Infection*, 3 INT'L J. OF MED. SCI. 41, 43(2006).

may reason that screening for certain conditions may obligate them to provide expensive care that may overwhelm health-care resources.²¹ Offenders may be asked about certain symptoms or high risk behaviors to determine whether testing may be appropriate, but for various reasons, the offender may not admit to high risk behaviors or may not know of any reason to suspect disease.²² Therefore, the offender may not be aware of the need for treatment or monitoring for his or her undiagnosed, organ-damaging disease. This is especially true for hepatitis C.²³ The lack of systematic screening for this and other disorders may mask the actual prevalence of certain disorders in prison and may also result in underestimation of the numbers of offenders who might meet the medical criteria for an organ transplant.²⁴ By the time the offender becomes aware of the need for or availability of treatment, he or she may no longer respond to the usual remedies. In some instances, the offender's health may deteriorate despite medical intervention.²⁵

C. Chronic Illness Treatment Costs

The cost of treatment for one of these chronic illnesses may be substantial. For example, the estimated cost per person of the usual hepatitis C treatment, a combination of pegylated interferon and ribavirin, is between \$9,000 and \$38,851.²⁶ Because of the high costs of some of these treatments, correctional officials sometimes set policies

²¹ *Estelle v. Gamble*, 429 U.S. 97, 104-05 (1976); *Farmer v. Brennan*, 511 U.S. 825, 835-36 (1994) (Under the "deliberate indifference standard," the prison official must be aware of an unreasonable risk of harm to the inmate and disregard the risk.) Not automatically screening for certain disorders allows prison officials to avoid awareness of an unreasonable risk of harm where the inmate does not exhibit overt symptoms. See generally *Gregg v. Georgia*, 428 U.S. 153 (1976).

²² See *Baillargeon*, *supra* note 1, at 809.

²³ *Id.* at 812.

²⁴ See Richard Sterling, et al., The Spectrum of Chronic Hepatitis C Virus Infection in The Virginia Correctional System: Development of a Strategy for the Evaluation and Treatment of Inmates with HCV, 100 AM. J. GASTROENTEROLOGY 313, 318 (2005) (addressing chronic HCV infection in Virginia prisons, the Commonwealth of Virginia discussed mandatory screening for all inmates, selective screening upon inmate request, and criteria for treatment eligibility).

²⁵ See Murray, *supra* note 2, at 17 ("Chronic HCV infection is now the leading cause of end-stage liver disease (ESLD) in TDCJ and other state prison systems . . .").

²⁶ Sterling, et al., *supra* note 24, at 317; Murray, *supra* note 2, at 16.

that limit eligibility for the treatments.²⁷ Many offenders do not meet these criteria. Denial of treatment, delay in treatment, treatment with drugs or procedures that do not meet the standard of care, or treatment that causes or exacerbates organ damage may result in the need for an organ transplant.²⁸ Attempts to limit health-care costs may actually result in much higher costs

D. Costs and the Transplant Process

The much higher costs mentioned above involve assessing a patient's need and eligibility for a transplant at the correctional system level, evaluating the patient's eligibility to be added to a transplant list, carrying out the transplant, and providing follow-up monitoring and treatment with anti-rejections drugs, all of which are expensive processes. Blood tests, imaging, biopsies, psychological assessments, drug screenings, history of disciplinary problems, and other measures may be part of the correctional system's assessment of the offender's eligibility. Evaluation for eligibility to be added to a transplant list, a process that is carried out by a transplant center rather than by correctional personnel, also involves extensive diagnostic testing, monitoring for changes in health status, and other measures of the probability of benefit from and success of the organ transplant. The transplant procedure itself requires personnel, equipment, and other resources to provide closely-monitored and high-tech care, possibly for an extended period of time. Post-operative care involves ongoing treatment with drugs that suppress the immune system so that the organ recipient does not reject the donor organ. Because of the patient's suppressed immune system, even minor injury or a common cold can become a serious threat to the patient's health. Therefore, frequent monitoring, careful compliance with treatment regimens, and extra efforts to maintain a sanitary living environment are essential to the success of the transplant.

E. Consequences

There may be a pressing need for organ transplants in Texas

²⁷ Murray, *supra* note 2, at 16-17.

²⁸ See *id.*

prisons when one considers the population characteristics and the prevalence of certain life-threatening disorders. Screening for certain disorders and subsequent treatment, though costly, may prevent unwanted consequences later. Furthermore, despite the expense of treatments for diseases such as hepatitis C and HIV and of necessary organ transplants, they may be required by law.

F. Other Considerations

Many offenders who suffer from organ-damaging disorders will be ineligible for placement on a transplant list. Some will achieve health stability without intervention. Some will not have organ damage sufficient to justify further evaluation for transplantation. Some with serious organ damage will not qualify medically for placement on a transplant list (e.g., due to other illnesses, substance abuse, inability to comply with treatment). Furthermore, offenders may be released or die before reaching the top of the priority list. They may lose eligibility due to threats to compliance (e.g., drug abuse) or for other medical reasons. Under new regulations, transplant centers will be evaluated based on the number of transplants they perform, the survival rate of the organs transplanted after one year, and the survival rate of the organ recipients after one year.²⁹ The potential threats to success with transplants in offenders may discourage transplant centers from giving priority to offenders listed for transplants out of fear of losing transplant-center status. Although the prevalence of organ-damaging illnesses may exceed current estimates, the actual number of transplants completed may be few. Some concerns about providing organ transplants may be exaggerated.

III. LAW

There is nothing simple about the law associated with correctional healthcare. Federal laws and regulations, state laws and regulations, and court opinions at various levels of the legal system

²⁹ Crosswalk of Transplant Center Final Rule, 72 Fed. Reg. 15, 202 (Mar. 30, 2007)(to be codified at 42 C.F.R. pt. 121). Transplant centers that fail to meet standards will be in jeopardy of losing transplant-center status.

all may apply. The laws and legal opinions overlap and sometimes appear to conflict. In some instances, it is less than clear which laws or rules apply to a given situation. Therefore, the information below is a considerably abbreviated discussion of deliberate indifference, medical negligence, and federal laws that apply to organ transplants.

A. The Eighth Amendment and the Deliberate Indifference Standard

The deliberate indifference standard is a decision-making tool developed by the U.S. Supreme Court in response to questions about whether inadequate healthcare for a convicted criminal incarcerated in a prison or jail amounts to a violation of the offender's Eighth Amendment right to be free from cruel and unusual punishments.³⁰ The standard and how it is applied are central to the question of whether to provide organ transplants to offenders.

The standard has two parts, both of which must be satisfied for an offender to succeed in a lawsuit against correctional personnel.³¹ The first part, sometimes referred to as the *objective prong* of the test, requires that the complaining party be able to demonstrate a "serious medical need."³² This is not the same as a having an injury or disorder. Therefore, something other than demonstrating the presence of symptoms is required. Courts in many jurisdictions have

³⁰ U.S. CONST. amend. VIII. ("Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.")

³¹ The Eleventh Amendment prevents an offender from suing the state or the state prison system for violating his or her Eighth Amendment rights, so the offender must sue individual officials. See U.S. CONST. amend. XI. This is not the case for certain other types of civil rights-related violations (e.g., discrimination on the basis of disability). The offender must rely on a federal statute for the authority to file a lawsuit against the individual who violates his or her civil rights "under color of state law." See *West v. Atkins*, 487 U.S. 42, 49-50 (1988). The procedure for a federal offender is somewhat different. If the incarcerated person is detained but has not been convicted, the court does not rely on the offender's Eighth Amendment rights. Instead, it considers a lawsuit complaining of inadequate health care under the Fourteenth Amendment and the offender's right to due process. The issues are the same. However, the reasoning behind this difference is that a detainee is not being punished, because he has not been proven guilty of a crime. The offender is owed adequate health care for the simple reason that being in custody prevents him from seeking it on his own behalf. Being detained is considered a temporary inconvenience. Therefore, the Eighth Amendment does not apply. Health care is treated as a property right that cannot be taken by the government without due process of the law.

³² *Estelle*, 429 U.S. at 104.

recognized two ways to identify a serious medical need.³³ The first way is to have a medical professional declare the injury or disorder sufficiently serious to warrant treatment by recommending or prescribing treatment.³⁴ This must be more than a suggestion about measures that may be appropriate at some indefinite time in the future. The second way does not require professional judgment; it requires only ordinary knowledge and awareness. If it is obvious to an ordinary lay person that an offender needs medical attention, the offender has a serious medical need.³⁵ The second part of the test, sometimes called the *subjective prong*, involves actual knowledge or awareness of the offender's serious medical need and acts or omissions on the part of correctional personnel that indicate failure to avert or to take reasonable steps to avert a serious risk of harm to the offender.³⁶ If a correctional official or correctional health official knows of the offender's serious medical need and disregards it by denying, delaying, or interfering with treatment, the official violates the offender's Eighth Amendment rights.³⁷

It is clear from legal precedent that medical negligence is not enough to make out a claim for a civil rights violation.³⁸ However, in some cases, even if some treatment is provided, there may be a violation of the offender's Eighth Amendment rights.³⁹ If a correctional healthcare provider's treatment of the offender is *egregiously* below the standard of care, the provider may be liable for

³³ Monmouth County Corr. Institutional Inmates v. Lanzaro, 834 F.2d 326, 347 (3rd Cir. 1987).

³⁴ *Id.*

³⁵ *Id.*

³⁶ *Id.* at 346-47.

³⁷ *Id.*

³⁸ Estelle, 429 U.S. at 105-06.[I]n the medical context, an inadvertent failure to provide adequate medical care cannot be said to constitute "an unnecessary and wanton infliction of pain" or to be "repugnant to the conscience of mankind." Thus, a complaint that a physician has been negligent in diagnosing or treating a medical condition does not state a valid claim of medical mistreatment under the Eighth Amendment. Medical malpractice does not become a constitutional violation merely because the victim is a prisoner. In order to state a cognizable claim, 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. This statement is followed by a footnote listing cases from the federal circuit courts that support this interpretation. *Id.*

³⁹ Williams v. Vincent, 508 F.2d 541, 546 (2d Cir. 1974).

deliberate indifference. A well-known example involved an offender whose outer ear was severed in a fight.⁴⁰ The treating physician threw the ear away and stitched up the stump rather than making any attempt to re-attach the ear.⁴¹ The offender sued for deliberate indifference to his serious medical need.⁴² The court ruled that the “easier and less efficacious treatment” provided by the physician was indeed cruel and unusual punishment.⁴³

1. The Clear Eighth Amendment Cases

To further clarify some of the legal concepts and issues discussed above, we have included the cases below. There are two types of clear cases. We will call the first type the right-to-care case. It is the case that may eventually result in giving an offender the right to a transplant. We will call the second type the no-right-to-care case. It involves a situation about which the courts have been consistent in deciding against the offender.

a. The Right-to-Care Case

The right-to-care case is a deliberate indifference case in which one or more of the offender’s rights have been violated. The violation may involve a correctional official’s denial, delay, or interference with care, or it may involve sub-standard healthcare provided by a correctional health provider.⁴⁴

The correctional official or healthcare provider who wrongfully delays, denies, or interferes with necessary care or provides inadequate or inappropriate care to a prisoner resulting in the prisoner’s need for an organ transplant may be liable for deliberate indifference and may be forced by the court to provide access to a transplant. According to news reports, the well-known million dollar California prison heart transplant that took place in 2002 was such an instance.⁴⁵ The 31-year-old offender needed a transplant after

⁴⁰ *Id.* at 543.

⁴¹ *Id.*

⁴² *Id.* at 543-44.

⁴³ *Id.* at 544.

⁴⁴ Monmouth County Corr. Institutional Inmates, 834 F.2d at 346-47.

⁴⁵ Rebecca Leung, *Change of Heart: Good Health Care for Those in Prison*, CBS NEWS, Sept. 14,

contracting a virus that attacked his heart.⁴⁶ Details about his care prior to winning his lawsuit are not available.⁴⁷ However, news reports indicate that the prisoner sued for deliberate indifference, won his case, and in addition to receiving a heart transplant, received an award of thirty-five thousand dollars.⁴⁸

As mentioned above, there are various hurdles to clear before one can receive an organ transplant through the Organ Procurement and Transplant Network. Each step presents an opportunity for violating the offender's Eighth Amendment rights.⁴⁹ Each violation would give rise to the right to receive the necessary healthcare.

The first step involves a recommendation by the correctional physician that the offender be assessed for the possibility of becoming a transplant candidate. Once the physician has given the opinion that the offender needs to be assessed by a specialist, the offender has a right to the assessment. Deliberately ignoring the known risk of harm to the offender that could result from frustrating the process would give rise to the offender's right to move forward with the process.⁵⁰

The second step involves the recommendation for transplant evaluation. Once the correctional physician makes a recommendation

2003, <http://www.cbsnews.com/stories/2003/09/12/60minutes/main572974.shtml> (last visited Feb. 28, 2009).

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ *Id.* A California corrections official, Steve Green, is quoted as follows: "The U.S. District Court ruled that he was entitled to the transplant, and that he was also entitled to \$35,000 from the state because of the state's deliberate indifference. So we have direct court rulings saying that we will meet the medical needs of our inmates. And we do."

⁴⁹ See, e.g., *How the Transplant System Works: Matching Donors and Recipients*, <http://www.unos.org/Resources/factsheets.asp?fs=1> (last visited Nov. 10, 2008); U.S. DEP'T OF HEALTH & HUMAN SERVICES, *OrganDonor.gov: The Matching Process – Waiting List*, http://organdonor.gov/transplantation/matching_process.htm (last visited Nov. 12, 2008). These sites describe the steps that a person must go through to obtain an organ transplant. See also Mark J. Posner, *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 (1992) (discussing the standard that serves as the basis for this argument. All parts of this argument require that the correctional system be responsible for frustrating the process to establish a case of deliberate indifference.). See also Ingrid Kinkopf-Zajac, *Assessing Patient Compliance in the Selection of Organ Transplant Recipients*, 6 HEALTH MATRIX 503, 509-21 (1996).

⁵⁰ *Id.*

for transplant, the offender has a right to see one or more specialists to undergo evaluation for candidacy.

The third step involves listing the candidate. If the specialist(s) agrees that the offender is a good candidate for a transplant, the offender has the right to be placed on a transplant list. If that means that correctional officials must provide funds required for listing the offender, the offender has the right to have those funds made available on his behalf.⁵¹

The fourth step involves receiving a donor organ and undergoing the transplant procedure. If the offender has gone through the evaluation processes successfully and has been listed as eligible for a transplant, correctional officials are obligated to allow the procedure to go forward in the event that a matching donor organ becomes available and the offender is at the top of the recipient priority list.⁵² Correctional officials' refusal to fund the transplant at this point would be a clear case of deliberate indifference.⁵³

These steps provide opportunities for deliberate indifference along the medical path toward an organ transplant. Obstacles to the process may involve decisions or omissions by specific individuals. Denial of care as a matter of policy offers another opportunity for deliberate indifference litigation. A recent Fifth Circuit Court of Appeals case resulted in an opinion indicating that a decision about medical care that is based on a prison policy, rather than on medical criteria, may violate the offender's Eighth Amendment rights.⁵⁴

⁵¹ See Posner, *supra* note 49, at 359-68; see Jessica Wright, Medically Necessary Organ Transplants for Prisoners: Who is Responsible for Payment? 39 B.C. L. REV 1251, 1269-76 (1998); see Kate Douglas, Prisoners are Constitutionally Entitled to Organ Transplants—So Now What? 49 ST. LOUIS U. L.J. 539, 559-61 (2005). Of course, legitimate factors that do not directly involve money may enter into prison officials' decisions concerning whether moving forward with the transplant is appropriate.

⁵² Douglas, *supra* note 51, at 555-57.

⁵³ *Id.* at 556.

⁵⁴ *Trigo v. Tex. Dep't. of Crim. Justice*, 225 F. App'x 211 (5th Cir. 2007). The court indicated that the case should not be considered precedent except under limited circumstances. However, the law is clear concerning deliberate indifference. Although it remains unstated in the opinion, the court appears to have reasoned that there was no legitimate penological interest supporting the policy that would outweigh Trigo's civil right to care for his serious medical need. Generally speaking, the concept of legitimate penological interests has not been officially applicable to Eighth Amendment cases for inadequate medical care. However, the courts have demonstrated considerable deference to correctional systems

In *Trigo v. Texas Department of Criminal Justice*, the offender was denied treatment for hepatitis C because eligibility for treatment was based on being in prison a set number of months and on the amount of time remaining on the offender's sentence rather than on the offender's medical needs.⁵⁵ The court found that there was sufficient evidence of deliberate indifference to allow the case to go to trial.⁵⁶ In two cases involving the Federal Bureau of Prisons, another federal appellate court warned that the bureau's blanket policy of denying transplants may violate offender's Eighth Amendment rights.⁵⁷ These cases are significant because they may indicate a shift in courts' interpretations of the importance of prison interests when weighed against offenders' healthcare needs. Many prison systems currently have policies or practices that operate to deny offenders publicly funded organ transplants. Further litigation may necessitate meaningful changes in policies and practices.

In addition to offenders who receive transplants while incarcerated, there may be transplant recipients who enter prison after receiving transplants. Failure to provide either type of offender adequate post-transplantation care provides another example of a clear case of an Eighth Amendment violation and a right to care. Post-transplant care could go on for years, possibly for as long as the offender is incarcerated. Care would go beyond providing appropriate medications and medical attention; it would include

concerning many protocols used to determine eligibility for certain types of health care. For further information on the concept of *legitimate penological interests*, see *Turner v. Safley*, 482 U.S. 78 (1987).

⁵⁵ *Trigo v. Tex. Dep't. of Crim. Justice*, 225 F. App'x 211 (5th Cir. 2007). The court indicated that the case should not be considered precedent except under limited circumstances. However, the law is clear concerning deliberate indifference. Although it remains unstated in the opinion, the court appears to have reasoned that there was no legitimate penological interest supporting the policy that would outweigh Trigo's civil right to care for his serious medical need. Generally speaking, the concept of legitimate penological interests has not been officially applicable to Eighth Amendment cases for inadequate medical care. However, the courts have demonstrated considerable deference to correctional systems concerning many protocols used to determine eligibility for certain types of health care. For further information on the concept of *legitimate penological interests*, see *Turner v. Safley*, 482 U.S. 78 (1987).

⁵⁵ *Trigo*, 225 F. App'x at 212 .

⁵⁶ *Id.*

⁵⁷ *Barron v. Keohane*, 216 F.3d 692 (8th Cir. 2000); *Clark v. Hedrick*, 233 F.3d 1093 (8th Cir. 2000).

providing safe living conditions that fit with the special needs of the patient. Because the offender must take immunosuppressant (anti-rejection) drugs that lower resistance to infections, the offender would probably need to be separated from the general prison population. A relatively mild infection for a healthy person could easily cause serious harm to one whose immune system is compromised. The courts have been clear in finding deliberate indifference where correctional officials refuse to provide anti-rejection medications and to respond to the offender's special health needs when the officials are aware that the offender has received an organ transplant.⁵⁸

The deliberate indifference standard applies to organ transplants in the same way that the standard applies to other medical care. If, in a physician's professional opinion, an offender has a life-threatening condition that requires an organ transplant (no lay person is qualified to arrive at this conclusion), and the offender is otherwise qualified, prison officials have a legal duty to take whatever next steps are necessary to make the treatment available to the offender. If the offender lacks the personal resources to pay, the officials must do so at public expense. It probably goes without saying that few offenders in state correctional facilities are likely to possess the necessary resources.

b. No-Right-To-Care Case

Just as there are clear cases in offenders' favor, there are clear cases that have gone against offenders. They usually fall into three categories. The first is characterized by a dispute between the physician and the patient about the appropriate treatment for the medical condition. The second arises when physicians disagree about the appropriate treatment. The third involves ordinary medical negligence.

In the first scenario, the offender complains that, although he is

⁵⁸ See *e.g.*, *Miller v. Schoenen*, 75 F.3d 1305 (8th Cir. 1996) or *Carl Smith v. Certain Unknown Cook County Department of Corr. Officers & Michael F. Sheahan*, 2006 U.S. Dist. LEXIS 87577 (N.D. Ill, E. Div. 2006). Although the outcomes of these cases are not binding precedent for Texas, it is clear that refusal to provide anti-rejection medications to an offender known to have received an organ transplant and to need the medications is sufficient to sustain a deliberate indifference case.

receiving care or has been offered care, there is a better treatment available or another treatment that he or she would prefer. This offender is unlikely to win in a court battle. Typically, the offender who wants a different treatment than offered is considered to have refused treatment. Courts reason that physicians are in the best position to make medical decisions. Furthermore, adequate care, the care required by law, does not necessarily mean the best care money can buy.

The second scenario, where physicians disagree about whether the patient needs a particular treatment (including an organ transplant), and the treatment is denied, the offender will almost always be unsuccessful in claiming he or she was the victim of deliberate indifference. Again, courts reason that physicians are in a better position than the courts to make medical judgments.

The third clear no-right-to-care case involves a claim that the medical services provided fall below the standard of care. As mentioned above, some egregious instances of medical malpractice may also violate the offender's Eighth Amendment rights. However, where it is clear that the offender received care that was not egregiously below the standard of care but is simply a matter of poor judgment or incompetence, the courts find no deliberate indifference. The disagreements mentioned above may give rise to malpractice litigation, but not civil rights cases.

2. The Imperfect Right-to-Care Case

There is reason to believe that other scenarios may give rise to deliberate indifference claims. The courts have been less clear on some points or have not addressed the issues directly in published opinions. Nevertheless, such scenarios could give rise to Eighth Amendment violations and subsequent litigation losses for departments of corrections.

One hypothetical involves a person who is on a transplant list prior to incarceration, but is removed from the list by correctional officials upon entry to prison. It is unclear whether removal from the list is a policy decision or a medical decision. If it is a policy decision that is not clearly based on the medical needs of the patient, the policy may violate the offender's Eighth Amendment rights. If the decision is based on medical judgment, there may be some question

about whose expertise is appropriate for making the decision.

Transplant specialists determine whether a patient should be listed; whereas, prison physicians generally lack the expertise and authority to add a patient to a transplant list. This situation raises the question of whether the prison physician's decision to remove the offender from the transplant list is (1) justifiable based on medical criteria, (2) medical malpractice because it is outside of the physician's expertise, (3) deliberate indifference because it denies care for a known serious medical need, or (4) violates Fourteenth Amendment rights to due process and equal protection. There is some potential for arguing that removing the offender from the list and assuming a watchful waiting approach is "easier and less efficacious" than listing the offender. Once a transplant physician indicates that a person is a good candidate for a transplant, a correctional physician would have little basis for concluding that the offender ceased to be eligible unless the physician is able to show credible evidence that the offender's eligibility should be changed for medical reasons. Listing the offender would provide access in the event that a suitable organ becomes available; watchful waiting provides no access.

The one well-known case of an offender who was on a transplant list prior to entering prison but was removed upon incarceration involved a federal prison inmate.⁵⁹ His deliberate indifference lawsuit failed due to technical mistakes he made in preparing and presenting his case.⁶⁰ There is reason to believe that a more carefully handled case could succeed.

Where there is wrongdoing on the part of a correctional official that results in inadequate health care for the offender who has a serious medical need, the law is relatively clear. However, what is less clear is whether organ transplantation should be included under the concepts of *adequate*, *basic*, or *necessary* health care. Some scholars argue that such expensive care falls outside the concepts of adequate, basic, and necessary care.⁶¹ The problem is not so simple. When a

⁵⁹ Van Over v. Dewalt, No. 06-CV-192-JMH, 2007 U.S. Dist. LEXIS 22623, at *7 (E.D. Ky. Mar. 28, 2007).

⁶⁰ *Id.*

⁶¹ See e.g., Lawrence J. Schneiderman & Nancy S. Jecker, Should a Criminal Receive a Heart Transplant? Medical Justice vs. Societal Justice, 17 THEORETICAL MED. 33, 33-44 (1996);

transplant is a last resort and a life-saving measure, it is difficult to argue that it is not necessary care. Where there are reasonable alternatives that are effective and less costly, a transplant may be less likely to fall under one of these concepts. More important, the *courts* have not set economic limits on what counts as adequate, basic, or necessary health care. The scope of these concepts is determined by health care professionals. The level of need is currently evaluated on a case-by-case basis. The courts have been reluctant to second-guess the medical profession.⁶²

B. Medical Malpractice and Negligence

As already mentioned, not every instance of inadequate health care in the correctional setting is serious enough to violate the offender's Eighth Amendment rights.⁶³ Nevertheless, the inadequate care may be the subject of an offender lawsuit. Under certain circumstances, an offender or offender's heirs are able to pursue litigation against a health-care professional for failing to do what a reasonable health-care professional in the same area of expertise would do under the same or similar circumstances.⁶⁴

Most offenders with complaints about their care, including those with clearly valid complaints of malpractice, lack the resources to pursue medical malpractice litigation, a costly process that usually involves hiring an expert witness. Despite the difficulties in pursuing a claim, litigation is a possibility if the quality of care is sub-standard. It may be important to note that inadequate or inappropriate care that results in the need for an organ transplant may serve as the basis for an Eighth Amendment claim *as well as* a claim for medical negligence.⁶⁵

Carrie S. Frank, Must Inmates Be Provided free Organ Transplants?: Revisiting the Deliberate Indifference Standard, 15 GEO. MASON U. CIV. RTS. L.J. 341; Martin F. McKneally & Robert M. Sade, The Prisoner Dilemma: Should Convicted Felons have the Same Access to Heart Transplantation as Ordinary Citizens? Opposing Views, 125 J. THORACIC & CARDIOVASCULAR SURGERY 451.

⁶² *Bowring v. Godwin*, 551 F.2d 44, 48 (4th Cir. 1977) ("We disavow any attempt to second-guess the propriety or adequacy of a particular course of treatment.").

⁶³ See *Trigo*, 225 F. App'x at 212 (5th Cir. 2007) (quoting *Mendoza v. Lyneugh*, 989 F.2d 191, 195 (5th Cir. 1993)).

⁶⁴ See generally *Rosado v. Alameida*, 497 F. Supp. 2d 1179 (S.D. Cal. 2007).

⁶⁵ The California heart transplant case may serve as an example. The failure to provide

The consequences of a successful medical negligence claim are different from the consequences of a successful Eighth Amendment claim. The medical negligence lawsuit may result in a monetary award for the offender, but will have no impact on other offenders. In contrast, the successful Eighth Amendment lawsuit typically will not provide the offender with a financial award, but the impact may be far-reaching, affecting the treatment of all similarly situated offenders. Both types of lawsuits may be lengthy and costly affairs, but the case involving the constitutional issue may force change throughout the jurisdiction.

C. Federal Laws on Organ Transplants

The National Organ Transplant Act of 1984 (NOTA) was passed by Congress to encourage cadaveric organ donation for organ transplants and to promote fair distribution of donor organs.⁶⁶ Sale of organs is prohibited in the United States.⁶⁷ Under NOTA, the Organ Procurement and Transplantation Network (OPTN) was created to develop and maintain a national registry for matching donor organs to people listed as eligible for transplants.⁶⁸ The Department of Health and Human Services (DHHS) oversees the OPTN. The Centers for Medicare and Medicaid Services, part of DHHS, monitors compliance with certain regulations that govern the OPTN. The OPTN is operated by the United Network for Organ Sharing (UNOS), a non-profit organization that maintains the computer system that matches donor organs with potential recipients based on need and a variety of medical criteria.⁶⁹ Under UNOS rules, all candidates on transplant lists are treated in a non-discriminatory

adequate care resulted in the need for a transplant. In the case about the severed ear, *Williams v. Vincent*, the care provided may have been carried out competently, but the choice of treatment approaches was not in accord with what any reasonable physician would have done under the same or similar circumstances. *Williams v. Vincent*, 508 F.2d 541 (2d Cir. 1974). Medical negligence cases have been made concerning failure to assist with obtaining transplants. See e.g., *Rosado v. Alameida*, 497 F. Supp. 2d at 1183; *Johnson v. Daley*, 339 F.3d 582 (7th Cir. 2003).

⁶⁶ National Organ Transplant Act of 1984, Pub. L. No. 98-507.

⁶⁷ *Id.* at § 301.

⁶⁸ *Id.* at § 372.

⁶⁹ United Network for Organ Sharing, *Who We Are*, <http://www.unos.org/whoWeAre/> (last visited Oct. 17, 2008).

manner.⁷⁰ Medical criteria alone are used in determining eligibility and priority for a transplant.⁷¹ The rules specifically state that offenders will be treated the same as other candidates.⁷² Conviction status and other social criteria are excluded as factors in transplant decisions.⁷³ Transplant centers may set their own criteria concerning how much money must be made available for a candidate to be placed on a transplant list, but UNOS rules say nothing about who must provide the funding.

III. ECONOMICS AND POLICY

Whether one thinks of economics in terms of dollars or in terms of resources in general (e.g., personnel, facilities, equipment, or time), economics usually has a role in any policy decision. A change in policy, without a serious evaluation of economic impact, may amount to nothing more than words on paper. Alternatively, implementation of an unfunded policy may create heavy burdens on existing resources. Undoubtedly, providing costly treatments to offenders is controversial, particularly when the same treatments are not available to some law-abiding citizens.⁷⁴ However, caring for an aging prison population suffering from chronic illnesses creates substantial economic burdens, which correctional institutions must satisfy to avoid costly litigation.⁷⁵ Furthermore, failing to treat some

⁷⁰ 42 U.S.C. § 274(2)(A)(22).

⁷¹ *Id.*

⁷² United Network for Organ Sharing, *U.S. Statement on Prison Status and Organ Allocation*, Feb. 6, 2002, <http://www.unos.org/news/newsDetail.asp?id=112> (last visited Nov. 6, 2008).

⁷³ *See generally id.*

⁷⁴ The California heart transplant case caused some to express their anger and frustration in print. Los Angeles Times columnist Steve Lopez was among the outraged. He suggested that the way to receive priority treatment was to commit crimes: "I mean it might be the best way to get the best health care available. You know, knock off a few banks." *See Change of Heart*, CBS NEWS, Sept. 14, 2003, <http://www.cbsnews.com/stories/2003/09/12/60minutes/main572974.shtml> (last visited Nov. 6, 2008).

⁷⁵ In the event that correctional health care fails to adequately address the health care needs of an aging prison population, lawsuits of deliberate indifference and wrongful deaths brought by family members of inmates may grow in number. *See supra* text accompanying notes 11-12.

infectious diseases may have economic impacts that extend beyond prison walls.⁷⁶ Finally, it is well-known that organ transplants are expensive. In addition, organ transplants involve resources that are not for sale in the United States, donor organs. The economics of providing organ transplants to offenders is a complex matter that will not be easily resolved.

One response to these economic concerns has been to require the offender or his family to pay for the offender's health care.⁷⁷ In the past, this approach has been used in Texas to address the issue of offender organ transplantation.⁷⁸ The practice has been to allow only live-donor transplants among family members, as long as the family is willing and able to pay for all aspects of the process.⁷⁹ When the offender is incarcerated in a county or municipal facility, a Texas statute allows the facility to require the offender to pay for his or her health care.⁸⁰ However, the government must provide compensation if the offender is indigent. Reimbursement from certain government programs may be available to the incarcerating entity under some conditions. This option is not available to state prisons. Court decisions indicate that offenders who are not indigent can be required to pay a small co-pay amount for medical services or reimburse the state for health care. However, the government cannot legally deny the offender care if the offender cannot afford the co-pay.⁸¹ Texas has its own statute permitting co-payments for health

⁷⁶ Infectious disease is a public health issue. HIV, hepatitis, venereal diseases, tuberculosis, MRSA, and other communicable disorders create new costs for each new person infected and for public safety net programs. The costs may not be in the realm of health care alone. Lost income, reduced productivity, and unemployment may also be impacted by illness. Many in prison eventually are released. People who work in the prisons or who provide care to incarcerated offenders may be exposed to these illnesses and may take them into the community.

⁷⁷ E-mail correspondence with Ben G. Raimer, TDCJ (June 20, 2007) (on file with author).

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ Tex. Code Crim. Proc. Ann. art. 104.002 (2006).

⁸¹ See *Bihms v. Klevenhagen*, 928 F. Supp. 717, 718 (S.D. Tex. 1996). *Bihms*, a case concerning a county jail inmate awaiting transfer to state prison, provides the following relevant discussion:

If the inmate can pay for his medical care, then the state may require reimbursement. Texas has a law that adopts that policy. TEX. CODE CRIM. PROC. ANN. art. 104.002(d)(Supp. 1996). No right described or adumbrated in the

care.⁸²

Under federal law, Medicare and Medicaid are not available to people incarcerated in state prisons; states are expected to cover the costs of offenders' food, shelter, clothing, and medical care that offenders cannot afford or otherwise obtain.⁸³ Medicare and Texas Medicaid are available to certain *others* who would otherwise be unable to afford the costs of transplant-related care. Many of the people with serious illnesses in state prisons are the same people who would qualify for one of these funding programs but for their incarceration.

Some scholars⁸⁴ find support in *Bowring v. Godwin* for the proposition that offenders should only receive expensive health care for which they are able to pay.⁸⁵ The court in that case indicated that the cost of treatment and its impact on the correctional system could be considered in determinations about providing care.⁸⁶ Nevertheless, the deliberate indifference cases indicate that the

Constitution is implicated by a decision of the state to seek compensation for its actual, reasonable costs in maintaining the prisoner.

If the prisoner cannot pay, he must be maintained at state expense; the state cannot deny minimal medical care to poor inmates. The prisoner makes no claim that he was denied care. Rather, he simply objects to being deprived of his liberty without the reverse "benefit" of cost-free maintenance from the state. As he was obliged to pay court costs, he may be obliged to pay his medical costs. Texas imprisoned him; it did not adopt him.

Id. Other cases supporting the view that offenders may be charged a co-pay or that the state may determine who will ultimately be responsible for covering the costs of the offender's health care are as follows: *City of Revere v. Massachusetts Gen. Hosp.*, 463 U.S. 239, 244; *Hutchinson v. Belt*, 957 F. Supp. 97, 100 (W.D. La. 1996); *Reynolds v. Wagner*, 128 F.3d 166, 174; *Shapley v. Nevada Bd. of State Prison Comm'rs*, 766 F.2d 404, 408 (9th Cir. 1984); *See also Breakiron v. Neal*, 166 F. Supp.2d 1110, 1115 (N.D. Tex. 2001).

⁸² Texas Gov't. Code, § 501.063 (Vernon 2007).

⁸³ This is the general rule. There are some exceptions. *See* 42 C.F.R. 411.4(b) (1999).

⁸⁴ *E.g.*, Frank, *supra* note 61.

⁸⁵ "[T]he right to treatment is limited to that which may be provided upon a reasonable cost and time basis and the essential test is one of medical necessity and not simply that which may be considered merely desirable." *Bowring v. Godwin*, 551 F.2d 44, 47 (4th Cir. 1977). This case discusses mental health care. The usual interpretation of this case is that necessary care must be provided, but it need not be the care the patient prefers or the best care. Need, efficacy of treatment, and the harm the offender may experience without the treatment are elements that must be taken into account in determining whether the patient should receive treatment and what treatment the patient should receive.

⁸⁶ *Id.* at 47-48.

correctional system *must* provide necessary care,⁸⁷ but it need not be the best care that money can buy. What that means in the context of organ transplantation is at the heart of the controversy. When an organ transplant is the only treatment available for a life-threatening condition, and the patient is otherwise qualified to receive the transplant, it is difficult to claim that the treatment is not *necessary*, even though the cost is relatively high. Furthermore, under Texas law, where a treatment is deemed the standard of care for a non-offender, it is also the standard of care for offenders. Therefore, if an organ transplant is the standard of care for treating a condition, an offender is entitled to receive an organ transplant for the same condition.⁸⁸

Despite concerns about costs, a 1998 survey of state correctional systems revealed that twenty five states had policies that allowed at least one type of organ transplant for offenders.⁸⁹ Although the report included no details about the policies, the fact that half of the states had some type of transplant policy indicates that correctional systems are mindful of the growing demands for organ transplants in prisons.

IV. ETHICAL AND SOCIAL ISSUES

Ethics and social values have important roles to play in the development and application of policy concerning organ transplants for offenders. The U.S. Supreme Court's decisions about cruel and unusual punishment are based on "evolving standards of decency."⁹⁰ Health care professionals have duties to their respective professions and to those they serve, regardless of their patients' social situations. Policy makers weigh public need and public opinion in developing and implementing solutions to perceived problems. They must do so

⁸⁷ Medicare legislation states that it covers both health care that is *reasonable and necessary* and organ transplants that are *reasonable and necessary*. Although the language is vague, *reasonable* and *necessary* are terms that appear relevant in case law that applies to Texas and that cites *Bowring v. Godwin*. See *Woodall v. Foti*, 648 F.2d 268 (5th Cir. 1981).

⁸⁸ TEX. GOV'T. CODE ANN. § 501.051 (Vernon 2007).

⁸⁹ Deborah Lamb-Mechanick & Julianne Nelson, *Prison Health Care Survey: An Analysis of Factors Influencing Per Capita Costs*, NATIONAL INSTITUTE OF CORRECTIONS (2000), available at <http://www.nicic.org/pubs/2000/015999.PDF> (last visited Aug. 3, 2008).

⁹⁰ *Trop v. Dulles*, 356 U.S. 86, 101 (1958).

in accord with existing law, taking into account social values and the benefits and burdens the policy will generate. Texas has a statute requiring that care provided to offenders on the campus of the University of Texas Medical Branch in Galveston must meet the community standard of care.⁹¹ The law considers the loss of liberty, not the lack of necessities, to be the punishment for most crimes.⁹²

As mentioned above, in 1998 at least 25 states had some sort of policy that allowed organ transplants for offenders.⁹³ Since the publication of the survey results, at least one other state has been added to the list, and the Federal Bureau of Prisons changed its policy to allow greater access to organ transplants.⁹⁴ These changes could be construed as indicating that "evolving standards of decency" include allowing organ transplants for offenders.⁹⁵

A. Professional Ethics

Professional ethics require health care professionals to give priority to the patient's medical interests.⁹⁶ Competing and

⁹¹ See Tex. Gov't Code § 501.051 (2007) (referring to the correctional health care facility, the statute states "the [correctional] facility shall provide the same level of care as is provided for patients in other facilities of the University of Texas Medical Branch of Galveston.")

⁹² The following expresses the reasoning behind distinguishing lack of health care from punishment:

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,' In re Kemmler, *supra*, the evils of most immediate concern to the drafters of the Amendment. In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose. Cf. *Gregg v. Georgia*, . . . The infliction of such unnecessary suffering is inconsistent with contemporary standards of decency as manifested in modern legislation codifying the common law view that "[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.

Estelle, 429 U.S. at 103-04.

⁹³ Lamb-Mechanic, *supra* note 89.

⁹⁴ See Frank, *supra* note 61, at 343 (noting that California was not on the list in 1998 and the Federal Bureau of Prisons changed its policy from denying all transplants unless a physician urged that an exception was necessary for allowing transplants at public expense under limited circumstances).

⁹⁵ *Trop*, 356 U.S. at 100.

⁹⁶ See AM. MED. ASS'N, PRINCIPLES OF MEDICAL ETHICS, <http://www.ama-assn.org/ama/pub/category/2512.html> (last visited Sept. 23, 2008); see also AM. NURSES ASS'N, CODE OF ETHICS WITH INTERPRETATIVE STATEMENTS at

conflicting interests are inevitable in modern medicine because of complicated health-care financing arrangements, workplace policies, scarce resources, and other contextual factors. Nevertheless, serving the best interests of the patient is essential to the ethical practice of medicine. Current definitions of “best interests” do not permit a physician to impose his or her own values, preferences, and biases on the patient.⁹⁷ Addressing the patient’s best interests usually means negotiating with the patient to arrive at a treatment decision that fits with the patient’s medical needs as well as the patient’s personal values and preferences.

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.⁹⁸ For this reason, those providing health care to offenders have demanding ethical duties to their patients and their profession.

Correctional health-care providers’ patients are especially vulnerable. Offenders live in a coercive environment. For a variety of reasons, they may be wary of others’ motives. Their social and economic situation may invite scorn. Health-care professionals who provide their care must be especially vigilant that their judgments are medically sound and untainted by negative feelings and attitudes toward their patients, and, to the extent possible, fit with their patients’ individual needs and preferences. Because of the correctional context, health-care providers’ familiar professional obligation to “do no harm” takes on a new depth of meaning.

As discussed *supra*, correctional health-care professionals must attend to the needs of individual patients. On the other hand, the correctional system has health-care duties to individual patients and

http://nursingworld.org/ethics/code/protected_nwcoe813.htm (last visited Aug. 4, 2008).

⁹⁷ See PRINCIPLES OF MEDICAL ETHICS, *supra* note 101; see also Code Of Ethics, *supra* note 101.

⁹⁸ See, e.g., E. Bernadette McKinney, Hard Time and Health Care: The Squeeze on Medicine Behind Bars, 10(2) Virtual Mentor 116-120 (February 2008) available at <http://virtualmentor.ama-assn.org/2008/02/pef/insoc2-0802.pdf> .

to the incarcerated offenders as a group. Infectious diseases can and do spread, especially when large numbers of people are housed together.⁹⁹ Failure to prevent harm to others through failure to treat offenders who have infectious diseases creates one ethical problem; devoting large amounts of resources to a small number so that little is left to address the needs of others creates yet another ethical problem. Finding the balance is something that individual health-care providers are neither authorized, nor equipped to do. This is true in part because of health-care providers' duty to focus on the patient's best interests. Prison health policies, however, must address this issue of resource allocation.

Transplant policies should be developed by TDCJ to allow medically qualified offenders access to transplants while making use of proven strategies to control costs. TDCJ has had considerable success in finding efficient and effective ways to provide care to offenders incarcerated in Texas prisons.¹⁰⁰

B. Ethics and Corrections

Offenders become wards of the state and must depend on the state the same as a child in the state's custody. They are not all alike. Some may be innocent despite being convicted of the crime of which they were accused. For example, if one can give credence to news reports about problems with Houston's crime lab, Texas has convicted many people on evidence that is questionable.¹⁰¹ In addition, not all crimes are equally serious, nor are all offenders equally culpable for offenses. Mental illness, learning disabilities, and mental retardation may contribute to or explain many offenses.

⁹⁹ See e.g., Nat'l Comm'n on Corr. Health Care, *The Health Status of Soon-to-Be Released Inmates: A Report to Congress*, Vol. 2, iii (2002) <http://www.ncchc.org/stbr/Volume2/Preface.pdf> (last visited November 9, 2008). This report is a compilation of articles pertinent to the issues of prevalence and spread of infectious diseases in prisons and jails.

¹⁰⁰ Mary Havard, *Correctional Managed Care Sets Standard for Texas*, *Nation*, UNIV. OF TEX. MED. BRANCH, Feb. 2007, at 3, available at http://www.utmb.edu/chs/cmc/News/03-10-07impact_article.pdf.

¹⁰¹ See, e.g., Steve McVicker & Roma Khanna, *More Problems Found in HPD Crime Lab Cases*, HOUS. CHRON., May 11, 2006, available at <http://www.chron.com/disp/story.mpl/front/3855792.html> (stating that investigations have produced reports that several DNA and serology cases dating back to 1980 are now identified as "having 'major issues'").

Finally, sometimes the difference between the person inside the prison and the person outside the prison is that the one inside was caught. Not all people in prison are bad, not all bad people are in prison, and most of those in prison will eventually get out of prison. Regardless of the incarcerated person's culpability, failure to properly evaluate him (or her) as an individual with particular needs is at odds with the goals of health care.

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.¹⁰² If correctional facilities fail to provide proper medical care, every incarceration could become a death sentence. Punishment for crimes should not involve denying offenders' humanity. Correctional systems are obligated to meet offenders' basic human needs; correctional health-care providers and those they consult for assistance in providing health care to offenders should do no less.

C. Transplant Ethics

The United Network for Organ Sharing (UNOS) is the non-profit organization that operates the Organ Procurement and Transplant Network, created under the National Organ Transplant Act.¹⁰³ It oversees organ procurement organizations and monitors outcomes of transplants.¹⁰⁴ UNOS maintains databases of potential organ recipients and their status and, when an organ becomes available, matches organs and recipients.¹⁰⁵ Its policies and processes govern organ transplants throughout the country. UNOS'S policy concerning when to make transplants available to offenders is based on two things: the concept of fairness, and the experience of those who made similar decisions in the early days of kidney dialysis.¹⁰⁶ When there were too few dialysis machines to treat all in need, a committee made

¹⁰² *Estelle*, 429 U.S. at 105-106; *see generally* *Hutto v. Finney*, 437 U.S. 678 (1978).

¹⁰³ 42 U.S.C. § 273 (2008).

¹⁰⁴ *Id.*

¹⁰⁵ 42 U.S.C. § 274(b)(2)(A)(ii) (2008).

¹⁰⁶ Sally Satel, *The God Committee: Should Criminals Have Equal Access to Scarce Medical Treatments?*, SLATE, June 17, 2008 available at <http://www.slate.com/id/2193753>.

decisions about who would be eligible for dialysis.¹⁰⁷ The committee members relied on their own personal preferences, biases, and prejudices in making decisions.¹⁰⁸ The use of social worth criteria in making decisions about who should be allowed to live came to be recognized as unfair and unethical and was abandoned.¹⁰⁹

V. POINTS TO CONSIDER IN DEVELOPING ORGAN TRANSPLANT POLICY

Any policy developed to address organ transplants for offenders must allow for legal obligations, offender rights, costs, alternatives, and the context in which actions take place.

Legally, the TDCJ should provide eligible, otherwise qualified offenders with access to organ transplants at public expense. There is little justification for denying costly transplants when other expensive treatments are commonly provided. Transplants are considered an accepted standard of care for certain life-threatening illnesses. However, the TDCJ has major concerns about holding down costs.

The TDCJ is not alone. Costs appear to be a major concern in any discussion about providing organ transplants for offenders. Although the costs for transplants are likely to be substantial, the number of transplants will probably be modest. Few offenders will qualify due to comorbidities and other legitimate constraints. In addition, the costs of other measures (e.g., long term care in an intensive care unit or long term dialysis) to keep offenders alive may be offset to some extent by transplants.¹¹⁰ Furthermore, explicit policies would help reduce inconsistent treatment of offenders and offenders' claims of inadequate healthcare.

Prevention is one way to avoid some of the perplexing problems

¹⁰⁷ *Id.*

¹⁰⁸ *Id.*

¹⁰⁹ ALBERT R. JONSEN, MARK SIEGLER, & WILLIAM J. WINSLADE, *CLINICAL ETHICS: A PRACTICAL APPROACH TO ETHICAL DECISIONS IN CLINICAL MEDICINE*, 111-112 (5th ed. 2002).

¹¹⁰ "The cost of kidney transplantation has steadily declined and is currently the least expensive treatment option for patients with ESRD." Susan L. Smith, *Quality Aspects of Transplantation*, in *ORGAN TRANSPLANTATION: CONCEPTS, ISSUES, PRACTICE, AND OUTCOMES* (2003), <http://www.medscape.com/viewarticle/451346> (last visited Aug. 5, 2008).

with providing organ transplants. Prevention may be less costly in the long-run than defending lawsuits, paying the resulting judgments, incurring exorbitant healthcare costs, and allowing infectious diseases to spread. Greater efforts to control chronic illnesses and infectious diseases will probably have the desired impact of reducing offender healthcare costs after a few years. Prevention may include such measures as early identification and treatment of infectious diseases, chronic illnesses, and serious mental illnesses; ongoing health education programs; a needle exchange program; condom distribution; substance abuse rehabilitation programs; improvements in dietary control; and illness support groups.

Additional policies and guidelines may be necessary to address the health care needs of those who are *not* eligible for organ transplants or those whose transplants fail. It is inevitable that some offenders will suffer from declining health and terminal illnesses while incarcerated. Dying alone, separated from family and friends, is a common fear among offenders. This is one reason offenders are especially eager to receive the most aggressive treatments available. Offenders also fear they will receive inferior care or even treatment that hastens their demise.¹¹¹ Palliative and hospice care provided by prisons that involve offender volunteers and include visiting healthcare providers from outside of the correctional healthcare system may help to alleviate some of these fears and concerns.¹¹² Offenders should be given the option of choosing palliation and hospice care.

Compassionate release, medical parole, medical furlough, medically intensive supervision, commuted sentences, and similar mechanisms facilitated by the correctional system would allow offenders to seek care without extraordinary costs to the correctional system. Offenders who would be eligible for Medicare or Medicaid, if no longer incarcerated, could benefit from applying for assistance from these programs. This option might be especially beneficial for those who would be eligible for release before important aspects of their treatment could be completed. The TDCJ could take steps to

¹¹¹ *Id.* at 899.

¹¹² *Id.* at 898-900.

advocate for these types of release in cases where the offender is not likely to present a threat to society. Providing assistance in developing the criteria for recommending a type of medical release, evaluating offenders, locating the appropriate medical care, and assisting in preparations to obtain Medicare or Medicaid coverage may be among the ways TDCJ can facilitate meeting the needs of both the correctional system and the offender.

Organ donation, *per se*, is not the focus of this article. However, discussion of the topic may offer perspective and potential avenues for resolving some of the concerns about organ transplants for offenders. Texas law gives offenders the right to donate organs.¹¹³ Their organs may be less healthy and less likely to be accepted for transplantation by would-be recipients than organs from other donors. Nevertheless, offenders are permitted to donate. At this point, there is no promise of benefit or reward for donating organs, despite attempts by some to offer sentence reductions, funding for funerals, and other compensation.¹¹⁴ Therefore, an offender's decision to donate organs is as much a humanitarian gesture as that of any other organ donor. Because the justification used to place restrictions on organ transplants for offenders is the scarcity of organs, perhaps a program that allows offenders to donate organs to other offenders would provide a reasonable compromise. At the very least, such a policy would offer an opportunity to receive transplants that corresponds with the legal right of offenders to donate.

VII. CONCLUSION

We have shown that legal and ethical norms support the provision of donated organs to medically qualified offenders at public expense. We have also shown that those same norms support providing screening and treatments to prevent the need for organ transplants and end-of-life care for offenders in need. The next step is

¹¹³ TEX. GOV'T CODE § 501.0551 (2007).

¹¹⁴ South Carolina considered a bill that offered a reduced sentence for offenders who voluntarily donated organs or tissue. See *Wanna Cut Your Jail Time? Donate a Kidney*; CBS NEWS, MAR. 8, 2007, <http://www.cbsnews.com/stories/2007/03/08/national/main2548860.shtml> (last visited Nov. 6, 2008).

to develop comprehensive policies to establish the framework for screening, referring, and securing organ transplant services for offenders in need. Additional policies will be necessary to address prevention and palliation.

Changing policies will be difficult. Changing minds about providing offenders with access to organ transplants will be an even greater challenge. Studies are needed to better understand the costs and other management issues associated with organ transplants. In addition, studies of the correctional health providers' perspectives and practices related to organ transplants should be undertaken as part of an effort to better understand what will be necessary to implement the necessary policy changes and practices.