G.A.V.E.
GIFTS OF ANATOMICAL VALUE FROM THE EVERYONE

MISSION

With the overwhelming need for living organ donors in the State of Oregon and nationwide, as well as the impact that allowing organ donations could have on the nations organ supply, it is necessary to look for realistic alternatives to make organs more widely available. It is the mission of G.A.V.E. to make changes that will allow for willing altruistic inmates to donate an organ to anyone in need, and to thus save lives.

Step One: Be able to make a living anatomical gift as an inmate to anyone in need of an organ transplant regardless of relationship of donor to recipient.

- Kidney, liver lobes, tissue (stem cells), etc.
- Currently most states have no written policy regarding inmate donations.

Step Two: As a condemned inmate on death row, be able to make an anatomical gift at the time of "Execution".

- Currently the only possible donation that a death row inmate can make is one to science; one that does not directly work to save a life or lives. This is due to security practices in place that are there to ensure that the inmate has in fact been "executed".
- Any harvesting must be done within minutes of heart stoppage; immediately. The only real way to accomplish this would be for an execution to take place within a medical facility or for the "execution" to be effectuated by administering the inmate with a concoction that causes brain death. Oregon's definition of death includes brain death, as do many other states. The ceasing of neurological function, as opposed to cardiopulmonary function, allows for adequate time to allow for organ removal for transplantation.
- If the executions must take place within the department of corrections and therefore are not within the necessary surgical confines of a medical facility, then the only alternative is to administer a different form of death than that which is now statutorily mandated, depending on how you read the statute. (See ORS 137.473 below). Without this, harvesting of organs cannot take place.

INTRODUCTION

At any given moment, over 100,000 Americans are in need of an organ to survive. Of those waiting, nineteen will die today before a donor can be found, and it's likely that another new patient in need of an organ transplant will be added before you finish reading this. [1]

Transplant surgery is necessary for patients who have no other possible treatment options and who are likely to die or be seriously impaired without a transplant. It is of lifesaving benefit to people with a variety of otherwise incurable problems.

Taking into consideration the current shortage of living donors in the United States, it makes sense to use all available resources. While there are many more potential donors amongst the living than among deceased, over 136 million people between the ages of 20 and 55,[2] there are typically only between 10,000 and 15,000 donations given annually during recent years.[3] However, inmates make up nearly 2 million of the potentially available donors; most of which are currently prohibited from such donations. While the vast majority of prisoners would likely decline to donate an organ, even if just one percent chose to participate it would yield nearly an additional 20,000 donations; more than doubling the number of current donors.

Anatomical gifts can be made at two stages: a living donation and a donation at death, (typically brain death[4] verses somatic death). Both types of donations are vital to provide for survival where there are no other options for those in need of an organ due to the unfortunate shortage in the United States. I believe that it's a realistic goal to be able to give at both stages as a willing inmate on death row and for altruistic inmates in general. Both types of donations are being researched and will be discussed. But this first effort takes a look at step one: The option of a living donation.

A living donation typically involves a kidney, a liver lobe, part of a lung, pancreas, intestines, or tissue (bone marrow). But the most common need, roughly two-thirds is for a kidney. Due to the overwhelming need for kidneys the current average waiting time is 1,121 days.[5] A close second for the most needed organ is the liver for which the average waiting time is 796 days. Both of these transplants have become common procedures which have a proven success and safety track record for both the donor and the recipient, making it a practical option for anyone willing to impart an altruistic anatomical gift to someone in need.

The following will briefly discuss the viability of allowing for inmates to make organ donations. First it will display the current statutes and administrative rules within the State of Oregon which govern the topic at hand. This will help to determine whether such inmate donations could be authorized within the framework already in place by this state before pursuing the option for states across the nation.

Next it will discuss the organ donation process in general so as to gain a better grasp on exactly what is entailed, followed by concerns that will likely be posed by prison administration when determining if this is a feasible option for the inmate population. We'll briefly look at some of the potential legal complications along with other considerations therein before taking a look at the successes of organ donation policies for inmates in other states.

Finally, we'll look at the possibility of proposing an organ donation policy within the State of Oregon while looking at how to expand on the use of willing inmates around the country in an effort to assist in the overwhelming need for viable organs. It is hoped that this will begin to pave the way for prisons administrations and society to take a rational look at the potential positivity such a program can bring to all involved.

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[1] See current numbers regarding waiting list candidates at www.unos.org or www.organdonor.gov. (103,095 as of 8/19/2009), (19 deaths per day as of 8/19/2009), (1 new patient added every 14 minutes as of 8/19/2009).
[2] See U.S. Census Bureau
[3] See www.unos.org or www.organdonor.gov for latest statistics.
[4] Brain Death: Irreversible cessation of all functions of the brain, including brain stem. Must be absent for at least 12 hours: Behavioral or reflex motor functions above the neck, including pupilary reflexes to testing, response to noxious stimuli, & any spontaneous respiratory movement. Purely spinal reflexes can remain. In case of organ donation the observation time can be reduced to 6 hours.
[5] See UNOS/OPTN Annual Report 2003

Step One:

Be able to make a Living Anatomical Gift as a resident of death row (or any inmate resident) to anyone in need of an organ transplant regardless of relationship of donor to recipient.

The state of Oregon authorizes its citizens to make "Living Donations" under the Uniform Anatomical Gift Act: (ORS Chapter 97), with no restriction against inmate donors:

97.955. Purpose of anatomical gift; persons authorized to make gift. (This states in part)

(1)Subject to ORS 97.963, a donor may make an anatomical gift of a donor's body or body part during the life of the donor for the purpose of transplantation, therapy, research or education.

(2)An anatomical gift may be made in the manner provided in ORS 97.957 by:
(a) The donor, if the donor is an adult…

97.957. Methods of making anatomical gift before death of donor.

(1)A donor may make an anatomical gift
(a) By a designation on the donor's driver license or identification card;
(b) In a will;
(c) During a terminal illness or injury of the donor, by any form of communication addressed to at least two adults, at least one of whom is a disinterested witness;
(d) By a donor card or other record signed by the donor or other person making the gift; or
(e) By authorizing that a statement, symbol or designation indicating that the donor has made an anatomical gift is to be included on a donor registry.

(2) If the donor or other person authorized to make an anatomical gift under ORS 97.955 is physically unable to sign a record, the record may be signed by another individual at the direction of the donor or other person and must:
(a) Be witnessed by at least two adults, at least one of whom is a disinterested witness, who have signed at the request of the donor or the other person; and
(b) State that it has been signed and witnessed as provided in paragraph (a) of this subsection.

(3) Revocation, suspension, expiration or cancellation of a driver license or identification card upon which an anatomical gift is indicated does not invalidate the gift.

(4) An anatomical gift made by will takes effect upon the donor's death whether or not the will is probated. Invalidation of the will after the donor's death does not invalidate the gift.

The Department of Corrections affords its inmate population, with no delineation between general population and death row, general healthcare as laid out in the Oregon Administrative Regulations under four specific levels of service:

OAR 291-124-0041 Health Care and Treatment

(1) The facility Health Services Manager shall establish, in consultation with the facility functional unit manager, the frequency, schedule, and procedures for health care attention appropriate for the facility population, including inmates in segregation.

(2) Each inmate shall be informed orally and in writing of methods for obtaining health care attention. The schedule for sick call shall be posted for the information of inmates at each Department of Corrections facility.

(3) Each inmate's request for health care attention will be evaluated and triaged by a licensed nurse who may:
(a) Instruct an inmate in self-care;
(b) Initiate treatment according to Oregon Department of Corrections standardized nursing protocol;
(c) Schedule the inmate for an appointment with a primary care physician, nurse practitioner or physician assistant; or
(d) Refer the inmate to be seen in the ambulatory care clinic that same day.

(4) Health care and treatment is authorized and provided according to priorities established by the Clinical Director:

(a) Level 1: Medically Mandatory is care and treatment that is essential to life and health, without which rapid deterioration may be an expected outcome and where medical/surgical intervention makes a very significant difference and/or has very high cost effectiveness. Level 1 care and treatment shall be routinely provided to all inmates by the Department. Any health service employee may authorize care and treatment of Level 1 conditions;

(b) Level 2: Presently Medically Necessary is care and treatment without which an inmate could not be maintained without significant risk of either further serious deterioration of the condition or significant reduction in the chance of possible repair after release or without significant pain or discomfort. Level 2 care and treatment may be provided to inmates subject to periodic utilization review by the Chief Medical Officer. Any treating practitioner may authorize care and treatment of Level 2 conditions;

(c) Level 3: Medically Acceptable but not Medically Necessary is care and treatment for non-fatal conditions where intervention may improve the quality of life for the inmate. Level 3 care and treatment may or may not be authorized based upon review of an individual case. Only the Clinical Director and as delegated, the Chief Medical Officer, may authorize or deny care and treatment of Level 3 conditions;

(d) Level 4: Of Limited Medical Value is care and treatment which may be valuable to a certain individual but is significantly less likely to be cost effective or to produce substantial long term improvement. Level 4 care and treatment will not be routinely provided to inmates by the Department;

(e) Inmates may elect to obtain services for conditions at any of these levels, at their own expense in accordance with OAR 291-124-0085(1). Treating practitioners employed by the Department are not obligated to carry out any recommendations or treatment plans formulated by another practitioner from whom the inmate elects to purchase care and treatment, if ongoing care is required.

(5) Infirmary care shall be made available to provide limited medical, dental, and nursing services for inmates with health problems whose care cannot be safely managed via ambulatory care services. Infirmary services consist of isolation, observation, first aid, postoperative care, short or long term nursing care, treatment of minor illnesses, sheltered living, and convalescence. Infirmary care shall not be used as an alternative to hospital level acute care. Infirmary beds are located at Oregon State Penitentiary, Eastern Oregon Correctional Institution and Snake River Correctional Institution. Only health service employees shall admit and discharge from infirmary care.

"Level 4" (4(d)) most closely matches the type of health care associated with organ donations, as the procedure is not medically necessary nor does it improve the quality of life for the inmate. While the regulation states, "Level 4 care and treatment will not be routinely provided to inmates by the Department", the guidelines make a further provision (4(e)) which authorizes, "Inmates may elect to obtain services for conditions at any of these levels, **at their own expense** in accordance with OAR 291-124-0085(1)".

There is no direct prohibition from allowing inmates to make organ donations. It can be argued that the between the Oregon Department of Corrections and under the Uniform Anatomical Gift Act: organ donations by inmates are allowable.

ORGAN DONATION PROCEDURE

Because of the advances in surgery techniques, the challenge of transplant surgery is less in connecting the donated organ to the recipient than in managing the tendency of the body to reject the donor organ as a foreign invader. Before transplantation surgery can take place, tissue-typing is done. Tissue-typing helps reduce the chance of infection by closely matching the immune system of the donor to that of the recipient, determining the best possible match. Designed to detect and destroy invading microorganisms and other foreign matter, the immune system treats the transplanted organ as an invader and attacks it. Over time, this can cause the body to reject the implant. Part of the reason for there being such a long waiting list for available donor organs is due to the difficulties in finding a close match.

Tissue-typing consists of identifying specific proteins, called antigens, which reside on the surfaces of white blood cells (*Lymphocytes*). Together these antigens make up the human leukocyte antigen (HLA) system. The HLA system plays a central role in helping the immune system distinguish the healthy cells of the body from those infected by invading microorganisms and can assist in determining whether an organ will be accepted or rejected by the recipient's body. Through a simple blood draw from the prospective donor the blood type can be determined and the most suitable match will be resolved deciding whether the donor and recipient are "histocompatible". Histocompatibility will ensure the most successful transplant overall for the recipient.

In the case of a liver donation, a blood test is utilized which assesses the general liver health of the donor. The donor's liver function tests (LFT's)should be normal, meaning that there is no indication of disease, and the donor's liver should contain no more than 30% fat. It has been shown that donated fatty livers function quite poorly and are often rejected soon after transplantation. The body size and blood type of the donor and recipient should be compatible.[6]

In addition to blood tests and screening for known infections, such as hepatitis or HIV, each potential donor is evaluated to determine his or her suitability to donate. Such an evaluation includes both the possible psychological and the physical responses to the donation process. This is necessary to ensure that there is no adverse physical, psychological, or emotional outcome during any stage of the donation process.

Physically, a living donor should be physically fit, in good health, between the ages of 18 and 60, and without having had diabetes, cancer, kidney or heart disease, or high blood pressure.[7] Nearly 85% of inmates fall into the appropriate age category and inmates are typically more physically fit than the general populous[8]. Concerns regarding the overall health of inmates will be discussed further on in this discussion.

Each healthy donor can safely part with a kidney, a liver lobe, parts of a lung, pancreas, intestines, or bone marrow. As they present the greatest needs, kidney and liver lobe removal has become most commonplace. Kidney donations are done laparoscopically, a procedure in which several dime-sized incisions are made in the abdomen & hollow tubes are inserted into the incisions. [9] Only tiny scars remain and the donor usually feels normal again in two to four weeks, while the remaining kidney is growing to compensate. Liver donation only consists of a lobectomy, where just a small portion of the liver is excised for transplantation. The organ is designed to regenerate and be fully functional as though no part of the organ was ever removed. Recovery of the remaining part of the organ is rapid, growing back to its normal size in 6-8 weeks with little further care necessitated, leaving only a scar as evidence that the surgery took place.

THE OREGON DEPARTMENT OF CORRECTIONS

The Oregon Department of Corrections has officially responded to inquiries regarding inmate organ donations.[10] The response states in part:

> "With regard to your question concerning organ donation, ODOC can consider prisoners for organ donation when the recipient of the organ is an established family member. ODOC will assist a recognized transplant team's request for a basic initial evaluation, and then work with the transplant team as indicated."

Currently the Oregon Department of Corrections does not allow for organ donations to be made to anyone not already related to the inmate. Therefore, friends, associates and strangers in need are disallowed from obtaining an organ from a willing inmate donor. While being able to donate to family is an obvious positive it does not do much to assist in the national shortage of viable organs for transplant. If the institution were to only grant donations to direct family, due to the necessity of HLA and blood matching the amount of organs available even for family members would be drastically reduced.

The Department of Corrections may be reluctant to offer inmates the opportunity to make non-family organ donations for a variety of reasons. The procedures themselves can be quite costly and as previously acknowledged not medically necessary. In addition there is uncertainty surrounding the follow-up care or any ongoing care and treatment necessary associated with the procedure. And there is some concern as to whether local transplant hospitals will accept organ donations from inmates to non-family members at all. However, a few simple facts may help to clear up any concerns.

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[6] *Dr. Palmers Guide to Hepatitis & Liver Disease*, 369, Dr. Melissa Palmer

[7] See US government information on organ and tissue donation at www.organdonor.gov.

[8] See US Census Bureau, Department of Justice statistics

[9] Laparoscopy: A fiber optic camera is placed in an incision transmits an image onto monitors that allow the surgeons to view the organ. Surgical instruments for retrieving the organ are placed in other tubes. The organ from the donor is encased in plastic & removed w/ a tool inserted into another incision about 2 inches wide.

[10] See Department of Corrections letter to CML dated September 29, 2009. On file.

WHO WILL PAY FOR THE EXPENSIVE MEDICAL COSTS SURROUNDING THE ORGAN DONATION PROCESS?

- There is typically no cost to the donor (or the Department of Corrections in this case) for these procedures. The recipient (and more typically their insurance) covers the cost of the donation itself. The only related additional expenses incurred would be in the testing phase (essentially a blood draw performed at the institution, which is oftentimes reimbursable through the recipients insurance) and transportation to and from the hospital, and the correctional institution may be reluctant to cover such expenses. [11] The health program of the institution should cover such expenses, but in the event that it does not, various public and private grants are set up to assist in precisely those types of expenses.[12]

WHAT ABOUT POTENTIAL COMPLICATIONS THAT COULD END UP COSTING THE FACILITY, HENCEFORTH STATE TAXPAYERS, ADDITIONAL MONEY TO CARE FOR THE NOW AILING INMATE?

- There are typically very few complications surrounding the health of an otherwise healthy organ donor after the donation procedure. The reason that they are allowed at all is premised on the theory that the donor will not normally suffer long-term harm.
- The most common living organ donation is a kidney. Kidney donations are done laparoscopically, a now common procedure. Only tiny scars remain and the donor usually feels normal again in two to four weeks, while the remaining kidney is growing to compensate. Even under the terrible scenario that a person gets kidney disease in the future, the disease affects both kidneys. So as far as that goes a donor is not giving away his spare.[13] Other risks are infrequent and the risk of a fatality is almost non-existent (currently less than .03% for kidneys).
- Similarly, liver donors typically fare well. Complications are "exceptionally infrequent"[14] The donation consists of a lobectomy, where just a small portion of the liver is excised for transplantation. Recovery of the remaining part of the organ is rapid, with little further care necessitated.
- Bone marrow donation presents the lowest risk of all transplantation procedures, especially with today's technology. Fatal complication's as of the mid-90's rested at less than .01% at their worst[15].

HOW CAN THE "SAFETY AND THE SECURITY" OF THE INSTITUTION BE GUARANTEED?

- The Department of Corrections has specific guidelines to ensure the safety and security of the public for all types of transports, especially in the case of medical related needs. The institution can provide records of numerous recent transports originating from the highest security setting, death row, to local area hospitals (Salem & Portland) where the inmate was not otherwise incapacitated by dire health conditions and where danger to the public was nonexistent.

More fundamental concerns may arise regarding inmates and their ability to donate organs. Some have expressed concerns over the transmission of diseases due to the "prison lifestyle". They argue that inmates have a propensity for drug abuse and tattooing involving dirty needles as well as sexual habits that increases the chance of spreading illnesses such as HIV and Hepatitis. However, stringent testing, as is done with any other potential organ donor, will negate this concern.

An HIV diagnostic can be made by evaluating the results of a blood test that looks for the presence of antibodies to HIV. Because it can take anywhere for 6 weeks to 3 months following infection for the body to produce these antibodies to HIV some have expressed concern that donations from inmates may be too risky; testing may not prevent the spread of HIV. However, recent advances in diagnostic technology have taken this

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[11] However, some institutions do pay for the costs associated with organ donations from its inmate population. Research is being to done to further determine how the State of Texas budgets for this. See Texas Department of CJ Health Services Manual.

[12] National Living Donor Assistance Center, 2461 South Clark Street, Suite 460, Arlington, Virginia, 22202, (703)414-1600. Providing financial assistance for travel and subsistence expenses associated with living organ donation.

[13] *The Kindest Cut*, Larissa MacFarquhar, The New Yorker, July 27, 2009, 40

[14] *Dr. Palmers Guide to Hepatitis & Liver Disease,* Dr. Melissa Palmer, 370

[15] *Encouraging Bone Marrow Transplants for Unrelated Donors*, Mark F. Anderson, 54 U. Pitt L. Rev. 477, 482 (1993)

"window period" from several weeks or months to one to two weeks using RNA testing. RNA[16] tests look for the actual virus, not antibodies. Typically RNA testing is used as an additional test for those who may have had a recent risk for HIV which the most standard HIV tests would not catch. Due to the concerns of inmates living in such a high risk environment, it would be my recommendation to use RNA testing for any inmate wishing to donate an organ to most greatly ensure that the donor is not infected.

Blood testing for Hepatitis will look for elevated enzymes in the liver. In the case of an elevation further monitoring is necessitated. Otherwise there is no risk of Hepatitis.

Through tissue-typing, immunological testing, and proper screening for disease, which not only ensure that no illness will be spread to the patient but also guarantees a better match and increasing likelihood of a successful transplant, more would likely be known about the inmate than what hospital staff would know from receipt of an organ donation from the victim of a catastrophic accident. This, combined with the continual need for organs, should prompt prison administration to allow for organ donations by anyone who is voluntary and able.

The Department of Corrections is a well respected entity in the community. It no doubt recognizes the benefit to the family of an inmate who is willing to make a donation to a family member in need. But it has also demonstrated a need to be of benefit to the community. As an entity the Department of Corrections states, "A continuous effort will be made to balance statewide system needs with local community needs."[17] It is one that is known for assisting the community through various institution authorized outreach programs within the facility. [18]

Inmates are regularly given authorization to raise resources and funds through its various club functions for the benefit of the community.[19] The institutions stance on community improvement can be seen through its visiting privileges within the institutions. They are offered to inmates as a means of, "facility management, inmate habilitation and community safety. Visiting can improve public safety, encourage responsible familial relationships and reduce the risk of future criminal behavior."[20] Anything that is of benefit to the community, while maintaining the overall safety and security of the institution and the public alike is typically authorized and promoted by the institution.

Additionally there are benefits to the prison, the inmate donor as well as the victims of the inmate's crime. Victim Services programs which are setup by the institution seek to "benefit and assist people who have been harmed by crime and to help inmates make amends or restitution for the harm caused by their crime".[21] While there has typically been a move away from rehabilitation in prisons today, anything that can assist an inmate in making reparation or recompense on any level should be encouraged.

The Oregon Department of Corrections no doubt would acknowledge the importance of rehabilitation and the desire to improve community relations. But there is a disconnect between the departments authorization of familial inmate donations and the disallowing of anatomical gifts by inmates to non-family members.

LEGAL ISSUES

Of some concern are potential legal complications. In 1969 a death row inmate took the issue of living organ donations to the Supreme Court[22]. He was seeking review of a decision of the United States District Court, which dismissed his complaint under the Civil Rights Act, requesting that the director of the Florida state division of corrections be required to permit him undergo a medical procedure in another state to determine if he qualified as a kidney donor to a local youth. The court affirmed the dismissal of the inmate's complaint,

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[16] Also called PCR or NAAT (nucleic acid amplification testing).
[17] Oregon Administrative Rules (OAR) 291-078-0005 (3(d)), Case Management (Community Services)
[18] See Oregon DOC Website, "Public Relations" tab.
[19] W.I.S.H. (Working Inside Serving Humanity)-type initiatives, raising money/awareness for community causes.
[20] OAR 291-127-0200 (3(a)), Visiting (inmate), Policy
[21] OAR 291-205-0010 (3(a)), Victim Services Program
[22] *Campbell v. Wainwright*, 416 F.2d 949; 1969 U.S. App. LEXIS 10551, Oct. 6, 1969

holding that the case involved an issue of prison administration over which the federal courts would not superintend. It also approved the lower court's finding that the inmate had no constitutional right to donate a kidney.

Taking the issue through the court system, or even threatening to do so, would seem a futile effort. However, in the immediate case, if brought up by the institution, the circumstances were far different than those which are being proposed now. Firstly, the year was 1969. The necessary testing to determine whether the inmate was a potential candidate for the donation of a kidney was far less simple than it is today. The testing and surrounding circumstances required that the inmate be taken from his Florida prison cell to a Denver, Colorado hospital. If he then qualified, the organ would be transplanted at the Denver Transplant Center after which the inmate would have to be transported back to his Florida penitentiary. If for any reason there were post-operative complications, the inmate was seeking to be for removed back to Denver for re-hospitalization.

Obviously organ donation has come a long way since that court case forty years ago. While it did not "constitute an abuse of discretion of the Director of the Division of Corrections of the State of Florida"[23] to disallow cross country travel for an unnecessary procedure, the case could be construed differently today. Tests can be performed with minimum intrusion or security concerns within the prisons clinic, and any procedures involved in the organ removal would be accomplished locally at a hospital where the institution already has a contract, which includes set security protocols and guidelines for use with "high security" inmates.

Regardless, as the Court stated in Campbell v. Wainwright referring to Granville v. Hunt, (5th Cir. 1969, 411 F.2d 9):

> "* * * However invoked and regardless of the judicial tool employed to involve the Federal judiciary, our surveillance of state penal and correctional institutions has a limited spectrum. These institutions are not under the control of the Federal courts, and we 'will not interfere with the conduct, management and disciplinary control of this type of institution except in extreme cases.' Douglas v. Sigler, 8 Cir. 1967, 386 F.2d 684, 688. * * *"

The Courts will be reluctant at best to become involved, much less overturn a decision made by the Department of Corrections against this issue. In the case of this being brought to a legal platform there are other considerations which may have an impact, such as current conflicts of law between the Uniform Anatomical Gift Act verses the use of willing inmates as organ donors, and potential liberty interests involved. However, any battle taken to court will be a long and likely unwinnable proposition.

PROPOSAL

The simplest way to propose organ donation by Oregon inmates may be through the demonstration of practices already taking place within other states prisons. These administrative rules set a precedent and an example which can be followed by Oregon's correctional administration.

The Texas Department of Criminal Justice (TDCJ) has such an organ donation policy for inmates written directly into its inmate handbook which all inmates receive.[24] TDCJ's policy requires that the inmate formally requests in his own words his intent to donate an organ. There must be a formal request by a physician to take the inmate's organs. And while typically the donation is made to family member in need of an organ transplant, there is no prohibition from being a donor to a stranger. This is an important distinction because the ultimate goal is to help to provide the greatest amount of organs for the pool of recipients.

It must be noted, however, that the current TDCJ organ donation policy does not allow for death row inmates to be organ donors. The primary reason for this prohibition, according to the Austin American Statesman reporting on Texas inmate donations, is the fear of transmission of disease from inmate to patient.[25] As previously discussed, with proper testing, this should invalidate the issue.

One of the near-term goals is to be able to obtain complete information from the TDCJ on any more specific requirements from the inmate as well as the success or failures of their program thus far. It will be important in determining a track record of how much the service is utilized as well as any other stats that can be gleaned.

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[23] Id. @ 951

[24] TDCJ General Health Services Division- 3009A Highway 30 West, Huntsville, TX, 77340-0769 (936)437-4271.

[25] *Austin Am-Statesman*, Leah Quin, October 8, 1998, at B1, 1998 WL 3627351

The TDCJ policy could be an integral part in accomplishing this mission within the state of Oregon and beyond.

Some have expressed concern that by allowing inmates to donate their organs there will be a propensity towards coercion. This is typically presented when institutions have presented initiatives which reward inmates for organ donations. The idea is that an inmate will do anything to add to their ultimate comfort level in prison, especially if it means something along the lines of a reduced sentence or a boost in "good time". Not only are concerns involving coercion evident but there are probable conflicts with the Uniform Anatomical Gift Act which will eventually be of detriment to any organ donation program which offers to "pay" the participants. Evidence of this can be seen by the demise of several past attempts to promote such programs in the past.

Because of that and a personal belief that such donations should be made altruistically, this discussion does not propose offering such incentives. Most of those who do choose to participate will likely, and should, be motivated by more than just self-interest, but by a true desire to want to assist someone in need. They will not be coerced into it. To ensure that this is the case, the institution should follow standard guidelines for assuring voluntary consent in any medical matter.

The next logical step is to make a formal proposal. A proposal will have to be made to the Oregon Department of Corrections which demonstrates the benefits to the institution, its inmates, and the State of Oregon in general. The proposal should include precedents and examples from other states, as well as any statistics that display any successes by those states institutions. And it should emphasize the need and importance for such an addition to be made in these state correctional institutions.

CONCLUSION ON INMATES MAKING LIVING DONATIONS

With the overwhelming need for living organ donors in the State of Oregon and nationwide, as well as the impact that allowing organ donations could have on the nations organ supply, we have an obligation to look for realistic alternatives to make organs more widely available. With no distinction in the Uniform Anatomical Gift Act prohibiting inmates from being organ donors, combined with no prohibition within Oregon's Department of Corrections administrative codes, as well as the willingness of other states institutions to adopt policies and procedures along these lines, organ donations by inmates should be allowed. The benefits to the community along with the potential benefits to the prison as well as the inmate donor far outweigh other considerations.

Organ donation creates an opportunity for prisoners to give back to the community whose social norms have been violated and it provides an opportunity to help a fellow citizen who desperately needs help. Cultivating such a generosity of spirit can do much to rehabilitate criminals conditioned by a life of hardship to think only of themselves. The more that is being done to prepare an inmate for a positive reentry into the community benefits all involved. And should the donor happen to be a death row inmate who is unlikely to see a release date, allowing good to come out of an otherwise hopeless situation only heightens the benefit to the institution and the community in general.

When presented with the possibility of more than doubling the amount of organs available to those in need nationwide, it's only rational that the possibility be given careful consideration. With your continued help and expertise I will keep pursuing this goal. Along with that I ask for your expert contributions to assist me in continuing to pursue an equally important mission of making changes in the death penalty execution protocols to allow for the condemned to be able to donate viable organs at the time of their death, thus saving up to a dozen lives with each execution. I will write further on that in the near future.

Together perhaps we can influence change that will eventually save hundreds of lives. Thank you immeasurably for your assistance.

Regards,

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