Gifts of Anatomical Value From the Executed

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Organ Donation from the Willful Executed Prisoner

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INTRODUCTION

Recently, exhaustive reviews have been performed to determine the costs and benefits of the death penalty. Most notably, New Jersey has concluded that the death penalty does not fit with evolving standards of decency, is more costly to the state than life in prison, does not effectively prevent violent crime, and can lead to innocent people being executed.[1] Many death penalty advocates and opponents alike acknowledge that the death penalty is used disproportionately across each state and the country as a whole. The alternative of life in prison without the possibility of parole would sufficiently serve the publics safety as well as address other legitimate social and penological interests, including those of the families of murder victims. Other states have echoed those same sentiments,[2] and six Justices of the United States Supreme Court have opined since 1970 that the death penalty is unconstitutional, either facially or as applied.[3]

Despite my belief that some crimes are so egregious and that some people are so seemingly heinous that they should removed permanently from society, and a feeling that the communities sense of justice may be satiated with a death sentence, I am against capital punishment. The negatives far outweigh the benefits of having capital punishment remain as an option.

There is no suggestion here that the larger goal of abolishment of capital punishment be sacrificed. It is a worthy cause which I truly hope someday is a success. I look at the death penalty as a lemon of an automobile. No matter what is done in an attempt to fix it, it will always be broken. But as long as we are stuck with it, we might as well deliver meals-on-wheels. As long as the Courts continue to declare the death penalty to be constitutional, there should be an effort to ensure that the inmate can die in a humane way that allows for as much dignity and pride as possible without the unspoken desire of some to use inhumane botches to prove a point.[4] And if there is a way as well for the opportunity of a tremendous positive, the gift of life for not only one but potentially for a number of people, an actual benefit is gained by all involved. As long as we have the ability to affect such changes, we should pursue it.

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. [5]

Taking into consideration the current shortage of donors in the United States, it makes sense to use all available resources. While there are over 136 million people between the ages of 20 and 55,[6] there are typically only between 10,000 and 15,000 donations given annually during recent years.[7] However, inmates make up nearly 2 million of the potentially available donors; most of which are currently prohibited from such

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[1] See: *Final Report*, New Jersey Death Penalty Study Commission Report, p. 1 (January, 2007)
[2] See: *Report and Recommendations on the Administration of the Death Penalty in California*, California Commission on the Fair Administration of Justice (June 30, 2008)
[3] See *Baze v. Rees*, 128 S.Ct. 1520 (2008)(Stevens, J., concurring in the judgment)(death penalty unconstitutional in all circumstances); *Callins v Collins*, 510 U.S. 1141 (1994)(Blackmun, J., dissenting from denial of certiorari)(death penalty unconstitutional in all circumstances), *Furman v. Georgia*, 408 U.S. 238 (1972)(separate opinions of Brennan, J. and Marshall, J.)(Death penalty unconstitutional in all circumstances); id.(separate opinions of Douglas, J., White, J., and Stewart, J.)(Death penalty statutes of Georgia and Texas unconstitutional as applied). One other justice expressed the following retirement. See John C. Jeffries, *Lewis Powell: A Biography*, at 451 (1994)(reporting Justice Powell's view that the one vote he regretted casting was his tie-breaking vote to sustain the death penalty in *McClesky v. Kemp*, 481 U.S. 279 (1986)).
[4] At the introduction of lethal injection, many death penalty opponents sought to block its use with a claim that it would be too humane an option and could derail efforts against capital punishment. The less humane option of electrocution was a better poster example of the horrors of the death penalty, and without that visual came fears that judges and juries would be more prone to sentence an inmate to death.
[5] 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).
[6] See U.S. Census Bureau
[7] See www.unos.org or www.organdonor.gov for latest statistics.

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[8] 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 effort takes a look at the former: The option of a condemned inmate to make organ donations upon execution.

One body can provide as many as 50 donation opportunities, according to the U.S. Department of Health and Human Services. The list of organs that can be transplanted includes but is not limited to the cornea, heart, lungs, kidney, liver, pancreas, small intestine, bone marrow, tendons and teeth.[9] However, anatomical gifts at death have a tight window of viability. So organs must be used within 6 to 72 hours after death, depending on the organ. (Heart and lung, 6 hours; Liver, 12-24 hours; Kidneys, 48-72 hours.) Tissues such as corneas, skin heart valves, bone, tendons, ligaments, and cartilage can be stored in tissue banks for future use.

The following will briefly discuss the ability of utilizing condemned donors who are willing to give their organs to those in need at the time of their execution. Part One will display the current statutes and administrative rules within the State of Oregon which govern the execution process and the lethal injection protocols. This will help to determine whether such inmate donations could be authorized within the framework already in place by this state before pursuing legislative options and the option for states across the nation. Part Two will take a look at a lethal injection protocol involving only a single drug which was recently adopted by the State of Ohio, while Part Three will consider that protocol and how it can be applied to the topic of organ donation.

In Part Four we begin a look into many of the potential difficulties along with other considerations involved in organ donations from executed inmates. These complications are ones expressed directly from the point of view of the U.S. government in response to inquiries on the subject, which include concerns related to the inmates' themselves regarding disease, consent, and death penalty disparities.

The following sections will take a look at reasons for opposition to condemned inmate organ donation and hopefully compelling arguments to counter this opposition. First, in Part Five, from the medical field in regards to physician participation in the execution process and the impact that these concerns may have on such donations. It will include standpoints from the American Medical Association and from the cornerstone beliefs within the field of medicine and it will draw conclusions based on historical examples of physician practice concerning past conflicts of a similar nature. Next, we'll discuss arguments from death penalty opposition groups, in Part Six, a traditional ally when it comes to the dignity and humaneness for death row inmates. And finally, Part Seven will look at a historical roadblock courtesy of the Chinese government and its past practices involving organ harvesting from the executed.

Part Eight will look briefly at some of the logistical concerns involving the specifics of donation itself, from the medical facilities to the necessity of matching donors with recipients.

Finally, Part Nine presents a plea for assistance before concluding why this issue is important to me and to those in need of organs to survive. It's my hope that this will both inform and motivate support for this mission.

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[8] 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.

[9] According to one commentary a healthy corpse could provide the following transplantable parts: 2 corneas, 2 inner ear hammers, anvils and stirrups, 1 jaw bone, 1 heart, 1 heart pericardium, 4 heart valves. 2 lungs, 1 liver, 2 kidneys, 1 pancreas, 1 stomach, 206 separate bones, 2 hip joints; 27 ligaments and cartilages; 20 square feet of skin; 60,000 miles of blood vessels; and 90 ounces of bone marrow. Danielle M. Wagner, *Property Rights in the Human Body: The Commerciaslization of Organ Transplantation and Biotechnology*, 33 Duq. L. Rev. 931, 943 n. 109(1995).

I. Death Penalty Statutes and Lethal Injection Protocols in the State of Oregon

Oregon's Execution Statute:
ORS 137.473. Means of inflicting death; place and procedures; acquisition of lethal substance.

(1) The punishment of death shall be inflicted by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent and potassium chloride or other equally effective substances sufficient to cause death. The judgment shall be executed by the superintendent of the Department of Corrections institution in which the execution takes place, or by the designee of that superintendent. All executions shall take place within the enclosure of a Department of Corrections institution designated by the Director of the Department of Corrections. The superintendent of the institution shall be present at the execution and shall invite the presence of one or more physicians or nurse practitioners, the Attorney General, the sheriff of the county in which the judgment was rendered and representatives from the media. At the request of the defendant, the superintendent shall allow no more than two members of the clergy designated by the defendant to be present at the execution. At the discretion of the superintendent, no more than five friends and relatives designated by the defendant may be present at the execution. The superintendent shall allow the presence of any peace officers as the superintendent thinks expedient.[10]

(2) The person who administers the lethal injection under subsection (1) of this section shall not thereby be considered to be engaged in the practice of medicine.

(3) (a) Any wholesale drug outlet, as defined in ORS 689.005, registered with the State Board of Pharmacy under ORS 689.305 may provide the lethal substance or substances described in subsection (1) of this section upon written order of the Director of the Department of Corrections, accompanied by a certified copy of the judgment of the court imposing the punishment.

(b) For purposes of ORS 689.765 (7) the director shall be considered authorized to purchase the lethal substance or substances described in subsection (1) of this section.

(c) The lethal substance or substances described in subsection (1) of this section are not controlled substances when purchased, possessed or used for purposes of this section.

(4) The superintendent may require that persons who are present at the execution under subsection (1) of this section view the initial execution procedures, prior to the point of the administration of the lethal injection, by means of a simultaneous closed-circuit television transmission under the direction and control of the superintendent.

A. Current Method for Lethal Injection:

The procedure of lethal injection is performed through three chemical agents to be used for the execution. They are injected intravenously in sequence, as follows:[11]

Agent # 1 (sodium thiopental) will be injected using one syringe containing 2400 milligrams of this agent, which is approximately 4.5 to 6.8 times the normal dose for a 195-pound person.

> Sodium thiopental is an ultra short acting barbiturate which is administered intravenously to induce surgical anesthesia.[12] According to the anesthesiologist, a normal dose for such purposes would be four to six milligrams per kilogram of body weight. (Approx. 450 mg for a 195-pound person.)

Upon injection, this agent will attain full concentration in the brain in less than 30 seconds. When administered at the execution amount, this agent will rapidly cause unconsciousness, with a significant decrease in blood pressure and respiratory depression. Within a minute after injection of approximately half of the execution amount, the inmate's breathing will be transient and would likely stop for several minutes at a time.

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[10] As noted in OAR 291-024-0080 (3): At 12:01 a.m. or as soon thereafter as possible, the Superintendent shall signal the executioner(s) to begin injection of lethal solutions by syringe(s) into the injection port of the intravenous catheters. As prescribed by ORS 137.473, the lethal solutions will include an ultra-short acting barbiturate in combination with a chemical paralytic agent and potassium chloride *or other equally effective substances sufficient to cause death.*

[11] See 1998 Ore. AG LEXIS 15-Attorney General Opinion

[12] *See* The Pharmacological Basis of Therapeutics, *Hypnotics and Sedatives*, ch 9 (5th ed).

According to the anesthesiologist, because of the decrease in blood pressure and depressed respiration, brain damage is likely to occur as soon as three minutes after commencement of the injection of this agent due to the substantially reduced perfusion of blood containing oxygen in the brain. Prior to this time, there is a possibility of irreversible brain damage, the exact point of which would be difficult to predict. After injection of the full execution amount of this first agent, resuscitation is conceivable, but the chances of success are slim. Even if resuscitation was successful, if brain damage had occurred, the situation would be irreversible.

Agent # 2 (pancuronium bromide) will be injected using two consecutive syringes containing a total of 100 milligrams of this agent, which is approximately eight times the normal dose for a 195-pound person.

> Pancuronium bromide is a neuromuscular blocking agent which is administered intravenously as an adjunct to a general surgical anesthesia to obtain relaxation of skeletal muscle. [13]

This agent has an onset of action of approximately two minutes and over the next minute or so would cause paralysis of skeletal muscles, including the breathing muscles of the ribs and diaphragm.

Following injection of the first agent, the injection of this second agent would insure that the inmate would not resume breathing. Although this second agent causes an increase in heart rate, that effect would be overwhelmed by the massive amount of the first agent. After injection of the full execution amount of this second agent, resuscitation is still conceivable, but the chances would be slim; the likelihood of irreversible brain damage would now be substantially greater because of the additional length of time that the brain was not perfused with blood containing oxygen. According to the anesthesiologist, a normal dose for such purposes would be 0.1 milligram per kilogram of body weight.

Agent # 3 (potassium chloride) will be injected using three consecutive syringes containing a total of 100 millequivalents of this agent,[14] which is five times the recommended safe hourly concentration.

> Potassium chloride is an important activator in many enzymatic reactions in the human body and, at the correct concentration, is essential for the transmission of nerve impulses, contraction of cardiac, smooth and skeletal muscle and renal function. The usual safe dosage for intravenous injection is 20 millequivalents per hour.

This lethal concentration will cause cardiac arrhythmias, heart block and cardiac arrest.

The injection of the execution amount of this third agent will cause the heart to be unable to sustain a beat, particularly in the face of the decrease in blood pressure caused by the first agent. After injection of the execution amount of this third agent, the chance of resuscitation is nil because the heart would not be able to respond to any attempt to restart a beat. Without the brain being perfused with blood containing oxygen, brain death will occur.

After injection of each of the three chemical agents, a syringe of saline solution will be injected in order to avoid any mixing of the different agents, which could cause chemical interactions. Thus, a total of nine syringes must be injected before the acts required by ORS 137.473(1) will be complete. It is understood that injection of all nine syringes will take six to eight minutes.

The combination of all three chemicals will cause the cessation of all cardiopulmonary function. The heart will stop pumping blood to the organs. The organs will be rendered useless immediately thereafter.

Organ donations are not possible under the current three drug lethal injection protocol. However, a viable alternative exists which is not only medically possible but which also allows for the inmate to die in a more humane manner. Until recently no state had adopted this method and until now organ donation at the time of execution was not a realistic option. But now a state has adopted a procedure for lethal injections which now makes organ donations feasible.

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[13] *See* The Pharmacological Basis of Therapeutics, *Neuromuscular Blocking Agents*, ch 28 (5th ed); American Hospital Formulatory Service, Drug Information 96, at 928-31, 940-41.

[14] A milliequivalent is a measure of potassium based on the number of available potassium ions.

II. Single Drug Protocol

On Thursday, November 12th, 2009 the State of Ohio became the first state to adopt a procedure for lethal injections that uses a single drug.[15] The use of this single drug, sodium thiopental , which is the first drug used in the three drug cocktail, has been debated as high as the Supreme Court as being a more practical and humane option for lethal injection. But until now no state had been willing to switch from the conventional method for a variety of reasons.

In Baze v. Rees[16], the three drug protocol was taken to trial. The petitioner contended that the current method of execution presented a significant risk of unnecessary infliction of pain to the defendant. The basis for the arguments were various studies which had been done which seemed to prove that after the administration of the second drug of the protocol, the paralytic pancuronium bromide, the first drug was diluted. Thus, a proper amount of barbiturate may not be in the system by the time that the third drug, potassium chloride, is introduced to stop the heart. They pointed to euthanasia protocols and veterinary guidelines which prohibit the use of the second drug due to its inherent dangers.

In total, petitioners argued that the effect of dilution or improper administration of the drugs is that the inmate dies an agonizing death through suffocation due to the paralytic effects of pancuronium bromide and the intense burning sensation caused by the last drug. However, through the injection of a single large dose of sodium thiopental, the execution can be painlessly accomplished. Any use of additional chemicals is entirely superfluous and presents an unnecessary risk of pain.

The Supreme Court ultimately rejected the argument stating, "Given what our cases have said about the nature of the risk and harm that is actionable under the Eighth Amendment, a condemned prisoner cannot successfully challenge a State's method of execution merely by showing a slightly or marginally safer alternative." However, the Court stated at the conclusion of its opinion, "…our approval of a particular method (of execution) in the past has not precluded legislatures from taking the steps they deem appropriate, in light of new developments, to ensure humane capital punishment. There is no reason to suppose that today's decision will be any different." The State of Ohio's change to the single drug protocol became a case in point.

III. Organ Donation & the Single Drug Protocol

As mentioned previously, the single drug Sodium thiopental is an ultra short acting barbiturate which is administered intravenously to induce surgical anesthesia. The agent is quickly concentrated in the brain and rapidly causes unconsciousness, with a significant decrease in blood pressure and respiratory depression. Because of the decrease in blood pressure and depressed respiration, brain damage is likely to occur as soon as three minutes after commencement of the injection. The dosage, exceeding that which would normally be administered, would be sufficient to render the condemned brain-dead.

Because the inmate would die from the cessation of brain function, which is the legal definition of death, the organs would still be intact. The heart can continue to pump blood to the various organs until which time they could be removed for transplantation. The procedure for this would be identical to that used regularly by physicians who procure organs from their brain-dead patients.[17] The inmate would be declared brain dead, thus officially deceased, and would then be ventilated and monitored to ensure the viability of the organs for healthy transplantation.

While this may sound like a seamless option it does not come without hurdles. Given the complexities of anesthesia and organ procurement, physician participation would necessarily play a prominent role. The medical community will object to any physician involvement in the process of organ procurement as it has with participation in executions. Too, there will likely be objections from the anti-death penalty community for

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[15] See Affidavit of Terry Collins, ODRC Director under U.S. District Court for the Southern District of Ohio, Case No. 2:04-cv-1156, specifying the changes to Ohio's lethal injection protocols. (One single drug: 5 grams of thiopental sodium.)

[16] *Baze v. Rees*, 128 S.Ct. 1520 (2008)

[17] The surgical removal of the organs occurs while the patient has an intact circulation and is mechanically ventilated. Once the organs are removed, the ventilator and cardiac monitor are removed.

reasons ranging from China's past practices regarding executions and organ procurement to the overall process seeming too humane and thus likely to prompt more juries to choose the death penalty over life in prison. And there are also potential logistical complications over where the transplantation surgery will commence or over what to do if an inmate changes his mind at the last minute. All of these issues deserve note and will be considered next.

IV. Primary Concerns (From the governments point of view.)

On November 17th, 2009, a Public Health Analyst from the U.S. Department of Health and Human Services responded to inquiries regarding the overall dilemmas and concerns regarding inmate organ donations from the executed or otherwise. Below are excerpts from that letter:

> "Much concern regarding organ donation by inmates is related to their high risk of exposure to communicable infectious diseases during incarceration, e.g. HIV and various forms of hepatitis. While the availability of better tests for infectious diseases has improved the safety of the supply of donated organs, tissues, marrow, and blood, no test is 100% accurate; consequently there is a small percentage of false negative results (meaning individual actually has the infection, but the test result is negative."
>
> "The OPTN/UNOS Ethics Committee has also deliberated on many issues related to organ donations from incarcerated individuals including: assuring appropriate informed consent for both donors and recipients; the ethical issues of the act of organ donation itself; the uneven application of the death sentence among socio-economic and ethnic groups in many States; and the overall effect of such policies on organ donation in general. Based on these deliberations, the Committee is opposed to any strategy or proposed statute that would facilitate organ donation from prisoners, condemned or otherwise. It is my opinion that the Committee's position is unlikely to change unless all of these issues can be satisfactorily addressed."[18]

As the Organ Procurement and Transplantation Network (OPTN) & The United Network for Organ Sharing (UNOS), under the U.S. Department of Health and Human Services, is the government contracted resource in charge of organ donations in the U.S., and since most institutions, courts, and individuals will refer to this organization as the expert in the field, it is necessary to consider each of their objections to inmate organ donation first.

1. Inmates at High Risk for Infectious Diseases

The National Commission on Acquired Immune Deficiency Syndrome has stated, regarding inmates, "no other institution in this society has a higher concentration of people at substantial risk of HIV infection."[19] A study conducted by the National Institute of Justice showed that the incidence rate of AIDS cases for the general public was 14.65 cases per 100,000 people compared with 202 cases per 100,000 in federal and state correction facilities.[20] And the Food and Drug Administration (FDA), since the early 90's, has advised blood and plasma donors not to accept donations from prison inmates. The risk of infection is very real and, while there are tests to ferret out many of those infected, as the Public Health Analyst above stated, "no test is 100% accurate; consequently there is a small percentage of false negative results."

Dilemma: While there is a need for such concerns, the reality is that the modern day testing has come a long way since those statements were adopted. Previously the biggest dilemma in testing involved the "window period" between exposure and detection of a disease. Literally an individual could contract HIV or Hepatitis and be tested for the disease several weeks or even months later with negative results. The reason for this in HIV was that the most standard HIV tests never looked for the actual virus, but rather antibodies to the virus. During the window period, a person may in fact have HIV but not enough antibodies yet to show up on a typical HIV test. Therefore, the result is a false negative.

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[18] Response is on file and was signed: Richard A Laeng, MPH, Public Health Analyst, Division of Transplantation, HSB/HRSA; U.S. Department of Health & Human Services, Rockville, MD 20857, (301) 443-5410, *rlaeng@hrsa.gov*

[19] *AIDS in Prison: Judicial Indifference to the AIDS Epidemic in Correctional Institutions Threatens the Constitutionality of Incarceration*, D. Stuart Sowder, 37 N.Y.L. Sch. L. Rev. 663, 666 (1992)

[20] Id. At 668

The Fix: In recent years testing has come much closer to that desired 100% threshold. RNA testing, also called NAAT[21] has been developed which detects the virus itself, as opposed to the buildup of antibodies, by looking for its genetic material. No longer is it necessary to wait the several weeks or months of the window period to know for sure if an infection exists. Now, through RNA testing, any HIV infection can be revealed within a week. There is actually more of a likelihood of a false positive than a false negative in this testing (2.6-5% of tests results in a false positive[22]) due to the nature of the test.

It would be proposed that every inmate who wishes to donate an organ be administered an RNA test in conjunction with other routine screenings. Given modern technologies in accurate testing, there is no reason that an inmate should be summarily precluded from organ donation due to concerns over infections. Testing has now surpassed the concerns regarding the risks of inmate donations. While statements regarding the lack of 100% accuracy may still be valid, a rational look at the advances should determine that the probability of lives being saved by willing inmate donors far outweigh the now slight chances of previously concerning infections.

2. Informed Consent

Assuring appropriate informed consent for both donors and recipients is a key issue when dealing with inmates especially. In 1977 the Commission for the Protection of Human Subjects of Biomedical and Behavioral Research was formed, which was established by Congress to make recommendations on issues involving prisoners. The concern was that inmates were being misused as test subjects despite the fact that the inmates had "consented". The Commission maintained that "although prisoners who participate in research affirm that they do so freely, the conditions of social and economic deprivation in which they live compromise their freedom." And as one Georgetown University Professor who maintains that the prison environment is inherently coercive stated, "When persons seen regularly to engage in activities which, were they stronger or in better circumstances, they would avoid, the principle of respect for persons dictates that they be protected."[23] In other words, prisoners are subject to coercion by virtue of the circumstances of their environment and they should be protected from doing things they might not do if they were not in this environment.

Coercion involves the threat of harm or punishment for non-compliance rather than the promise of benefit for compliance. In the case of a condemned inmate such threats are unlikely and moot, as the inmate is at the end of his life. Some might argue this from a spiritual point of view; that this is an internal motivation that is so intense that it influences the actor's ability to reason effectively and creates conflict between competing values, beliefs and desires. When a mental compulsion is so overpowering that it is considered to be irresistible, it renders the resulting behavior un-free. But such coercions affect the daily lives and decisions of nearly everyone alive and should have no special consideration here.

The only way to avoid the negative perceptions associated with inmate organ donations and the issues of consent or coercion is to assure that the inmate who is about to give his organs has done so absolutely voluntarily. It has been suggested that the best way to assure this is to limit the donation option to those condemned inmates who initiate talks of such donations themselves, possibly even going so far as to require that the inmate articulate his desire and reasons in writing with a legal and lay witness watching the inmate sign his declaration of intent. These are steps above the voluntary consent rules associated with organ donation from one who has been declared terminally ill or injured. Often a physician or counselor will themselves broach the subject of organ donation with the potential donor or family of the terminally ill.[24]

The condemned prisoner, upon mention of his wish to be an organ donor, should receive the same counseling as anyone who is making end of life decisions. Oregon's Death with Dignity Act provides a good example of this to mirror.[25] The patients' ability to exercise their right to assisted-suicide is balanced with the state's interest in preserving human life as well as the patients' right to refuse an unwanted elective medical procedure. The Oregon resident must first be examined by a physician who must "verify that the patient is capable, has acted

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[21] Nucleic Acid Amplification Testing. See *www.wikipedia.com* subject: HIV test.
[22] See RNA Facts brochure at *%7e/media/health/publichealth/documents/hiv/rna_facts.ashx*.
[23] Professor Patricia King, a strong opponent of research on prisoners.
[24] 97.957 Methods of making anatomical gift before death of donor. (1)A donor may make an anatomical gift: (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.
[25] ORS 127.815 § 3.01 - 127.850 3.08

voluntarily, and has made an informed decision."[26] If the patient is diagnosed with any underlying psychological disorder or depression causing impaired judgment, the patient is referred to appropriate counseling until deemed competent to make a request. [27]

In addition, Oregon's DWD Act enforces a waiting period from the time of request to the date they are given their lethal prescription to ensure adequate time to reconsider the decision.[28] And there is explicit wording to ensure that the patients' right to rescind is protected.[29] The right to rescind is an important one and must be granted unequivocally. And due to concerns with vacillation, an inmate who does choose to take back his decision to donate should never again be allowed the option to be a donor.

If the condemned prisoner makes an unsolicited decision to donate and meets the same stringent criteria as is required in Oregon's DWD Act, his voluntary choice to be an organ donor upon execution is absolute and clear. With these careful guidelines the issue of consent from the inmate's point of view should be satisfied.

In addition, the medical community has provided an explicitly detailed method by which to obtain prisoner consent for any medical treatment.[30] If prisoners, even condemned ones, can give consent to medical treatment generally, or even choose to exercise a constitutionally protected right to die or refuse medical treatment[31], then they must be presumed to be capable of consenting to organ donation.

There is also an issue from the potential recipient's perspective. Typically there is confidentiality regarding the donor unless the donor's family specifies otherwise. Should the recipient have a right to be informed that the donor is in fact a condemned inmate, especially given previously discussed concerns over the high-risk environment of prison?

Currently, most organ donations come from accident victims with varying degrees of knowledge of the medical history of the victim. But in the case of a condemned inmate with a scheduled execution, much more is medically known about the inmate. 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.

Any apprehensions that a potential recipient might have would likely vanish once properly informed. It would be proposed that the recipient should be informed that their organs are coming from someone who is condemned as a bonus to the likely success of their transplant. But it's equally as important that the recipient know of the steps the inmate had to take to be able to give his consent so that the concerns over other countries organ procurement practices do not way on the recipient. The issue of appropriate consent is easily satisfied for both the donor and the recipient.

3. Racial & Economic Class Imbalance; Overall effect of such policies on organ donation in general

There is some concern regarding the uneven application of the death penalty among socio-economic and ethnic groups in many States. Many believe that the death penalty discriminates against African-Americans and

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[26] ORS 127.820 § 3.02

[27] ORS 127.825 § 3.03. Counseling referral. "If in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counseling. No medication to end a patient's life in a humane and dignified manner shall be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment."

[28] ORS 127.850 § 3.08 "No less than fifteen (15) days shall elapse between the patients' initial oral request and the writing of a prescription…"

[29] ORS 127.845 § 3.07. Right to rescind request. **"**A patient may rescind his or her request at any time and in any manner without regard to his or her mental state. No prescription for medication under ORS 127.800 to 127.897 may be written without the attending physician offering the qualified patient an opportunity to rescind the request."

[30] *Consent to Treatment, A Practical Guide*, Fay A. Rozofsky (2d Edition 1990), 216-219

[31] *Thor v. Superior Court,* 855 P.2d 375, 5 Cal. 4th 725 (1993)

the poor. Thus, the discriminatory application of the death penalty, coupled with law allowing organ procurement upon execution, could potentially have tragic effects. The fear is that the negative perception of organ procurement would most likely have the effect of wiping out every potential African-American donor. Likewise, there would be a stigma attached to organ donation which would result in fewer donations by the typical donor. Thus, the impact on the current altruistic donation system would be damaged beyond any benefit which may be derived from a policy allowing for donations by the condemned.

Perceptions can be difficult to reverse if allowed to permeate. Therefore, it is vital to emphasize the process by which organ donations from the condemned can be made. This is strictly a voluntary process which would be governed by the application above regarding consent. This is not a presumed consent plan. The inmate must broach the subject and prove that he is altruistically making the choice to donate his organs. Too, if historical trends that were established in medical research programs for prisoners continue, African-American and other minority prisoners will likely choose to participate at lower levels than Caucasian prisoners. For reasons not exactly clear, prisoners who participated in medical research programs tended to be predominantly white, even in institutions where the population as a whole was predominantly non-white.[32]

The fact is that nobody knows what sort of impact such a policy may have on existing organ donation efforts. Any proposals for change usually engender opposition where every effort is made to decipher reasons something will not work. Whether those arguments accord with reality remains to be seen. But practical reasoning and the necessity for additional methods for obtaining organs in the U.S. should afford opportunities that might otherwise appear controversial, so long as the appropriate steps are taken to ensure as many rights and protections as possible.

V. Physician Participation
Protecting the Integrity of the Medical Profession

The medical community has been at odds concerning physician participation in the execution process since the inception of capital punishment. It's no surprise that similar conflicts would arise in dealing with the organ donation process in regards to an executed inmate. Therefore, it's important to learn the history of physician involvement in the capital punishment process to determine how to resolve potential ethical dilemmas with our current discussion.

A. Hippocratic Oath

Physicians belong to an honorable and ethical profession and are bound by the Hippocratic Oath, an important part of which begins: "First, do no harm.", and includes, "I will give no deadly drug to any, though it be asked of me, nor will I counsel such."

Hippocrates, the father of medicine in western civilization, was a renowned Greek physician, writer and teacher of the 4th century, B.C. The Hippocratic or Coan School (named for Cos, the island he lived on in Greece) that formed around him was of enormous importance in separating medicine from superstitious and philosophical speculation. It placed medicine on a strictly scientific level based on objective observation and critical deductive reasoning. While the Hippocratic Oath cannot directly be attributed to Hippocrates, it undoubtedly represents his ideals and principles.[33]

Those opposed to allowing organ donation from executed prisoners still rely primarily on the Hippocratic Oath to forbid physician participation. But the Oath, while an extraordinary mantra of health professionals, has never been regarded as an all-inclusive code of behavior. Interpretation of the Oath has, to some extent, been an evolutionary process. Only parts of the Oath are still being used today, as medicine and ethics have evolved beyond the knowledge of Hippocrates time. For example, the next sentence of the Oath mentioned above literally reads, "Similarly, I will not give to a woman an abortive remedy."[34]

Thirty years ago, it was contended that performing abortions violated the Hippocratic Oath; today, it claims that assisting in organ donation of condemned inmates does likewise. Clearly, the Hippocratic Oath can have no greater import in deciding this than it did in determining whether women had a constitutional right to have

[32] See 42 F.R. 3076, 3079 (1999)
[33] *Hippocrates*, Columbia Encyclopedia, 6th Edition
[34] *The Hippocratic Oath* 10, L. Edelstein (1943)

an abortion. In *Roe,* the Court cited a scholar's conclusion that the Hippocratic Oath "originated in a group representing only a small segment of Greek opinion and that it certainly was not accepted by all ancient physicians." Hippocrates did not face the same ethical and practical questions that medical technology has created for today's physician. The Court stressed the Oath's "rigidity" and was not deterred by its prohibitory language regarding abortion. As *Roe* shows, a literalist reading of the Hippocratic Oath does not represent the best or final word on medical or legal controversies today.

Were we to adhere to the rigid language of the oath, not only would doctors be barred from performing abortions or helping terminally ill patients hasten their deaths, but according to a once-accepted interpretation, they would also be prohibited from performing any type of surgery at all, a position that would now be recognized as preposterous by even the most tradition-bound physicians. More importantly, experience shows that most doctors can readily adapt to a changing legal climate. Once the Court held that a woman has a constitutional right to have an abortion, doctors began performing abortions routinely and the ethical integrity of the medical profession remained undiminished. Similarly, doctors would engage in the permitted practice of procuring organs from willing condemned inmates when appropriate, and the integrity of the medical profession would survive without blemish.

Instead of using the Oath as a shield to evade meaningful debate on this controversial issue, the same principles of objective observation and critical deductive reasoning applied by the Oath should provide the best rationale to guide physician's logic on this topic now.

B. AMA Conflicts

In 1980 the American Medical Association formally took its stance against physician participation in state-sponsored executions. The AMA officially states that physician participation in executions is grounds for sanctions and license revocation. The state has a legitimate interest in assuring the integrity of the medical profession, an interest that includes prohibiting physicians from engaging in conduct that is at odds with their role as healers. Therefore, many states have implicitly adopted the AMA's ethical standards into their licensing standards. Amongst those standards are a set of guidelines to direct physicians on the topic.

> "Physician participation in execution is defined generally as actions that would fall into one or more of the following categories: (1) an action which would directly cause the death of the condemned; (2) an action which would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; (3) an action which could automatically cause an execution to be carried out on a condemned prisoner." [35]

The AMA further stipulates what is and is not considered to be "participation" in executions. They cite prohibitions against prescribing medications, monitoring vital signs, rendering technical advice, or even attending or observing an execution as a physician. The only allowances given by the AMA, considered to be non-participatory, are actions strictly testamentary during criminal trials or in a non-professional capacity during the execution.[36]

The AMA does, however, now list organ donation by condemned prisoners as a permissible option, assuming three specific criteria are met.[37] (1)The decision to donate must have been made prior to the inmates conviction, (2)the donated tissue must be removed only after the pronouncement of death and after the body has been removed from the death chamber., and (3)physicians cannot provide advice on modifying the execution to facilitate organ donation.

The same obstructions, as far as the AMA is concerned, are still in place, but the fact that the AMA provides guidelines regarding organ donation by those executed at all shows that things are moving in the appropriate direction. Considering the AMA's outspoken opposition on all other aspects of lethal injection, this alone should be seen as a sign of the necessity and common sense of utilizing willing inmates' organs for the benefit of another's survival.

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[35] AMA Code of Ethics; Opinion 2.06 – Capital Punishment

[36] Id. - Physicians are also allowed by the AMA to help the condemned to relieve anxiety and suffering in anticipation of their execution.

[37] Id.

a. Historical AMA Conflicts & Physician Participation

i. Physician-Assisted Suicide

Not too dissimilar from physician assistance during executions the American Medical Society has prohibited physicians from assisting in hastening the death of those with terminal illnesses. Again they cite the Hippocratic Oath and emphasize that by any involvement in a patients' death a physician risks the integrity of the medical community. In an amicus brief filed in a key assisted-suicide case[38], the AMA attached a Journal of American Medicine article, reporting the conclusion of the AMA's Council on Ethical and Judicial Affairs on assisted suicide. The article concluded, "The societal risk of involving physicians in medical interventions to cause patients' death is too great in this culture to condone euthanasia or physician-assisted suicide at this time."

The arguers of that case responded, "The assertion that following the wishes of an already dying patient will erode the commitment of doctors to help their patients rests both on an ignorance of what numbers of doctors have been doing for a considerable time and on a misunderstanding of the proper function of a physician." They argued that doctors have been discreetly helping terminally ill patients hasten their deaths for decades and probably centuries, while acknowledging privately that there was no other medical purpose to their actions. "They have done so with the tacit approval of a substantial percentage of both the public and the medical profession, and without in any way diluting their commitment to their patients."

In addition, doctors have been able to openly take actions that will result in the deaths of their patients. They may terminate life-support systems, withdraw life-sustaining gastronomy tubes, otherwise terminate or withhold all other forms of medical treatment and may even administer lethal doses of drugs with full knowledge of their "double effect", or in some states, openly satisfy the patients' willingness to die. Given the similarity between what doctors are now permitted to do and what opponents asserted they should be permitted to do, there is no risk at all to the integrity of the profession. This is a conclusion that is shared by a growing number of doctors who openly support issues such as physician-assisted suicide and proclaim it to be fully compatible with the physicians' calling and with their commitment and obligation to help the sick. According to a survey by the American Society of Internal Medicine, one doctor in five said he had already assisted in a patients' suicide, without such legal backing.[39]

In assisted suicide, whether or not a patient can be cured, the doctor has an obligation to attempt to alleviate his pain and suffering. If it is impossible to cure the patient or retard the advance of his disease, then the doctor's primary duty is to make the patient as comfortable as possible. When performing that task, the doctor is performing a proper medical function, even though he knows that his patients' death is a necessary and inevitable consequence of his actions.

Recognizing the right to "assisted-suicide" did not require doctors to do anything contrary to their individual principles. A physician whose moral or religious beliefs would prevent him from assisting a patient to hasten his death is free to follow the dictates of his conscience. Those doctors who believe that terminally ill, competent, adult patients should be permitted to choose the time and manner of their death are able to help them do so. Extending a choice to doctors as well as to patients has helped protect the integrity of the medical profession without compromising the rights or principles of individual doctors and without sacrificing the welfare of their patients.

ii. Physician Participation in Executions

The same extension of choice is true of physician participation in capital punishment. The first line of the AMA code of ethics regarding this topic states, "An individual's opinion on capital punishment is the personal moral decision of the individual." However the AMA goes on to state specifically, "A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution." While a doctor should not be a participant in an execution, according to the AMA, there is no hope of preserving life in the case of the execution. At the moment when all appeals and petitions for clemency have been turned down and the condemned is strapped down to the gurney, the man is

[38] *Compassion in Dying v. Washington*, 79 F3d 790 (1994)(9th Circuit US Court of Appeals)

[39] *Physician-Assisted Suicide and the Right to Die with Assistance,* 105 Harv. L.Rev. 2021, 2021 n. 7 (1992) (citing Richard A. Knox, One in Five Doctors Say They Assisted in a Patients' Death, Survey Finds, Boston Globe, Feb. 28, 1992 at 5). According to the same survey, one doctor in four said he had been asked by a patient for assistance in ending his life.

condemned to death by execution in a way where he cannot escape his fate. In thinking practically, the man facing imminent execution has no more hope of recovery than a brain dead patient.

Even taking the AMA's code as its intended though, there are numerous examples of physicians who participate in state-administered executions. Some physicians argue that because there is no doctor-patient relationship between the condemned inmate and the physician participation in the execution, assisting in the execution does not violate any of the medical ethics. This is assuming that it's not the prisons doctor who is participating. Some physicians feel that they have a duty to serve their country, comparing their participation to other civic duties like serving on a jury and voting.

Whatever the reasoning, physicians have taken part in executions since the inception of capital punishment as well as beyond the AMA's resolutions against it. In 1990, three physicians administered Illinois' first lethal injection. The physicians inserted the intravenous lines into the inmates arm, monitored his condition throughout the execution, and finally pronounced him dead; all against the specific AMA guidelines setup years earlier, and despite the fervent appeals of medical societies to the Governor to remove the physicians from the process.[40] Nearly all capital punishment statutes refer to the presence of a physician in some fashion undoubtedly for the reasons of their expertise. While not wanting to step on the toes of the AMA or other medical societies they may phrase the statute as "shall" or must attend while assigning no official duties. However, the sensible reason is obvious.

This is demonstrated by the proposed federal governments rule establishing lethal injection as the method of execution. The proposed rule required the presence of a physician during all federal executions. Due to the opposition of the AMA, numerous calls and letters in opposition to the proposed rule flooded the Justice Department. After reviewing the resistance, the final rule eliminated the requirement of physician attendance. The rule did not, however, prohibit physician attendance. According to the federal regulation, "Because the Department may conclude that a physician's presence is necessary to a responsible execution, physician participation will not be barred."[41] And the final codification simply left it up to the Wardens discretion stating that the 'Warden may grant access to anyone deemed necessary'.[42]

Regardless of these kinds of debates and the stance of medical societies, physicians do participate in lethal injections. In 2001, a cross-sectional survey of 413 practicing physicians showed that forty-one of the respondents were willing to perform at least one action involving capital punishment that was disallowed by the AMA.[43] Those who chose to go against the AMA's guidelines ranged from the 19% who were willing to administer the lethal chemicals to the 36% who were willing to determine death.[44]

C. Conclusion Regarding Physician Participation in Organ Transplantation from the Executed

While the AMA vehemently opposes physician assistance in capital executions the AMA is not a governing body, and it does not possess the power to either sanction or discipline physicians who choose to ignore its policies. That power is reserved to state licensing boards for physicians, which are instruments of the government. And while the AMA is a powerful entity in the medical community, it has been struggling to maintain its physician membership. Early in the 20th century nine in ten doctors were members. Today, with about 250,000 members, that number is fewer than one in three, and some estimates are lower.

There is obviously a pull away from the AMA's importance in medical matters and, as has been demonstrated, there is a clear lack of consensus between individual doctors and the AMA. It is no doubt that this lack of consensus will carry over to the issue of physician participation in organ donation from an executed inmate. In some cases the facts that lives are being saved will potentially serve to assuage some concern over participation. However, based on the history of physicians' willingness to participate in other equally controversial issues,

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[40] *A Doctor's Dilemma: Resolving the Conflict Between Physician Participation In Executions and the AMA's Code of Ethics*, 10 U. Dayton L. Rev. 975, 984

[41] 58 Fed. Reg. 4898 (1993)

[42] 28 CFR Part 26

[43] *Physicians' Willingness to Participate in the Process of Lethal Injection for Capital Punishment*, Neil J. Farber et al., 135 ANNALS INTERNAL MEDICINE 884, 886 (2001)

[44] *Physicians' Attitudes about involvement in Lethal Injection for Capital Punishment*, Neil J. Farber et al., 160 ARCHIVES OF INTERNAL MED. 2912, 2912 (noting that in a recent survey of physicians, more than half approved of the AMA's disallowed medical actions involving capital punishment.)

there will likely be little difficulty in obtaining the participation of doctors to assist in the processes involving organ donations from the condemned.

VI. Anti-Death Penalty Community Opposition

Amnesty International, Human Rights Watch, the Death Penalty Information Center, and other anti-death penalty groups have not proposed a lethal injection protocol which they believe is more humane. This may be due to, as Jack Kevorkian noted, "Because it seems to be the macabre aspects of the death penalty which best sustain their crusade, opponents tend to conspire against anything capable of diminishing its horror."[45] Death penalty opponents have tacitly acknowledged at times that the move to lethal injection was a more humane method of execution, fearing that with the more palatable form of death there would be an increase in the acceptability and use of the death penalty.[46] Lethal injection seemed too humane to some death penalty opponents to be able to claim the "cruel and unusual punishment" arguments. Therefore some had gone so far as to fight against lethal injection, favoring electrocution because lethal injection "sanitizes" and "sugarcoats" killings.[47]

In Baze v. Rees, the Supreme Court noted that it was undisputed that, in moving to lethal injection, the States were motivated by a desire to find the most humane and decent means of death possible given our knowledge of human science. Quoting a statement by the State Representative who sponsored the bill to replace electrocution with lethal injection in Kentucky, the Court said, "if we are going to do capital punishment, it needs to be done in the most humane manner." [48] Electrocution remains a constitutional method of execution. But most states have adopted lethal injection as a more humane alternative.[49] Therefore, the most recent move in Ohio to a yet more humane execution method works against the anti-death penalty group's ultimate goal. Taking this one more step, to allow for organ donations from those executed under this new protocol could likewise be perceived as a further setback to that goal.

Death penalty opponents have two primary concerns when it comes to the possibility of organ donation at the time of execution. First they worry that the positive and more humane aspects of a death by anesthesia will prompt more judges and juries to opt for the sentence of death, a slippery slope belief that the inmate will have the option of creating something good from his debauched state and thus be a good candidate for the death penalty. Secondly, they surmise that far more death row inmates will decide to drop their appeals and opt for this new, seemingly painless and altruistic-leaning method of execution. The contention is that life in prison can be so abysmal that such a death could actually seem like an escape from an otherwise tortured existence, prompting more "volunteers". The reasoning is that inmates don't volunteer now because there's a fear surrounding the existing methods and given a more painless option may open the floodgates.

As to whether such a change will force more judges and juries to opt for death with a more humane alternative, for the time being this is conjecture. The consensus has been that lethal injection is humane and visually palatable. It is a method of death that many death penalty proponents argue as too humane, believing that the serenity of sleep of the executed in no way makes up for the horrors that the victims of their crimes faced. A statement by Supreme Court Justice Scalia echoes the feeling of many. He was describing a gruesome case which he considered particularly eligible for the death penalty – the rape and murder by four men of an eleven year old girl. He stated, "How enviable a quiet death by lethal injection compared to that!"[50] Whether the public, juries, would find this new form of lethal injection any more humane and whether that would have an impact on their decision making to send more to their death is unlikely, as there is little difference from the publics' perspective.

Finally, as to the issue of whether an alternative method of death and the ability to donate organs would be a cause for more inmates to volunteer for execution, I can only speak from a personal perspective. Living on

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[45] See Jack Kevorkian, *Medicine, Ethics, and Execution by Lethal Injection*, 4 Med. & L. 307, 311 (1985)
[46] David Firestone, *Court to Rule on Method's Constitutionality*, New York Tiimes, March 7, 2001
[47] Bill Cohen, *Ohio Considers Junking Electric Chair*, www.stateline.org (July 30, 2001)
[48] (See Fordham Brief 2-3) See *id.*, at 29-30
[49] It should be noted that the petitioners in this case did not propose a more humane method of execution, likely for the same reasons that death penalty opponents resist the humane organ donation possibility. From their vantage point anything more humane defeats their purpose. No method of execution would be acceptable. (see Baze v Rees)
[50] Callins v. Collins, 510 U.S. 1141, 1143 (1994)(Scalia, J., concurring)

death row, granting that this particular death row is a microcosm when compared with other more sizable death rows, you have a better view of the general attitudes of those facing the prospect of death and of the possibility of a life in prison. There is a certain segment that, for personal reasons, will choose to volunteer for death. Whether that means death by guillotine or firing squad or by having each cell pinched out of their bodies painfully, that same segment will still choose to die. The method is of minimal concern. I myself, for my own reasons, have chosen to die not having given much thought to the way that I was going to die. My only wish was that I would be able to affect some good with my death that would be of benefit to someone besides me. After looking into the manner of execution and discovering that the best that I could do with my body was to make an anatomical gift to science, I decided to stall my death long enough to try to make a change in procedures in a personal wish to make a greater gift, a gift of life that I was hoping for. Finding out that my body could potentially save several lives solidified that mission. Would having the option to potentially save lives with my death have influenced my decision to forego my appeals? Personally, my reasons for choosing the end to my life would trump any such ideals. And if I fail at this mission, I will still choose to end my appeals and die. I suspect that other inmate's decisions to end their appeals had little to do with the recurring benefits of their death. Therefore, I believe it unlikely that an adjustment to a slightly more humane protocol, even combined with the ability to donate, would be a game changer for an inmate not already predisposed to "volunteering" to be executed.

While both of these arguments are worth noting, the reality is that the death penalty is currently here, legislatively and socially accepted in the U.S. The fight against the death penalty is a worthy one. But as long as we cannot eliminate current use of the death penalty, we should work to ensure that those who must face death can do so in a way that is most humane and which allows for some dignity and pride.

VII. China Syndrome

Those opposed to organ donation by condemned inmates bring up the organ harvesting atrocities in China as the primary reason to disallow this practice in this country. Experts report that approximately ninety percent of all organ transplants in China come from executed prisoners,[51] many of whom were sentenced for non-violent crimes and some of whom were sentenced after rushed trials based on confessions extracted under torture and who were likely innocent.[52] The Chinese government denied this practice but insisted that even if organs were taken from executed prisoners, it was only done so after the inmates or their families gave consent to do so.

In March of 2006 China's Health Ministry officially banned the sale of human organs in China and strengthened regulation over organ transplants by mandating the written consent of organ donors.[53] The Chinese government instituted a law banning a problem that they had insisted did not exist. Some speculated that the timing of this had something to do with the upcoming 2008 Beijing Olympics and the recent increase of worldwide media attention. But with the new ban China, in essence, admitted that there was previously a problem with organ procurement from involuntary donors from death row.

Largely due to the abuses in China the Transplantation Society issued a revised set of "Ethical Guidelines" which advises its members not to get involved in obtaining or transplanting organs from executed prisoners.[54] There has been an obvious and understandable reaction to avoid adopting policies which could associate the U.S. with practices which are so ethically egregious.

The unfortunate reality of an organ procurement plan gone wrong should not undermine every program based on that premise. The execution processes in the States differs in just about every ethical way from those in China. To follow the logic that the U.S. cannot consider organ procurement from the condemned because China set a bad example should have the U.S. likewise reconsidering its stance on capital punishment. But unlike China's practices, organ donation in the U.S. is by voluntary consent. Any organ procurement policy regarding the condemned will likewise necessarily be at the willful consent of the condemned. And unlike China, organs will not go to the highest bidder. Organs procured from the executed prisoner will only be available to those recipients who are registered on the national waiting list. Although China's organ procurement system should serve as a powerful reminder what not to do, it must not be used to distract

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[51] *Death Row is Organ Source, China Admits*, L.A.Times, Mark Magnier & Alan Zarembo, Nov. 18, 2006, at A1
[52] *Quandary in U.S. over Use of Organs of Chinese Inmates*, N.Y. Times, Nov. 11, 2001, at A1, Craig S. Smith
[53] *China Says To Ban Sale of Human Organs,* Reuters, March 28, 2006, Lindsay Beck
[54] *Transplantation Society Revises Ethical Guidelines*, Transplant News, Sept. 16, 1994

attention away from the ability to allow organ donations from condemned prisoners in an ethical and practical manner.

VIII. LOGISTICAL CONCERNS

A. Organ Transplantation Facility

Most states statutes stipulate something similar to Oregon's statute in regards to where the execution must occur. "All executions shall take place within the enclosure of a Department of Corrections institution designated by the Director of the Department of Corrections".[55] But most correctional facilities do not already have fully equipped surgical facilities on the premises. Ideally, organ procurement should occur immediately after the donator has been pronounced dead. And it is important to the institutions to pronounce death within the corrections facility. Without a surgical facility on the grounds of the institution, this presents a challenge.

Further research would have to be done regarding the necessity of transportation of the deceased inmate from the death chamber to transplantation facilities for the removal organs. Organs have a shelf life once removed so there are procedures in place which ensure that organs get from the place of removal to the transplant recipient. But whether the State will allow for the inmates body to be transported after brain death has been pronounced yet while being ventilated is a question mark. In the event that the State will not allow this to take place, do the transplantation hospitals have a surgical vehicle which can be prepped within the institution to accommodate organ donation?

B. Donor Matching Between Executed Prisoner & Recipient

Donor matching for all solid organs will necessarily involve a detailed pre-screening to not only ensure that matches are found but also to guarantee that the inmate has no pre-existing diseases or conditions that would preclude the inmate from being a donor. It is possible for these types of tests to be run once the organs are procured, but it would make sense to have as many compatibility factors lined up as possible to allow for maximum utilization of viable organs.

Some have expressed concerns that most prisoners on death row have been involved in risky behaviors and lifestyles that would make them more susceptible to transmittable diseases. Due to the possible prevalence of drugs, unsafe sexual practices, and tattooing they advance that prisoner organs are likely to be infected with TB, HIV, or hepatitis because of participating in high risk activities.[56] While this may be the case amongst some death row inmates, these are all conditions which will be properly screened. No inmate will be allowed to donate organs which are infected. The organ procurement process is well developed and the procedures necessary for screening the organ donor should present no significant obstacle to for prison officials who already closely monitor the condemned prisoners' physiology.

IX. HELP

Thus far, what you've read is through referenced research. I'm now to a point where additional outside assistance is needed. The following steps are what I believe are necessary to accomplish this goal. However, with such a limited view, additional steps will likely be required. Therefore, I welcome your input and suggestions.

- Step One – Consult Anesthesiologist

By the time that you are reading this, Ohio will have executed their first condemned inmate using the adopted one-drug method.[57] Until then, this option has been generally untested on humans. It's likely that no inmate has yet been given the opportunity to utilize this method for the purposes discussed in this writing. Therefore, it will take discussions with an expert in the field of anesthesiology to determine the appropriate method by which organ donation from an executed inmate can take place.

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[55] Oregon Revised Statutes: 137.473

[56] *AIDS in Prisons: Judicial Indifference to the AIDS Epidemic in Correctional Facilities Threatens the Constitutionality of Incarceration*, D. Stewart Sowder, 37 N.Y.L. Sch. L. Rev. 663, 666, 667, 668 (1992). See also *Giving Until It Hurts: Prisoners Are Not the Answer to the National Organ Shortage*, Whitney Hinkle, 35 Ind. L. Rev. 593

[57] Scheduled for December 8th, 2009.

What will be most vital is to the determination of the time of brain death and the pronouncement of death prior to the inmate being ventilated for the survivability of his organs. The timing is key and will necessitate the supervision, if not the direct assistance, from a licensed anesthesiologist. As previously discussed, physician participation in executions on any level is a controversial topic. But it is hoped that the competing interests of saving others lives will encourage such participation.

- Step Two – Change Oregon's Lethal Injection Protocol

It is necessary to change the lethal injection protocols from the current three drug protocol to the one drug method as Ohio has done. Now that one state has adopted this change, this step has become much simpler but by no means automatic. This is where the expertise of the attorney profession comes in.

The way to proceed may be to petition the prison institution to use a lethal injection protocol that would allow for organ donation. It should not take much effort to have an anesthesiologist confer with the prison to devise a safe and sure method that would ensure the viability of the inmate's organs while maintaining the prisons need for security and assurance of the death of the inmate. If the prison decides that there is no such way to proceed, then perhaps discussions should take place with the Attorney Generals office to assist in the adoption of the one-drug protocol. It is likely that the AG's office is already considering the option in order to quell any challenges to current or future litigation associated with Oregon's lethal injection protocols.

Possibly the most extreme course of action may be to mirror the fight for Assisted-Suicide here in Oregon to encourage the citizens of Oregon to adopt the change. While other states such as New York and Washington proceeded to fight through the Court system, claiming that there was a constitutional right to physician assisted suicide, Oregon chose to go the route of the voter ballot initiative. Washington was eventually successful in getting a physician-assisted statute on the books in 2008, but only after more than a decade of court battles on the subject.

The issue is not whether a state must allow for organ donation protocols for the to-be executed inmates, but rather can the state permit it. The answer to that is obviously yes, so there really is no need to fight it out in court. Instead of going through the backdoor – the courthouse door – go through the front door – the statehouse door.

Part of why the state of Oregon was able to successfully pass the Death with Dignity initiative had to do with the confluence of demographic variables in Oregon. Oregonians are known for placing a high value on personal choice and autonomy.[58] Consistent with that is an observation by Oregon State University political science Professor William Lynch, "Oregon is by a variety of statistical measures the most secular state of the union."[59] These demographic factors could also work for the benefit of passing any organ donation initiative for the condemned.

While this is not a desired course of action, as the road is much longer, it is an avenue that I am willing to pursue if all other efforts fail. But with the talents of persuasion and common sense, it is hoped that this is an issue resolved internally within the Department of Corrections or in the AG's office.

- Step Three – Implement the Change Nationwide

When you look into each of the 35 states statutes and guidelines that govern the use of the death penalty, you find three general types of statutes. (1) Eleven states refer to an injection of a "substance or substances in a quantity sufficient to cause death", or similar language.[60] (2) Eleven states refer to an actual combination of chemicals used, namely an ultra-short acting barbiturate in combination with a paralytic.[61] (3) One state simply refers to "lethal injection".[62] Many states either do not make public their actual execution protocols or simply have no written protocols largely due to lack of use of the actual execution in those states. There is generally a

[58] Mark O'Keefe, *Freedom From Religion*, Oregonian, Nov. 9, 1997, at G1
[59] Id. at G2.
[60] Arizona, Connecticut, Delaware, Georgia, Indiana, Kansas, Kentucky, Louisiana, New York, Ohio, and Texas.
[61] Arkansas, Illinois, Maryland, Mississippi, Montana, North Carolina, Oklahoma, Oregon, Pennsylvania, South Dakota, and Wyoming.
[62] Tennessee.

vagueness surrounding the lethal injection statutes, and typically room for adjustments with most states giving the caveat, "or other substance sufficient to cause death" when referring to the chemical process. This is likely by design so that the states would not be locked into one method in a hotly debated scheme.

The adoption of the one-drug protocol in the lethal injection states will not likely be much of a challenge. To likewise get these states to recognize the importance of an organ donation policy associated with the execution will likely be more difficult due to the aforementioned controversies surrounding the topic. The greatest way to achieve this goal is to set a precedent. Oregon, for reasons previously mentioned, seems to be a good state in which to be able to set this precedent. Once organ donation by a willing condemned inmate has been achieved, it will be much simpler for other states to adopt this as an option.

CONCLUSION

There are great efforts aimed at abolishing the death penalty; Minds much more educated on the topic and ambitious for its demise than I'll ever be. When you sit where I do and see that there are some who should be removed from this earth, it makes for conflicted activism.

But living under a death sentence, regardless of what you believe that your fate should be you begin to look for ways to improve or adjust the system in a way which brings needed benefit to some while the greater fight is being fought.

If a life can be saved in the process or at least the possibility and in a state sanctioned way, then it's an issue that must be explored. If it turns out that eight or ten lives can be saved in the process, then it's something that I want to actively pursue.

If because of those efforts adjustments are made in the state or nations system so that others if a similar mindset who want to altruistically give where they can from their unfortunate circumstances, helping to save hundreds of lives…There's never going to be a more motivating goal in life than that.

Death resulting from the unavailability of an organ is unnecessary when you begin ignoring alternatives. Instead of regarding these deaths as inevitability or just as one sadder statistical occurrence, it should be seen for what it really is: an irrational tragedy which could have been avoided by overcoming needlessly restrictive taboos.

Regards,

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