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Wanted Dead or Alive? Kidney Transplantation in Inmates Awaiting Execution

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The United States Supreme Court has held since 1976 that prison inmates are entitled to the same medical treatment as the free public.[1] In most states, this care includes major organ transplants—a matter that has produced widespread debate following California's decision in 2002 to subsidize a $1 million heart transplant for a 31-year-old convicted robber in his fourth year of a 14-year sentence,[2] and Minnesota's provision of a $900,000 lifesaving bone-marrow transplant to an incarcerated murderer with leukemia.[3] This controversy surrounding the cost of prisoners' health needs—both economic and social—took a macabre turn in 2003 when Horacio Alberto Reyes-Camarena, a 47-year-old dialysis patient on Oregon's death row, formally requested a kidney transplant. Such a procedure would have been likely to save the state money in the long run, as the transplant itself would have cost between $80,000 and $120,000 with an approximately $12,000 additional annual charge for immunosuppressant drugs. Dialysis, on the other hand, costs Oregon $121,025 per patient each year.[4] The surgery also appeared to be in Reyes-Camarena's best medical interests; studies report that a kidney transplant can decrease mortality in end-stage renal patients by up to 82 percent.[5] However, with more than 59,000 Americans waiting for kidneys, nearly 200 of them in Oregon, the prospect of such a transplant drew considerable criticism.[6] A review panel ultimately rejected Reyes-Camarena's request—for undisclosed reasons.[7] Yet with a graying and increasingly ill prison population, the question is bound to resurface: Should death row inmates be eligible for kidney transplantation? A combination of ethical and practical considerations suggests that they should be considered.

The American healthcare system still has an ambivalent attitude toward the premise that, to paraphrase George Orwell, some patients are more equal than others. In a society that is reluctant to expand overall medical expenditures, care continues to be allocated based upon a patient's ability to pay. However, the medical community has grown increasingly unwilling to allow non-economic social factors, such as the sick individual's perceived moral worth, to shape the quality of his or her care. Negative experiences with the "God committees" of the pre-Medicare era, in which lay people and physicians used criteria of "social worth" such as "level of education" and "future potential" to decide which renal patients were to receive scarce dialysis treatments and which would die, have turned many in both the medical profession and the public at-large against this sort of rationing.[8] While some commentators argue that patients' past disease-inducing behaviors should be used to determine their eligibility for scarce medical resources, such as barring liver transplants for recovered alcoholics, far fewer argue that the general social value or moral history of

patients should determine the quality or nature of their care.[9] When it comes to healthcare, "bad people" are as equal as the rest of us.

The case of a death row inmate who requests a kidney transplant challenges these general principles in two ways. First, the criminal justice system—and not the medical community—has made a determination of social worth; according to the state, the inmate's social value is so low that he or she deserves execution. Second, although kidney transplants increase survival rates over dialysis, the decision not to transplant is not an automatic death sentence. Ignoring for a moment the ethics of capital punishment and the morality of a physician facilitating the practice—both somewhat dubious propositions—it does not follow that just because the state can take an individual's life, the medical community can lower the quality of that life in the interval prior to execution. Reducing the food rations of death row inmates, for example, would certainly be unacceptable. The state's determination of social worth only finds that the condemned prisoner no longer deserves life—a far higher bar than a determination that he or she is no longer worthy of healthcare prior to death. Moreover, the accuracy of the state's determination is often questionable. Conservative estimates suggest that 75 percent of death sentences are overturned on appeal, and one in 15 death row prisoners is eventually exonerated of all charges.[10] If physicians were to use the state's imprecise and fluctuating determination of social value to determine transplant eligibility, even innocent individuals of high social worth would suffer—and some would inevitably die. Alternatively, an effort by doctors to re-examine the criminal justice system's decision and to deny transplant only in cases of obvious guilt would place physicians in the awkward "social worth" evaluating role they are seeking to avoid.

A second set of objections to death row transplantation relies not upon considerations of social worth, but instead upon those of medical prognosis. Life expectancy, for instance, is considered to be a perfectly legitimate factor in allocating kidneys among free individuals. To place a kidney in an inmate who will soon die, the argument goes, is nothing more than squandering an organ. Several false premises underlie this reasoning. First, only a small fraction of death row inmates are ever actually executed. Of those who are eventually executed, the Bureau of Justice Statistics estimates that their life expectancy on death row now approaches 13 years;[11] 13 years is also the estimated half-life of a cadaver-donor kidney transplant—meaning that half of all transplanted death row inmates would die of natural causes before their execution dates.[12] When all of these factors are combined, the number of organs that would be "squandered" is relatively small. Second, the difference between the use of "natural" life expectancy as a factor in the allocation of kidneys and the use of the probability of execution as a factor is morally significant. The former has long been a staple of medical justice. In a system in which scarce resources must be distributed on some basis, this system affords optimal organ use *without* making or affirming value judgments about the lives of individuals. In contrast, the use of a prediction of life expectancy that incorporates the probability of execution inevitably subrogates "medical justice" to "social justice,"[13] and affirms value judgments about the "social worth" of individuals. Such an approach rejects the egalitarian notion that noneconomic social factors should play no role in the allocation of healthcare resources.

The general public, and many in the medical community, may have a visceral objection to death row transplants. When it comes to kidneys, however, the economics should give them some solace. Since transplantation costs less than dialysis, the state can reallocate the revenue saved toward other healthcare projects—presumably including many lifesaving endeavors. More lives might be saved by re-allocating these funds than would be saved by making the kidneys available to free people, especially when one remembers that kidney transplant is often a life-enhancing rather than a life-lengthening procedure. Many people do not want to hear this, of course. Much of the public would probably be willing to sacrifice healthcare resources if it meant that convicted murderers would *not* receive medical care. Courts have had the wisdom to think otherwise. They have not carved out exceptions for transplant cases and/or death row inmates, and no convincing reason exists for them to do so.

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NOTES

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