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Prison Inmates are Constitutionally Entitled to Organ Transplants—So Now What?

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PRISON INMATES ARE CONSTITUTIONALLY ENTITLED TO ORGAN TRANSPLANTS—SO NOW WHAT?

I. INTRODUCTION

In recent years, reports concerning the receipt of organ transplants by prison inmates have surfaced. In February of 2003, for example, the media reported that the state of Nebraska was planning to provide a female inmate with a life-saving liver transplant at the expense of Nebraska taxpayers.[1] Carolyn Joy, the inmate seeking the transplant, was convicted of first degree murder and is currently serving a life sentence at the Nebraska Correctional Center for Women in York.[2] Doctors who evaluated Joy's liver disease concluded that her only chance of long-term survival was a liver transplant.[3] Although Joy was initially cleared for receipt of a liver, her placement on a liver transplant waiting list was contingent upon her losing weight and better controlling her diabetes.[4]

Similarly, in the spring of 2003, the media learned that Oregon was considering providing convicted murderer and death-row inmate Horacio Alberto Reyes-Camarena with a kidney transplant.[5] Although a prison doctor had concluded that Reyes-Camarena was a good transplant candidate,[6] the prisoner ultimately failed to receive a transplant because a medical review board determined that Reyes-Camarena failed to meet several criteria for transplant eligibility.[7] Despite the fact that Reyes-Camarena was denied a

1. Karyn Spencer et al., *Inmate Approved for Transplant List*, OMAHA WORLD-HERALD, Feb. 4, 2003, at 2B.

2. *Id.* Joy, a former prostitute, was convicted of "robbing, sexually assaulting and murdering another prostitute." *Id.*

3. *Id.* Joy attributed her liver condition to the alcohol and heroine she abused during her years as a prostitute. *Id.*

4. *Id.*

5. Michael Higgins, *Death-row Inmate up for Transplant: Murderer may get Kidney*, NAT'L POST, May 28, 2003, at A3. In 1996, Reyes-Camarena brutally attacked two women. One of the women died from multiple stab wounds. Reyes-Camarena was convicted of murder and sentenced to die by lethal injection. *Id.*

6. Lee Douglas, *Killer in Need of New Kidney Starts Ethics Row*, CHI. TRIB., May 29, 2003, at 10.

7. Camille Spencer, *Panel Denies Transplant for Inmate on Death Row but Issue Remains*, OREGONIAN (Portland), June 12, 2003, at B1 (article fails to specify what criteria led to Reyes-Camarena's failure to receive a transplant).

kidney transplant for medical reasons, many Oregonians were concerned that prison officials would even consider providing a death-row inmate with a transplant at the taxpayers' expense.[8]

Reports concerning prisoners' actual receipt of organ transplants have also surfaced. The most extensively covered story involved a California inmate who, in January of 2002, received a heart transplant at Stanford Medical Center at a cost to taxpayers of one million dollars.[9] The unidentified inmate was serving a fourteen-year sentence for an armed robbery conviction.[10] Less than a year after receiving the life-saving transplant, the unknown inmate died. Officials attributed the inmate's death to his being a "less than model patient."[11] The prisoner had failed to strictly adhere to the rigorous post-operative care regimen.[12]

Reports such as those concerning Joy, Reyes-Camarena, and the unidentified California inmate incited rage among many law-abiding citizens and debate among medical, ethical, and legal experts.[13] In the wake of the California prisoner's heart transplant, authorities feared citizens might destroy their organ donor cards in outrage.[14] This public outcry, in turn, has caused leaders in government to attempt to fashion solutions to the problem of prisoners receiving transplants. In the summer of 2003, for example, a bill was introduced in the Louisiana state legislature that would have prohibited state-funded organ transplants "for people who have exhausted all appeals after a conviction for first-degree murder, punishable by death or a life sentence, and second-degree murder, which carries a mandatory life sentence."[15] Likewise, in early 2003, legislation was introduced in California that would permit those who sign organ donor cards to exclude prisoners from receiving their donated organs.[16]

8. *Id.*

9. *Prisoner Gets $1M Heart Transplant* (Jan. 31, 2002), *at* http://www.cbsnews.com/stories/2002/01/31/health/main32605.shtml?CMP=ILC-Search/.

10. *Id.*

11. *Bill Allowing Donor Card Signers to Exclude Prisoners from Getting Their Organs Introduced in California*, TRANSPLANT NEWS, Jan. 15, 2003, at O [hereinafter *Bill Allowing Donor Card Signers*].

12. *Id.* (article does not specifically identify the causes of the inmate's death).

13. Bryan Robinson, *Death-Row Privilege: Condemned Prisoner May Get Kidney Transplant While Law-Abiding Citizens Wait*, May 28, 2002, *at* http://abcnews.go.com/sections/us/GoodMorningAmerica/deathrow_transplant030528.html [hereinafter *Death-Row Privilege*]. *See also* Douglas, *supra* note 6, at 10; Jeremy Olson, *Urgency Comes First in Transplant Criteria*, OMAHA WORLD-HERALD, Feb. 9, 2003, at 1B.

14. *Bill Allowing Donor Card Signers*, *supra* note 11, at O.

15. *Panel Backs Ban on Inmate Transplants*, THE BATON ROUGE ADVOC., June 13, 2003, at 15A.

16. *Bill Allowing Donor Card Signers*, *supra* note 11, at O.

Any attempt to quell the public outcry against organ transplants for prisoners necessarily involves three issues. First, one must understand why prisoner organ transplants have so greatly enraged the American public. Therefore, Part II of this Note briefly addresses organ transplants, America's aging prison population, and the troublesome intersection of these two issues. Once the basis for the public outcry is understood, one must then ask whether states are constitutionally required to provide prison inmates with organ transplants.[17] Part III of this Note discusses the legal standard by which prison health care is assessed. Part IV analyzes the prisoner transplant issue in the context of Part III and ultimately determines that states are required under the Eighth Amendment of the Constitution to provide prisoners with medically necessary organ transplants. In light of Part IV's conclusion that states cannot appease the public by simply refusing to provide prisoners with organ transplants, Part V examines three classes of possible solutions to the public's outrage. After examination of potential solutions, this Note concludes that proposals aimed at reducing the country's aging prison population are the most promising and in fact the only viable solution to this serious problem.

II. THE FACTUAL BACKGROUND

In order to truly understand the debate concerning prisoner receipt of organ transplants, it is essential to first understand the nature of organ transplants and the current state of America's prison population. Section A gives a brief history of organ transplantation and an overview of the current state of organ transplantation in America. Section B explains the current state of America's prison population. Section C examines the intersection between the current state of organ transplantation and the demographics of the country's prison population.

A. Organ Transplants

The history of organ transplants in the United States is relatively short. The first successful kidney transplant was performed in 1954, the first successful liver transplant in 1967, and the first successful heart-lung transplant in 1981.[18] Though transplantation was considered experimental by some at its advent, the practice has become widely accepted and frequently practiced in recent years.[19]

17. Indeed, if states are not constitutionally required to provide prisoners with organ transplants, the public outcry could be quelled simply by refusing to provide inmates with organ transplants.

18. *Timeline of Key Events in U.S. Transplantation and UNOS History*, *at* http://www.UNOS.org/whoweare/history.asp (last visited Sept. 8, 2004).

19. *See generally* Eric F. Galen, Comment, *Organ Transplantation at the Millennium: Regulatory Framework, Allocation Prerogatives, and Political Interests*, 9 S. CAL. INTERDISC.

From January to June of 2004, for example, the United Network for Organ Sharing ("UNOS")[20] reported that 13,222 organ transplants were performed in America alone.[21] Success rates for organ transplants similarly indicate that such procedures are no longer experimental. For example, of those who received heart transplants from 1996 to 1999, three-year survival rates varied from 72.0% to 83.5% depending on the age of the person undergoing the procedure.[22] Similarly, three-year survival rates for kidney recipients ranged from 78.0% to 100.0% depending on the age of the patient.[23] Consequently, organ transplantation is no longer considered an experimental procedure in the United States but rather is a frequently performed surgery with generally successful results.[24]

Despite the frequency and success of organ transplants, the procedures are not without their downfalls. In particular, finding a suitable organ is difficult.[25] Moreover, once a suitable organ is found, the cost of the transplant can be exorbitant.[26]

As of September 8, 2004, UNOS reported that 86,743 people were candidates on organ transplant waiting lists.[27] The number of people on transplant waiting lists, however, greatly exceeds the number of organ donors in the United States. As a consequence, thousands of individuals die annually while waiting for a suitable organ to come along. In 2003, for example, 6,257 people who had been placed on transplant waiting lists died before a suitable

L.J. 335 (1999); Kelly Ann Keller, Comment, *The Bed of Life: A Discussion of Organ Donation, its Legal and Scientific History, and a Recommended "Opt-Out" Solution to Organ Scarcity*, 32 STETSON L. REV. 855 (2003).

20. UNOS is non-profit organization that manages transplant waiting lists and organ allocation in the United States. Jessica Wright, Note, *Medically Necessary Organ Transplants for Prisoners: Who is Responsible for Payment?*, 39 B.C. L. REV. 1251, 1255–56 (1998).

21. *U.S. Transplantation Data*, *at* http://www.UNOS.org/data/default.asp?displayType =usdata (last visited Sept. 8, 2004). Data is updated daily. Readers interested in learning the most recent figures should visit the website.

22. *Heart Kaplan-Meier Graft Survival Rates for Transplants Performed: 1996-2001*, *at* www.optn.org/latestData/rptStrat.asp (Sept. 3, 2004). The UNOS website contains detailed survival information for all organ transplants organized by specific medical criteria. See the UNOS website at http://www.unos.org for a fuller discussion.

23. *Kidney Kaplan-Meier Patient Survival Rates for Transplants Performed: 1996-2001, at* http://www.optn.org/latestData/rptStrat.asp (Sept. 3, 2004).

24. Dulcinea A. Grantham, Comment, *Transforming Transplantation: The Effect of the Health and Human Services Final Rule on the Organ Allocation System*, 35 U.S.F. L. REV. 751, 751 (2001) ("Organ transplantation, once a risky and uncommon procedure, is now a routine medical procedure with a relatively high success rate.").

25. *See infra* note 28 and accompanying text.

26. *See infra* notes 29–31 and accompanying text.

27. *U.S. Transplantation Data*, *supra* note 21.

organ was located.[28] Due to drastic organ shortages, the decision to provide one candidate with an organ transplant necessarily sentences another waitlisted candidate to death.

Even if one is able to find a suitable organ, the cost of the procedure is staggering. The average organ transplant costs $214,860.[29] Consequently, the vast majority of Americans would be unable to cover the cost of a transplant out-of-pocket. While some health insurance companies have begun to expand coverage to medically necessary transplants, coverage is far from consistent.[30] Similarly, Medicaid does not consistently cover the costs of these procedures.[31] As a result, many citizens who need an organ transplant to survive will die because of their inability to finance the life-saving surgery.

B. America's Aging Prison Population

America's prison population is aging. Inmates fifty-five and older constitute approximately forty-five percent of all prisoners.[32] In addition, this same prison population is rapidly growing and is expected to continue on this upward trend.[33] As prisoners grow older, their health deteriorates. Studies have found that elderly inmates suffer from "a variety of physical problems associated with aging."[34] In light of their failing health, elderly inmates are likely to require medically necessary organ transplants.[35]

As the health of elderly inmates declines, the cost of caring for and incarcerating such inmates skyrockets. Estimates indicate that the cost of

28. *Fast Facts about Transplants Jan. 1, 2003-Dec. 31, 2003, at* www.ustransplant.org/csr_0704/facts.php (last visited Sept. 8, 2004).

29. Paul Lesko & Kevin Buckley, *Attack of the Clones . . . And the Issues of Clones*, 3 COLUM. SCI. & TECH. L. REV. 1, 19 (2002). The average heart transplant costs $303,400, the average kidney transplant $111,300, the average liver transplant $244,600, the average pancreas transplant $113,700, and the average heart-lung transplant $301,200. *Id.* at 19 n.10.

30. Wright, *supra* note 20, at 1254.

31. *Id.*

32. Sam Torres, Article Review, FEDERAL PROBATION, June 2003, at 62 (reviewing Catherine M. Lemieux, et al., *Revisiting the Literature on Prisoners Who are Older: Are We Wiser?*, *in* THE PRISON J., Dec. 2002, at 440). For the purposes of this Note, the prison demographic termed "elderly inmates" generally refers to prisoners age fifty-five and up.

33. Tammerlin Drummond, *Cellblock Seniors*, TIME, June 21, 1999, at 60. In fact, "[m]en 55 and older comprise one of the fastest-growing cohorts in the prison population." George F. Will, *A Jail Break for Geriatrics*, NEWSWEEK, July 20, 1998, at 70.

34. Torres, *supra* note 32. Common conditions include hypertension, emphysema, and heart and respiratory diseases. *Id*.

35. Some have hypothesized that the recentness of the prisoner organ transplant debate is attributable to the fact that "prisons are only recently seeing inmates who are aging." Wright, *supra* note 20, at 1252. Similarly, CBS News reported that "taxpayer-financed transplants are likely to increase as the prison population ages." *Prisoner Gets $1M Heart Transplant*, *supra* note 9. Therefore, one can expect the concern about prisoner organ transplant to rise in accordance with the consistent increase of elderly inmates.

caring for an elderly inmate is generally two to three times that of caring for an average young inmate.[36] Some approximate that incarcerating an elderly inmate costs $65,000 per year.[37] Given that the number of elderly inmates is projected to substantially increase, it is inevitable that taxpayers will spend more each year to incarcerate these prisoners.

C. Framing the Public Debate: The Intersection of Organ Transplants and America's Aging Prison Population

Many law-abiding citizens resent paying for the medical care of those behind bars. The issue of providing inmates with organ transplants at the taxpayer's expense, however, has led to arguably the loudest public outcry against state-financed medical care for prisoners. This tremendous public backlash can be attributed to the intersection of organ transplant issues and America's aging prison population.

In addition to simply having to pay for prisoner organ transplants, many taxpayers also dislike the idea that tax dollars go to provide inmates with a medical procedure that many law-abiding citizens are unable to afford. For example, Dudley Sharp, a spokesperson for a Houston-based victims' rights group, has argued that "[i]t is unconscionable that we would put [prisoners] . . . ahead of hard working citizens that are not even on the list [for transplants] because they can't afford the insurance."[38] Others have expressed similar sentiments.[39]

In addition to the cost-prohibitive nature of the procedures, the idea of providing prison inmates with organ transplants has also been attacked because of the scarcity of organs available for transplant. Because thousands die yearly while awaiting an organ transplant, the allocation of an organ to a prison inmate necessarily sentences another candidate, likely a law-abiding citizen, to death.[40]

When the previous sentiments are viewed in light of America's aging prison population, it becomes clear that the issue of organ transplants for inmates is not going to fade away. Rather, inmate receipt of transplants is

36. Will, *supra* note 33, at 70; Drummond, *supra* note 33, at 60.

37. Drummond, *supra* note 33, at 60.

38. *Death-Row Privilege*, *supra* note 13.

39. *See generally* Jo Dondis, *Organ Debate: Should Inmates Qualify for Publicly Financed Organ Transplants?*, *at* http://abcnews.go.com/sections/ant/DailyNews/inmates_organs020323.html (Mar. 3, 2002); *Change of Heart*, *at* http://oaktree.cbsnews.com/stories/2003/09/12/60minutes/main572974.shtml (Sept. 14, 2003).

40. As noted on 60 Minutes, "by giving [a] prisoner [a transplant], a death sentence [is] passed to someone else." *Change of Heart*, *supra* note 39. Similarly, Dudley Sharp, spokesperson for a Houston-based victims' right group, has asserted that "[t]here's no doubt—there's no debate—that people have lost their lives while murderers have received transplants." *Death-Row Privilege*, *supra* note 13.

likely to increase as the prison population grows older and less healthy. Consequently, more inmates may receive transplants at the taxpayers' expense while individuals on the outside continue to die either because of lack of funding or lack of an available organ.

Though public backlash in light of recent transplant events has been serious, the first issue facing states is not how to please the masses, but rather whether they are constitutionally required to provide such controversial procedures to inmates at all. Section III outlines the standard by which a prisoner's constitutional right to health care is determined.

III. THE CONSTITUTIONAL STANDARD

The Eighth Amendment provides that "[e]xcessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted."[41] The cruel and unusual punishment clause of the Eighth Amendment controls the provision of health care to the incarcerated.[42] Originally, the constitutional ban on cruel and unusual punishment was viewed as simply prohibiting "torture and barbaric punishments."[43] However, the meaning of the amendment has expanded over the years and now encompasses a variety of issues ranging from disproportionate prison sentences to prison health care.[44]

Inmates who feel that their Eighth Amendment rights have been violated may state a cause of action under 42 U.S.C. § 1983, civil action for deprivation of rights.[45] In *Robinson v. California*,[46] the Supreme Court held that the Eighth Amendment prohibition against cruel and unusual punishment was applicable to the states via the Fourteenth Amendment. Therefore, prisoners may bring suit for Eighth Amendment violations against both state and federal prison authorities.

41. U.S. CONST. amend. VIII.

42. *See* Estelle v. Gamble, 429 U.S. 97 (1976).

43. Ray S. Pierce, Note, *Constitutional and Criminal Law —Eighth Amendment—Now You Can't Do That: Disproportionate Prison Sentences as Cruel and Unusual Punishment*, 24 U. ARK. LITTLE ROCK L. REV. 775, 781 (2002).

44. *See generally id. See also Estelle*, 429 U.S. at 102–103.

45. 42 U.S.C. § 1983 provides that

> [e]very person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

42 U.S.C § 1983 (2000).

46. 370 U.S. 660, 667 (1962).

In 1976, the Supreme Court decided *Estelle v. Gamble*,[47] the seminal case in inmate challenges to the adequacy of medical treatment under the Eighth Amendment. Section A discusses *Estelle* and the standard articulated therein. Section B uses later cases to better explain and define the *Estelle* standard.

A. Estelle v. Gamble: *Deliberate Indifference to a Prisoner's Serious Medical Needs*

In *Estelle*, a state prisoner was injured when, in the process of unloading a truck, he was struck with a bale of cotton.[48] Seeking treatment for injuries sustained in the accident, inmate Gamble visited prison medical personnel seventeen times over the course of three months.[49] Despite these numerous visits and the resulting treatments, Gamble instituted a civil rights action pursuant to 42 U.S.C. § 1983, alleging "lack of diagnosis and inadequate treatment of his back injury."[50] The Court rejected Gamble's claim, concluding that the actions of the defendant-physician failed to rise to the level of cruel and unusual punishment under the Eighth Amendment.[51]

Despite the ultimate failure of the prisoner's claim, the *Estelle* Court nonetheless emphasized the "government's obligation to provide medical care for those whom it is punishing by incarceration."[52] In support of this proposition, the Court in *Estelle* relied on previous cases that had defined and broadened the scope of Eighth Amendment protection beyond its original prohibition on inhumane and torturous punishment.[53] Prior to deciding *Estelle*, the Court had "held repugnant to the Eighth Amendment punishments which are incompatible with 'the evolving standards of decency that mark the progress of a maturing society.'"[54] Similarly, just months before, the Court had determined that punishments that "involve the unnecessary and wanton infliction of pain" violate the Eighth Amendment prohibition against cruel and unusual punishment.[55] In *Estelle*, the Court reasoned that the government's failure to provide adequate medical care to prisoners could result in "torture or a lingering death"[56] or "pain and suffering . . . [that] would serve [no]

47. 429 U.S. 97.
48. *Id.* at 99.
49. *Id.* at 107.
50. *Id.*
51. *Id.*
52. *Estelle*, 429 U.S. at 103.
53. *Id.* at 102.
54. *Id.* (quoting Trop v. Dulles, 356 U.S. 86, 101 (1958)).
55. *Id.* at 103 (quoting Gregg v. Georgia, 428 U.S. 153, 173 (1976) (joint opinion of Stewart, Powell, and Stevens, JJ.)).
56. *Id.* (quoting *In re* Kemmler, 136 U.S. 436, 447 (1890)).

penological purpose."[57] Accordingly, the government's failure to provide inmates with adequate health care violates the Eighth Amendment.[58]

Concluding that the government owed a duty of medical care to its incarcerated, the *Estelle* Court then determined that government officials fail to meet this duty when they act with "deliberate indifference to serious medical needs of prisoners."[59] The Court noted that two groups of prison officials may manifest deliberate indifference to prisoners' serious medical needs.

First, prison doctors may manifest deliberate indifference "in their response to the prisoner's needs."[60] Failure of prison medical officials to provide a prisoner adequate medical treatment, however, is not a per se violation of the Eighth Amendment.[61] "[I]nadvertant failure to provide adequate medical care[,] . . . negligen[ce] in diagnosing or treating a medical condition[,] . . . [and] [m]edical malpractice" on the part of prison doctors fail to rise to the level of deliberate indifference.[62] Rather, the "acts or omissions [of prison doctors must be] sufficiently harmful to evidence deliberate indifference."[63]

The *Estelle* Court also found that prison guards and other prison officials can evidence deliberate indifference in two distinct ways. Prior to a prisoner receiving medical care, prison guards may manifest deliberate indifference by "intentionally denying or delaying access" to the medical care sought.[64] Subsequent to a prisoner's receipt of medical treatment, prison guards may manifest deliberate indifference by "intentionally interfering with the treatment . . . prescribed."[65]

In the twenty-eight years since *Estelle*, lower federal courts have received countless invitations to explain and apply the deliberate indifference standard articulated by the Court in 1976. The following section examines subsequent cases and organizes post-*Estelle* case law into themes to illustrate how the deliberate indifference standard is applied today.

*B. Recurring Themes in Post-*Estelle *Cases*

As described above, *Estelle* articulated a two-prong test for determining whether prison authorities have provided a prisoner with adequate medical care. The prisoner's medical need must be serious, and the prison authorities must manifest deliberate indifference to that serious medical need. Part 1 of

57. *Estelle*, 429 U.S. at 103.
58. *Id.* at 102–04.
59. *Id.* at 104.
60. *Id.*
61. *Id.* at 105.
62. *Estelle*, 429 U.S. at 105–06.
63. *Id.* at 106.
64. *Id.* at 104–05.
65. *Id.* at 105.

this section examines recurring themes in defining "serious medical needs," while Part 2 examines recurring themes in defining "deliberate indifference."

1. Serious Medical Needs

Examination of post-*Estelle* cases addressing the serious medical need prong of the deliberate indifference test reveals that courts apply three different tests to determine whether a prisoner's medical need is serious. The medical need of the prisoner need not meet all three tests to be considered "serious." Rather, the following are simply three different manners in which courts have articulated the "serious medical need" prong of the *Estelle* analysis.

In the first test, courts rely on the diagnosis and prescribed treatment of a doctor or other health-care provider. In applying this test, courts have uniformly held that "[a] medical need is 'serious' . . . if it is 'one that has been diagnosed by a physician as requiring treatment.'"[66] Under this test, therefore, a prisoner's medical need is serious for purposes of the *Estelle* standard when a medical professional has diagnosed the condition and prescribed treatment.

In the second test, courts look to the obviousness of the medical condition. Under this standard, courts are not concerned with the diagnosis of a medical professional, but rather the reaction such a condition would cause in a lay person. In *Ramos v. Lamm*, for example, the Tenth Circuit held that "[a] medical need is serious if it is . . . 'one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention.'"[67] The court in *Monmouth County Correctional Institutional Inmates v. Lanzaro* articulated an identical standard.[68]

In the third test, "[t]he seriousness of an inmate's medical need may . . . be determined by reference to the effect of denying the particular treatment."[69] In applying this test, courts attempt to determine the effect of leaving the prisoner's medical condition untreated. Where refusal of treatment would cause "'unnecessary and wanton infliction of pain' . . . [or would cause] an inmate to suffer a lifelong handicap or permanent loss, the medical need is

66. Monmouth County Corr. Institutional Inmates v. Lanzaro, 834 F.2d 326, 347 (3d Cir. 1987) (quoting Pace v. Fauver, 479 F.Supp. 456, 458 (D.N.J. 1979)) (involving female inmates seeking therapeutic abortions). The Tenth Circuit articulated an almost identical standard in *Ramos v. Lamm*, where it held that "[a] medical need is serious if it is 'one that has been diagnosed by a physician as mandating treatment.'" 639 F.2d 559, 575 (10th Cir. 1980) (quoting Laaman v. Helgemoe, 437 F.Supp. 269, 311 (D.N.H. 1977)) (alleging various constitutional violations on the part of Colorado prison officials).

67. *Ramos*, 639 F.2d at 575 (quoting *Helgemoe*, 437 F.Supp. 269 at 311).

68. "A medical need is 'serious,' . . . if it is . . . 'one that is so obvious that a lay person would easily recognize the necessity for a doctor's attention.'" *Lanzaro*, 834 F.2d at 347 (quoting *Pace*, 479 F.Supp. at 458).

69. *Lanzaro*, 834 F.2d at 347.

considered serious."[70] In *Brock v. Wright*, for example, the Second Circuit observed that "a tooth cavity is a serious medical condition, not because cavities are always painful or otherwise dangerous, *but because a cavity that is not treated will probably become so.*"[71]

2. Deliberate Indifference

Examination of post-*Estelle* cases reveals four recurring themes in addressing the deliberate indifference prong of the *Estelle* standard. Each of the four is examined in the sections below. While, for purposes of this Note, the four themes have been neatly divided, the same is not true in many of the cases. The four themes frequently overlap, and where one is addressed by a court, another is often implicated. The following sections attempt to highlight these connections.

a. A "Difference of Opinion" Does Not Constitute Deliberate Indifference

The Court in *Estelle* did not speak in the traditional "difference of opinion" language that is now common in many Eighth Amendment cases. Nonetheless, the Court did address this fundamental theme. In *Estelle*, the prisoner alleged that the prison doctor had acted with deliberate indifference to his serious back injury by failing to X-ray his lower back.[72] The Court rejected this claim, however, noting that whether "additional diagnostic techniques or forms of treatment [are] indicated is a classic example of a matter for medical judgment."[73] Exercise of this medical judgment, the Court concluded, failed to violate the Eighth Amendment.[74]

Although some courts still speak of medical judgment, many cases instead refer to this concept as a "difference of opinion."[75] Where a decision concerning treatment or medication manifests nothing more than a difference of medical opinion, the courts have consistently held that this difference of opinion does not constitute deliberate indifference.[76] Closer examination of

70. *Id.*

71. 315 F.3d 158, 163 (2d Cir. 2003) (emphasis added). In *Ramos*, the Tenth Circuit reached a similar conclusion in observing that dental conditions constitute serious medical needs because "when not treated in a timely fashion [inflicted inmates] are prone to develop infections and abscesses leading to continued pain and loss of teeth." 639 F.2d at 576.

72. Estelle v. Gamble, 429 U.S. 97, 107 (1976).

73. *Id.*

74. *Id.* At most, the Court found that a poor exercise of medical judgment would constitute medical malpractice, which would fail to rise to the level of a constitutional violation. *Id.*

75. *See* Estate of Cole by Pardue v. Fromm, 94 F.3d 254, 261 (7th Cir. 1996); Sanchez v. Vild, 891 F.2d 240, 242 (9th Cir. 1989); Randall v. Wyrick, 642 F.2d 304, 308 (8th Cir. 1981).

76. *See supra* notes 72–75.

post-*Estelle* cases reveal two occasions in which a difference of opinion may arise.

First, a difference of opinion may arise between medical professionals. In *Fields v. Rahimparast*, for example, two physicians disagreed about the proper course of post-operative care for an inmate recovering from the surgical removal of hemorrhoids.[77] The inmate sued when the prison doctor provided treatment different from that prescribed by the prisoner's physician. The Seventh Circuit affirmed the dismissal of the inmate's complaint, holding that "mere differences of opinion among medical personnel regarding a patient's appropriate treatment does not give rise to a deliberate indifference claim."[78]

The Ninth Circuit faced a similar challenge in *Sanchez v. Vild*.[79] There, prison doctors disagreed about whether surgery was an appropriate method for curing the prisoner's rectal boils.[80] When the inmate sued because the surgery was not performed, the *Sanchez* court affirmed the dismissal of the prisoner's claim, holding that "[a] difference of opinion does not amount to a deliberate indifference to Sanchez' serious medical needs."[81]

A difference of opinion may also arise between the inmate and the prison health-care provider. Courts have uniformly rejected suits brought by inmates who disagree with a prison doctor's prescribed course of treatment, holding that "[t]he right to be free from cruel and unusual punishment does not include the right to the treatment of one's choice."[82] In *Johnson v. Stephan*, for example, the Tenth Circuit affirmed the dismissal of a prisoner's claim that prison doctors had manifested deliberate indifference by prescribing a leg stocking to stimulate circulation and to decrease cramps and swelling in the prisoner's leg rather than prescribing the prisoner's preferred course of treatment.[83] The court quickly disposed of the claim, finding that the inmate's complaint "amount[ed] to a difference of opinion with the medical staff, which does not rise to the level of a constitutional violation."[84]

A similar result was reached in *Levy v. Kafka*.[85] There, a prisoner brought suit because prison doctors failed to perform surgery to correct his hernia.[86]

77. No. 01-3828, 2002 WL 1453594, at *1 (7th Cir. June 26, 2002). The inmate's physician had recommended sitz baths to alleviate the pain and to guard against infection. The prison's doctor modified the recommended treatment, however, substituting hot compresses for the suggested sitz baths. *Id.*

78. *Id.* at *2.

79. 891 F.2d at 242.

80. *Id.* at 241. The inmate never underwent surgery but instead was provided with hot packs and was prescribed various anti-inflammatory and antibiotic medications. *Id.*

81. *Id.* at 242.

82. Layne v. Vinzant, 657 F.2d 468, 473 (1st Cir. 1981).

83. 6 F.3d 691, 692 (10th Cir. 1993). The prisoner had brought suit alleging that the use of the leg stocking was "an improper prescription for his condition." *Id.*

84. *Id.*

85. No. 00-3306, 2001 WL 363312 (10th Cir. Apr. 12, 2001).

Noting that the inmate disputed the medical personnel's diagnosis and prescribed treatment, the court concluded that "[h]is allegations [did] not demonstrate deliberate indifference to serious medical needs."[87]

b. A Refusal to Provide Experimental Treatment Does Not Constitute Deliberate Indifference

Cases involving experimental treatment most frequently involve a prisoner's request for cutting-edge medication.[88] When faced with such a demand, courts have held that refusal to provide prisoners with experimental treatment does not rise to the level of a constitutional violation.[89] In *Hawley v. Evans*, for example, prisoners who had tested positive for the Human Immunodeficiency Virus ("HIV") sought prescriptions for Zidovudine ("AZT").[90] Though the court in *Hawley* conceded that "AZT [had] been approved by the FDA and [was] the only antiviral agent that [had] been clearly shown to improve immune function in AIDS patients[,]"[91] it ultimately refused to find the defendants deliberately indifferent for refusing to provide their HIV prisoners the life-prolonging drug. Because the "[e]xperts disagree[d] about who should receive [AZT], at what stage patients should be treated with it, and proper dosage,"[92] the court found that AZT was an experimental drug.[93] Holding that prisoners "are not entitled, as a matter of constitutional right" to receive experimental drugs, the court concluded that the state's refusal to provide certain HIV-positive prisoners with AZT failed to constitute deliberate indifference.[94]

Other courts have reached similar conclusions. In *Dias v. Vose*, for example, the court found that failure to provide an inmate with experimental medication did not constitute deliberate indifference.[95] Describing the drug

86. *Id.* at *1. The prisoner "believe[d] that corrective surgery and pain medication [was] required whereas the medical staff . . . provided a truss belt . . . and concluded that surgical intervention was not [then] indicated." *Id.*

87. *Id. See also* Bradshaw v. Corr. Medical Services, Inc., No. 00-1664, 2001 WL 391497, at *1 (1st Cir. Apr. 12, 2001); Mosley v. Snider, No. 00-6310, 2001 WL 281213, at *1 (10th Cir. Mar. 22, 2001).

88. *See generally* Johnson v. Raba, No. 93-C-2285, 1997 WL 610403 (N.D. Ill. Sept. 24, 1997); Dias v. Vose, 865 F.Supp. 53 (D. Mass. 1994); Hawley v. Evans, 716 F.Supp. 601 (N.D. Ga. 1989).

89. *See supra* note 87.

90. 716 F.Supp at 602.

91. *Id.*

92. *Id.*

93. *Id.* at 603.

94. *Id.* at 603–04.

95. 865 F.Supp 53, 58 (D. Mass. 1994). The prisoner had brought suit after a prison doctor failed to authorize immediate treatment of the prisoner's Hepatitis with Interferon, a prescription drug. *Id.*

sought as "highly experimental," the court held that refusal to immediately provide the inmate with the medication did not constitute deliberate indifference.[96]

c. The Cost of Treatment Does Not Affect the Deliberate Indifference Analysis

Some legal scholars have argued that cost should never be a factor in determining the right of the incarcerated to receive medical treatment.[97] In support of this position, such scholars argue that the Supreme Court in *Estelle* failed to include cost as a factor in articulating the deliberate indifference to serious medical needs standard.[98] Because the Court in *Estelle* wholly failed to mention the issue of cost, these scholars conclude that cost is irrelevant in determining whether states must provide prisoners with certain medical treatments and procedures.[99] Lower courts that have applied the *Estelle* standard have reached similar conclusions.[100]

Some courts have realized that it is not unconstitutional for prison officials to consider the cost of various methods in deciding how to treat a prisoner's medical ailment.[101] Although recognizing that "[t]he state's interest in limiting the cost of detention . . . ordinarily will justify the state's decision to provide detainees with a reasonable level of. . . . medical care[,]" these same courts have also concluded that the state's interest in saving money "will justify neither the complete denial [of medical care] nor the provision of [medical care] below some minimally adequate level."[102] One can reasonably assume that the "minimally adequate level" referred to by the court in *Hamm v. DeKalb County* is equivalent to the deliberate indifference standard articulated by the Supreme Court in *Estelle*. Consequently, *Hamm* stands for the proposition that states need not provide prisoners with the most expensive

96. *Id.* For another case involving Interferon that reached the same conclusion, see *Johnson v. Raba*, where the court held that refusal to prescribe the "semiexperimental" drug failed to rise to the level of deliberate indifference. No. 93-C-22851997, WL 610403, at *4 (N.D. Ill. Sept. 24, 1997).

97. Wright, *supra* note 20, at 1269–76. *See also* Marc J. Posner, *The* Estelle *Medical Professional Judgment Standard: The Right of those in State Custody to Receive High-Cost Medical Treatments*, 18 AM. J.L. MED. 347, 347 (1992) ("[T]he financial considerations of states should play no role in determining the rights of [prisoners] to receive high-cost medical care.").

98. Posner, *supra* note 97, at 353 ("[T]he *Estelle* medical professional judgment standard . . . does not seem to take the cost of the treatment into consideration at all."); Wright, *supra* note 20, at 1269 ("[T]he *Estelle* standard . . . does not consider the cost of the treatment as influencing the prisoner's right to medical care.").

99. *See supra* notes 97–98.

100. Posner, *supra* note 97, at 353–54; Wright, *supra* note 20, at 1269–76.

101. Hamm v. DeKalb County, 774 F.2d 1567, 1573 (11th Cir. 1985); Taylor v. Barnett, 105 F.Supp. 2d 483, 489 n.2 (E.D. Va. 2000).

102. *Hamm*, 774 F.2d at 1573.

treatments so long as they do not act with deliberate indifference to the serious medical needs of their inmates. Conversely, deliberately indifferent actions cannot be justified on the grounds that providing the necessary treatment would be too costly; this would allow medical care to fall below a "minimally adequate level."

This interpretation of *Hamm* finds support in other post-*Estelle* cases. Cases addressing cost considerations do not generally arise in the context of a prison's refusal to provide treatment because such treatment is too costly. Rather, these cases generally arise where prison authorities have withheld treatment in an attempt to coerce inmates to pay for their own treatment.[103] While some courts have recognized that it is not improper to require a prisoner to pay for treatment out of his own funds,[104] the courts generally agree that refusing to pay for treatment of a prisoner's serious medical needs constitutes deliberate indifference.[105] In essence, the high cost of a medical procedure or treatment cannot constitutionalize a prison official's otherwise deliberately indifferent refusal to provide an inmate with that treatment. Consequently, the cost of the treatment sought plays no part in determining whether prison officials have acted with deliberate indifference to a prisoner's serious medical needs.

d. Providing "Easier and Less Efficacious" Treatment Constitutes Deliberate Indifference

The provision of "easier and less efficacious treatment" refers to treating an inmate's medical condition with a simpler, yet less effective remedy, when a more complex, more effective remedy is available.[106] This theme connects with several of the other deliberate indifference themes previously discussed. For example, providing an easier and less efficacious treatment may be viewed as the reverse of an appropriate exercise of medical judgment. While

103. *See generally* Monmouth County Corr. Institutional Inmates v. Lanzaro, 834 F.2d 326 (3d Cir. 1987); Ancata v. Prison Health Servs., Inc. 769 F.2d 700 (11th Cir. 1985); Archer v. Dutcher, 733 F.2d 14 (2d Cir. 1984); Martin v. DeBruyn, 880 F.Supp. 610 (N.D. Ind. 1995).

104. *Martin*, 880 F.Supp. at 615 ("[I]nsisting that an inmate with sufficient funds use those funds to pay for medical care is neither deliberate indifference nor punishment.").

105. *Lanzaro*, 834 F.2d at 345 ("[P]risons should be and are constitutionally required to provide for [i.e., at the institution's expense] all the serious medical needs of the inmates, whose imposed financial dependency is . . . a result of their incarceration.") (quoting Monmouth County Corr. Institutional Inmates v. Lanzaro, 643 F.Supp. 1217, 1227 (D.N.J. 1986); *Ancata*, 769 F.2d at 704 ("Delay in medical treatment cannot be justified as a means to coerce payment."); *Martin*, 880 F.Supp. at 615 ("A prison official who withholds necessary medical care, for want of payment, from an inmate who could not pay would violate the inmate's constitutional rights if the inmate's medical needs were serious.").

106. *See generally* Estelle v. Gamble, 429 U.S. 97 (1976); Brock v. Wright, 315 F.3d 158 (2d Cir. 2003); McElligott v. Foley, 182 F.3d 1248 (11th Cir. 1999); West v. Keve, 571 F.2d 158 (3d Cir. 1978); Williams v. Vincent, 508 F.2d 541 (2d Cir. 1974).

differences of opinion fail to constitute deliberate indifference, prescription of an easier and less efficacious treatment "alleges more than . . . solely . . . a disagreement with a doctor's professional judgment."[107] Similarly, the prescription of an easier and less efficacious treatment may be motivated by an impermissible consideration of cost.[108]

The "easier and less efficacious" treatment language first appeared in the pre-*Estelle* case of *Williams v. Vincent*.[109] There, the Second Circuit held that a prison doctor violated an inmate's Eighth Amendment rights when, rather that reattaching the prisoner's severed ear, the doctor discarded it, told the prisoner that "he did not need his ear," and stitched up the stump.[110] Reversing the lower court's decision to dismiss Williams's claim, the court found that the doctor's use of an "easier and less efficacious treatment" may have constituted deliberate indifference.[111]

Though *Williams* predates *Estelle*, it nonetheless remains good law,[112] and post-*Estelle* decisions frequently employ its "easier and less efficacious" language.[113] In *West v. Keve*, for example, the Third Circuit reversed a lower court decision dismissing a prisoner's claim that prison officials had acted with deliberate indifference to his serious medical needs.[114] There, the inmate had received surgery to correct various afflictions of his right leg, yet he asserted that prison officials were deliberately indifferent in their provision of post-operative care.[115] While the prisoner had been provided aspirin for his pain, the court in *West* concluded that such a treatment plan may constitute "an easier and less efficacious treatment."[116] The case was reversed and remanded for further proceedings.[117]

107. *Williams*, 508 F.2d at 544. More recently, the Second Circuit observed that providing easier and less efficacious treatment "could constitute deliberate indifference rather than a mere difference of opinion over a matter of medical judgment." Chance v. Armstrong, 143 F.3d 698, 703 (2d Cir. 1998). *See also Ancata*, 769 F.2d at 704.

108. *Chance*, 143 F.3d at 704 (A dentist's motivation for extracting teeth rather than filling cavities may have been "monetary incentives.").

109. 508 F.2d 541.

110. *Id.* at 543.

111. *Id.* at 544.

112. The Supreme Court in *Estelle* cited to *Williams* as an example of when prison doctors' actions may manifest deliberate indifference to the serious medical needs of an inmate. Estelle v. Gamble, 429 U.S. 97, 105 n.10 (1976).

113. *See generally* Brock v. Wright, 315 F.3d 158 (2d Cir. 2003); McElligott v. Foley, 182 F.3d 1248 (11th Cir. 1999); West v. Keve, 571 F.2d 158 (3d Cir. 1978).

114. 571 F.2d at 162–63.

115. *Id.* at 160–62.

116. *Id.* at 162.

117. *Id.* at 164.

The Eleventh Circuit reached a similar conclusion in *Ancata v. Prison Health Services, Inc.*[118] There, Ancata complained of myriad afflictions, including ankle swelling, chills, lower back pain, and severe pain in his back and leg.[119] Prison health-care workers observed that Ancata needed medical evaluation but provided him with only Tylenol II and Ben Gay for his pain.[120] He died of leukemia approximately four months later.[121] In reversing the lower court's decision to dismiss the case, the Eleventh Circuit held that the treatment provided by prison officials may have constituted "an easier and less efficacious treatment."[122]

IV. PRISONS ARE REQUIRED TO PROVIDE INMATES WITH MEDICALLY NECESSARY TRANSPLANTS

Prisons are unquestionably required to provide inmates with medically necessary organ transplants in light of the themes developed in Part III. Section A of this Part examines the serious medical needs prong of the *Estelle* analysis in the context of organ transplants and determines that the need for a medically necessary transplant constitutes a serious medical need. Section B examines the deliberate indifference prong of the *Estelle* standard in relation to organ transplants and concludes that failure to provide an inmate with a medically necessary transplant constitutes deliberate indifference. Because both prongs of the *Estelle* standard are met, failure to provide inmates with organ transplants violates the Eighth Amendment prohibition against cruel and unusual punishment.

A. The Need for a Medically Necessary Organ Transplant is "Serious"

Although the need for a medically necessary organ transplant may not be "so obvious that a lay person would easily recognize the necessity for a doctor's attention,"[123] such a medical condition is serious under the two other tests articulated by courts. The need for an organ transplant is often detected by medical professionals, who then recommended a transplant as a course of treatment. Thus, a transplant is serious in that it "has been diagnosed by a physician as mandating treatment."[124]

Similarly, the need for a transplant can be deemed serious by reference "to the effect of denying the particular treatment."[125] Failure to provide a prisoner

118. 769 F.2d 700 (11th Cir. 1985).
119. *Id.* at 702.
120. *Id.*
121. *Id.*
122. *Id.* at 704 (quoting *West*, 571 F.2d at 162).
123. *See supra* notes 67–68 and accompanying text.
124. *See supra* note 66 and accompanying text.
125. *See supra* notes 69–71 and accompanying text.

with a medically necessary transplant can result in pain, suffering, and in many instances, death. Consequently, under either test, the need for a medically necessary transplant is clearly serious.

B. Refusing to Provide Inmates with Medically Necessary Organ Transplants Constitutes Deliberate Indifference

While it is fairly simple to conclude that the need for a medically necessary organ transplant is serious, the more difficult analysis involves determining whether refusal to provide an inmate with such a transplant constitutes deliberate indifference in violation of the Eighth Amendment. Though no published court opinion has expressly held that failure to provide inmates with transplants constitutes deliberate indifference, two recent Eighth Circuit opinions indicate that this is the direction in which the courts are moving.

In *Barron v. Keohane*, the Eighth Circuit affirmed a lower court's dismissal of a prisoner's Eighth Amendment challenge.[126] There, Barron brought suit alleging that the prison doctor's refusal to provide him with a kidney transplant constituted deliberate indifference to his serious medical needs.[127] The court rejected the prisoner's claim because the prison was currently providing Barron with dialysis, a treatment which his doctors approved of and which was successfully treating his condition.[128] In dicta, however, the Eighth Circuit disapproved of the Federal Bureau of Prisons' organ transplant policy, which refuses to provide inmates with transplants at the state's expense, noting that "denial of a transplant to an inmate who needs—but cannot pay for—a transplant may raise constitutional concerns."[129]

In *Clark v. Hendrick*, the Eighth Circuit again disapproved of the Federal Bureau of Prison's transplant policy in dicta.[130] In *Clark*, the inmate sought a bone marrow transplant as treatment for his leukemia.[131] The prison had allowed Clark to have his bone marrow extracted and frozen for such use in the future.[132] Because the inmate's condition had not yet deteriorated to the point where a transplant was necessary, the court found that Clark was receiving appropriate treatment, and that the defendant had not acted with deliberate indifference. [133] Citing to *Barron*, however, the Eighth Circuit again

126. 216 F.3d 692, 693 (8th Cir. 2000).

127. *Id.* at 692.

128. *Id.* at 692–93. Because Barron was responding positively to the dialysis, his desire for a kidney transplant merely represented a difference of opinion between the inmate and his treating physician. This fails to rise to the level of a constitutional violation. *See supra* notes 71–86 and accompanying text.

129. *Id.* at 693.

130. 233 F.3d 1093, 1094 (8th Cir. 2000).

131. *Id.*

132. *Id.*

133. *Id.*

"remind[ed] the Bureau of Prisons that its policies in connection with transplants, if applied inflexibly, may raise constitutional questions."[134]

The following sections address the issue of medically necessary organ transplantation for prisoners in the context of the four deliberate indifference themes developed in Part III of this Note. Such analysis proves that the Eighth Circuit was correct in *Barron* and *Clark*; refusal to provide inmates with medically necessary organ transplants does raise constitutional concerns. Indeed, such a refusal unquestionably constitutes deliberate indifference to a prisoner's serious medical needs.

1. The Need for Medically Necessary Organ Transplants Goes Beyond a Difference of Opinion

When a treating physician has recommended that a prisoner receive a life-saving transplant, prison officials' refusal to provide such a procedure cannot be justified as a difference of opinion. Differences of opinion arise in two ways. First, a prisoner and his treating physician may have different views on the appropriate course of treatment.[135] Second, different medical personnel can disagree about the most appropriate way to treat an inmate's medical condition.[136] Disagreement between other prison officials and medical personnel as to the appropriate course of treatment, however, does not justify refusal to provide an inmate with a recommended procedure. After a doctor has prescribed a course of treatment, prison officials manifest deliberate indifference by interfering with or refusing to provide an inmate with the prescribed treatment.[137]

Where medical personnel have determined that a prisoner is a good candidate for organ transplantation and have recommended that the inmate undergo the procedure, neither type of difference of opinion will arise. The prisoner seeking the transplant is in accord with his physician because both support organ transplantation. Consequently, there is no difference of opinion between the prisoner and medical personnel. Also, where a prisoner has been assessed as a viable candidate for a life-saving transplant, it is highly unlikely that medical personnel would disagree over whether to allow the prisoner to undergo the procedure. Therefore, it is also unlikely that a difference of opinion will arise between medical personnel as to the appropriate course of treatment. As such, the difference of opinion justification fails in the context of refusal to provide necessary organ transplants to prisoners.

The "difference of opinion" theme is important in transplant cases, however, because it helps to distinguish cases in which courts have refused to

134. *Id.*

135. *See supra* notes 77–81 and accompanying text.

136. *See supra* notes 82–87 and accompanying text.

137. Estelle v. Gamble, 429 U.S. 97, 104–05 (1976).

find deliberate indifference from those cases where a finding of deliberate indifference would be appropriate. In *Hampe v. Hogan*, for example, the district court concluded that the prison's refusal to provide a prisoner with a sphincter muscle transplant did not violate the Eighth Amendment.[138] Hampe suffered from severe rectal problems, caused primarily by reoccurring rectal abscesses.[139] After enduring numerous surgeries that failed to remedy his problem, Hampe was advised by a prison doctor that a sphincter muscle transplant was a possible treatment.[140] However, the court found "the consensus . . . among the physicians involved that the constant recurrence of rectal abscesses, rather than sphincter muscle damage [was Hampe's] real problem."[141]

The prison's refusal to provide Hampe with the requested transplant, therefore, constituted nothing more than an exercise of medical judgment. Consequently, *Hampe* stands for the proposition that a difference of opinion between medical personnel does not constitute deliberate indifference. As such, the case entirely fails to address the issue of whether prisons are required to provide transplants where the prisoner and medical personnel agree that transplantation is an appropriate method of treatment.

Hodge v. Coughlin, in which the district court refused to find prison officials deliberately indifferent for refusing to provide an inmate with a corneal transplant, similarly can be distinguished on the grounds of a difference of opinion between the prisoner and prison medical personnel.[142] In *Hodge*, the prisoner sought a second corneal transplant as treatment for his eye infection.[143] In refusing to find the prison officials deliberately indifferent for their refusal to provide Hodge with the requested transplant, the court observed that several eye specialists had determined that a corneal transplant was inappropriate given the prisoner's medical state.[144] Like *Hampe*, therefore, *Hodge* merely stands for the well-accepted proposition that a difference of opinion between medical personnel fails to constitute deliberate indifference. As such, *Hodge* similarly has no bearing on whether refusal to provide transplants that are not subject to a difference of opinion would constitute deliberate indifference.

138. 388 F.Supp. 13, 15 (M.D. Penn. 1974). Because *Hampe* was decided two years before the Supreme Court handed down its seminal decision in *Estelle*, the case does not speak in the traditional language of deliberate indifference to a prisoner's serious medical needs. However, because of the rarity of transplant cases, the opinion is included.

139. *Id.* at 13–14.

140. *Id.* at 14.

141. *Id.* at 15.

142. No. 92 Civ. 0622 (LAP), 1994 WL 519902 (S.D.N.Y. Sept. 22, 1994).

143. *Id.* at *1. Hodge suffered from herpes zoster ophthalmicus, a viral infection that causes pain, scarring, and inflammation of the eye. *Id.*

144. *Id.* at *9–*10.

2. Medically Necessary Organ Transplants are not Experimental

Hampe and *Hodge*, discussed above, provide a clear understanding of what constitutes an experimental transplant. The sphincter muscle transplant at issue in *Hampe*, for example, was "still in the extremely early stages of development and [could] be performed by only a very few surgeons in a very few circumstances."[145] Similarly, the corneal transplant sought in *Hodge* was rarely performed on patients suffering from the prisoner's affliction, and the success of such a procedure was questionable at best.[146]

In stark contrast to the experimental procedures at issue in *Hampe* and *Hodge*, organ transplantation is no longer considered experimental.[147] Rather, transplantation is "now a routine medical procedure with a relatively high success rate."[148] Transplants are conducted frequently in all parts of the country. In the United States alone, 13,222 organ transplants were performed from January to June of 2004.[149] While deeming an organ transplant experimental may have justified refusal of the life-saving procedure at the advent of transplantation, such a claim is no longer plausible today. Consequently, refusal to provide an organ transplant to a prisoner is not justifiable on the grounds that the procedure is experimental.

3. Cost is not a Factor to Consider in the Deliberate Indifference Analysis

The argument that organ transplants are too expensive to provide to prison inmates at the taxpayers' expense is perhaps the easiest argument to defeat. Simply put, cost is not a factor to be considered in determining whether refusal to provide treatment to a prisoner constitutes deliberate indifference.[150] Therefore, the expense of providing inmates with transplants is wholly irrelevant to determining whether refusal of an organ transplant constitutes deliberate indifference under the Eighth Amendment. As such, the issue of cost will not be further discussed.

4. The Use of an "Easier and Less Efficacious" Treatment Constitutes Deliberate Indifference

In 1991, the Eleventh Circuit decided *Fernandez v. United States*, the only published opinion to hold that refusal to provide an inmate with a life-saving transplant does not constitute deliberate indifference.[151] Fernandez suffered

145. 388 F.Supp at 15.
146. No. 92 Civ. 0622 (LAP), 1994 WL 519902 at * 1.
147. *See supra* notes 18–23.
148. Grantham, *supra* note 24, at 751.
149. *See supra* note 21 and accompanying text.
150. *See supra* notes 97–105 and accompanying text.
151. 941 F.2d 1488, 1494 (11th Cir. 1991).

from a serious heart condition.[152] A prison physician predicted that Fernandez would die within two years unless he received a life-saving heart transplant.[153] Pursuant to the Federal Bureau of Prisons' organ transplant policy, however, prisoners seeking medical furlough in order to receive a transplant were required to establish "their ability to pay for the procedure and the willingness of a transplant program to consider accepting them."[154] Fernandez had failed to meet these criteria.[155]

The court cursorily rejected Fernandez's claim that the prison's failure to grant relief constituted deliberate indifference to his serious medical needs.[156] The opinion is short on reasoning; after articulating the *Estelle* standard, the court hastily concluded that "Fernandez ha[d] not met this standard."[157] Though the court did not speak in the traditional language of post-*Estelle* cases, it seems to have based its conclusion on a finding that Fernandez received more than "easier and less efficacious treatment."[158] The only justification offered by the court for its refusal to find deliberate indifference is the other treatments provided to Fernandez by the Bureau of Prisons:

> During his time [Fernandez] has received treatment at the world-renowned Mayo Clinic and has undergone several specialized procedures, including angioplasty. Fernandez's doctor has written letters to various prison authorities concerning the life-threatening nature of Fernandez's condition, resulting in Fernandez's freedom from prison work duties. Fernandez's condition continues to be monitored at FMC-Rochester and is maintained by medication. In addition, two wardens have advised the Parole Commission of Fernandez's medical condition and requested consideration of an early parole date.[159]

The Eleventh Circuit entirely missed the mark. While the extensive treatment provided to Fernandez was substantially greater than the easier and less efficacious treatments in other cases,[160] the prison's refusal to provide Fernandez with a life-saving heart transplant nonetheless constituted deliberate indifference for several reasons.

First, no difference of opinion existed between Fernandez and medical personnel. A prison doctor had recommended that Fernandez receive the heart transplant he sought.[161] Refusal of the prison to provide Fernandez with a

152. *Id.* at 1491.
153. *Id.*
154. *Id.* at 1493.
155. *Id.*
156. *Fernandez*, 941 F.2d at 1493–94.
157. *Id.* at 1494.
158. *See supra* note 106.
159. *Fernandez*, 941 F.2d at 1494.
160. *See supra* notes 106–22.
161. *Fernandez*, 941 F.2d at 1491.

heart transplant after a doctor had recommended the procedure manifested deliberate indifference. Indeed, the Court in *Estelle* recognized that "intentionally interfering with the treatment . . . prescribed" by a physician constitutes deliberate indifference.[162]

Second, the heart transplant sought by Fernandez was not experimental. The case was decided in the early 1990s, by which time organ transplants had become commonplace in the United States.[163] Consequently, the novelty of the transplant sought did not justify the prison's refusal to provide Fernandez with the life-saving heart transplant.

Finally, the prison denied Fernandez a transplant, in part, because he could not pay for the procedure out-of-pocket.[164] Courts have consistently held that refusing to treat an inmate's serious medical needs because of the prisoner's inability to personally finance the procedure constitutes deliberate indifference.[165]

Simply put, *Fernandez v. United States* was wrongly decided. Despite the fact that the prison officials provided him with other expensive and cutting-edge treatment, they nonetheless refused to provide Fernandez with a life-saving, non-experimental, doctor-recommended procedure, in part because of his inability to pay for the operation out of his own funds. Under current Eighth Amendment jurisprudence, the prison clearly manifested deliberate indifference to Fernandez's serious medical needs.

V. QUIETING THE PUBLIC OUTCRY

In light of the foregoing, refusal by prison officials to provide inmates with medically necessary transplants constitutes deliberate indifference to the prisoner's serious medical needs in violation of the Eighth Amendment. Recurring themes in defining a serious medical need unequivocally indicate that the need for a medically necessary organ transplant is serious. Similarly, the four recurring themes in defining deliberate indifference clearly suggest that failure to provide a prisoner with the life-saving procedure required to remedy this serious medical need constitutes deliberate indifference. Although providing these procedures to inmates has caused strong public backlash, it is inevitable that, to comply with the Eighth Amendment, prisons must continue to provide prisoners with life-saving organ transplants.

162. 429 U.S. 97, 105 (1976).

163. *See generally* Grantham, *supra* note 24.

164. *Fernandez*, 941 F.2d at 1493. The Bureau of Prisons' policy required that inmates seeking medical furlough for organ transplantation "establish their *ability to pay for the procedure* and the willingness of a transplant program to consider accepting them." *Id.* (emphasis added). Consequently, Fernandez's inability to receive a transplant was attributable in part to his inability to finance the procedure.

165. *See supra* notes 97–105 and accompanying text.

In the context of organ transplants for inmates, therefore, the constitutional issue is the "easy" one. Because prisons are constitutionally required to provide inmates with life-saving organ transplants, the more difficult question then becomes how to quell the strong public outcry against the provision of organ transplants to prisoners. This section considers possible ways to diminish the public's aversion to prisoner organ transplants.

Because the public's dislike of prisoner organ transplants is rooted in three interrelated matters, this section will address possible solutions to each matter independently. Section A considers potential ways to alleviate the public's concern that the country's limited organ supply is going to inmates rather than law-abiding citizens. Section B considers how to decrease the public's perception of the costs associated with providing prisoners with life-saving transplants. Finally, Section C considers possible methods to decrease the number of elderly inmates in the country's prison system. In light of this examination, this Note concludes that methods aimed at decreasing the country's elderly inmate population represent the only practical solution to the public's rage at providing organ transplants to prison inmates.

A. Addressing Scarcity

One of the primary reasons for the public's dislike of prisoner organ transplants is the concern that a life-saving organ transplant may be provided to a prisoner at the expense of a law-abiding citizen.[166] Framed in this manner, the debate over organ transplants for prisoners is essentially a dispute about how to best allocate our nation's scarce resources. Solutions to the public's perception of prisoner transplants that focus on scarcity can best be divided into two categories.

The first category argues that the public outcry can best be quieted by revising the method by which organ recipients are selected. Currently, organ allocation is based on medically objective criteria.[167] Those in favor of altering the organ allocation system propose injecting subjective factors into the consideration in an attempt to measure the social worth of potential recipients. By considering subjective, as well as objective factors, proponents of this solution hope to ensure that our limited organ supply goes to the most "socially worthy" individuals.[168]

166. *See supra* notes 38–40 and accompanying text.

167. *What We Do: Organ Center*, *at* www.unos.org/whatWeDo/organCenter.asp (last visited Sept. 8, 2004). UNOS considers such factors as "blood type, tissue type, size of the organ, medical urgency . . . as well as time already spent on the waiting list and distance between donor and recipient." *Id.*

168. *See* Robert F. Weir, *The Issue of Fairness in the Allocation of Organs*, 20 J. CORP. L. 91, 96–97 (1995). Weir does not address the receipt of transplants by prison inmates but does discuss a proposal for organ allocation that would consider social factors such as

Scholars passionately disagree, however, about the prudence of using social criteria in organ allocation.[169] In fact, articles published on the subject seem evenly divided between those in support of and those in opposition to the allocation of organs according to the social worth of the recipient.[170] Due to the controversial nature of this proposal, it is unlikely that modifying the system of organ allocation to exclude prisoners constitutes a viable way to quiet the public outcry against prisoner receipt of organ transplants.

Additionally, and perhaps more importantly, UNOS refuses to consider social criteria in determining to whom organs will be provided.[171] Because UNOS, the sole organization responsible for prioritizing candidates for organ transplants in this country, has wholly rejected the concept of considering social worth in organ allocation, such a solution to the public's dislike of prisoner organ transplants is entirely unrealistic.

In contrast to modifying the current system of organ allocation, the second proposed solution focuses on solving the organ-scarcity dilemma by increasing the number of organs available for transplant. By doing so, the receipt of an organ by a prisoner will not mean the death of a law-abiding citizen. Solutions intended to increase the number of organs available for transplant can be divided into two categories.

> the family role factor, which gives preference to parents of minor children over single adults . . . the 'potential future contributions' factor, according to which society would choose to 'invest' a scarce resource in individuals who are thought likely (based on age, talents, training, and past record) to give valuable 'return' on the investment in terms of prospective service, and . . . the 'past services rendered' factor . . . in which society recognizes and rewards the retrospective service rendered by individuals.

Id.; John C. West, et al., *Organ Allocation: A Case for not Transplanting the Violent Criminal*, *in* SEMINARS IN DIALYSIS 362, 362 (Aaron Spital ed., 2003) (arguing that "transplanting even one [violent felon] should be deemed inadvisable"); David L. Perry, *Criminals Should Be Far Down on the Heart Transplant List*, SAN JOSE MERCURY NEWS, Jan. 31, 2002, at 10B ("[I]f we knowingly commit . . . crimes and thus violate others' basic rights not to be harmed or killed, we lose the right to an organ transplant when it could save the life of an innocent person.").

169. *See* Jeffery Kahn, *The Ethics of Organ Transplantation in Prisoners*, *in* SEMINARS IN DIALYSIS, *supra* note 168, at 365 (arguing that "[w]hile prisoners forfeit many freedoms, access to and the provision of adequate heath care are guaranteed to them, and ought to include access to organ transplants"); *Change of Heart*, *supra* note 39 (quoting Dr. Lawrence Schneiderman, a proponent of refusing heart transplants to murders, as recognizing that consideration of such subjective criteria is a "slippery slope").

170. *See supra* notes 168–69 and accompanying text.

171. *What We Do: Organ Center*, *supra* note 167. Criteria aimed at measuring a potential recipient's social worth are entirely absent from factors considered by UNOS when allocating available organs. *Id. See also* Wright, *supra* note 20, at 1257 ("UNOS bases its policy decisions on objective medical criteria, not on the perceived social worth of those seeking organs. The UNOS ethics committee believes, for example, that being accused or convicted of a crime is irrelevant to the selection of transplant recipients.") (footnote omitted).

The first category encompasses controversial solutions aimed at altering the organ-harvesting system currently in place in the United States. Such proposed solutions include presumed consent,[172] a theory under which individuals are presumed to consent to organ donation unless they explicitly indicate otherwise; the creation of a market for human organs;[173] and the use of prison inmates as an additional source of organs available for transplantation.[174] While these ideas provide seemingly endless fodder for legal scholars,[175] there are as many advocates for each solution as there are opponents. Consequently, much like the use of social criteria in organ allocation, these controversial proposals aimed at increasing the nation's organ supply fail to present feasible solutions to the organ shortage.

The second category of solutions aimed at increasing organ supplies in the United States is far from controversial. Rather than modifying the nation's organ-harvesting system, this proposed solution argues that organ supplies can best be increased by educating the public about the need for organs and the rewards of organ donation. This more moderate solution is already in place in

172. *See* Keller, *supra* note 19, at 895 (arguing that presumed consent "should be expanded to include the procurement of all organs"); Samantha A. Wilcox, Comment, *Presumed Consent Organ Donation in Pennsylvania: One Small Step for Pennsylvania, One Giant Leap for Organ Donation*, 107 DICK. L. REV. 935, 951 (2003) (arguing that presumed consent "offers several benefits that the current organ donation system does not"). *But see* Troy R. Jensen, Comment, *Organ Procurement: Various Legal Systems and Their Effectiveness*, 22 HOUS. J. INT'L L. 555, 572–73 (2000) (observing the ineffectiveness of Brazil's failed presumed consent law, and concluding that presumed consent "is a quickly dissipating method of organ procurement"); Carrie Parsons O'Keeffe, Note, *When an Anatomical "Gift" Isn't a Gift: Presumed Consent Laws as an Affront to Religious Liberty*, 7 TEX. F. ON C.L. & C.R. 287, 316 (asserting that "[p]resumed consent offends state, national, and international values as they are stated in our federal Constitution. . . . American laws and ethics demand that . . . an 'anatomical gift' is, indeed, a gift").

173. *See* David Kaserman, *Markets for Organs: Myths and Misconceptions*, 18 J. CONTEMP. HEALTH L. & POL'Y 567, 580 (2002) (arguing that organ markets are the "most promising option" to solving the country's organ shortage). *But see* Christian Williams, Note, *Combatting the Problems of Human Rights Abuses and Inadequate Organ Supply Through Presumed Donative Consent*, 26 CASE W. RES. J. INT'L L. 315, 344 (1994) (labeling the creation of a market in human organs as "the most controversial of all proposed organ procurement systems").

174. *See* Laura-Hill M. Patton, Note, *A Call for Common Sense: Organ Donation and the Executed Prisoner*, 3 VA. J. SOC. POL'Y & L. 387, 433 (1996) (offering "compelling arguments in favor of organ donation by executed prisoners" and asserting that the practice "comports with common sense"); Donny J. Perales, Comment, *Rethinking the Prohibition of Death Row Prisoners as Organ Donors: A Possible Lifeline to Those on Organ Donor Waiting Lists*, 34 ST. MARY'S L.J. 687, 732 (2003) (arguing that the use of executed prisoners' organs for transplant presents a "viable method" to solving the country's organ shortage). *But see* Whitney Hinkle, Note, *Giving Until it Hurts: Prisoners Are Not the Answer to the National Organ Shortage*, 35 IND. L. REV. 593, 593 (2002) (arguing that "prisoners, whether executed or living, should not become organ donors").

175. *See supra* notes 172–74 and accompanying text.

the United States and is the solution embraced by UNOS.[176] In furtherance of this goal, UNOS founded The Coalition on Donation in 1993, "a separate, non-profit alliance of national organizations and coalitions across the United States, dedicated solely to educating the public about organ and tissue donation."[177] Similarly, in 2001, UNOS created the National Speakers Bureau, an organization of lecturers dedicated to "assist[ing] corporate America and national organizations with educating individuals about the need for organ and tissue donation and how to become a donor."[178]

Because educating the public about organ donation is not controversial and because it has been embraced and implemented by UNOS, it would at first glance seem to be a viable solution to America's organ shortage. Time has proven, however, that this is not the case. The Coalition on Donation has been in existence for more than a decade, and the National Speakers Bureau has been educating the public for approximately three years.[179] Despite these nationwide attempts to increase organ donation, the ratio of available organs to hopeful recipients remains abysmally low.[180] Consequently, while public education may have some impact on the number of available organs, it fails to offer a practical solution to the organ shortage in America. As such, it similarly fails to present a solution to the public's outrage at providing prisoners with organ transplants.

B. Addressing Cost

The second factor that plays a part in the public's abhorrence of prisoner receipt of organ transplants is the cost of the procedures. With the cost of an organ transplant averaging more than $200,000,[181] many dislike the idea of providing inmates with such procedures at the taxpayers' expense.[182] Framed in this manner, the public outcry against prisoner organ transplants is actually a concern about how valuable tax dollars are being spent. Consequently, another potential solution to the public outcry against prisoner organ transplants may be to educate the public about the actual, rather than the perceived, costs of providing inmates with organ transplants.

176. *See Help Save a Life: Promote Organ Donation*, *at* http://www.unos.org/helpSaveALife/promoteOrganDonation/ (last visited Sept. 8, 2004); *What We Do: Donation Education*, *at* http://www.unos.org/whatWeDo/donationEducation.asp (last visited Sept. 8, 2004).

177. *What We Do: Donation Education*, *supra* note 176. For more extensive information on the Coalition on Donation, visit http://www.donatelife.net.

178. *Help Save a Life: Promote Organ Donation: Find a Speaker*, *at* http://www.unos.org/helpsavealife/promoteorgandonation/findaspeaker.asp (last visited Sept. 21, 2004).

179. *See supra* notes 177–78 and accompanying text.

180. *See* Will, *supra* note 33, at 70.

181. Lesko & Buckley, *supra* note 29, at 19.

182. *See supra* notes 38–39 and accompanying text.

Perhaps the best way to change the public's perception of organ transplant costs is to show that prisoner organ transplants are, in reality, saving the taxpayers money. This is particularly true in the case of kidney transplants. When an inmate is suffering from kidney failure, two options are available: The inmate may either undergo dialysis or receive a new kidney.[183] A prisoner's dialysis is estimated to cost $120,000 per year.[184] Because dialysis is not a cure for kidney failure, but rather a treatment, taxpayers are required to pay $120,000 every year for every prison inmate in need of dialysis. In contrast, the estimated cost of a kidney transplant is only $100,000.[185] Provided the procedure goes as planned, the $100,000 will be a one-time cost and a cure, rather than a treatment, for the inmate's kidney failure. Consequently, providing inmates with kidney transplants, rather than dialysis, is sure to save the taxpayers millions.

The argument that prisoner kidney transplants are cost effective is not novel. In 2003, when convicted killer and death-row inmate Horacio Alberto Reyes-Camarena was seeking a kidney transplant, newspapers and Reyes-Camarena alike pointed out that his receipt of a transplant would save the taxpayers a significant sum of money in the long run.[186] Considering that Reyes-Camarena's dialysis could have lasted more than a decade, during which time the prisoner exhausted his appeals,[187] his receipt of a kidney transplant could potentially have saved Oregon taxpayers $1.1 million.[188] These numbers unequivocally indicate that prisoner receipt of kidney transplants is sure to save taxpayers millions.

While the cost of kidney transplants provides compelling support for the argument that prisoner organ transplants are cost-effective, the cases of other organ transplants fail to lend any support to the theory. Whereas a prisoner may be treated with either dialysis or provided a kidney transplant as a solution to kidney failure, medical conditions that lead to the need for other organ transplants do not have alternative treatments analogous to dialysis. This fact is readily apparent from media coverage of prison inmates who are seeking other organ transplants. Coverage of the California inmate who received a

183. *See* Douglas, *supra* note 6; Higgins, *supra* note 5.

184. *See* Douglas, *supra* note 6; Higgins, *supra* note 5.

185. *See* Douglas, *supra* note 6; Higgins, *supra* note 5.

186. Douglas, *supra* note 6 (stating that a providing Reyes-Camarena with a kidney transplant "could save the state money"); Higgins, *supra* note 5 (quoting Reyes-Camarena as arguing that his transplant would be "a bargain for Oregon taxpayers"); Ruben Rosario, *Health Care Costs Out of Control? Try Prison*, ST. PAUL PIONEER PRESS, June 23, 2003, at B1 (finding Oregon prison officials would likely have favored Reyes-Camarena's transplant because it "would [have] end[ed] up saving the budget-strapped state . . . money").

187. *See* Douglas, *supra* note 6.

188. The cost of dialysis over a ten-year span would have cost taxpayers $1.2 million. Subtracting the $100,000 cost of a kidney transplant from this total would equate to $1.1 million saved. *See* Douglas, *supra* note 6.

heart transplant, for example, is entirely void of the argument that the prisoner's heart transplant was cost-effective.[189] Similarly, media coverage of Carolyn Joy's attempts to obtain a liver transplant failed to present the argument that Joy's receipt of a liver transplant would save the Nebraska taxpayers money.[190]

Thus, despite the fact that providing inmates with necessary kidney transplants is sure to save taxpayers a great deal of money, the "transplant as cost-effective" argument entirely fails when applied to other organ transplants such as heart and liver. Therefore, educating the public about the actual, rather than perceived, costs of organ transplants fails to present a comprehensive solution to the public's strong dislike of paying for prisoners' organ transplants.

C. Addressing the Aging Prison Population

The final factor contributing to the public's dislike of prisoner organ transplants is America's aging prison population. The recent growth of the public outcry against prisoner organ transplants has been linked to the recent growth of the country's elderly prison population.[191] Because experts predict that the elderly sector of America's prison population will continue to grow at alarming rates,[192] it seems inevitable that the number of inmates receiving transplants will similarly increase.[193] Conversely, it would appear that a reduction in America's elderly prison population would lead to a decrease in the number of inmates receiving organ transplants. As such, another possible panacea to the public's outcry against prisoner organ transplants would be to reduce the number of incarcerated elderly in this country.

The dilemmas posed by this country's aging prison population are not limited to the context of prisoner organ transplants. Rather, prison overcrowding and the sky-rocketing cost of prison health care are at least in

189. *See generally* Higgins, *supra* note 5 (detailing the cost-effectiveness of prisoner receipt of kidney transplants but failing to present the same argument when discussing the California inmate's receipt of a heart transplant); Rosario, *supra* note 186 (noting the cost-effectiveness of Reyes-Camarena's proposed kidney transplant but failing to offer the same rationale when discussing the unidentified California inmate's heart transplant).

190. *See* Olson, *supra* note 13. Olson notes that, despite the cost to taxpayers, a liver transplant is the "standard of care" for liver failure. Consequently, Joy's liver transplant did not constitute the most cost-effective procedure, but rather the *only* acceptable procedure. *Id. See also* Spencer et al., *supra* note 1 (estimating the liver transplant to cost taxpayers $500,000 but failing to present an argument that such a procedure was cost-effective).

191. *See supra* note 35 and accompanying text.

192. *See* Drummond, *supra* note 33, at 60 (finding that male prisoners age fifty-five and older represent one of the most rapidly growing prison populations in the country).

193. *See Prisoner Gets $1M Heart Transplant*, *supra* note 9 (stating that "taxpayer-financed transplants are likely to increase as the prison population ages").

part attributable to the large numbers of elderly currently incarcerated.[194] When framed in this manner, therefore, the public's dislike of prisoner organ transplants is actually just one aspect of the public's larger concern about America's aging prison population.

Due to the myriad problems rooted in elderly prisoners, scholars have proposed various methods by which to decrease the country's number of elderly incarcerated. Such proposals include medical parole for terminally ill prisoners,[195] early release for elderly prisoners,[196] and consideration of age in sentencing.[197] Unlike the proposed solutions to organ scarcity, which exist in the United States only within scholarly literature,[198] proposed solutions to the dramatic increase in elderly inmates are actually in place in some states.[199] Furthermore, the majority of states that lack "an inmate age-based policy" nonetheless have "some kind of elder inmate response."[200]

While this Note does not attempt to determine which of the above proposed solutions to the elderly inmate crisis will ultimately be most effective,[201] it does conclude that proposals aimed at reducing the number of elderly incarcerated in this country are by far the most promising solution to the public outcry against prisoner organ transplants. Proposals targeting organ scarcity are simply too controversial to present any feasible solution to the problem,[202] while the "transplant as cost-effective" argument wholly fails

194. *See generally* Nadine Curran, Note, *Blue Hairs in the Bighouse: The Rise in the Elderly Inmate Population, Its Effect on the Overcrowding Dilemma and Solutions to Correct It*, 26 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 225 (2000); Drummond, *supra* note 33, at 60; Jason S. Ornduff, Note, *Releasing the Elderly Inmate: A Solution to Prison Overcrowding*, 4 ELDER L.J. 173 (1996).

195. *See* William E. Adams, Jr., *The Intersection of Elder Law and Criminal Law: More Traffic Than One Might Assume*, 30 STETSON L. REV. 1331, 1351 (2001); Patricia S. Corwin, *Senioritis: Why Elderly Federal Inmates are Literally Dying to Get Out of Prison*, 17 J. CONTEMP. HEALTH L. & POL'Y 687, 699 (2001); Curran, *supra* note 194, at 258–61; Ornduff, *supra* note 194, at 192–97.

196. *See generally American Bar Association Criminal Justice Resolution*, 2002, FED. SENT. REP. 53; Curran, *supra* note 194, at 257–59; Ornduff, *supra* note 194 at 191–200.

197. *See* Corwin, *supra* note 195, at 698; Ornduff, *supra* note 194, at 189–91.

198. *See supra* notes 168–69 and accompanying text.

199. *See* Corwin, *supra* note 195, at 698–99 ("States are dealing with their elderly prisoner populations in a variety of ways," including modified sentencing for elderly inmates who become ill during incarceration, compassionate release for terminally ill elderly inmates, and the consideration of a defendant's age at time of sentencing.). *See also* Curran, *supra* note 194, at 258–61 (finding that, as of 2000, eighteen states had compassionate release statutes in place to deal with terminally ill prisoners).

200. Corwin, *supra* note 195, at 699.

201. For a general discussion of the merits of the various proposals to reduce the country's elderly prison population, see generally Curran, *supra* note 194; Ornduff, *supra* note 194.

202. *See supra* notes 166–75 and accompanying text.

outside the context of kidney transplants.[203] In contrast, given the link between an aging prison population and prisoner organ transplants, proposals aimed at reducing the number of elderly incarcerated present viable solutions that are already being adopted by some states.[204]

VI. CONCLUSION

In the realm of prisoner organ transplants, the constitutional question is the "easy" one: Prison officials must provide inmates with medically necessary transplants to conform to the dictates of the Eighth Amendment. The more vexing problem, therefore, is how to quell the fierce public outcry that has resulted from complying with this constitutional mandate. In answering this question, this Note has identified the three underlying causes for the public's dislike of organ transplants and has considered proposed solutions to each.

Solutions targeting the scarcity of organs prove utterly unworkable. The use of social criteria in organ allocation is extremely controversial, as are proposals to alter the system of organ-harvesting in this country. Such proposals remain topics of scholarly debate, not practical solutions. Moreover, programs that educate the public about the benefits of organ donation have failed to sufficiently address the issue of organ scarcity in this country. Solutions addressing the cost of providing organ transplants to inmates similarly prove ineffective. While the "transplant as cost-effective" argument works superbly in regard to kidney transplants, the theory breaks down when applied to other organ transplants.

In contrast, solutions aimed at reducing the number of the country's elderly incarcerated prove promising. The connection between the increase in elderly inmate populations and the advent of the public debate over prisoner organ transplants is well-established. Furthermore, policies directed at reducing elderly prison populations are presently in place in several states. While this Note does not advocate any particular method of reducing elderly prison populations, it does conclude that future research should focus on this class of potential solutions. Given the constitutional mandate that prisoners must be provided with medically necessary organ transplants, in combination with the public's strong dislike of such a directive, such research is unquestionably critical.

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203. *See supra* notes 181–90.

204. *See supra* notes 191–200.

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