low-up and has rehabilitated himself by performing social work within the prison walls. This case persuaded me to research the law and resulted in a publication in the *Journal of Indian Law Institute*.² The subject was capital punishment and medical science.

In the case referred to in the editorial, it appears that medical professionals and legal professionals can come together and seek an alternative where valuable human resource is not wasted in the hope of retribution. I am referring to the large number of prisoners waiting a death sentence in US prisons. They could be potential organ donors for the community. With the assistance of the medical profession, each prisoner who is to be executed can provide organs for 8 to 10 patients.

This would certainly appeal to society at large. The article published in the *Journal of Indian Law Institute*² has interested the law commission in India, which is considering this suggestion. However, capital punishment itself is rarely given out in Indian courts. Perhaps this thought may be worth a closer look in your community, where the number of convicts on death row is large.

A. Sampath Kumar, MCh
Department of Cardiothoracic/Vascular
Surgery
All India Institute of Medical Sciences
New Delhi, India

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Reply to the Editor:

Readers will be grateful for the informative letter from Dr Sampath Kumar, who raises two interesting themes for ethical analysis. The case that he reports shows how changes in contextual details can clarify values and illuminate moral reasoning developed from analysis of an index case, like our heart transplant patient. This approach

to ethics is referred to as casuistry. In his case, the patient was not just in prison but was on death row, intensifying the apparent strength of the argument from justice to withhold treatment because of the seriousness of the crime. The treatment was an expensive valve operation, although it did not consume as scarce and as valuable a resource as a donor heart. The principle that guided his decision was that prisoners are our fellow citizens and fellow human beings, to whom physicians have a fiduciary duty to provide care within the boundaries of resource availability. It is enriching that he can give us the outcome, underlining the appropriateness of his decision to apply this principle.

The second theme that he raises is the issue of allowing prisoners to be organ donors. The voluntary or involuntary removal of vital organs after execution in China is an efficient but potentially abusive solution to the donor shortage. Clifford Bartz, a federal inmate in Pennsylvania, described the Inmate Organ Donor Network in the March issue of the *Kennedy Institute of Ethics Journal*.¹ Bartz and his colleagues propose that qualified inmates who pledge up to three organs on their death should be given 1 year of suspended prison time, and those who serve as living donors should receive 7 years of reduced time. He describes several voluntary donations of organs from prisoners to their needy relatives. These are examples of a form of trade, trading time for organs. In my Minnesota case of the prisoner who wanted to collect "rent" for his donated kidney, described in my reply to Dr Richenbacher's letter,² this proved to be a Faustian bargain, but this single example should not lead to a categorical ban. I recommend a more empirical approach to test the optimistic hypothesis that under the best circumstances, prisoner organ donation can be an act of heroism leading to trust and rehabilitation of a fallen comrade on the road of life.

We need rewards for donation. As a blood donor, I favor some advantage within the health care system for those who enrich it by donation. This might parallel the airlines' policy of rewarding frequent flyers for their loyalty with expedited boarding and free air travel on some under-filled flights. Blood donors, and particularly organ donors, deserve reasonable rewards within the health care system, as

long as they do not unfairly disadvantage other patients. Such a reward system would strengthen the value assigned by society to the act or intention to donate.³ Finally, the use of financial rewards should be explored as even Veatch,⁴ a longtime opponent of this policy, has grudgingly come to accept. The Council on Ethical and Judicial Affairs of the American Medical Association, stimulated no doubt by Bob Sade's presence on the council, has recommended that an empirical trial of financial rewards for organ donors should be conducted to determine whether it will favorably or unfavorably affect the overall rate of donation or reduce the donor pool.⁵

Martin McKneally, MD, PhD
Department of Surgery
University of Toronto
Toronto, Ontario, Canada

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Bivalirudin as alternative to both danaparoid and heparin in off-pump coronary artery bypass grafting To the Editor:

I enjoyed the recent article "Heparin Versus Danaparoid in Off-Pump Coronary Bypass Grafting: Results of a Prospective Randomized Clinical Trial" by Carrier and colleagues.¹ I favor off-pump coronary artery bypass grafting in patients with heparin-induced thrombocytopenia (HIT). Did Carrier and colleagues¹ consider using a short-acting thrombin inhibitor such as bivalirudin (Angiomax) rather than danaparoid as the heparin alternative?

I have used bivalirudin,² a short-acting thrombin inhibitor, in several patients with