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Death with Dignity for the Seemingly Undignified: Denial of Aid in Dying in Prison

Kathleen Messinger

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COMMENTS

DEATH WITH DIGNITY FOR THE SEEMINGLY UNDIGNIFIED: DENIAL OF AID IN DYING IN PRISON

Kathleen S. Messinger*

The medical community has fundamentally changed how we think about life and death. Humans in privileged parts of the world are living longer and have access to life-saving treatment. The focus on quantity of life then has shifted to emphasizing quality of life and questioning whether longevity should at the expense of comfort or satisfaction. The conversation surrounding quality of life, and by extension end-of-life care, has included whether a competent adult has a right, or should have a right to end their own life on their own terms. The history of aid in dying is wrought with political ideology, notions of morality, and discussions of autonomy. In the wake of an aging population, aid in dying is more relevant now than ever. Aid in dying is often supported by notions of autonomy and dignity in choosing the conditions of if, when, and how to end one's life, however, there is one noticeable segment of the population entirely left out: incarcerated individuals. The incarcerated population is particularly relevant to the aid in dying conversation because, as the justice system continues to balloon and incarcerate more people, prisons are overcrowded, underfunded, and ill-equipped to support terminally ill and aging inmates. This leaves the aging incarcerated population vulnerable. As states continue to contemplate and pass legislation that permits aid in dying in particular circumstances, one is left wondering how, if at all, this legislation will affect those incarcerated.

* B.A., University of California, Berkeley, 2014; J.D., Northwestern Pritzker School of Law, 2019. I want to thank all of the members of the *Journal of Criminal Law & Criminology*, specifically Natalie Unger, Nicole Steinberg, Emelia Carroll, and Andrew Page for their thoughtful and diligent edits. Last, but certainly not least, I owe immense gratitude to my partner, Jennifer Pesce, for her encouragement, support, editorial acumen, and unwavering love throughout this process.

Early signs, in the form of prison policies and regulations, of how prisons will approach aid in dying for qualifying inmates suggests that the same dignitary respect afforded to non-incarcerated folk is explicitly forbidden to inmates in prison.

This Comment seeks to answer the question of who may choose to die on their own terms, in their own way. If we find that incarcerated individuals have a right to aid in dying, are there reasons or justifications for why we should not permit it?

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INTRODUCTION

Few topics in American society illicit the strong reactions that suicide and aid in dying do. For some, suicide arouses moral and religious condemnation, and for others intellectual intrigue.¹ Whatever the reaction or interest, suicide is studied by a wide range of academic disciplines, and the conversation has progressed from debating the morality of suicide to debating the morality of the “right to die.” For the purposes of this Comment, aid in dying refers to “a terminally ill competent patient’s decision to seek a physician’s help in prescribing medication to hasten the dying process.”² In

¹ In Judaism, the Talmud prohibits suicide and for those who take their own life “whatever is [normally] done out of respect for the dead should not be observed.” Jewish Virtual Library, *Issues in Jewish Ethics: Suicide*, AMERICAN-ISRAELI COOP. ENTER., www.jewishvirtuallibrary.org/suicide-in-judaism [<http://perma.cc/RXX7-Y6A9>] (last visited Feb. 17, 2019). In Christianity, suicide is neither expressly condemned nor encouraged, but since the fifth century, St. Augustine claimed that suicide was a violation of the sixth commandment, “Thou shall not kill.” Robin E. Gearing & Dana Lizardi, *Religion and Suicide*, 48 J. RELIG. HEALTH 332, 334 (2009). Further, the “view of suicide as sin dominates current Christian attitudes across the dominations (e.g., Catholics, Baptists, and Protestants).” *Id.* In Islam, the Qu’ran expressly forbids suicide, which states “do not kill yourselves.” *Al-Nisa’* 4:29–30 (Alan Jones trans., E.J.W. Gibb Memorial Trust 2007). Different sects of Islam treat suicide differently, for example for countries that have incorporated Sharia Law, suicide and suicide attempts remain criminal offenses. *Id.* at 336 (internal citations omitted). Buddhism by contrast is not as harsh as Christianity and Islam, but that is not to say that it permits suicide because “a main Buddhist principle . . . is the principle of nonviolence, i.e. not killing or harming living beings.” Robin E. Gearing & Dana Lizardi, *Religion and Suicide: Buddhism, Native American and African Religions, Atheism, and Agnosticism*, 49 J. RELIG. HEALTH 377, 379 (2010). Thus, killing oneself is seen as a negative action that “results in another form of suffering.” *Id.* Lastly, Hinduism treats suicide according to the sect and intention of the act. Suicide in general is condemned in Hinduism, but if an individual practices *prayopavesa*, or “fasting to death,” then it is an acceptable way to end one’s own life. *Euthanasia and Suicide*, BBC NEWS, <http://www.bbc.co.uk/religion/religions/hinduism/hinduethics/euthanasia.shtml> [<http://perma.cc/B4N7-8HZ6>] (last updated Aug. 25, 2009). However, *prayopavesa* is available in limited and certain circumstances. *Id.* Note that the aforementioned religions and religious views of suicide are incomplete and do not cover all religions, but only the most commonly practiced.

² Yvonne Lindgren, *From Rights to Dignity: Drawing Lessons from Aid in Dying and Reproductive Rights*, 16 UTAH L. REV. 779, 780 n.1 (2016). Many terms are used interchangeably in the “right to die” movement including suicide, physician assisted suicide, and euthanasia. While this interchange is understandable, the terms are not synonymous and in fact are quite different from each other. “Suicide” is the “act of taking one’s own life.” *Suicide*, BLACK’S LAW DICTIONARY (10th ed. 2014). “Aid in dying” is defined as the “intentional act of providing a person with the medical means or the medical knowledge to commit suicide.” *Physician-Assisted Suicide*, BLACK’S LAW DICTIONARY, (10th ed. 2014). Lastly, “euthanasia” is the “act or practice of causing or hastening the death of a person who suffers from an incurable or terminal disease or condition, especially a painful one, for reasons

the past several years, a number of states have either passed or proposed laws that permit aid in dying.³ While these debates continue, little attention has been given to a prisoner's access to aid in dying. This Comment weaves together the historical and philosophical underpinnings of suicide and aid in dying to assess how the Supreme Court and state courts have interpreted and evaluated a constitutional right to die. In addition, this Comment will address some of the most prevalent oppositional arguments to the availability, constitutionality, and morality of aid in dying. In the end, this Comment finds the denial of aid in dying in prison violates the Eighth Amendment of the Constitution's prohibition on "cruel and unusual punishment."⁴ This Comment will proceed in four parts. Part I will undertake a philosophical and religious historical account of suicide and how it has informed Western ideals about suicide, which in turn have influenced the conversation surrounding aid in dying. Part II offers a comparative analysis of how courts have dealt with the issue of a patient's right to withdraw medical support or refuse potentially life-saving treatment as compared to a prisoner's right equivalent (or lack thereof). Part III provides an overview of how the Supreme Court has weighed in on aid in dying and how it has conceptualized various liberty interests in bodily integrity and autonomy, as well as the Court's jurisprudence on a prisoner's right to health care and how this body of case law has required states to provide prisoners with rights and access that are not endowed on non-incarcerated individuals. Lastly, in Part IV I argue that denying a terminally ill patient access to aid in dying violates the Eighth Amendment based on the historical and philosophical underpinnings of the "right to die" debate, the Supreme Court and various state courts' treatment of health care decisions (both in the context of prison and outside of it), and the evolution of the Supreme Court's treatment of "cruel and unusual" punishment.

of mercy." *Euthanasia*, BLACK'S LAW DICTIONARY (10th ed. 2014). Within euthanasia there is active euthanasia which occurs when "the physician takes direct action" to end a patient's life as opposed to passive euthanasia which "is simply withholding or withdrawing the treatment needed to sustain life and allowing the patient to die." DIXIE L. DENNIS, *LIVING, DYING, GRIEVING* 40 (2008). Euthanasia differs from physician-assisted suicide because in this scenario, the doctor "gives the patient the means to end his or her own life" and the patient takes the action, which allows the patient to "decide not to go ahead with the act." *Id.* at 43 (internal citation omitted). For a nuanced discussion of the evolution of the term "aid in dying" from "physician-assisted suicide," see Kathryn L. Tucker, *In the Laboratories of States: The Progress of Glucksberg's Invitation to States to Address End-of-Life Choice*, 106 MICH. L. REV. 1593, 1594–96 (2008); Kathryn L. Tucker & Fred B. Steel, *Patient Choice at the End of Life: Getting the Language Right*, 28 J. LEGAL MED. 305 (2007).

³ See *infra* Part III.A.

⁴ U.S. CONST. amend. VIII.

I. PHILOSOPHICAL AND RELIGIOUS HISTORY CONTRIBUTING TO THE AID IN DYING DEBATE

In many court cases, judges invoke the history and philosophy of suicide to reject aid in dying.⁵ It is therefore necessary to not only situate the taking of one's own life within philosophical understandings of suicide, but also to highlight general inaccuracies underlying the judiciary's opinions about suicide and aid in dying. While legal and moral philosophy have influenced courts and society more generally, Western religions have helped form our contemporary understanding of suicide. Many opponents of aid in dying, currently and historically, have used philosophical and religious understandings of suicide as persuasive authority to condemn suicide and aid in dying and argue that it is immoral to take one's own life.⁶ Opponents then use their beliefs to argue that aid in dying should be illegal.⁷ Part I of this Comment will provide a brief historical overview of the views of Greek and Roman philosophers and critique how certain opponents of aid in dying have characterized philosophical understandings.

A. GREEK AND ROMAN UNDERSTANDINGS OF SUICIDE

Some of the earliest prescriptive and descriptive philosophical opinions of suicide come from ancient Greece.⁸ Elise P. Garrison, a scholar studying the topic of suicide in Greek tragedy, argues that historical Greek attitudes

⁵ See, e.g., *Washington v. Glucksberg*, 521 U.S. 702, 710–15 (1997) (presenting a historical analysis of suicide and thereby assisting in suicide from our Nation's founding); *Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 261, 294 (Scalia, J., concurring) (noting that case law at the time the Fourteenth Amendment was adopted "generally held that assisting suicide was a criminal offense"); *Compassion in Dying v. Washington*, 79 F.3d 790, 845–47 (9th Cir. 1996) (en banc) (Beezer, J., dissenting), *rev'd by Washington v. Glucksberg*, 521 U.S. 793 (1997) (recounting the philosophy of Judeo-Christianity, Plato, Aristotle, Roman law, St. Augustine, and Blackstone, among others, to argue against a constitutional right to aid in dying); *People v. Kevorkian*, 527 N.W.2d 714, 730–31 (Mich. 1994) (finding that there was "no indication of widespread societal approval" of acts of suicide and "[t]o the contrary, suicide was a criminal offense, with significant stigmatizing consequences."). See generally *Woods v. Kentucky*, 142 S.W.3d 24, 61–62 (Ky. 2004) (Wintersheimer, J., dissenting) (reviewing the Roman Church's historical stance on suicide and euthanasia)).

⁶ See Part I.A–B.

⁷ Neil M. Gorsuch, *The Right to Assisted Suicide and Euthanasia*, 23 HARV. J.L. & PUB. POL'Y 600, 620–31 (2000); see generally JENNIFER M. HECHT, *STAY: A HISTORY OF SUICIDE AND THE PHILOSOPHIES AGAINST IT*, 45–62 (2013).

⁸ See MICHAEL CHOLBI, *SUICIDE: THE PHILOSOPHICAL DIMENSIONS* 11 (2011). See generally *Suicide*, STANFORD ENCYC. OF PHIL., <https://plato.stanford.edu/entries/suicide/> (last updated July 21, 2017) [<http://perma.cc/M39V-LVA4>].

toward suicide stem from the concepts of shame and honor.⁹ These concepts were of “profound significance” in ancient Greece and “motivate[d] many of the suicides recorded by historians and nearly all suicides in Greek tragedy.”¹⁰ For example, suicide could be a reasonable reaction to one’s own performance in battle.¹¹ Another example of honor and shame in suicide arises in fifth century Greece where Messenian prisoners “refused to be tried by their captors” and took their own lives instead.¹² The Messenians died by their own hands “in order to escape punishment and further disgrace.”¹³ Thus, it appears that in antiquity Greece, far from being universally condemned or punished, suicide was permitted if shame or honor were at stake.¹⁴ Garrison notes that “neither Thucydides¹⁵ nor Herodotus¹⁶ makes any explicit value judgment concerning the suicide victims they mention.”¹⁷ The language they evoke, in part, explains the circumstances that led to suicide and gives the impression that “suicide created no ‘moral revulsion,’ but rather provided people with an honorable release from an undesirable life.”¹⁸

Opponents of aid in dying have suggested that historically, suicide was forbidden. However, several counterexamples to this assumption exist. For example, in *The Right to Assisted Suicide*, Justice Gorsuch argues that in

⁹ Elise P. Garrison, *Attitudes Toward Suicide in Ancient Greece*, 121 TRANSACTIONS AM. PHILOLOGICAL ASSOC. 13 (1991).

¹⁰ *Id.*

¹¹ *Id.*

¹² *Id.*

¹³ *Id.* at 14.

¹⁴ *See id.* Garrison cites another example of suicide committed to escape punishment. She writes that the Queen of Babylon “flung herself into a room of ashes” after “taking revenge on the Egyptians for killing her brother.” In Herodotus, Adrastus “stabbed himself from shame at his bad luck.” *Id.*

¹⁵ Thucydides was a Greek historian born around 460 B.C. and is considered one of the “greatest Greek historians.” Britannica Academic, *Thucydides*, ENCYC. BRITANNICA, <http://academic.eb.com.turing.library.northwestern.edu/levels/collegiate/article/Thucydides/72310> (last visited Nov. 6, 2017) [perma.cc/FJ6S-VKH3]. He authored the *History of the Peloponnesian War*, “which recounts the struggle between the Athens and Sparta in the fifth century B.C. His work was the first recorded political and moral analysis of a nation’s war policies.” *Id.*

¹⁶ Herodotus was a Greek writer born around 484 B.C.E. and is credited with authoring the “first great narrative history” of the Greco-Persian Wars. In addition, he is considered the “leading source of original information . . . for Greek history . . . between 550 and 479 B.C.E. Britannica Academic, *Herodotus*, ENCYC. BRITANNICA, <http://academic.eb.com.turing.library.northwestern.edu/levels/collegiate/article/Herodotus/40200> (last visited Nov. 6, 2017) [http://perma.cc/V37H-FCVW].

¹⁷ Garrison, *supra* note 9, at 14.

¹⁸ *Id.* (internal citation omitted).

Compassion in Dying v. Washington,¹⁹ Judge Reinhardt misinterpreted how suicide was treated in Ancient Greece.²⁰ Gorsuch argues that Athenian law “treated suicide” as a crime, “‘punishing’ the ‘guilty’ by amputating the corpse’s right hand and denying traditional burial rituals.”²¹ However, Gorsuch may have misinterpreted the practice. As Garrison contends, the passage from a speech given by Aeschines in 330 B.C. “is the only reference to such treatment of a suicide” and as such it is unclear “how regularly the cutting off of a hand occurred.”²² Further, while Gorsuch argues that Athenian Law treated suicide as a crime per se—indicated by severing the deceased’s right hand—Garrison argues that evidence of antiquity Greece suggests that there was “an uneasiness about suicides . . . [but] the evidence does not suggest a categorical mistreatment of or societal revulsion from suicides.”²³ Opponents of aid in dying also point to what they perceive as Plato and Aristotle’s condemnation of suicide, however, that too is a simplified view of the kind of nuanced distinguishing factors that the philosophers accounted for.²⁴ In *Phaedo*, Plato opposes suicide because it was “against the will of the gods and thus not allowed.”²⁵ Despite his general disapproval towards those who commit suicide, however, Papadimitriou et al. interprets Plato’s text as demonstrating that Plato is “tolerant of people who suffer insurmountable pain. He recognizes the right of the desperate individual to commit suicide when faced with unavoidable misfortune due to having led a less than good life. [He] takes into account the insuperable unhappiness of such people.”²⁶ Support for this proposition is found in *Gorgias* and *Laws*; in *Gorgias* Plato presents a scenario where those afflicted with “incurable diseases” of body or mind may not be better off living²⁷ and in *Laws* he seems to carve out an exception to wrongful suicide where the

¹⁹ 79 F.3d 790 (9th Cir. 1996) (en banc) (Beezer, J. dissenting), *rev’d sub nom.* *Washington v. Glucksberg*, 521 U.S. 702 (1996).

²⁰ See Gorsuch, *supra* note 7, at 623–27.

²¹ *Id.* at 623.

²² Garrison, *supra* note 9, at 9.

²³ *Id.* at 12.

²⁴ See Gorsuch, *supra* note 7, at 623–25.

²⁵ John D. Papadimitriou, et al. *Euthanasia and Suicide in Antiquity: Viewpoint of the Dramatists and Philosophers*, 100 J. ROYAL SOC’Y MED. 25, 26 (2007).

²⁶ *Id.* See also PLATO, GORGAS (E.M. Cope, trans., Deighton, Bell & Co. 1883) (~380 B.C.). The full text of *Plato’s Gorgias* is available at <https://www2.southeastern.edu/Academics/Faculty/jbell/gorgias.pdf> [<https://perma.cc/2VRB-MYQD>].

²⁷ PLATO, GORGAS 109, line 512a (E.M. Cope, trans., Deighton, Bell & Co. 1883) (~380 B.C.). For a further interpretation, see David Levy, *Socrates v. Callicles: Examination & Ridicule in Plato’s Gorgias*, 13 PLATO J. 27, 30 (2013); Daniel R. N. Lopes, *Moral Psychology in Plato’s Gorgias*, 11 J. ANCIENT PHIL. 20, 37 (2017).

person is “compelled by some terribly painful and inescapable bad luck”²⁸

Rather than openly condemning suicide, in *Write to Death*, Professor Elizabeth A. Gailey, argues that Greeks had an “open tolerance” of euthanasia.²⁹ She grounds her argument on three principal reasons. The first reason is the “fundamental trust in human *reason*.”³⁰ That is, individuals have the “right to make rational decisions about . . . their own deaths.”³¹ The second reason is “[i]ndividual autonomy” or the notion that “man is the master of his own body, with the right to decide his own fate.”³² Last, Gailey points to the Greek “idealization of youth.”³³ She argues that euthanasia was considered a “viable means of achieving a ‘good death’³⁴ [and was] an appropriate option for individuals faced with debilitating or terminal illness [or a] loss of dignity at life’s end.”³⁵

B. HOW RELIGION HELPED SHAPE THE AID IN DYING DEBATE

While philosophical texts help frame the discussion on the morality of suicide, as societies evolved, religion—particularly forms of Christianity—began to play a greater role in setting and guiding moral standards.³⁶ It is

²⁸ PLATO, THE LAWS OF PLATO 268, lines 873c–d (Thomas L. Pangle, trans., Basic Press 1980) (~348 B.C.).

²⁹ ELIZABETH ATWOOD GAILEY, *WRITE TO DEATH: NEWS FRAMING OF THE RIGHT TO DIE CONFLICT, FROM QUINLAN’S COMA TO KEVORKIAN’S CONVICTION* 25 (2003).

³⁰ *Id.*

³¹ *Id.*

³² *Id.* (citing Thane J. Messinger, *A Gentle and Easy Death: From Ancient Greece to Beyond Cruzan: Toward a Reasoned Legal Response to the Societal Dilemma of Euthanasia*, 71 DENV. L. REV. 175, 182 (1993)).

³³ *Id.* at 26 (citing Nancy Osgood, *Assisted Suicide and Older People: A Deadly Combination*, 10 ISSUES IN L. & MED. 415 (1995)).

³⁴ “Good death” literally translates to euthanasia. *Euthanasia*, MEDICINENET, <https://www.medicinenet.com/script/main/art.asp?articlekey=7365> (last visited on Nov. 6, 2017) [<http://perma.cc/PA2V-KG6M>]. “Eu” means “goodly or well” + “thanatos,” which means death. *Id.* Thus “eu” + “thanatos” = good or well death. *Id.* Ian Dowbiggin notes that a “good death” was considered by ancient Greek and Roman philosophers as “an appropriate and rational response to a wide variety of circumstances. . . . Motives ran the gamut from pains due to cancer, bladders stones, stomach disorders . . . the fear of dishonor and the hope of avoiding judgment and execution.” IAN DOWBIGGIN, *A CONCISE HISTORY OF EUTHANASIA: LIFE, DEATH, GOD, AND MEDICINE* 8 (2007).

³⁵ *Id.*

³⁶ See *Suicide*, STAN. ENCYC. OF PHIL. at § 2.2, <https://plato.stanford.edu/entries/suicide/#HigHisTho> (last updated July 21, 2017) [<http://perma.cc/KQ3E-T2PX>] (postulating about the advent of Christianity on the prohibition on suicide). Uncertainty exists as to when exactly Roman and Greek societies began to transition from ancient views to Christianity, but there is speculation that Constantine’s conversion to Christianity in or around

believed that “Christianity [is] perhaps the most important event in the philosophical history of suicide, for Christian doctrine has by and large held that suicide is morally wrong, despite the absence of clear Scriptural guidance.”³⁷ As western societies moved away from ancient and classical views on the morality of suicide, religion played and continues to play a critical role in how we conceptualize life and death.

Religious sects overwhelmingly reject aid in dying.³⁸ Opposition to aid in dying stems predominately from ideas about a “natural” life: religious leaders believe that aid in dying or hastening a natural death is contrary to God’s intentions.³⁹ The evolution of Judeo-Christian thought in society explains the shift away from Greco-Roman beliefs about suicide and death. As Judeo-Christianity established a strong-hold throughout Europe, beliefs about suicide and a “good death” changed. Christianity in third century A.D. emphasized the value of life, and unlike the Greco-Romans school of thought that encouraged avoiding suffering,⁴⁰ Christians viewed “suffering” as a “consequence of—and reparation for—the wages of sin.”⁴¹ Without stating the obvious, the very nature of Christianity centers on suffering, as exemplified by the crucifixion of Christ.⁴² The culmination of Christian thought on the issue of suffering is that it leads to “spiritual growth and salvation.”⁴³ One could see then how Christianity shaped ideas around pain and suffering so that a painful death should not necessarily be ameliorated, but rather in some ways celebrated. It should come as no surprise that the Catholic Church “strongly opposes aid in dying” because “life should not be prematurely shortened because it is a gift from God.”⁴⁴ In addition, the

312 A.D. sparked a movement towards accepting Christianity, and over the next several centuries Christianity gradually became entrenched. *See generally* Sophie Lunn-Rockliffe, *Christianity and the Roman Empire*, BBC, http://www.bbc.co.uk/history/ancient/romans/christianityromanempire_article_01.shtml, [<http://perma.cc/KEY3-L68X>] (last updated Feb. 17, 2017).

³⁷ *Id.*

³⁸ For a discussion on religious attitudes towards aid in dying, see *supra* note 1.

³⁹ Christina L.H. Traina, *Religious Perspectives on Assisted Suicide*, 88 J. CRIM. L. & CRIMINOLOGY 1147, 1148–49 (1998).

⁴⁰ *See, e.g.*, PLATO, GORGIAS line 480a–481b (E.M. Cope, trans., Deighton, Bell & Co. 1883) (~380 B.C.). *See also* Miriam Griffin, *Philosophy, Cato, and Roman Suicide*, 33 GREECE & ROME 64, 73 (1983) (death and pain are to be avoided) (citing *SVF* 1.190)).

⁴¹ GAILEY, *supra* note 29, at 28.

⁴² JUDITH PERKINS, *THE SUFFERING SELF* 13 (1995).

⁴³ *Id.*

⁴⁴ *Religious Groups’ Views on End-of-Life Issues*, PEW RESEARCH CTR. 3, (Nov. 21, 2013), <http://www.pewforum.org/2013/11/21/religious-groups-views-on-end-of-life-issues/> [<http://perma.cc/LPS2-SKGX>].

Mormon, Lutheran, and Episcopal churches also firmly oppose aid in dying on similar grounds.⁴⁵

C. RELIGION AND THE ORIGINATION OF THE PRISON SYSTEM

While it is clear that western religion opposes suicide, and by extension aid in dying, there is reason to believe that these views may be strengthened in the context of prison. This is because religion also influences how society views the criminal justice system.⁴⁶ In *Do Moral Communities Play a Role in Criminal Sentencing?*, the authors argue that “religion and the criminal justice system are often connected”⁴⁷ because both the criminal justice system and religion “revolve around the concepts of social control and maintenance of normative community.”⁴⁸ Thus, looking at how society has formed in conjunction with religiosity provides a useful starting point for analyzing how religion has shaped the aid in dying debate.

What this means for aid in dying in the prison context is that, in some ways, to allow aid in dying in prison would be counter to and offend the

⁴⁵ Lyman Kirkland, a spokesman for the Mormon Church stated that the Church “firmly believe[s] in the sanctity of human life and its role in God’s plan.” *Id.* at 4. Reverend Roger Willer, the director of theological ethics for the Lutheran Church opined “[l]ife is a gift from God, to be received with thanksgiving, and there is an integrity of the life process that should be respected.” *Id.* Lastly, Timothy Sedgwick, a professor of Christian ethics, acknowledged that the Episcopal Church passed a resolution against aid in dying because “it is morally wrong and unacceptable to take a human life in order to relieve the suffering caused by incurable illness.” *Id.* at 5 (internal quotation marks omitted).

⁴⁶ AMITAI ETZIONI & DAVID CARNEY, *REPENTANCE: A COMPARATIVE PERSPECTIVE* 7 (1997). When we deal with crime and punishment, “we do not put it in the context of Christian repentance, we do use language reminiscent of Christian teaching.” *Id.* at 38. For example, “we place [offenders] in a ‘penitentiary’ and speak of ‘rehabilitation.’” *Id.* The use of “penitentiary” then reflects society’s desire that prisoners “would repent, and would be able to return to society . . . changed.” *Id.* Etzioni and Carney argue that there is then a religious component to prisons, which is highlighted in the historical foundation of contemporary prisons as well as the fact that prisons “usually have chaplains, and various ministries operate within them.” *Id.* See Chai Woodham, *Eastern State Penitentiary: A Prison With a Past*, SMITHSONIAN MAG. (Sept. 30 2008), <https://www.smithsonianmag.com/history/eastern-state-penitentiary-a-prison-with-a-past-14274660> [<http://perma.cc/9F6G-E537>]. The relationship between religion and criminal justice can be most readily seen in post-American Revolution jail systems. Dr. Benjamin Rush, a Philadelphia physician with an interest in politics proposed a new conception of American jails because he was “convinced that crime was a ‘moral disease,’ and suggested a ‘house of repentance’ where prisoners could meditate on their crimes, experience spiritual remorse and undergo rehabilitation. *Id.* The “house of repentance” later became known as a “penitentiary.” *Id.* Repentance of course is a concept derived from Judeo-Christian values.

⁴⁷ Jeffrey T. Ulmer, Christopher Bader, & Martha Gault, *Do Moral Communities Play a Role in Criminal Sentencing? Evidence From Pennsylvania*, 49 SOC. Q. 737, 738 (2008).

⁴⁸ *Id.*

central tenants of Christianity. Given the history of the relationship between religiosity and the criminal justice system, it necessarily follows that the interference in a prisoner's suffering by a third party, in this case a medical professional, is impermissible.

II. COURT TREATMENT OF WITHDRAWAL OF MEDICAL SUPPORT, REFUSING MEDICAL CARE, FORCE FEEDING AND AID IN DYING

The Supreme Court of the United States has never ruled on access to aid in dying in prison. Given the absence of binding precedent, our discussion on the constitutionality of aid in dying in prisons is informed by the way courts have treated withdrawal of medical technology and do not resuscitate orders, and how the Supreme Court has ruled on aid in dying. In addition to the aforementioned topics, one particular issue of relevance is how courts have treated hunger strikes and attempts at starvation in prison.

Prior to *Washington v. Glucksberg*,⁴⁹ the landmark case resolving the issue of aid in dying, both the Supreme Court and lower courts addressed a patient's right to refuse unwanted medical treatment.⁵⁰ Cases prior to *Glucksberg* largely grounded the right to determine end of life decisions on the right to privacy and liberty interests protected by the Fifth and Fourteenth Amendment's Due Process Clauses.⁵¹ However, as is often the case, prisoners are treated differently than non-prisoners in terms of constitutional rights because their constitutional right to liberty has already been removed as a criminal punishment.⁵² When it comes to bodily integrity, right to privacy, and liberty interests in refusing medical treatment, courts have been more willing to infringe on these rights for prisoners.⁵³ Additionally, there are constitutional rights that prisoners have been granted—including the right

⁴⁹ 521 U.S. 702 (1996).

⁵⁰ See *infra* Part II.A.

⁵¹ See *infra* Part II.B.

⁵² For an interesting discussion on courts treatment of a prisoner's right to refuse unwanted medical treatment, see Peter Wood, Comment, *The Right to Refuse Medical Treatment: Courts' Disparate Treatment of Incarcerated Patients*, 112 PENN ST. L. REV. 1167 (2008). Wood argues that while courts have "generally held that a patient had a constitutionally protected right to refuse unwanted treatment," but that a patient's "incarceration status" changes the balancing analysis courts conduct in deciding whether the patient's right asserted outweighs the state's interest. *Id.* at 1167–68. Whereas in these circumstances the "state interests are normally held to be subordinate to a patient's autonomy," in the prison context, courts have recognized the interest of correctional facility and thus when a prisoner wants to refuse medical treatment, his right to do so is balanced against the state interest *and* the interests of the correctional facility, which has "led numerous courts to deny prison inmates the right to refuse medical treatment." *Id.* at 1168 (internal citation omitted).

⁵³ See *infra* Part II.B.

to medical care—that non-prisoners have not.⁵⁴ In sum, a prisoner’s bodily liberty interests and medical rights differ from those of a free person.

A. OUTSIDE PRISON WALLS: WITHDRAWAL OF MEDICAL SUPPORT AND PATIENT REJECTION OF CARE

“[S]ignificant advances in medical technology and its potential to prolong life”⁵⁵ shaped the debate about whether a patient has the right to withdraw medical technology or prevent a doctor from performing life-saving treatments.⁵⁶ Despite the possibility of such life-saving technology, some individuals “find themselves confronted with dire medical situations where life may be extended but never truly bettered.”⁵⁷ In other words, longevity may be stretched, but the quality of the person’s life may be greatly diminished. As the medical field advanced, the conversation evolved from increasing life longevity to considering the quality of life lived.⁵⁸ As medical intervention became a real and probable circumstance in a patient’s life, protections for patients’ autonomy and ability to retain control over their own bodies became increasingly important. In 1977, Beauchamp and Childress released the *Principles of Biomedical Ethics*, which emphasized the importance of patient autonomy and has “been widely accepted as one of the

⁵⁴ See *Estelle v. Gamble*, 429 U.S. 97 (1976). See also *infra* Part IV.B.

⁵⁵ I MICHAEL S. GREEN & SCOTT L. STABLER, *IDEAS AND MOVEMENTS THAT SHAPED AMERICA: FROM THE BILL OF RIGHTS TO “OCCUPY WALL STREET”* 864 (2015); see also KANT PATEL & MARK E. RUSHEFSKY, *HEALTH CARE POLICY IN AN AGE OF NEW TECHNOLOGIES* 61 (2002) (“The second half of the twentieth century witnessed a major revolution in the field of biomedical technology that . . . increased capacity to prolong and sustain the life of terminally ill patients indefinitely through medical intervention.”). But see Margaret P. Battin et al., *Legal Physician-Assisted Dying in Oregon and the Netherlands: Evidence Concerning the Impact on Patients in “Vulnerable” Groups*, 33 J. MED. ETHICS, 591, 597 (2007) (In a study conducted to evaluate the fear that aid in dying would disproportionately affect vulnerable populations, the authors found “no evidence to justify the . . . fear that legalized physician-assisted dying will target the vulnerable.”).

⁵⁶ See PATEL & RUSHEFSKY, *supra* note 55, at 61 (detailing the relationship between medical advances in the second half of the twentieth century, prolonged life, and concerns about patients’ rights that placed “greater emphasis on patients’ rights to self-determination and autonomy” which in turn “generated intense debate about . . . the right to die.”). See also Andrew J. McCormick, *Self-Determination, the Right to Die, and Culture: A Literature Review*, 56 SOC. WORK 119, 120 (2011) (detailing the history of the right-to-die movement and highlighting how medical technology informed concepts of autonomy and self-determination). See generally Thomas Bein & Daniel Brodie, *Understanding Ethical Decisions for Patients on Extracorporeal Life Support*, 43 INTENSIVE CARE MED. 1510 (2017) (exploring ECMO and its implications for who should decide whether the patient should continue use).

⁵⁷ GREEN & STABLER, *supra* note 55.

⁵⁸ See *supra* notes 55–56.

four principles of medical ethics.”⁵⁹ Indeed, the transformation of patient autonomy led to a circumstance where “rights-bearing entered both the law and the medical community through the creation for the requirement of informed consent.”⁶⁰

As the technology evolved, the relationship between doctor and patient evolved as well. More than simply providing treatment as the doctor saw fit, doctors began to incorporate and consider the patient’s desires in end-of-life care. Simultaneously, perhaps as a matter of consequences, tensions surrounding end-of-life care and the rights of the patient summoned courts into the fray.

1. *In Re Quinlan*⁶¹

The debate about patient autonomy and the right to withdraw medically necessary technology really galvanized the nation in 1975 when Karen Ann Quinlan fell into a coma after consuming tranquilizers and alcohol.⁶² Because of her medical condition, she required a ventilator to breathe and was being administered artificial nutrition.⁶³ Five months after she fell into the coma, her father asked the physicians to “withdraw care” and take her off the ventilator.⁶⁴ Despite offering to relieve the doctors of liability, the doctors refused Joseph Quinlan’s request.⁶⁵ Doctor Haider Warraich, a researcher and physician at Duke University Medical Center, noted that the doctors refusal was not necessarily surprising at the time because Quinlan’s case arose when medical decisions were in a “complete ethical and legal vacuum[,]” and doctors followed their own moral compasses.⁶⁶

Joseph Quinlan brought suit in October 1975 to establish himself as Karen’s guardian and assert Karen’s right to privacy.⁶⁷ Justice Robert Muir Jr. of the New Jersey Superior Court ruled on November 10, 1975 that Mr.

⁵⁹ Lucija Murgic et al., *Paternalism and Autonomy: Views of Patients and Providers in a Transitional (Post-Communist) Country*, 16 BMC MED. ETHICS 1, 1 (2015).

⁶⁰ Nan D. Hunter, *Rights Talk and Patient Subjectivity: The Role of Autonomy, Equality and Participation Norms*, 45 WAKE FOREST L. REV. 1525, 1529 (2010).

⁶¹ 355 A.2d 647 (N.J. 1976).

⁶² Roberto D. McFadden, *Karen Ann Quinlan, 31, Dies; Focus of ‘76 Right to Die Case*, N.Y. TIMES (June 12, 1985), <http://www.nytimes.com/1985/06/12/nyregion/karen-ann-quinlan-31-dies-focus-of-76-right-to-die-case.html?pagewanted=all> [<http://perma.cc/93JA-KNVL>].

⁶³ HAIDER WARRAICH, M.D., *MODERN DEATH: HOW MEDICINE CHANGED THE END OF LIFE* 74 (2017).

⁶⁴ *Id.*

⁶⁵ *Id.*

⁶⁶ *Id.* at 74–75.

⁶⁷ *Id.* at 76–78.

Quinlan was not Karen's guardian and left the decision to remove the ventilator to the physicians.⁶⁸ Justice Muir's opinion reflected the judicial sentiment at the time that medical decisions should be made by medical professionals who are "exemplar of the ethical and moral standards of society."⁶⁹ Mr. Quinlan subsequently appealed to the New Jersey Supreme Court and in a unanimous decision, the Court held that the right to privacy was "broad enough to encompass a patient's decision to decline medical treatment under certain circumstances."⁷⁰ In addition to holding that Karen Ann Quinlan maintained a privacy interest in the withdrawal of her treatment, the Court also held that her father could serve as her guardian and assert Karen's right to privacy on her behalf.⁷¹ Doctor Warraich, in *Modern Death: How Medicine Changed the End of Life*, argues that the *Quinlan* case represents three major points about the relationship between patient and doctor: first, a patient has a right to withdraw life-saving treatment; second, if the patient is not competent to make such a decision, the patient's guardian may make it on her behalf; and third, physicians will not be held criminally liable for adhering to such requests.⁷²

The *Quinlan* case is largely regarded as the first⁷³ major step in the "right to die movement" because it established and clarified the rights of patients in determining their care. The case rose to national prominence, garnering attention from medical professionals, religious leaders, legal scholars, and the public at large.⁷⁴ This notoriety is evidenced by the fact that in 1977, merely two years after Karen had been admitted to the hospital, 50% of Americans supported some form of legalized euthanasia, and that number increased to 75% in the late 1990s.⁷⁵ Perhaps exposure to forms of

⁶⁸ *Id.* at 77–78.

⁶⁹ *Id.* at 78.

⁷⁰ *In re Quinlan*, 355 A.2d 647, 663 (1976).

⁷¹ *Id.* at 664.

⁷² WARRAICH, *supra* note 63, at 84.

⁷³ While Karen Ann Quinlan's case rose to national prominence, the first legal case involving assisted suicide took place in 1816 in Massachusetts where a prisoner was tried for murder for persuading a fellow inmate to kill himself in order to avoid execution. GAILEY, *supra* note 29, at 51–52. Though Massachusetts' law equated encouraging suicide with murder, the jury acquitted the accused prisoner. *Id.* at 51 (internal citation omitted). This raises an intriguing question about the culpability of assisted suicide in the eyes of the public.

⁷⁴ WARRAICH, *supra* note 63, at 81.

⁷⁵ GAILEY, *supra* note 29, at 51. Note, as set forth in note 2, terms for aid in dying are sometimes used interchangeably, and as such, the wording of public opinion polls may impact results. See generally Morten Magelssen et al., *Attitudes Towards Assisted Dying are Influenced by Question Wording and Order: A Survey Experiment*, 17 BMC MED. ETHICS (Dec. 2015) (studying the effects of question wording and order on attitudes towards assisted

aid in dying and euthanasia not only desensitized a very polarizing topic in the eyes of public, but also established the role of the courts in determining where the line must be drawn in terms of patient autonomy and self-determination.⁷⁶

While *Quinlan* was the first reported end-of-life case,⁷⁷ the Supreme Court subsequently ruled in a series of cases dealing with the constitutionality of withdrawing and refusing life-saving medical treatment.

2. *Cruzan v. Director, Missouri Department of Health*⁷⁸

In *Cruzan v. Director*, the guardians of a patient in a persistent vegetative state brought suit seeking to terminate artificial hydration and nutrition for the patient.⁷⁹ The Court confronted the issue of whether Missouri's requirement for clear and convincing evidence of an incompetent patient's wish to withdraw life-sustaining treatment was unconstitutional,⁸⁰ and whether the Due Process Clause of the Fourteenth Amendment required the state to accept the substituted judgment of a close family member in the absence of substantial proof that their views match the patient's.⁸¹ The Court first confirmed that the Due Process Clause ensures that a "competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment."⁸² Whether a person has a liberty interest is but the first step in the constitutional analysis.⁸³ The next step is balancing the liberty interest against the state's interest.⁸⁴ The patient's guardians in the case argued that the Court's treatment of a competent patient should extend to an incompetent

dying). The use of the statistic here is merely to show an upward trend in support for terminating one's own life.

⁷⁶ For an example highlighting a patient's right to refuse medical treatment, see *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 1136–46 (1986). The court in *Bouvia* held that medical staff who, fearing that *Bouvia*'s expression that she wanted to die and would intentionally starve herself, inserted a feeding tube against the patient's will and against her express written instructions violated her personal dignity and thus ordered the hospital staff to remove the feeding tube. Note that the Superior Court found that the trial court erred in considering *Bouvia*'s motive for failing to eat, namely that she expressed a desire to die, and certain decisions that hasten death are permitted because the quality of life is diminished. *Id.* at 1142, 1145.

⁷⁷ ALAN MEISEL & KATHY L. CERMINARA, 3 THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISIONMAKING § 2.01 (3d ed. 2004).

⁷⁸ 497 U.S. 261 (1990).

⁷⁹ *Id.* at 267.

⁸⁰ *Id.* at 284.

⁸¹ *Id.* at 286.

⁸² *Id.* at 278 (citing and reviewing cases).

⁸³ *Id.* at 279.

⁸⁴ *Id.*

patient.⁸⁵ The Court disagreed with this contention stating that because of the interest at stake, it could adopt a clear and convincing standard.⁸⁶ To the second issue regarding whether the state is required to accept the family's substitute judgment, the Court ruled in the negative. The Court reasoned that there was "no automatic assurance that the view of close family members w[ould] necessarily be the same as the patient's would have had she been confronted with the situation while competent."⁸⁷ Thus the State is permitted to require a clear and convincing standard of evidence of the patient's wishes rather than defer to family members.⁸⁸

B. COURT TREATMENT OF A PRISONER'S RIGHT TO REFUSE MEDICAL TREATMENT

While jurisprudence generally finds that a patient has a constitutional right to refuse unwanted medical treatment, the line of cases inferring such a right has dealt with those who are "free." What then have courts said about a prisoner's right to refuse unwanted medical treatment?⁸⁹ Courts are generally split on this topic, some courts state a prisoner's liberty interest in privacy and bodily integrity is paramount, while others allow prison officials to force medical treatment even though the court finds a liberty interest present.⁹⁰

1. *Commissioner of Correction v. Myers*⁹¹

Commissioner of Corrections v. Myers is one of the seminal cases addressing whether an incarcerated individual has a right to refuse unwanted, albeit life-saving, medical treatment. While incarcerated at a Massachusetts correctional facility, Mr. Myers developed a kidney condition that required hemodialysis.⁹² The combination of failing to receive dialysis and refusing

⁸⁵ *Id.* at 280.

⁸⁶ *Id.* at 282.

⁸⁷ *Id.* at 286.

⁸⁸ *Id.* at 286–87.

⁸⁹ See Wood, *supra* note 52; see also Mara Silver, Note, *Testing Cruzan: Prisoners and the Constitutional Question of Self-Starvation*, 58 STAN. L. REV. 631 (2005); Daniel H. Mendelson, *The Right to Refuse: Should Inmates be Allowed to Discontinue Treatment for Noncommunicable Medical Conditions*, 71 MD. L. REV. 295 (2011); Marc D. Ginsberg, Comment, *A New Perspective in Prisoners' Rights: The Right to Refuse Treatment and Rehabilitation*, 10 J. MARSHALL J. PRAC. & PROC. 173 (1976).

⁹⁰ See *infra* II.B.

⁹¹ 399 N.E.2d 452 (Mass. 1979).

⁹² *Id.* at 453. Hemodialysis is a procedure whereby blood is pumped out of the body, cleansed of its toxins, and then returned to the body in addition to being prescribed medication that would lower the defendant's blood potassium level. *Id.*

to consume a particular medication would result in his death.⁹³ It would be accurate to categorize the dialysis and medication as life-saving treatment. After a year of receiving dialysis, Mr. Myers refused to adhere to his regularly scheduled treatment.⁹⁴ In 1979, the Commissioner of Correction brought suit in the Superior Court of Suffolk County, Massachusetts, for a declaratory judgment enabling him to compel Mr. Myers to undergo treatment.⁹⁵ The Court in *Myers* specifically acknowledged the motive for Myers' refusal to undergo treatment stating that it was not for his disease, the effects of the dialysis treatment, religious objections, or a general desire to die, but rather as a form of protest against being placed in a medium as opposed to minimum security prison.⁹⁶

The superior court in evaluating the claim considered that Mr. Myers was young, the dialysis procedure was relatively painless, he was a potential candidate for a kidney transplant, and that Mr. Myers would otherwise be able to live a normal life.⁹⁷ The superior court acknowledged that precedent revealed that a person has a strong interest in being free from nonconsensual invasion of his bodily integrity and has a constitutional right of privacy that can be asserted to prevent unwanted medical treatment.⁹⁸ Despite this, the Court found that the prison's interest in "upholding orderly prison administration" outweighed Mr. Myers constitutional right.⁹⁹ Indeed the Court explicitly acknowledged that while "incarceration d[id] not per se divest him of his right to privacy and interest in bodily integrity, it d[id] impose limitations on those constitutional rights in terms of the State interests unique to the prison context."¹⁰⁰ Taken together, the *Myers* Court upheld the appeals court's decision that authorized prison officials to use "reasonable force" to restrain Mr. Myers during dialysis and other life-saving treatment.¹⁰¹ The *Myers* decision represents one of the many court cases that

⁹³ *Id.* at 454.

⁹⁴ *Id.*

⁹⁵ *Id.* at 453.

⁹⁶ *Id.* at 454.

⁹⁷ *Id.*

⁹⁸ *Id.* at 455–56.

⁹⁹ *Id.* at 457. The Commissioner contended that the prison had an interest in preserving the prison's internal order and discipline and maintaining institutional security. *Id.* Further, he argued that "the maintenance of proper discipline and supervision of inmates "mandate[d] an authority to administer life-saving medical treatment without consent" and the prison's failure to prevent the prisoner defendant's death would pose a "serious threat" to prison order by possibly triggering an "explosive" reaction among other inmates and encouraging other inmates to attempt similar forms of coercion in order to "attain illegitimate ends." *Id.*

¹⁰⁰ *Id.*

¹⁰¹ *Id.* at 453, 457–58.

have allowed prison officials to intervene when a prisoner is refusing medical treatment.¹⁰²

2. *Washington v. Harper*¹⁰³

Prior to the 1990 decision in *Washington v. Harper*, state courts had relatively unbridled freedom to determine whether and when a patient in prison could be forced to undergo medical treatment against his will. The *Harper* Court provided some semblance of an analytical approach to how courts should decide “right to refuse” cases in prison. Mr. Walker Harper, was incarcerated at the Washington State Penitentiary in 1981.¹⁰⁴ He was housed in a special correctional institute that diagnosed and treated prisoners with serious mental health illnesses, where he was diagnosed with manic-depressive disorder.¹⁰⁵ After initially agreeing to treatment, he refused to continue taking the antipsychotic medications he was prescribed.¹⁰⁶ Upon refusal, the treating physician sought to medicate Mr. Harper over his objections.¹⁰⁷ In 1985, Mr. Harper brought suit under 42 U.S.C. § 1983 for failing to provide a hearing before prison officials administered his drugs without his consent, in violation of the Due Process and Equal Protection Clauses of the Fourteenth Amendment.¹⁰⁸ The U.S. Supreme Court recognized that Harper had a “significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause.”¹⁰⁹ However, the Court disagreed with Harper’s assertion that his freedom to refuse medication, protected by the Due Process Clause, could

¹⁰² See Stephen Smith, *Clarence Allen, 76, Executed*, ABC NEWS (Jan. 16, 2006), <https://www.cbsnews.com/news/clarence-allen-76-executed> [<https://perma.cc/8ZQJ-MNE3>] (Clarence Allen was sentenced to death in California, in September of 2005 he suffered a heart attack in which prison officials revived him). Although Allen requested that the prison officials not resuscitate him if he went into cardiac arrest prior to his execution, prison officials denied his request and suggested that they would in fact resuscitate despite his request. See Meredith Martin Rountree, *Criminals Get All The Rights: The Sociolegal Construction of Different Rights to Die*, 105 J. CRIM. L. & CRIMINOLOGY 149, 188–89 (2015). See also *Polk Cty. Sheriff v. Iowa Dist. Ct. for Polk Cty.*, 594 N.W.2d 421, 431 (Iowa 1999) (holding that the pretrial detainee’s interest in refusing medical treatment was outweighed by State’s interests in preserving life and maintaining prison security); *Langton v. Comm’r of Corr.*, 614 N.E.2d 1002, 1006 (Mass. App. Ct. 1993) (holding that prisoners had no constitutional right to refuse a mandatory tuberculosis test).

¹⁰³ 494 U.S. 210 (1990).

¹⁰⁴ *Id.* at 214.

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ *Id.* at 214–15.

¹⁰⁸ *Id.* at 217.

¹⁰⁹ *Id.* at 221–22.

not be overridden by the prison officials because “[t]he extent of a prisoner’s right under the Clause to avoid unwanted [medical treatment] must be defined in the context of the inmate’s confinement.”¹¹⁰ The Court then turned to its precedent in *Turner v. Safley*,¹¹¹ which established the standard of review for constitutional claims brought by prisoners.¹¹² Under *Turner*, the Court reasoned the Due Process Clause permits prison officials to “treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will.”¹¹³

The case law demonstrates that while non-incarcerated individuals are granted rights to refuse medical treatment on the basis of bodily integrity, privacy, and autonomy, represented in cases like *In re Quinlan* and *Cruzan*, the same liberties—although recognized by the Supreme Court in *Harper*—are not afforded to incarcerated individuals.¹¹⁴ A prisoner’s constitutional liberties are more readily affronted.¹¹⁵

C. FORCE FEEDING

An incarcerated individual’s inability to per se refuse medical treatment highlights one scenario where courts treat prisoners’ autonomy different than non-incarcerated individuals. The ability of prison officials to force feed inmates is another example of how courts treat incarcerated and non-incarcerated individuals’ autonomy differently. Based on the holding in *Cruzan*—that a competent person has a Fourteenth Amendment liberty

¹¹⁰ *Id.* at 222.

¹¹¹ 482 U.S. 78 (1987). *Turner* established that “when a prison regulation impinges on inmates’ constitutional rights, the regulation is valid if it reasonably relates to legitimate penological interests.” *Id.* at 89. The reasonability of a prison regulation is governed by several factors. The first is, there must be a “valid, rational connection” between the regulation and the purported legitimate interest. The second is whether there are alternative means of exercising the right that are an avenue by which the prisoner can exercise his asserted right. The third factor is, the impact that the accommodation will have on the prison community and institutional resources. The last factor is “the absence of ready alternatives is evidence of the reasonableness of a prison regulation. *Id.* at 89–90.

¹¹² *Harper*, 494 U.S. at 223–24.

¹¹³ *Id.* at 227.

¹¹⁴ *But see* *Thor v. Superior Court*, 855 P.2d 375 (Cal. 1993) (en banc).

¹¹⁵ *See* *Wood*, *supra* note 52, at 1176–77 (arguing that courts’ rationale of preserving order and security as a legitimate interest are hypocritical because while the courts recognize a liberty interest in being free from unwanted medical treatment, which can be overridden by state interests, courts have recognized a right to privacy as to HIV-positive status, which despite the potential for spreading the disease, courts have held that the disclosure of an inmate’s status would violate the inmate’s right to privacy because “the disclosure was not reasonably related to any legitimate [penological] interest.” (citing *Powell v. Schriver*, 175 F.3d 107 (2d Cir. 1999); *Hilaire v. Ariz. Dep’t of Corr.*, 934 F.2d 324 (9th Cir. 1991))).

interest in withdrawing medical care—prisoners should be able to starve themselves under the Fourteenth Amendment and autonomy principles.¹¹⁶ While the Supreme Court has not weighed in on a constitutional right to starve, several state court cases are informative on the issue.

In *Zant v. Prevatte*,¹¹⁷ Mr. Prevatte stopped eating on October 29, 1981 as a form of protest.¹¹⁸ Prison doctors monitored his condition until November 21, 1981 at which point Mr. Prevatte refused to allow the medical staff at the prison to continue to monitor him.¹¹⁹ The doctors estimated that based on his physical condition, Mr. Prevatte would be dead within three weeks if he did not receive nutrition.¹²⁰ The State believed it should be able to force feed the prisoner to prevent his death because the state has an interest in the preservation of life.¹²¹ The Supreme Court of Georgia disagreed and held that the prisoner did not lose his right to privacy and therefore the State could not override his decision to starve, even though it would likely save his life.¹²²

Despite the reasoning and ruling in *Zant*, other courts have failed to recognize a protected liberty interest in the right to starve.¹²³ For example, *In re Caulk* sought to answer the question of whether a competent New Hampshire prisoner had a constitutional right to die without State interference and whether the prisoner “knowingly and voluntarily decided to die by starvation.”¹²⁴ The New Hampshire Supreme Court ultimately held that the state’s interest in maintaining the criminal justice system and preserving the prisoner’s life overrode the prisoner’s right to privacy.¹²⁵

The aforementioned jurisprudence regarding the right to refuse medical treatment in the prison and non-prison contexts and a prisoner’s right to

¹¹⁶ See generally Silver, *supra* note 89, at 632, 661 (arguing that “force-feeding a competent inmate necessarily violates that inmate’s fundamental privacy rights” and the right to starve “should not be affected by a prisoner’s incarcerated status. It should not be contingent on a prisoner’s physical state. And it should not be conditioned on the purpose of a hunger strike.”).

¹¹⁷ 286 S.E.2d 715 (Ga. 1982).

¹¹⁸ *Id.*

¹¹⁹ *Id.* at 716.

¹²⁰ *Id.*

¹²¹ *Id.*

¹²² *Id.* at 717; see also *Stouffer v. Reid*, 993 A.2d 104 (Md. 2010); *Thor v. Superior Court*, 855 P.2d 375 (Cal. 1993) (en banc).

¹²³ See Silver, *supra* note 89, at 632 (showing that there are nearly fifteen state and federal courts that have found force-feeding inmates is permissible in certain circumstances). See also *Comm’r of Corr. V. Coleman*, 38 A.3d 84 (Conn. 2012); *McNabb v. Dep’t of Corr.*, 180 P.3d 1257 (Wash. 2008) (en banc).

¹²⁴ 480 A.2d 93, 94 (N.H. 1984).

¹²⁵ See *id.* at 97.

starve show that while autonomy and dignity decisions are protected for those who are not incarcerated, for prisoners, their rights are subject to the whims of prison officials.

III. AID IN DYING

A. OUTSIDE OF PRISON

In 1997, the Supreme Court addressed the constitutionality of aid in dying in two cases: *Washington v. Glucksberg*¹²⁶ and *Vacco v. Quill*.¹²⁷ In *Washington v. Glucksberg*, the Court held that a Washington statute banning assisted suicide did not violate the due process rights of terminally ill patients.¹²⁸ However, the Court still permitted states to experiment and pass legislation that permitted aid in dying.¹²⁹ The *Glucksberg* Court distinguished its holding in *Cruzan* by highlighting the difference between “refusing” medical care, in which the patient dies from the underlying disease, and aid in dying, where the patient dies from the ingested medication.¹³⁰ In the same year, the Supreme Court held in *Vacco v. Quill* that New York’s prohibition on aid in dying did not violate the Equal Protection Clause.¹³¹ Thus, the Supreme Court recognized in 1997 that aid in dying is not a constitutional right covered by the Due Process and Equal Protection Clauses of the Fourteenth Amendment.¹³²

In the wake of the Supreme Court’s holdings in *Glucksberg* and *Quill*, many believed that the decisions effectively closed the door on the constitutionality of aid in dying.¹³³ However, though *Glucksberg* and *Quill* upheld the rights of states to ban aid in dying by legislative initiative, the Court did not reach the question of whether the practice of aid in dying itself is unconstitutional. The significance of the Court’s decision not to reach the constitutionality of aid in dying per se meant that states *could* decide to legalize the practice. Because the Court in *Glucksberg* and *Quill* left open

¹²⁶ 521 U.S. 702 (1996).

¹²⁷ 521 U.S. 793 (1997).

¹²⁸ *Glucksberg*, 521 U.S. at 735.

¹²⁹ *Id.*

¹³⁰ *Id.* at 723–25 (relying on *Quill*, 521 U.S. at 800–08).

¹³¹ *Quill*, 521 U.S. 793.

¹³² For a criticism of the two cases, see Erwin Chemerinsky, *Washington v. Glucksberg Was Tragically Wrong*, 106 MICH. L. REV. 1501, 1503 (2008). He argued that the Supreme Court failed to recognize that the Washington statute prohibiting aid in dying infringed on a fundamental right to privacy and thus only applied a rational basis review rather than the appropriate strict scrutiny review. *Id.*

¹³³ See John B. Mitchell, *My Father, John Locke, and Assisted Suicide: The Real Constitutional Right*, 3 IND. HEALTH L. REV. 45, 47–48 n.14 (2006).

the door to aid in dying, many proponents of aid in dying began to take their cause to the grassroots level and push for legislation that would legalize the practice.¹³⁴

After the *Glucksberg* and *Quill* rulings, some states began to pass legislation permitting aid in dying. Many of these statutes were a culmination of evolving beliefs about autonomy, self-determination, and dignity.¹³⁵ To date, seven states and the District of Columbia permit aid in dying.¹³⁶ Oregon, Washington, and Colorado permit the practice via public initiative.¹³⁷ California, Vermont, and Hawaii permit aid in dying by legislative action.¹³⁸ Montana permits the practice via court ruling.¹³⁹ Lastly, the District of Columbia permits the practice by city council vote.¹⁴⁰ In addition to the aforementioned states, several states have recently or are currently considering legislation to legalize aid in dying.¹⁴¹

¹³⁴ See Lindgren *supra* note 2, at 791–92, 97; *Chronology of Assisted Dying in the U.S.*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/assisted-dying-chronology/> (last visited Mar. 22, 2018) [<http://perma.cc/6A2G-URXC>].

¹³⁵ See *supra* Part II.

¹³⁶ CNN Library, *Physician-Assisted Suicide Fast Facts*, CNN (Jan. 3, 2019), <https://www.cnn.com/2014/11/26/us/physician-assisted-suicide-fast-facts/index.html> [<http://perma.cc/TT6P-BMC3>].

¹³⁷ Oregon Death with Dignity Act, OR. REV. STAT. ANN. §§ 126.800–.897 (2016); The Washington Death with Dignity Act, WASH. REV. CODE § 70.245 (West) (2009); Colorado End of Life Options Act, COLO. REV. STAT. ANN. § 25-48-101-25-48-123 (West) (2016).

¹³⁸ California End of Life Option Act, CAL. HEALTH & SAFETY CODE §§ 443-443.22 (West) (2016); Vermont Patient Choice at the End of Life Act, VT. STAT. ANN. Title 1-5293 (West) (2013); Hawaii Our Care, Our Choice Act, HAW. REV. STAT. ANN. § 327L-2 (West 2019).

¹³⁹ In 2009, the Montana Supreme Court declined to decide an aid in dying case on constitutional grounds and focused on a consent defense to a homicide charge under Montana criminal law. *Baxter v. State*, 224 P.3d 1211, 1214–15 (Mont. 2009). The Court found that the Montana Terminally Ill Act shielded physicians from liability if they acted in accordance with a patient’s end-of-life decision. *Id.* at 1222. Furthermore, the Court found that physician aid in dying does not violate public policy. *Id.* Similarly, in 2014, a New Mexico District Court found that a New Mexico statute that criminalized “assisting suicide” violated the New Mexico Constitution because “the liberty, safety and happiness interest of a competent, terminally ill patient to choose aid in dying is a fundamental right under [the] New Mexico Constitution.” *Morris v. Brandenburg*, 2014 WL 10672986 (N.M. Dist. Ct. Jan. 13 2014), *rev’d*, *Morris v. Brandenburg*, 356 P.3d 564, 567 (N.M. Ct. App. 2015). The New Mexico Supreme Court upheld the Appeals Court reversal because the Court did not “recognize a fundamental or important right to physician-assisted suicide” and New Mexico had a rational basis for criminalizing aid in dying. *Morris v. Brandenburg*, 376 P.3d 836, 855 (N.M. 2016).

¹⁴⁰ District of Columbia Death with Dignity Act of 2016, D.C. Law 21-182 (West) (2017).

¹⁴¹ In January 2017, a House representative from Connecticut introduced H.B. 6024, An Act Concerning Aid in Dying for Terminally Ill Patients; in February 2017, an Iowa Senator introduced S.B. 2015, A Bill for an Act Creating the Iowa End-of-Life Options Act; in March 2017, a House representative from Alaska introduced H.B. 54, Voluntary Termination of Life;

States that permit aid in dying impose strict regulations on the accessibility and availability of aid in dying. Some of the restrictions include being a resident of the state or territory where aid in dying is legal, being above the age of eighteen, mental competency, and being diagnosed with a terminal illness in which you have six months to live.¹⁴² In addition, the patient must make an oral request, wait a minimum of fifteen days, make a second oral request, and then make a written request; in some states you must wait another forty-eight hours after the second request.¹⁴³ If the procedural requirements are met, the doctor may prescribe end-of-life medication that must be taken by the individual and without assistance from the doctor.¹⁴⁴

B. BUT WHAT ABOUT AID IN DYING IN PRISONS?

Despite growing success at the state level in securing access to aid in dying, individuals incarcerated in states with pro-aid in dying laws are barred from access, and individuals incarcerated in states without pro-aid in dying laws are prevented from moving to favorable states given their incarcerated status.¹⁴⁵

While aid in dying is available in states that permit it, the same compassion is not extended to prisoners with terminal illnesses. Prisoners over the age of fifty represent the fastest growing prison population.¹⁴⁶ The aging and terminally ill prison population poses unique health care challenges such as chronic illness, heart disease, and diabetes that prisons are

in May 2017, a House representative introduced H.B. 160, An Act to Amend Title 16 of the Delaware Code Relating to End of Life Options; in January 2018, a Utah State Representative introduced H.B. 210, Utah End of Life Options Act, a House representative from Indiana introduced H.B. 1157, End of Life Options; in February 2018, the Arizona House and Senate introduced two bills that would legalize aid in dying (2018 AZ H.B. 2611, 2018 AZ S.B. 1414). As of April 2018, twenty-five states were considering passing aid in dying legislation. Michael Ollove, *Support For Aid-in-Dying Laws Has Been Growing*, WASH. POST. (Apr. 2, 2018), https://www.washingtonpost.com/national/health-science/support-for-aid-in-dying-laws-has-been-growing/2018/04/27/9acd942a-3109-11e8-8abc-22a366b72f2d_story.html?noredirect=on&utm_term=.63d80d2c5fd2 [perma.cc/LZ6BQ49A].

¹⁴² See State-by-State Guide to States With Physician-Assisted Suicide, PROCON.ORG, <https://euthanasia.procon.org/view.resource.php?resourceID=000132#Washington> (last updated on Feb. 21, 2017) [<http://perma.cc/FB3W-UUU9>]; see also *How to Access and Use Death with Dignity Law*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/learn/access/#Eligibility> [<http://perma.cc/NP7T-WM7P>] (last visited Nov. 8., 2017).

¹⁴³ *Id.*

¹⁴⁴ *Id.*

¹⁴⁵ See *infra* Part III.B. and Part IV.

¹⁴⁶ Sari Horwitz, *The Painful Price of Aging in Prison*, WASH. POST (May 2, 2016), http://www.washingtonpost.com/sf/national/2015/05/02/the-painful-price-of-aging-in-prison/?utm_term=.4ffdc077191 [<http://perma.cc/F7DE-JFES>].

ill-equipped to manage.¹⁴⁷ Incarcerated individuals age faster than their non-incarcerated counterparts. Research has shown that a prisoners' physiological age averaged ten to fifteen years older than their chronological age.¹⁴⁸ Furthermore, medical care is woefully inadequate for the aging and terminally ill prison population.¹⁴⁹ Imagine then the following scenario:

A prisoner starts to feel ill and notices that he has lost some weight. He goes to the prison's infirmary and medical personnel tell him that he is faking his pain and that there is nothing wrong with him. The prisoner goes back to his cell and as weeks pass, his pain becomes excruciating to the point where he returns back to the infirmary. When he is finally seen by a medical official, he is diagnosed with cancer—he is given six months to live.¹⁵⁰ While pain management becomes the logical next step, medical officials are concerned about the inmate “gaming for drugs,” which creates potential

¹⁴⁷ *Id.*

¹⁴⁸ Brie A. Williams, et al., *Aging in Correctional Custody: Setting a Policy Agenda for Older Prisoner Health Care*, 102 AM. J. PUB. HEALTH 1475, 1477 (2012).

¹⁴⁹ See Jalila Jefferson-Bullock, *Are You (Still) My Great and Worthy Opponent? Compassionate Release of Terminally Ill Offenders*, 83 UMKC L. REV. 521, 539–43 (2015); see also Violet Handtke et al., Commentary, *The Pains of Imprisonment: Challenging Aspects of Pain Management in Correctional Settings*, PAIN MGMT. (2016) (detailing that inmates often have difficulty obtaining even over-the-counter pain medication, restricted access to opioids for pain management, and lack of access to nonmedication treatment options because of lack of ability to be transported outside of the correctional facility); Brie A. Williams, et al., *Balancing Punishment and Compassion for Seriously Ill Prisoners*, 155 ANNALS INTERNAL MED. 122, 135 (2011) (as of 2011, only 75 of 1719 state correctional facilities and 6 of 102 federal facilities had hospices); John F. Linder & Frederick J. Meyers, *Palliative Care for Prison Inmates: “Don’t Let Me Die in Prison”* 298 JAMA 894, 895 (2007) (timely access to medical care is sometimes impeded by security concerns). Indeed, there are various court cases reflecting the move health care treatment the aging and terminally ill patient experiences behind bars. For example, Walter Jordan, an inmate at the Arizona Department of Corrections, died of an invasive skin cancer that “ate through his skull and invaded his brain.” David Fathi, *How Poor Health Care Turned Walter Jordan’s Prison Sentence Into a Death Sentence*, ACLU: BLOG (Jan. 11, 2018, 11:00 AM), <https://www.aclu.org/blog/prisoners-rights/medical-and-mental-health-care/how-poor-health-care-turned-walter-jordans> [<http://perma.cc/QV4P-WDHD>]. One expert noted that “Mr. Jordan may well have survived had he been treated by a competent dermatologist and referred to an oncologist sooner.” Decl. of Dr. Todd R. Wilcox, at 2 ¶ 26–28, ECF No. 2496, *Parsons v. Ryan*, 2:12-cv-00601-DKD. Indeed, “the severe and unlawful mistreatment of prisoners through grossly inadequate provision of medical . . . health care” played a significant role in the Supreme Court’s order to California state officials to reduce their prison population. *Brown v. Plata*, 563 U.S. 493, 502, 545 (2011).

¹⁵⁰ Based on a composite of individuals outlined in Jefferson-Bullock, *supra* note 149, at 526; Bruce Rushton, *Horrific Healthcare: In Illinois Prisons, Getting Sick Can be a Death Sentence*, ILL. TIMES (June 25, 2015, 12:14 AM) <http://illinoistimes.com/article-15777-horrific-health-care.html> [<http://perma.cc/9TEP-2BG4>].

barriers to his pain management and end-of-life care.¹⁵¹ The denial of pain medication then leaves the terminally ill prisoner in great pain.¹⁵²

Though aid in dying is available in seven states and the District of Columbia, some prison policies within those states explicitly prohibit prisoners from obtaining aid in dying. For example, in the Washington Department of Corrections Offender Health Plan manual, it explicitly states that, “[t]he Department does not provide medication to a patient with a terminal illness for self-administration to end his or her life.”¹⁵³ In addition, California’s Department of Corrections and Rehabilitation (CDCR) adopted a resolution that prevented California Correctional Health Care Services or those affiliated from participating in “activities under the end of Life Option Act” on CDCR premises or those owned by and “[c]onsistent with th[e] policy, patients shall not be permitted to access aid-in-dying drugs under the End of Life Option Act.”¹⁵⁴ As the pioneering state in aid in dying, Oregon’s Department of Corrections has a policy that it does not “participate in or allow other health care providers to participate on its premises in the Death with Dignity Act.”¹⁵⁵ Lastly, in Colorado, one of the states to more recently pass aid in dying legislation, the Department of Corrections adopted a regulation prohibiting health care providers “from prescribing medication to

¹⁵¹ Susan J. Loeb et al., *End-of-Life Care and Barriers for Female Inmates*, 40 J. OBSTET. GYNECOL. & NEONATAL NURSING. 477, 479 (2011). Prison medical personnel are often conservative in prescribing pain medication for fear that it will make its way to the general prison population and be abused. See Jefferson-Bullock, *supra* note 149, at 557; Victoria J. Tann, *Prison Hospice Care: Life and Death Behind Bars*, 13 AM. J. PSYCH. RES. J. 1, 3 (2018).

¹⁵² *Id.*

¹⁵³ *Washington DOC Health Plan*, WASH. DEP’T OF CORR., 600-HA001 at 5 (Jan. 1, 2019), available at <http://www.doc.wa.gov/docs/publications/600-HA001.pdf> [<http://perma.cc/VFW7-UCX5>]

¹⁵⁴ Inmate Medical Services Policies and Procedures Volume 1: Governance and Administration, Chapter 40; 1.40: End of Life Option Act: EXEMPTION POLICY, CAL. CORR. HEALTH CARE. SERVS. (Effective June 6, 2016), available at <https://cchcs.ca.gov/wp-content/uploads/sites/60/2017/08/IMSPP-v01-ch40.pdf>. [<http://perma.cc/4DPT-JUX2>]. The resolution was subsequently codified as a regulation at 15 CAL. CODE REGS. tit. 15, § 3999.200(e) (2019) (“Patients in the custody of CDCR shall not be provided aid-in-dying drugs under the End of Life Option Act.”).

¹⁵⁵ *Authority, Purpose, and Policy*, OR. DEP’T OF CORR. (effective Nov. 7, 2017), available at <https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=236014> [<http://perma.cc/HX3F-6QQN>]. See also OR. ADMIN. R. 291-124-0005(3)(e) (2017) (“Death with Dignity Act: It is the policy of the department not to participate in or allow other health care providers to participate on its premises in the Death with Dignity Act (ORS 127.800 to 127.897). Consistent with this policy, inmates will not be permitted to access end of life counseling or drugs under the DWDA[.]”).

any offender within a DOC facility to assist him/her with medical aid in dying.”¹⁵⁶

IV. THE EIGHTH AMENDMENT APPLIED TO AID IN DYING

A. CONTEMPORARY UNDERSTANDINGS OF THE EIGHTH AMENDMENT

The Eighth Amendment of the Constitution prohibits the infliction of “cruel and unusual punishment.”¹⁵⁷ The Supreme Court’s interpretation of the contours and scope of the Amendment’s protection has evolved over time. In one of the earliest cases, the Court held that “torture” was prohibited by the Amendment.¹⁵⁸ The Court next determined that death by electrocution did not violate the Eighth Amendment.¹⁵⁹ In dicta, however, the Court noted that “[p]unishments are cruel when they involve torture or a lingering death[.]”¹⁶⁰ While torture and a “lingering death” seemingly fall under the purview of the Eighth Amendment, the Court later widened the scope of interpretation where the Amendment not only encompassed barbaric punishment tactics of the past, but must also apply to contemporary standards. The Court in *Weems v. United States* noted, “[t]he clause of the Constitution . . . may be therefore progressive, and is not fastened to the obsolete, but may acquire meaning as public opinion becomes enlightened by a humane justice.”¹⁶¹ The Court in *Weems*, then, is largely responsible for infusing the concept of evolving standards of decency through public opinion.

The contemporary understanding of the Eighth Amendment was established by *Trop v. Dulles*.¹⁶² The *Trop* Court established that the Eighth “Amendment must draw its meaning from the evolving standards of decency that mark the progress of a maturing society.”¹⁶³ *Trop* is responsible for the modern-day interpretation of cruel and unusual punishment and, at the very

¹⁵⁶ COLO. DEP’T OF CORR., Administrative Regulation No. 700-27: Offender Health Services: Medical Decisions and Advance Directives (Effective July 1, 2018), available at <https://drive.google.com/file/d/1RjBNNXZWDurDvXDNcp5j62tSZDbFxyUH/view> [<http://perma.cc/RWK4-BE7T>].

¹⁵⁷ U.S. CONST. amend. VIII. The Eighth Amendment of the Constitution was made applicable to the states through the Fourteenth Amendment in *Robinson v. California*, 370 U.S. 660 (1962).

¹⁵⁸ *Wilkerson v. Utah*, 99 U.S. 130, 136 (1879).

¹⁵⁹ *In re Kemmler*, 136 U.S. 436, 439–43 (1890).

¹⁶⁰ *Id.* at 446–48.

¹⁶¹ 217 U.S. 349, 378 (1910) (internal citations omitted).

¹⁶² 356 U.S. 86 (1958) (plurality opinion).

¹⁶³ *Id.* at 100–01.

least, is responsible for invoking evolving standards of decency in the evaluation of certain punishments.¹⁶⁴

In interpreting “evolving standards of decency,” the Court must look to “objective indicia”¹⁶⁵ of contemporary public opinion or values¹⁶⁶ because “cruelty” is not “merely descriptive, but necessarily embodies a moral judgment” that may change with time.¹⁶⁷ The Court has found that legislative enactments,¹⁶⁸ jury sentences,¹⁶⁹ and international opinions are appropriate objective indicia of “evolving standards of decency.”¹⁷⁰ In addition, the Court has considered the roles of public opinion polls¹⁷¹ and expert communities, such as doctors, in its evolving standards of decency analysis.¹⁷² In *Hall v. Florida*, to determine whether a Florida statute that prohibited a defendant from offering mitigating evidence of his intellectual disability because his IQ was 71 instead of the state-sanctioned threshold of 70 was unconstitutional, the Court consulted psychiatric and professional studies to determine “whether there [was] a consensus”¹⁷³ Writing for the dissent, Justice Alito distinguished traditional interpretations of evolving standards of decency as encapsulated in the objective indicia of “American society as a whole,” whereas the *Hall* majority relied on the “evolving standards of professional societies.”¹⁷⁴ While *Hall* specifically dealt with

¹⁶⁴ See generally *Moore v. Texas*, 137 S.Ct. 1039, 1048 (2017) (affirming that the Court looks to “evolving standards of decency in deciding what constitutes “cruel and unusual punishments”); *Atkins v. Virginia*, 546 U.S. 304, 321 (2002) (holding that the execution of a “mentally retarded criminal” offends “evolving standards of decency” and therefore violates the Eighth Amendment); *Estelle v. Gamble*, 429 U.S. 97 (1976) (finding that deliberate indifference to a prisoner’s medical need offends “evolving standards of decency” in violation of the Eighth Amendment).

¹⁶⁵ See *Moore*, 137 S.Ct. at 1052; *Hall v. Florida*, 134 S.Ct. 1986, 1996 (2014); *Miller v. Alabama*, 567 U.S. 460, 483 (2012); *Atkins*, 546 U.S. at 312. Note that the “objective indicia” originated in *Coker v. Georgia* as “objective evidence.” 433 U.S. 584, 584 (1977).

¹⁶⁶ *Coker*, 433 U.S. at 584; *Atkins*, 546 U.S. at 311.

¹⁶⁷ *Graham v. Florida*, 560 U.S. 48, 58 (2010) (internal citation and quotation omitted).

¹⁶⁸ *Atkins*, 536 U.S. at 312.

¹⁶⁹ *Endmund v. Florida*, 458 U.S. 782, 788 (1982).

¹⁷⁰ *Id.*

¹⁷¹ See *Atkins*, 536 U.S. at 316 n.21 (“polling data shows a widespread consensus among Americans”); see also *Miller v. Alabama*, 567 U.S. 460, 510 (2012) (“In [the] search for objective indicia, the Court toyed with the use of public opinion polls.”).

¹⁷² See *Hall v. Florida*, 134 S.Ct. 1986, 1993–94 (2014); see also *Atkins*, 536 U.S. at 316 n.21 (considering the “official positions” of organizations such as the American Psychological Association); *Thompson v. Oklahoma*, 487 U.S. 815, 830 (1988) (The Court in finding that executing a person less than sixteen years old “would offend civilized standards of decency” relied on the “views that have been expressed by respected professional organizations.”).

¹⁷³ *Hall*, 134 S.Ct. at 1993.

¹⁷⁴ *Id.* at 2002 (Alito, J., dissenting) (internal italics omitted).

intellectual disability claims, at least one scholar believes that “[c]ountless other issues can be viewed and litigated through the [medical] consensus framework if the Court adheres consistently to the principle that evolving standards of decency govern not only what punishments are constitutionally prohibited but also the procedures by which those punishments are imposed.”¹⁷⁵

Applying the standards articulated by Supreme Court jurisprudence, the prohibition on aid in dying in prison is a violation of the Eighth Amendment’s prohibition on “cruel and unusual punishment,” indicated objectively by public opinion and the opinion of the medical community.¹⁷⁶ Furthermore, while some would argue that access to aid in dying is an affirmative act and thus not required under the Eighth Amendment, this Comment argues that based on *Estelle* precedent,¹⁷⁷ states that permit aid in dying or do not criminalize it have an affirmative duty to allow prisoners to access the procedure. States that criminalize aid in dying or are silent on the issue have an affirmative duty to provide access to the procedure because of the Constitution’s federalism notion of states as laboratories.

B. ESTELLE’S AFFIRMATIVE DUTIES TO PROVIDE MEDICAL CARE

In states that have legalized aid in dying, denying it to prisoners is a violation of the Eighth Amendment’s prohibition on “cruel and unusual” punishment.¹⁷⁸ However, one potential counterargument is that there is no Eighth Amendment violation in states that do not allow aid in dying, by either criminalizing the act directly or indirectly in homicide statutes.¹⁷⁹ While facially, the relationship between the Eighth Amendment and states that do not allow aid in dying seems nonexistent, closer examination of the *Estelle* holding—establishing a right to medical care in prison—as well as examining the Framers’ intent to have states act as laboratories both lead to a plausible conclusion that even states that criminalize aid in dying have an affirmative duty to provide such care in the context of prison.

¹⁷⁵ Bidish J. Sarma, *How Hall v. Florida Transforms the Supreme Court’s Eighth Amendment Evolving Standards of Decency Analysis*, 62 UCLA L. REV. DISC. 186, 196 (2014).

¹⁷⁶ See Part IV, *supra*.

¹⁷⁷ This will be further discussed in Part IV.B.

¹⁷⁸ See generally Part V.A–C, *supra*.

¹⁷⁹ As of July 2018, forty-three states considered assisted suicide illegal. *States with Legal Physician-Assisted Suicide*, PROCON.ORG (Last updated July 9, 2018, 7:37 AM), https://euthanasia.procon.org/view.resource.php?resourceID=000132#illegal_states [perma.cc/FB3W-UUU9]. Of those forty-three, thirty-six states have law prohibiting assisted suicide, three states prohibit assisted suicide by common law, and four states have no specific laws regarding assisted suicide or are otherwise unclear on the legality of the issue. *Id.*

The Court in *Estelle* reviewed the history and evolution of the Eighth Amendment's treatment of conditions, circumstances, or acts that constituted "cruel and unusual" punishment.¹⁸⁰ In dicta, the Court found that the government has an "obligation to provide medical care for those whom it is punishing by incarceration."¹⁸¹ The government has such an affirmative duty because "[a]n inmate must rely on prison authorities to treat his medical needs; if authorities fail to do so, those needs will not be met."¹⁸² The Court then looked at modern legislation and concluded that the legislation espoused the view that, in the Court's own words, "it is but just that the public be required to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself."¹⁸³ Therefore, because incarcerated individuals are unable to freely get the medical attention they need, the State is obligated to provide it.¹⁸⁴ The Supreme Court reiterated this principle in *Brown v. Plata*.¹⁸⁵ In *Plata*, Justice Kennedy, writing for the majority, noted that prisoners are deprived of rights that are "fundamental to liberty" and though they are incarcerated, prisoners "retain the essence of human dignity inherent in all persons."¹⁸⁶

While the Supreme Court has not spoken directly to various affirmative duties that arise under the duty to provide medical care, there are at least two instances where this affirmative duty has been interpreted broadly to include a duty to prevent an inmate's suicide and a duty to provide access to abortion while incarcerated. For example, the Third, Fourth, Fifth, Sixth, Seventh, Eighth, Ninth, Tenth, and Eleventh Circuit have all analyzed suicides and suicide prevention, or lack thereof, under the affirmative right to medical care.¹⁸⁷ Additionally, while there is currently a circuit split regarding

¹⁸⁰ *Estelle v. Gamble*, 429 U.S. 97, 102–03 (1976).

¹⁸¹ *Id.* at 103.

¹⁸² *Id.*

¹⁸³ *Id.* (internal citation omitted).

¹⁸⁴ See generally Jeffrey Natterman & Pamela Rayne, *The Prisoner in a Private Hospital Setting: What Providers Should Know*, 19 J. HEALTH CARE L. & POL'Y 119, 126 (2016) ("A prisoner, by definition, is not free to seek treatment for serious medical conditions that may be . . . extremely painful. Allowing a prisoner to suffer with a . . . medical condition that the prisoner cannot address on his own due to confinement imposed by the state could result in liability for the state under the Eighth Amendment." (internal citation omitted)).

¹⁸⁵ 563 U.S. 493 (2011).

¹⁸⁶ *Id.* at 510.

¹⁸⁷ *Palakovic v. Wetzel*, 854 F.3d 209, 222 (3d Cir. 2017) (finding that "'particular vulnerability to suicide' is just one type of 'serious medical need'") (internal citation omitted); *Estate of Clark v. Walker*, 865 F.3d 544, 553 (7th Cir. 2017) ("Risk of suicide is a serious medical need."); *Salter for Estate of Salter v. Mitchell*, 711 F. App'x. 530, 537 (11th Cir. 2017) ("Jail suicides are akin to failure to provide medical care."); *Cox v. Glanz*, 800 F.3d 1231, 1248(10th Cir. 2015) (Prison and jail officials "have a constitutional duty to take reasonable

abortion in prison, several circuits have analyzed the right to abortion in prison as an affirmative right to medical care. For example, *Monmouth County Correctional Institutional Inmates v. Lanzaro*, the Third Circuit found that nontherapeutic abortions¹⁸⁸ constituted a serious medical need, covered by the Eighth Amendment's prohibition on cruel and unusual punishment.¹⁸⁹ Additionally, the Third Circuit found that while the women were responsible for funding their own abortions, if they were unable to do so, the county was required to assume the full costs of the procedure.¹⁹⁰ Taken together, some circuit courts have found an affirmative duty to prevent suicide and to facilitate abortion access to incarcerated individuals. The inclusion of suicide prevention and access to abortion while incarcerated demonstrates a widening of courts understanding of what constitutes medical

steps to protect the prisoners' safety and bodily integrity. Claims based on a jail suicide are considered and treated as claims based on the failure of jail officials to provide medical care for those in their custody.") (internal citation and alterations omitted); *Williams v. Branker*, 462 F. App'x. 348, 354 (4th Cir. 2012) (Prison officials have a duty to "limit the opportunities" for prisoners to harm themselves); *Conn. v. City of Reno*, 591 F.3d 1081, 1095 (9th Cir. 2010), *vacated sub nom. Connick v. Thompson*, 563 U.S. 51 (2011), *opinion reinstated in part by Conn. v. City of Reno*, 658 F.3d 897 (9th Cir. 2011) (mem.) ("A heightened suicide risk or an attempted suicide risk is a serious medical need" that falls under the purview of the Eighth Amendment.); *Anderson v. Dallas Cty. Texas*, 286 F. App'x. 850, 847 (5th Cir. 2008) ("[A] failure to provide adequate protection against a prisoner's known suicidal impulses is actionable" under the Eighth Amendment.); *Comstock v. McCrary*, 273 F.3d 693, 703 (6th Cir. 2001) ("[A] prisoner's psychological needs may constitute serious medical needs, especially when they result in suicidal tendencies.") (internal citation and alteration omitted); *Liebe v. Norton*, 157 F.3d 574, 577 (8th Cir. 1998) ("[O]nce one is classified as a suicide risk, the right to be protected from that risk would seem to fall under the ambit of the right to have medical needs addressed.").

¹⁸⁸ A therapeutic abortion is defined as an "abortion induced when pregnancy constitutes a threat to the physical or mental health of the mother." *Therapeutic Abortion*, MERRIAM-WEBSTER MED. DICTIONARY (2018), <https://www.merriam-webster.com/medical/therapeutic%20abortion> [perma.cc/X267-3VDJ] (last visited Mar. 17, 2018). A nontherapeutic abortion is also known as an "elective abortion." See Angelo Benzo Norman, Comment, *Beal v. Doe, Maher v. Roe, and Non-Therapeutic Abortions: The State Does Not Have to Pay the Bill*, 9 LOY. U. CHI. L.J. 288, 289 (1977).

¹⁸⁹ 834 F.2d 326, 345–49 (3d Cir. 1987). *But see* *Roe v. Crawford*, 514 F.3d 789 (8th Cir. 2008) (holding that "an elective, non-therapeutic abortion does not constitute a serious medical need, and a prison's institution's refusal to provide an inmate with access . . . does not rise to the level of deliberate indifference to constitute an Eighth Amendment violation."); *Victoria W. v. Larpenter*, 369 F.3d 475 (5th Cir. 2004); *Gibson v. Matthews*, 926 F.2d 532 (6th Cir. 1991). While the Supreme Court has yet to weigh in on this issue, perhaps interestingly, the same year that *Crawford* was decided, the Court declined to grant certiorari on an Arizona case where the State Superior Court assumed that an abortion was a serious medical need and found that the prison was required to transport the woman to an abortion center. *Doe v. Arpaio*, No. CV 2004-009286, 2005 WL 2173988, at *1–2, (Ariz. Super. Ct. Aug. 25, 2005), *aff'd*, 150 P.3d 1258 (Ariz. Ct. App. 2007), *cert. denied*, 552 U.S. 1280 (2008) (mem.).

¹⁹⁰ 834 F.2d 326, 351 (3d Cir. 1987).

care. This expanding view of medical care suggests that aid in dying, a form of end-of-life care, may fall under courts umbrella term of “medical care.”

One issue that has risen post-*Estelle* is what constitutes “serious medical need.”¹⁹¹ The Court has never explicitly defined what constitutes “serious medical need” or “medical care.” In the absence of an explicit Supreme Court pronouncement, the Court’s dicta in health care cases is instructive. The Court at least tangentially recognized that terminal illnesses are a legitimate medical condition, and that the subsequent prescription for a lethal dose of drugs to end one’s own life may be considered treatment. In *Gonzalez v. Oregon*, the Supreme Court addressed the issue of “whether the Controlled Substances Act allows the United States Attorney General to prohibit doctors from prescribing regulated drugs for use in aid in dying, notwithstanding a state law permitting the procedure.”¹⁹² In 2001, the U.S. Attorney General promulgated an Interpretive Rule that declared using controlled substances to aid suicide is not a legitimate medical practice and dispensing them for the purpose of aid in dying is unlawful under the Controlled Substances Act (CSA).¹⁹³ While the Supreme Court found that the Interpretive Rule was an overreach by the Attorney General and that the Controlled Substances Act “does not authorize the Attorney General to bar dispensing controlled substances for assisted suicide,” for our purposes, the importance of the opinion is the language employed by the Court in coming to that decision.¹⁹⁴ The opinion characterizes the individual seeking aid in dying as a “patient,”¹⁹⁵ the substance used to terminate one’s own life as a “prescription,”¹⁹⁶ the patient received a “diagnosis” from a physician, and conflates “medical judgment”¹⁹⁷ with “medical treatment.”¹⁹⁸ From this language it is plausible that a terminal illness that leads a prisoner to seek aid in dying would fall under and fit within the “serious medical need” conceptualized by the *Estelle* Court.

Further evidence of the Court’s implicit acknowledgment that an underlying terminal illness is a “serious medical need” and the prescription used to end one’s own life constitutes medicine or medication can be found in Justice Scalia’s dissent in *Gonzalez v. Oregon*.¹⁹⁹ In his dissent, Justice

¹⁹¹ *Estelle v. Gamble*, 429 U.S. 97, 104, 106 (1976).

¹⁹² 546 U.S. 243, 248–49 (2006).

¹⁹³ *Id.* at 249.

¹⁹⁴ *Id.* at 274–75.

¹⁹⁵ *Id.* at 271.

¹⁹⁶ *Id.* at 251.

¹⁹⁷ *Id.*

¹⁹⁸ *Id.*

¹⁹⁹ *Id.* at 243.

Scalia argued that intentionally assisting suicide does not constitute medicine or a “legitimate medical purpose.”²⁰⁰ To support this contention he relies on a dictionary definition of “medicine,” which defines the word as “prevent[ing], curi[ng], or alleviate[ng] disease”²⁰¹ and finds that “virtually every medical authority . . . confirms that assisting suicide has seldom or never been viewed as a form of ‘prevention, cure, or alleviation of disease.’”²⁰² Based on this rationale, Justice Scalia finds that assisting suicide is “not a legitimate medical purpose.”²⁰³ In sum, Justice Scalia admonishes the majority’s conception of aid in dying and the drugs that facilitate the intentional taking of one’s own life as medicine or medical treatment. This suggests that the majority, at least in dicta, conceptualizes the underlying reason for aid in dying as an illness in need of medical care and that care arrives in the form of life-ending medicine. If we are to construe aid in dying as “medical treatment,” then the prison administration would be obligated to provide for it as set forth in *Estelle*.

C. EVOLVING STANDARDS OF DECENCY

1. Public Opinion

Public opinion about aid in dying has dramatically changed in the last several years. While I do not suggest that public opinion should be a determinative factor in the constitutionality of a prisoner taking his or her own life, it reveals how society has come to view an issue that is largely received in ethical, moral, and religious terms.

A 2013 public opinion analysis conducted by Pew Research Center found that between 1990 and 2013, support for the notion that “there is a moral right to suicide when a person . . . [i]s suffering great pain with no hope of improvement” increased from 55% to 62%.²⁰⁴ Between 2013 and 2015, support for the view that aid in dying increased from 45% to 56%.²⁰⁵ Perhaps

²⁰⁰ *Id.* at 285 (Scalia, J., dissenting).

²⁰¹ *Id.* (quoting WEBSTER’S NEW INTERNATIONAL DICTIONARY 1527 (2d ed. 1950)).

²⁰² *Id.* at 286.

²⁰³ *Id.*

²⁰⁴ *Views on End-Of-Life Medical Treatments*, PEW RESEARCH CTR. 7 (Nov. 21, 2013), <http://www.pewresearch.org/wp-content/uploads/sites/7/2013/11/end-of-life-survey-report-full-pdf.pdf> [<http://perma.cc/LC5Q-ECHR>].

²⁰⁵ Michael Lipka, *California Legalizes Assisted Suicide Amid Growing Support for Such Laws*, PEW RESEARCH CTR. (Oct. 5, 2015), <http://www.pewresearch.org/fact-tank/2015/10/05/california-legalizes-assisted-suicide-amid-growing-support-for-such-laws/> [<http://perma.cc/4UCA-P23M>]. While this paper is not delving into the topic of support for aid in dying along demography, it is interesting to note that approval/disapproval of aid in dying was largely split by race and race in relation to religion. *Views on End-of-Life Medical*

more intriguing is the increase in support of those polled who believed that there is a moral right to suicide when a person is “ready to die because living has become a burden.”²⁰⁶ While support for this notion is less than a majority, in 1990 support hovered at 27%, whereas in 2013 support increased 11 percentage points to 38%.²⁰⁷

Much of the argument in favor of aid in dying stems from ideas about patient autonomy and self-determination.²⁰⁸ The Pew Research Center suggests a relationship between how those polled conceptualize quality of life and autonomy. For example, in 2013, 49% of those polled agreed that “[b]eing able to talk/communicate” was important for a good quality of life in older age.²⁰⁹ In addition, “[b]eing able to feed oneself,” and “[g]etting enjoyment out of life” were next in order of what is important for a good quality of life in older age.²¹⁰ Interestingly, while much of the conversation surrounding support for aid in dying emphasizes pain (usually in the context of terminal illness), “[l]iving without severe, lasting pain” was ranked fourth in terms of what is important for a good quality of life in older age.²¹¹ That pain was only ranked fourth seems to support the notion that those seeking aid in dying as an option are not just motivated by pain, but other quality of life factors. For example, in a 2008 study by the Oregon Public Health Division, only 5% of individuals in Oregon who died by aid in dying were concerned with pain or experienced physical pain.²¹² In addition, in 2009 Oregonians who had requested aid in dying were surveyed on a scale of 1–5, 1 being “not at all important” and 5 being “very important,” about their reasons for wanting aid in dying. Present physical pain only received a

Treatments, *supra* note 203, at 22. For example, 53% of white adults approved of laws to allow aid in dying for terminally ill patients, whereas 32% of Hispanic and 29% of black individuals polled approved of laws to allow aid in dying for terminally patients. *Id.* The skepticism that Hispanic and black folks feel may stem from the risks aid in dying “may pose to the poor, minorities, and other traditional victims of discrimination” where there are “inequities in medical care” based on race, gender, age, and class. GAILEY, *supra* note 29, at 9–10. See also Fenit Nirappil, *Right-to-Die Law Faces Skepticism in Nation’s Capital: ‘It’s Really Aimed at Old Black People*, WASH. POST (Oct. 17, 2016), https://www.washingtonpost.com/local/dc-politics/right-to-die-law-faces-skepticism-in-us-capital-its-really-aimed-at-old-black-people/2016/10/17/8abf6334-8ff6-11e6-a6a3-d50061aa9fae_story.html?utm_term=.cb993b3b19a1 [<http://perma.cc/Z7BJ-P6WC>].

²⁰⁶ *Id.*

²⁰⁷ *Id.* at 7.

²⁰⁸ See Part III.A., *infra*, for a discussion on autonomy and medical technology withdrawal.

²⁰⁹ *Views on End-of-Life Medical Treatments*, *supra* note 203, at 26.

²¹⁰ *Id.*

²¹¹ *Id.*

²¹² ELIZABETH PRICE FOLEY, *THE LAW OF LIFE AND DEATH* 180 (2011).

median of 1, anticipation of future pain received a median of 3, and the highest median-scoring for aid in dying was “wanting to control the circumstances of their own death, fear of future poor quality of life”²¹³ More recently, a Gallup Poll measured public opinion on aid in death for terminally ill patients and approximately 67% of those surveyed believe that a doctor should assist a terminally ill patient in death.²¹⁴ The aforementioned data revealing the rationale behind an individual’s decision to end their life, as well as public opinion surrounding the morality of suicide and the emerging support for aid in dying suggests that as a society we are moving towards allowing compassionate death or rather death with dignity.²¹⁵

2. *Opinion of the Medical Community*

Opinions of the medical community on the ethics of aid in dying are far from uniform. The American College of Physicians, American Medical Association, and American Nurses Association oppose the legalization of aid in dying.²¹⁶ Despite opposition from several national associations, a number of state medical societies are dropping their opposition to aid in dying.²¹⁷ In

²¹³ *Id.* at 180–81.

²¹⁴ *Majority of Americans Remain Supportive of Euthanasia*, GALLUP (June 12, 2017), <http://news.gallup.com/poll/211928/majority-americans-remain-supportive-euthanasia.aspx> [perma.cc/LS5T-QY7D].

²¹⁵ Note that while public opinion is available for aid in dying, such opinion data is not available in regards to how public opinion fares when the subject of aid in dying is incarcerated.

²¹⁶ See e.g., Lois Snyder Sulmasy et al., *Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper*, 167 ANNALS INTERNAL MED. 576, 578 (2017); Physician-Assisted Suicide, in Ch. 5 Opinions on Caring for Patients at the End of Life, AM. MED. ASS’N PRINCIPLES OF MED. ETHICS (2016), available at <https://www.ama-assn.org/sites/default/files/media-browser/code-of-medical-ethics-chapter-5.pdf> [http://perma.cc/KE96-F87H]; *Euthanasia, Assisted Suicide, and Aid in Dying*, AM. NURSES ASS’N, Apr. 24, 2013, <http://www.nursingworld.org/euthanasiaanddying> [http://perma.cc/8ZGW-ZRDS].

²¹⁷ Laura Crimaldi, *Massachusetts Medical Society Ends Opposition to Physician-Assisted Suicide, Adopts Neutral Stance*, BOSTON GLOBE, Dec. 2, 2017, <https://www.bostonglobe.com/metro/2017/12/02/massachusetts-medical-society-decide-whether-doctors-should-help-dying-end-their-lives/GtVH8TuY1IebcMmltEoy4M/story.html> [http://perma.cc/Y88J-96KY]; Charles Eichacker, *Maine Doctors Softening Stance on Physician-Assisted Suicide*, PRESS HERALD, <http://www.pressherald.com/2017/04/30/with-aging-population-and-more-states-allowing-it-maine-doctors-warm-to-idea-of-physician-assisted-suicide> [http://perma.cc/NYT7-U3WJ]; *Vermont Medical Society Policy on End-of-Life-Care*, VT. MED. SOC., Nov. 4, 2017, <http://www.vtmd.org/sites/default/files/2017End-of-Life-Care.pdf> [http://perma.cc/95VE-J9ZU]; Dan Whitcomb, *California Medical Association Drops Opposition to Doctor-Assisted Suicide*, REUTERS, May 20, 2015, <https://www.reuters.com/article/us-usa-assisted-suicide-california/california-medical-association-drops-opposition-to-doctor-assisted-suicide-idUSKBN0052TI20150520?irpc=>

addition, healthcare providers themselves are also changing their stances. In 2014, Medscape, an online information resource for clinicians and the general public, conducted a survey of over 17,000 U.S. physicians about a series of contentious issues.²¹⁸ When asked whether aid in dying should be allowed, 54% said yes, 31% said no, and 15% said “it depends.”²¹⁹ The percent who said yes increased by 10% since the survey was last issued in 2010.²²⁰ More recently in 2016, when physicians were asked about whether aid in dying should be allowed for terminally ill patients, 57% said yes.²²¹

There are several possible explanations for physician opposition to or skepticism about aid in dying. The first is that some in the medical community believe that participation in aid in dying violates the Hippocratic Oath.²²² The Hippocratic Oath is taken by medical students and provides the moral and ethical foundation for medicinal practice.²²³ “Do no harm” is believed to be derived from the Hippocratic Oath and is offered as a justification for a physician to reject participation in both death penalty

932 [<http://perma.cc/M2GG-T87L>]. As of March 2018, ten state chapters of the AMA have dropped their opposition to aid in dying. See Michael Ollove, *Aid-in-Dying Gains Momentum as Erstwhile Opponents Change Their Minds*, PEW CHARITABLE TRUSTS (Mar. 9, 2018), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/03/09/aid-in-dying-gains-momentum-as-erstwhile-opponents-change-their-minds> [<http://perma.cc/X728-ETAJ>].

²¹⁸ Leslie Kane, *Ethics Report 2014: Part I: Life, Death and Pain*, MEDSCAPE (Dec. 16, 2014), https://www.medscape.com/features/slideshow/public/ethics2014-part1?src=ban_wnl_2#1 [<http://perma.cc/4L5X-B3W9>].

²¹⁹ *Id.*

²²⁰ *Id.*

²²¹ Shelly Reese, *Ethics Report 2016: Life, Death and Pain*, MEDSCAPE, Dec. 23, 2016, <https://www.medscape.com/features/slideshow/ethics2016-part2> [<http://perma.cc/E77E-9DVE>]. In 2018, the percent of physicians who believed aid in dying should be allowed for terminally ill patients experienced a modest increase to 58%. See Keith L. Martin, *Ethics Report 2018: Life, Death, and Pain*, MEDSCAPE, Dec. 12, 2018, <https://www.medscape.com/slideshow/2018-ethics-report-life-death-6011014#2> [<http://perma.cc/KX74-DYB8>].

²²² See, e.g., Paul McHugh, Editorial, *Dr. Death Makes a Comeback*, WALL ST. J., Jan. 22, 2015, <https://www.wsj.com/articles/paul-mchugh-dr-death-makes-a-comeback-1421970736> [<http://perma.cc/24MB-AWNP>] (noting that historically doctors have refused to aid a patient in taking their own life because it is contrary to the Hippocratic Oath); Lawrence R. Huntton, *Physician-Assisted Suicide and Euthanasia: The Destruction of Morals, Ethics, and Medicine*, 21 J. AM. PHYSICIANS & SURGEONS 98, 100 (2016) (aid in dying laws violate the Oath of Hippocrates); Dennis M. Sullivan & Robert M. Taylor, *The Ethical Landscape of Assisted Suicide: A Balanced Analysis*, 34 ETHICS & MED.: AN INTERNAT'L J. BIOETHICS 49, 50–51 (2018).

²²³ *Hippocratic Oath*, ENCYCL. BRITANNICA (last updated Nov. 15, 2017), <https://www.britannica.com/topic/Hippocratic-oath> [<http://perma.cc/NEB5-TRP7>].

executions and aid in dying.²²⁴ However, despite popular belief, “do no harm” is never actually mentioned in the Hippocratic Oath.²²⁵ Further, even if adherents follow “do no harm,” there are many ways to conceptualize “harm.” For example, some proponents of aid in dying suggest that “[n]eedless suffering is more painful for patients . . . [and] allowing prolonged suffering is doing more harm than” aid in dying.²²⁶ Indeed one doctor suggested that contemporary understandings of “harm” have shifted, which at least in part explains the shift in physician support: “[w]e’re having a paradigm shift about what’s viewed as harmful . . . [p]eople are getting used to the idea that death is sometimes the least worst alternative. It can be deliverance.”²²⁷

While the National Medical Association has yet to support aid in dying, evidence of state associations and doctor support over the past several years suggest a trend towards acceptance of aid in dying as an option for terminally ill individuals. Indeed, the Court in *Hall* was receptive of considering “trends” as a component of an objective indicia analysis for evaluating evolving standards of decency as part of the Eighth Amendment’s prohibition on cruel and unusual punishment.²²⁸

3. *But What About Tyranny of the Majority?*²²⁹

One obvious concern with relying, even in part, on public opinion and the medical community is that it offends the very point of having a Constitution,²³⁰ namely to tamper the passions of the majority.²³¹ This innate

²²⁴ See Tony Yang & Farr A. Curlin, *Why Physicians Should Oppose Assisted-Suicide*, 315 JAMA 223, 247–48 (2016).

²²⁵ Daniel K. Sokol, “*First Do No Harm*” Revisited: following the *Dictum Means Balancing Moral Principles*, 347 BMJ 23 (2013).

²²⁶ Alicia Ault, *Doctor Support for Assisted Death Rises, But Debate Continues*, MEDSCAPE (July 7, 2017), <https://www.medscape.com/viewarticle/882334> [<http://perma.cc/5887-B9KT>].

²²⁷ Robert Lowes, *Physicians Support for Assisted Death Continues to Grow*, J. MED., (Jan. 1, 2017).

²²⁸ See *Hall v. Florida*, 134 S.Ct. 1986, 1998 (2014).

²²⁹ THE FEDERALIST NO. 51 (Hamilton or Madison) (“It is of great importance in a republic not only to guard the society against the oppression of its rulers, but to guard one part of the society against the injustice of the other part . . . If a majority be united by a common interest, the rights of the minority will be insecure.”).

²³⁰ See generally Martin H. Redish & Elizabeth J. Cisar, “*If Angels Were to Govern*”: *The Need for Pragmatic Formalism in Separation of Powers Theory*, 41 DUKE. L.J. 449 (1991).

²³¹ See *W. Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624, 638 (1943) (“The very purpose of a Bill of rights was to withdraw certain subjects from the vicissitudes of political controversy, to place them beyond the reach of majorities and officials and to establish them as legal principles to be applied by the courts.”).

distrust of majoritarian rule empowered the Anti-Federalists to demand a list of rights that the government could not take away; the list became the first ten amendments to the Constitution.²³² Professor Mary Sigler argues that the Court's "reliance on objective measures of contemporary values stacks the deck in favor of majoritarian outcomes and is thus at odds with the nature and significance of a constitutional right."²³³ Indeed it seems that the kind of majoritarian analysis that the Court undertakes in evaluating "evolving standards of decency" is equivalent to the "fox guarding the hen house;" it is difficult to imagine a group more despised and in need of protection than criminal offenders. Thus the fear and reality of the "evolving standards of decency" usurping the protective function of the Eighth Amendment is valid. However, there are three points that weaken this argument.

The first is that while the Court considers the pulse of the public in determining "evolving standards of decency," the analysis does not end there. While "objective evidence" is important, it does not "wholly determine the controversy" because "the Constitution contemplates that in the end [the Court's] own judgment will be brought to bear."²³⁴ In other words, the "objective indicia" are necessary, but are not sufficient in deciding whether a punishment violates the Eighth Amendment's prohibition on cruel and unusual punishment. The second argument is that while the danger of the majority's harmful imposition on the minority is fair, in the context of aid in dying, the prisoner is choosing to utilize aid in dying as opposed to it being forced upon him. Of course, the concept of "choice" in prison has been well-written about and raises issues about the general autonomy and "choice" of an incarcerated individual.²³⁵ Lastly, while the current standard may be interpreted as bending towards the tyranny of the majority, there is an argument to be made that the standard in actuality exists as a kind of "political morality." That is to say, the "evolving standards of decency" analysis "should reflect the kind of people we are—or aspire to be—and the

²³² Ugonna Eze, *The Anti-Federalists and Their Important Role During the Ratification Fight*, NAT'L CONST. CTR.: CONST. DAILY (Sept. 27, 2017), <https://constitutioncenter.org/blog/the-anti-federalists-and-their-important-role-during-the-ratification-fight/> [<http://perma.cc/4T64-4RBJ>].

²³³ Mary Sigler, *The Political Morality of the Eighth Amendment*, 8 OHIO ST. J. CRIM. L. 403, 405 (2011).

²³⁴ *Atkins v. Virginia*, 536 U.S. 304, 312 (2002) (quoting *Coker v. Georgia*, 433 U.S. 584, 597 (1977)).

²³⁵ Ann Neumann, *The Limits of Autonomy: Force-Feedings in Catholic Hospitals and in Prisons*, 58 N.Y.L. SCH. L. REV. 305 (2013–2014) (arguing that the practice of force feeding limits an inmate's autonomy); see generally Jukka Varelius, *The Value of Autonomy in Medical Ethics*, 9 MED. HEALTH CARE & PHIL. 377, 377, 379 (2006) (noting the potential diminished autonomy of prisoners).

treatment of offenders that entails, calling offenders to account without displaying the vice of cruelty characteristic of the offenses themselves.”²³⁶ In other words, in the context of aid in dying, we shall not deny unto others what we would not deny unto ourselves. The unavailability of aid in dying for inmates who are gravely suffering offends the most basic standards of evolving decency in light of the emerging consensus on the accessibility and availability of aid in dying.

Few would disagree that terminal prison patients face a myriad of complications such as pain, nausea, and a host of other physical issues.²³⁷ Indeed, while palliative care and pain management are often encouraged for elderly and terminal prisoners, a study conducted of cancer care in prison showed that there were “obstacles to effective cancer pain management” due to “institutional barriers . . . [i]nclud[ing] restricted availability of opioids,” “reluctance of physicians to prescribe opioids,” and under-treatment of the elderly.²³⁸ The treatment of terminally ill prisoners and the subsequent denial of aid in dying fits within the “cruel and unusual” punishment jurisprudence. That is to say, terminally ill prisoners are essentially being left to die and often times, in pain. The inevitability and wasting away that terminally ill prisoners face fits within the *Kemmler* Court’s conception of “lingering.” Further, despite the fact that aid in dying statutes were specifically designed to alleviate pain and facilitate a death with dignity, the same is not true for prison inmates. Therefore, terminally ill inmates must suffer through the remaining days they have left. The availability of aid in dying for non-incarcerated individuals and the prohibition on access for incarcerated individuals seems to fit within the conceptualization of a “lingering” death that constitutes “cruel and unusual punishment.” That is, by denying terminally ill patients in prison the opportunity to die with dignity, the State is exercising unnecessary punishment on a group of vulnerable, ill, and hurting individuals that would offend our notions of human dignity.

V. STATES AS LABORATORIES: WHY AID IN DYING SHOULD BE AVAILABLE TO ALL PRISONERS

Underlying the Court’s rationale in both *Estelle* and *Plata* are notions about states as laboratories. Justice Louis Brandeis spoke of what is now an

²³⁶ Sigler, *supra* note 232, at 407.

²³⁷ See Brie A. Williams et al., *Pain Behind Bars: The Epidemiology of Pain in Older Jail Inmates in a County Jail*, 17 J. PALLIATIVE MED. 1336 (2014). See generally Guy Maytal & Theodore A. Stern, *The Desire for Death in the Setting of Terminal Illness: A Case Discussion*, 8 PRIM. CARE COMPAN. J. CLIN. PSYCHIAT. 299 (2006).

²³⁸ James T. Lin & Paul Mathew, *Cancer Pain Management in Prisoners: A Survey of Primary Care Practitioners and Inmates*, 29 J. PAIN & SYMPTOM MGMT. 466, 466–67 (2005).

oft quoted celebration of federalism. He believed that the role of the states was to perform a “laboratory” function:

To say experimentation in things social and economic is a grave responsibility. Denial of the right to experiment may be fraught with serious consequences to the Nation. It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.²³⁹

Justice Brandeis celebrated a federal system that enables states to serve as laboratories because that system allows states to implement policies that are “more sensitive to the diverse needs of a heterogeneous society.”²⁴⁰ Viewed from this perspective, “states are . . . encouraged to try out new approaches to dealing with social, and even moral, problems.”²⁴¹ Indeed in *Washington v. Glucksberg*, the Court’s landmark case on the subject of aid in dying, Justice Souter in his concurring opinion notes that the Court did not find that aid in dying was unconstitutional, but rather left the decision to the discretion of the individual states to decide whether they wanted to experiment with legalizing aid in dying.²⁴² Justice Souter recognized that it is “highly desirable” to have state legislatures experiment with aid in dying²⁴³ and he expected, quite prophetically, that experimentation would be “attempted in some of the States.”²⁴⁴ In a 2011 Supreme Court decision the Court acknowledged that states as laboratories permits “innovation and experimentation and enabled greater citizen involvement in democratic processes and makes government more responsive by putting the States in competition for a mobile citizenry.”²⁴⁵

Tied to the notion of states as laboratories, is the idea of a mobile citizenry. The concept of federalism presupposes diversity of implementation of varying ideas “coupled with mobility.”²⁴⁶ Underlying the states-as-laboratories argument, whereby the Court recognizes arenas of

²³⁹ *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

²⁴⁰ *Id.*

²⁴¹ Brian H. Bix, *Physician-Assisted Suicide and Federalism*, 17 NOTRE DAME J.L. ETHICS & PUB. POL’Y 53, 55 (2003).

²⁴² 521 U.S. 702, 787 (1997) (Souter, J., concurring); *see also id.* at 737 (1997) (O’Connor, J., concurring) (noting that States are evaluating aid in dying, which is a “liberty interest[. . . entrusted to the ‘laboratory’ of the States . . . in the first instance.”) (citing *Cruzan v. Dir., Mo. Dep’t. of Health*, 497 U.S. 261, 292 (1990) (O’Connor, J., concurring)).

²⁴³ *Id.* at 789.

²⁴⁴ *Id.* at 788.

²⁴⁵ *Bond v. United States*, 564 U.S. 211, 221 (2011).

²⁴⁶ Michael W. McConnell, *Federalism: Evaluating the Founders’ Design*, 54 U. CHI. L. REV. 1484, 1504 (1987) (reviewing RAOUL BERGER, *FEDERALISM: THE FOUNDERS’ DESIGN* (1987)).

social policy best left to the discretion of states for the purposes of experimentation, is that this idea requires a mobile citizenry. By allowing states to experiment with various social policies, the idea is that “given the plurality of jurisdictions and the possibility of mobility among them, persons can move out from under oppressive policies,” including a jurisdiction’s approach to morality, moral regulation, and other policy domains.²⁴⁷ Though the concept of mobility as a fundamental right is beyond the scope of this Comment, it is important nonetheless to note that the Supreme Court has recognized mobility as a fundamental right that facilitates and necessitates federalism notions of “states as laboratories.”²⁴⁸

Thus applying the Court’s rationale in *Esetelle*, *Pata*, *Bond*, and *Liebmann*, by incarcerating an individual, you deny him the ability to freely move to states that align with his values. Because incarceration status strips the individual’s right to move freely and to live in certain jurisdictions that are amenable to his views of morality, healthcare, and more, then the prison has an obligation to provide for the individual what he cannot provide for himself. For aid in dying in the context of prison, this rationale applies as follow: if the incarcerated individual were free, he could move to a state that allows aid in dying and would be permitted to obtain the procedure. However, by virtue of his incarceration, he is unable to move freely and thus unable to procure a course of treatment available elsewhere that a non-incarcerated individual could readily obtain. Combining this logic established by Justice Brandeis concerning “states as laboratories,” with the Court’s rationale in *Bond*, explaining the relationship between a mobile citizenry and federalism, and the logic established in *Estelle* explaining why the prison system has a duty to provide healthcare with the logic in *Estelle/Pata*, a prison consequently has an affirmative duty to provide such medical care for him.

²⁴⁷ Jacob T. Levy, *Federalism, Liberalism, and the Separation of Loyalties*, 101 AM. POL. SCI. REV. 459, 460 (2007).

²⁴⁸ See *Gregory v. Ashcroft*, 501 U.S. 452, 458 (1991) (“This federalist structure preserves to the people numerous advantages. It assures decentralized government that will be more sensitive to the diverse needs of a heterogeneous society; it increases opportunity for citizen involvement in democratic processes; it allows for more innovation and experimentation in government; and it makes government more responsive by putting the States in competition for a mobile citizenry.”); see also *Shapiro v. Thompson*, 394 U.S. 618, 629–30 (1969) (“This Court . . . recognized that the nature of our Federal Union . . . require that all citizens be free to travel throughout . . . our land.”), *overruled in part on other grounds by Edelman v. Jordan*, 415 U.S. 651 (1974).

CONCLUSION

Opinions about aid in dying have evolved in recent years and the public has become more accepting of the underlying rationale for permitting it. The autonomy, self-determination, and pain that a terminally ill patient may feel justifies the decision to die with dignity. Not only has the public become more receptive, but courts and state legislatures have as well. Despite an overall trend towards compassion in aid in dying, terminally ill incarcerated individuals are not afforded the same compassion, nor the same opportunities to end-of-life care. This is a violation of the Constitution's prohibition on cruel and unusual punishment because it is unnecessarily punitive and exacerbates the pain of individuals already suffering. When the state strips individuals of their freedom and denies them their ability to "provide for their own needs," the government has an affirmative duty to provide for the inmate.²⁴⁹ Regardless of how we morally feel about aid in dying as an option, and perhaps believe that those incarcerated deserve to suffer, the state must fulfill its obligation to provide for aid in dying because anything less is "incompatible with the concept of human dignity"²⁵⁰

²⁴⁹ *Brown v. Plata*, 563 U.S. 493, 510 (2011).

²⁵⁰ *Id.* at 510–11.

