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# DEATH BEHIND BARS: Applying the New Jersey Medical Aid in Dying for the Terminally Ill Act to Terminally Ill Inmates

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## Applying the New Jersey Medical Aid in Dying for the Terminally Ill Act to Terminally Ill Inmates

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## Introduction

A prisoner, convicted of murder, has been behind bars for twenty years when he receives an arguably worse sentence than life in prison; he is terminally ill. His life will end in six months or less. Whether or not his impending death will hurt physically, it will undoubtedly haunt his every thought from this moment forward. This prisoner's only way out of jail is no longer due to external factors like hearings and review boards. Stuck between a rock and a hard place, this prisoner is left with all but one option: hope for medical parole. If he is denied medical parole, he will die behind bars.

**Life** is defined as the sequence of physical and mental experiences that make up the existence of an individual, or more medically defined as the quality that distinguishes a vital and functioning being from a dead body.[1] A human life is invaluable under the constitution, and as a result, a free person is undoubtedly granted the right to live. However, contrary to any dictionary, there is no true definition for the word life. The value of a life varies drastically from one individual to the next. For some, the ability to eat and move constitutes living. Others find comfort in knowing that they will be hooked up to a respirator, irrespective of their brain activity, and it provides comfort in knowing their *body* will still be living. The intricacies of societal values and expectations in regard to the end of life may have one meaning during one's lifetime, but as the end of life swiftly approaches, life can take on an entirely new meaning.

**Death**, a permanent cessation of all vital functions; the end of life. Due to the permanency and the irreversibility of death, the law has been slowly evolving. The State of New Jersey, like many others, has recognized the undeniable desire of individuals to be in control of every aspect of their lives, including their death. New Jersey law not only recognizes a

[1] *Life*, MERRIAMWEBSTER.COM, https://www.merriam-webster.com/dictionary/life (last visited Dec. 5, 2019).

competent adult's right to refuse life-saving medical treatment, under both Constitutional and Statutory law, but also, a competent person's right to kill themselves with the assistance of a physician.

Physician-assisted suicide grants a terminally ill person the dignity in planning and executing how they are going to die. Although inmates are entitled to fundamental rights and interests under both the United States Constitution and the New Jersey Constitution, there are certain rights and interests that only law-abiding citizens enjoy the benefit of exercising. One principle question is whether non-free, terminally ill individuals deserve the same dignity and autonomy in determining how their life shall end. A question of this depth requires an analysis of the New Jersey's Medical Aid in Dying for the Terminally Ill Act, the constitutional rights of prison inmates and limitations placed on said rights, the impact of terminally ill inmates on State taxes, the American Medical Association's opposition to aid in dying, as well as the positive impact prisoner aid in dying could have on society as a whole.

This article will review the practicality of how the New Jersey Medical Aid in Death for the Terminally Ill Act could be applied to non-free individuals, determine why prisoners should receive such a privilege, review the impact a program of this nature could have on State tax allocation, while also taking into consideration the States, prisoners, and society's interests.

This paper posits that granting access to qualifying, terminally ill incarcerated persons is not only logical, but, more importantly, humane. However, as with all good law, there must be specific standards met in order to be eligible to use this right. Therefore, the suggested standards for a logical implementation of a Medical Aid in Dying for the Terminally Ill Inmate Policy will be proposed after an in-depth evaluation, of the current laws and policies, is discussed.

## **Background**

I. *Constitutional Rights*

*A. The Right to Live*

The New Jersey Constitution grants all persons natural and unalienable rights. Among these rights is the right to enjoy life. A patient has the capacity to consent to medical treatment if he or she can reasonably understand his or her condition, the effect of the proposed treatment, and the risks of both undergoing and refusing the treatment.[2] However, the United States Supreme Court has "repeatedly and unequivocally affirmed the sanctity of human life and rejected the notion that there is a right of self-destruction inherent in any common-law doctrine or constitutional phase."[3] Furthermore, The United States Constitution does not prohibit the State from imposing criminal penalties on one who assists another in committing suicide.[4] However, the Supreme Court continues to hold that the debates and decisions regarding the legality of physician-assisted suicide can and shall remain in the laboratory of the States. Thus, a State's discretion is of the upmost importance.

B. *Rights to healthcare generally*

New Jersey has been in the forefront of recognizing an individual's right to refuse medical treatment. It is now well settled that competent persons have the right to refuse life-sustaining treatment.[5] Even incompetent persons have the right to refuse life-sustaining treatment through a surrogate decision maker.[6] The parameters of the right to refuse medical treatment were first addressed in the seminal case *In re Quinlan*, 70 *N.J.* 10, 355 *A.*2d 647.[7]

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[2] *In re J.M.*, 416 N.J. Super. 222, 230, 3 A.3d 651, 655-56 (Ch. Div. 2010).
[3] *People v. Kevorkian*, 447 Mich. 436, 480-481, 527 N.W.2d 714 (1994) (*Kevorkian I*).
[4] U.S. CONST. amend. XIV.
[5] *State v. Pelham*, 176 N.J. 448, 456-57, 824 A.2d 1082, 1087 (2003) (citing *In re Farrell*, 108 *N.J.* 335, 529 *A.*2d 404 (1987)).
[6] *Id.* (citing *In re Conroy*, 98 *N.J.* 321, 486 *A.*2d 1209 (1985)).
[7] *Matter of Quinlan*, 70 N.J. 10, 18, 355 A.2d 647, 651 (1976) ("The central figure in this tragic case is Karen Ann Quinlan, a New Jersey resident. At the age of 22, she lies in a debilitated and allegedly moribund state at Saint Clare's Hospital in Denville, New Jersey . . . Due to extensive physical damage fully described in the able opinion of

C. *The Right to Refuse Life Sustaining Treatment*

New Jersey law tends to lean in favor of protecting individuals' rights in regard to medical decisions. It is well settled, in New Jersey, that both competent and incompetent persons are afforded the right to refuse life-sustaining treatment.[8] One of the most specific rights afforded to individuals choosing to refuse life-sustaining treatment, is the right to refuse lifesaving hydration and nutrition. *Cruzan v. Director, Missouri Dept. of Health* was the first "right to die" case and set many important precedents regarding the rights of individuals. While *Cruzan* had established that there was no constitutional right to die, it was also decided that States had the power to determine their own right-to-die standards. However, the most critical take away from the *Cruzan* case, in respect to physician-assisted suicide, lies in the question this Court raised. In determining that a person has a "liberty interest" under the Due Process Clause, the Court in *Cruzan* set out that "whether respondent's constitutional rights have been violated must be determined by balancing his liberty interest against the relevant State interests."[9]

II. *Prisoners' Rights to Healthcare*

While prisoners are no longer considered persons, who by nature are free and independent, they are not stripped of all rights afforded to them under Federal and State Constitutions. An important right that an inmate retains is the right to receive reasonable medical care. Generally, it is accepted that conviction of a crime and incarceration, while limiting an inmate's right to freedom from confinement, does not extinguish his or her right to liberty

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the trial judge, Judge Muir, supporting that judgment, Karen allegedly was incompetent. Joseph Quinlan sought the adjudication of that incompetency. He wished to be appointed guardian of the person and property of his daughter. It was proposed by him that such letters of guardianship, if granted, should contain an express power to him as guardian to authorize the discontinuance of all extraordinary medical procedures now allegedly sustaining Karen's vital processes and hence her life, since these measures, he asserted, present no hope of her eventual recovery.")

[8] *State v. Pelham*, 176 N.J. 448, 456, 824 A.2d 1082, 1087 (2003) (citing *In re Conroy*, 98 *N.J.* 321, 486 *A.*2d 1209 (1985)).

[9] *Cruzan by Cruzan v. Dir., Missouri Dep't of Health*, 497 U.S. 261, 262, 110 S. Ct. 2841, 2843, 111 L. Ed. 2d 224 (1990).

altogether.[10] Furthermore, subject to the legitimate requirements of prison discipline and security, prison inmates retain their fundamental constitutional rights and protections. Prison inmates retain the right to minimally adequate medical care, the right to exercise control of his own body, the right to informed consent and the right to refuse treatment. Perhaps, most importantly, prisoners are protected against cruel and unusual punishment.

a. *Prisoner's Rights to Adequate Healthcare*

During incarceration, prisoners retain a constitutional interest in receiving adequate medical treatment. Denying access to treatment, or providing a lesser form of treatment necessary, would present a deliberate indifference to a prisoners' medical needs.[11] Failing to treat a prisoners' medical needs causes an infliction of unnecessary suffering, which is inconsistent with the contemporary standards of decency and thus, violates the Eighth Amendment.[12] In *Estelle v. Gamble*, the respondent claims to not have been treated adequately for a back injury that he sustained while engaging in prison work. The respondent was seen by eighteen medical personnel, over a three-month span, to treat not only his back injury, but also other injuries. Respondent's claim arose from the medical director's failure to perform an X-ray, or utilize other forms of diagnostic techniques, to further diagnose the back injury. While the Court did not find that Respondent's Eighth Amendment rights had been violated, the Court found that the government has an obligation to provide medical care for those it is punishing by incarceration. Due to his or her lack of freedom, prisoners must rely on prison authorities for treatment. The failure of prison authorities to treat prisoners' medical needs may result in physical "torture or a

[10] *Bell v. Wolfish*, 441 U.S. 520, 590 n.22, 99 S. Ct. 1861, 1901, 60 L. Ed. 2d 447 (1979) (Stevens, J. dissenting) (citation *e.g., Wolff v. McDonnell,* 418 U.S. 539, 555-556, 94 S.Ct. 2963, 2974, 41 L.Ed.2d 935 (1974); *Pell v. Procunier*, 417 U.S. 817, 822, 94 S.Ct. 2800, 2804, 41 L.Ed.2d 495 (1974); *Cruz v. Beto*, 405 U.S. 319, 92 S.Ct. 1079, 31 L.Ed.2d 263 (1972); *Lee v. Washington*, 390 U.S. 333, 88 S.Ct. 994, 19 L.Ed.2d 1212 (1968).
[11] *See* U.S. CONST. amend. VIII; *see also, Jackson v.* Fauver, 334 F.Supp.2d 697 (D.N.J. 2004).
[12] *See* U.S. CONST. amend. VIII; *see also Estelle v. Gamble*, 429 U.S. 97, 97 S.Ct. 285, 50 L.Ed.2d 251 (1976).

lingering death" or in less serious cases, pain and suffering.[13] The Court in *Estelle* held that "in order to state a cognizable claim, a prisoner must allege acts or omissions sufficiently harmful to evidence of deliberate indifference to serious medical needs. It is only such indifference that can offend 'evolving standards of decency' in violation of the Eighth Amendment."[14] As a State and Federal law, the government's duty to see that a prisoner has received adequate medical care attaches the moment the prisoner is placed under the jailer's custody.[15]

*b. Prisoners' Right to Refuse Treatment and Right to Know*

In *White v. Napoleon*, a class action against a prison physician alleged both Eighth and Fourteenth Amendment violations. The court held that "where the inmate demonstrates that the medical care system is inadequate, so that he is effectively denied access to medical care for his condition, liability has been established."[16]

> "Accordingly, a prison may compel a prisoner to accept treatment when prison officials, in the exercise of professional judgment, deem it necessary to carry out valid medical or penological objectives . . . the judgment of prison authorities will be presumed valid unless it is shown to be such a substantial departure from accepted professional judgment, practice or standards as to demonstrate that the person responsible actually did not base the decision on such judgment."[17]

The only way for prisoners to make informed decisions regarding their health care is through the knowledge of a proposed treatment. Even behind bars, prisoners are afforded the right to a reasonable explanation of the proposed treatments and viable alternatives available to them necessary to accept or reject treatment. A prisoners' right to know, in order to give informed consent or refuse treatment, has limitations. A prisoner is not entitled the right to bring treatment to a halt by "demanding answers that are unreasonable, time-wasting or intended to

[13] *Estelle*, 429 U.S. at 103.
[14] *Id.* at 106.
[15] *McCormick v. City of Wildwood*, 439 F.Supp. 769, 776 (D.N.J.1977).
[16] *Howard v. City of Columbus*, 239 Ga. App. 399, 406, 521 S.E.2d 51, 62 (1999).
[17] *White v. Napoleon*, 897 F.2d 103, 113 (3d Cir. 1990).

turn the doctor-patient relationship into a batter for control over treatment." Thus, the right to know must also be balanced against valid State interests.

c. *Prisoner's Right to Advance Health Care Directives*

Advance Health Care Directives are written legal instruments which allow a capable adult to declare their wishes regarding health care decisions.[18] Through the use of an advanced health care directive, New Jersey permits individuals to expressly state what forms of life support they wish, or do not wish, to receive, whether or not they would like to be resuscitated, specific time frames to allow for the administration of extraordinary measures and to appoint a healthcare representative on their behalf should they become incapacitated. The creation of a health care directive allows individuals to exercise complete control over their lives and possible death and protects physicians from liability and disciplinary action for alleged unprofessional conduct. Thus, the statute respects the individuals' decisions regarding their autonomy and penalizes any heath care institution which intentionally fails to act in conformance with the bill's provisions. However, the law is silent on the effect of an advance health care directive during incarceration.[19] The use of advance health care directives, living wills, and Do-Not-Resuscitate Orders (DNRs) could be invaluable to the dying inmate and his family, and could prevent unnecessary litigation.[20] Further, the creation of an advance health care directive for terminally ill inmates, would create a feasible way to create and enforce a Medical Aid in Dying Policy for terminally ill inmates.

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[18] N.J. STAT. ANN. § 26:2H-53.
[19] Roberto Andorno, David M. Shaw & Bernice Elger, *Protecting Prisoners' Autonomy with Advance Directives: Ethical Dilemmas & Pol'y Issues*, MED. HEALTH CARE, & PHIL., 18:1 at 34 (2015), https://search.proquest.com/docview/1643366772?accountid=13793.
[20] Nancy Neveloff Dubler, *The Collision of Confinement & Care: End-of-Life Care in Prisons & Jails*, 26 J.L. MED. & ETHICS, 149, 152, (1998) https://advance.lexis.com/api/permalink/466ab74b-dabe-463e-aa54-2d1f67d8fad2/?context=1000516.

**Discussion**

III. *The State's Interests*

The Constitutional right to refuse medical treatment is not an absolute right. The State's interests may outweigh the individual's right to decline life-sustaining medical treatment.[21] There are four State interests, (1) preserving life, (2) preventing suicide, (3) safeguarding the integrity of the medical profession, and (4) protecting innocent parties. Of the four State interests, the State's interest in preserving life is arguably the most important interest. However,

> In cases that do not involve the protection of the actual or potential life of someone other than the decisionmaker, the State's indirect and abstract interest in preserving the life of the competent patient generally gives way to the patient's much stronger personal interest in directing the course of his own life.[22]

IV. *New Jersey's Medical Aid in Dying for the Terminally Ill Act*

a. *Overview of the Law*

Medical aid in dying, rather, the theory of allowing free persons to determine how and when they are going to die, has recently been accepted in the State of New Jersey.[23] The legislature provides compassionate medical aid in dying to free persons suffering from a terminal illness.[24] After being approved for medical aid in dying by a qualified medical health care professional, the patient will be prescribed a lethal medication, which the patient may choose to personally administer themselves.[25] Prior to prescribing the medication, an attending physician will consider the following factors: the patient's terminal illness; the patient's prognosis; current

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[21] *Matter of Conroy*, 98 N.J. 321, 346, 486 A.2d 1209, 1222 (1985) (citing Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 RUTGERS L.REV. 228, 237 (1937)).

[22] *Matter of Conroy* at 350.

[23] On April 12, 2019, The New Jersey's Medical Aid in Dying for the Terminally Ill Act was approved, with an effective date of August 1, 2019.

[24] Medical Aid in Dying for the Terminally Ill Act, 2019 NJ Sess. Law Serv. Ch. 59 (ASSEMBLY 1504) (WEST 2019).

[25] N.J.S.A. § 26:16-3.

and past courses of treatment prescribed for the patient in connection with the patient's terminal illness, including the results of any such treatment; and any palliative care, comfort care, hospice care, and pain control treatment the patient is currently receiving or has received in the past.[26] In order to protect the general health and safety, "no later than 30 days after the dispense of the medication, the physician or pharmacist who dispensed the medication shall file a copy of the dispensing record with the department, and shall otherwise facilitate the collection of such information as the director may require regarding compliance with P.L.2019, c. 59 (C.26:16–1 et al.)."[27]

b. *Requirement of Voluntary Physician Participation*

A major component of New Jersey Medical Aid in Dying for the Terminally Ill Act is that the State is safeguarding the public welfare by requiring and ensuring that the process is entirely voluntary on the part of all participants, including patients and the health care providers that are providing care to dying patients.[28] The voluntary facet is the most important when it comes to ascertaining how a law such as this would work, as there is no guarantee that a physician will agree to performing the procedure. Furthermore, "any action taken by a health care professional to participate [Medical Aid in Dying] shall be voluntary on the part of that individual. If a health care professional is unable or unwilling to carry out a patient's request . . . and the patient transfers the patient's care to a new health care professional or health care facility, the prior health care professional shall transfer, upon request, a copy of the patient's relevant records to the new health care professional or health care facility."[29]

c. *Disposal of Unused Medication*

[26] N.J.S.A. § 26:16-10.
[27] N.J.S.A. § 26:16-13.
[28] N.J.S.A. § 26:16-2(c)(4); N.J.S.A. § 26:16-17(c).
[29] N.J.S.A. § 26:16-17.

While patients who have been approved for medical aid in dying have been evaluated by qualified physicians and passed the application process, there is still a possibility that the patient will change his or her mind and opt out of administering the medicine. In situations where the patient no longer has the desire to end his or her life, the unused, dispensed medication must be disposed of in the lawfully required way that is consistent with State and Federal guidelines.[30] Furthermore, and arguably more importantly, the prescribing physician must inform the department of the actual death of the patient through the use of the prescription to ensure that a lethal drug is not accessible to others.

## V. *Physician's Oath*

The Hippocratic Oath is an oath that doctors take prior to the practice of medicine in which they pledge to treat patients ethically and efficiently and, further, to abide by the obligations and standards of practicing medicine.[31] A common misconception of the oath is that it specifically states "First, do no harm." However, this phrase does not appear in the original version of the Oath. Over the years, the Hippocratic Oath has been adopted and modified to suit the medical profession in the 21st century. An important clause that many modern versions of the oath have done away with is the oath swearing that doctors "will neither give a deadly drug to anybody who asked for it, nor will [they] make a suggestion to this effect."[32] A literal interpretation of this oath would allude to the prohibition of a doctor's participation in prescribing lethal drugs, such as the medication prescribed for patients participating in medical aid in death. However, some have argued that under this oath, a doctor is prohibited from further

[30] N.J.S.A. § 26:16-12.
[31] Michael North, *Greek Med.*, NAT'L LIBR. OF MED., https://www.nlm.nih.gov/hmd/greek/greek_oath.html (last updated Feb. 7, 2012).
[32] ROBERT M. VEATCH, HIPPOCRATIC, RELIGIOUS, & SECULAR MED. ETHICS: THE POINTS OF CONFLICT, 34 (Georgetown University Press 2012).

participating in the death of a patient through nonpharmaceutical means.[33] The problem with the Hippocratic Oath is that there are many interpretations of the requirements and oaths. These multiple interpretations lend a helping hand to both sides of the argument regarding aid in death. Therefore, the Hippocratic Oath is a wonderful reminder of the expected conduct of an ethical and upstanding physician, but it can no longer be used as proof of what limitations are placed on a physician's professional decisions.

## VI. *American Medical Association's Stance on Physician-Assisted Suicide*

The American Medical Association (AMA) is an organization that "promotes the art and science of medicine and the betterment of public health."[34] As an ally in patient care, the AMA creates a platform for physicians to express their views, specifically those involving the intersection of medicine and ethics, and support those physicians in court and with legislative bodies. The AMA is often advising the United States' Supreme Court on prudent matters and they have taken a clear stance on physician-assisted suicide: they strongly disapprove. According to the AMA, "physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult to impossible to control, and would pose serious societal risks."[35] While the professional obligations of a physician allow for discretion in deciding whether to act in a particular manner, dependent on the physician's conscience, the AMA raises the concern that this freedom is not unlimited. As discussed previously, the Hippocratic Oath can be read from two very different points of view. The first view is that physicians are to do no harm, which would mean do not kill or help kill. The second view is that physicians are to help their patients to the extent necessary to put the patient out of their pain and suffering, even if this means

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[33] *Id.*
[34] AMA, https://www.ama-assn.org (last visited Dec. 2, 2019).
[35] *Ethics: Physician-Assisted Suicide*, AMA, https://www.ama-assn.org/delivering-care/ethics/physician-assisted-suicide (citing AMA Principles of Med. Ethics: I, II, IV, VI, VIII, IX) (last visited Dec. 2, 2019).

assisting in his or her death. The AMA provides guidance to physicians with respect to participating in physician-assisted suicide, by taking a stance that the oath makes clear that the former view is the correct view and suggesting instead that "physicians: (a) Should not abandon a patient once it is determined that cure is impossible; (b) Must respect patient autonomy; (c) Must provide good communication and emotional support; and, (d) Must provide appropriate comfort care and adequate pain control.[36] While the AMA has rejected the concept of physician-assisted death, this practice has already been accepted by New Jersey. Therefore, the desire of New Jersey physicians to help their patients by any means necessary and the desperation of persons (free or incarcerated) to end their suffering in a non-barbaric way exemplifies the need of further development to address all persons of the State.

VII. *New Jersey's Medical Parole (also known as Compassionate Release)*

In theory, terminally ill prison inmates could be granted compassionate release and be given the opportunity to live out the end of their lives as free persons. However, it is nearly impossible for terminally ill inmates to be set free on Medical Parole. Statistics show that since 2010, no more than two inmates have been granted early release under New Jersey's Medical Parole.[37] Out of the fifty States, New Jersey is one amongst forty-nine other States that have at least one compassionate release policy in place.[38] A compassionate release policy allows States to make an exception for early release on the basis of diagnosis of a terminal illness or severe medical condition. In order for an inmate to be eligible for early release through medical parole, prisoners must "have a medical condition that did not exist at the time of sentencing that renders the prisoner permanently unable to perform activities of basic daily living and requires 24-hour

[36] *Id.*
[37] Mary Price, *Everywhere & Nowhere: Compassionate Release in the States*, FAMM, June 2018, at 13, https://famm.org/wp-content/uploads/Exec-Summary-Report.pdf.
[38] *Id.*

care" or "have a terminal condition, disease, syndrome (defined as having prognosis of six months or less to live[39]) and be so debilitated or incapacitated by the condition, disease, or syndrome as to be 'permanently physically incapable' of committing a crime if released on parole."[40] Of course, there are exclusions to the Medical Parole Policy. Those who are serving a sentence for the following offenses are ineligible: murder, manslaughter, kidnapping, aggregated sexual assault, aggravated arson, endangering the welfare of a child, robbery in which the prisoner attempted to kill another person, or "purposely inflicted or attempted to inflict serious bodily injury, or was armed with or used or threatened the immediate use of a deadly weapon," or any attempt to commit any of these offenses.[41] However, obtaining a compassionate release is almost as difficult as it is to apply for.[42] New Jersey is one of the very rare States that is required to keep statistics regarding their medical parole policy.

> As of May 1, 2018, the Parole Board must comply with new reporting requirement: [The Board's annual report to the Governor, Legislature, and Juvenile Justice Commission] shall include information regarding medical parole including, but not limited to, the number of inmates who applied for medical parole, the number of inmates who were granted medical parole, and the number of inmates who were denied medical parole.[43]

On one hand, the statistics gathered are disturbing, as they exemplify how underutilized this option is and how rarely early release is granted to the few inmates who try and achieve it. "According to a news report in August 2017, the New Jersey Office of Legislative Services said that Medical Parole has been granted 'at most, two times annually since 2010.'"[44] However, this

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[39] *Id.*; *see also* N.J. Admin. § 10A:71-3.53 (c); N.J. Parole Board, The Parole Book: A Handbook on Parole.
[40] N.J. REV. STAT. § 30:4-123.51c-1 (a) (2); N.J. Admin. Code § 10A:71-3.53 (b); Parole Handbook, Appendix 10, § A
[41] N.J. REV. STAT § 30:4-123.51c-1 (a) (3); N.J. Admin. Code § 10A:71-3.53 (b); Parole Handbook Appendix 10, § B
[42] PRESS RELEASE FROM RABIAH BURKS, FAMM, NEW STATE-BY-STATE REPORT REVEALS COMPASSIONATE RELEASE PROGRAMS ARE RARELY USED (June 27, 2018) (on file with the author).
[43] N.J. REV. STATE. § 30:4-123.48.4(f).
[44] *FAMM Compassionate Release N.J.*, Med. Parole, FAMM, June 2018 at 4, https://famm.org/wp-content/uploads/New-Jersey_Final.pdf.

information is beneficial and aids in determining how few options terminally ill inmates have. Additionally, it emphasizes the need for new laws and policies to better serve this suffering prison community.

A. *The Medical Parole Application Process*

The application process is lengthy and detailed, but the worst part of the process is that many prisoners do not even know where to begin. The approval or denial of a Medical Parole request is made by the New Jersey State Parole Board (Board). The process begins with a written request for a medical diagnosis.[45] Next, there is a documentation and assessment phase in which the medical diagnosis is made by two licensed physicians designated by the Commissioner of Corrections. [46] After an appropriate diagnosis, the decision making process begins with an assessment that all of the required factors are met by the prisoner: appropriate notice from the Board was given to the appropriate sentencing court, the county prosecutor or Attorney General, whichever is appropriate, and that any victim or victim's family member received notice, of the prisoner's medical diagnosis and that the Board will review and consider the Prisoner's application or referral for Medical Parole.[47] After notice has been given and no responses are elicited, the Board must give written notice of their Hearing Decision explaining, in depth, the reasons supporting the approval or denial to the same parties as the initial notice.[48] If a Prisoner's application is denied or he or she return to confinement after being on Medical Parole, the prisoner is not prevented from applying for or being considered for other valid State Paroles. [49] However, the law is silent on whether or not the denied prisoner can appeal the Board's decision.

[45] N.J. REV. STAT. § 30:4-123.51(c); N.J. Admin. Code § 10A:71-3.53 (f); Parole Handbook, Appendix 10, § F.
[46] N.J. REV. STAT. § 30:4-123.51(b) (1); N.J. Admin. Code § 10A:71-3.53 (d).
[47] N.J. REV. STAT. § 30:4-123.51(d); N.J. Admin. Code § 10A:71-3.53 (f); N.J. Admin. Code § 10A:71-3.53 (g).
[48] N.J. REV. STAT. § 30:4-123.51(e); N.J. REV. STAT. § 30:4-123.51c-1 (a) (2); N.J. Admin. Code § 10A:71-3.53 (k).
[49] N.J. REV. STAT. § 30:4-123.51(i); N.J. Admin. Code §§ 10A:71-3.53 (j) and (q).

If a prisoner's application is approved, he or she then becomes a parolee. The parolee's early release can be rescinded and returned to confinement:

> "if updated medical information indicates that he or she (1) is no longer so debilitated by the terminal condition or physical incapacity, as to be physically incapable of committing a crime; or (2) in the case of a prisoner with a permanent physical incapacity, now poses a threat to the public safety."[50]

Furthermore, any violation of the conditions to Medical Parole will result in the parolee's return to prison or other sanctions.[51] While Medical Parole is the best alternative in theory, the reality is that it is almost impossible to achieve and further demonstrates the need for another logical alternative for those facing death during incarceration.

VIII. *New Jersey Tax Allocation for Prison Inmates*

Similar to society at large, prison inmates are susceptible to the illnesses that inadvertently come along with age. It costs approximately $70,000 a year to house an inmate over the age of fifty[52], roughly $36,000 more than the cost of housing a younger inmate.[53] The price increase is a result of the additional healthcare costs associated with the increased medical conditions that one experiences with old age.[54] Prison inmates in New Jersey are not eligible for Medicaid or Medicare coverage and they do not qualify for Social Security Payments. For prisoners who request medical care, the State of New Jersey has required prisoners to give a co-pay of five dollars to be applied to the medical care requested. While the co-pay for inmate requested medical care comes from the money prisoners earn while working or from contributions from their families, "most of the inmates' health care costs are paid for by the

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[50] N.J. REV. STAT. § 30:4-123.51 (h); N.J. Admin. Code § 10A:71-3.53 (n); NJ Admin. Code § 10A:71-3.53 (n) (1) (iv).
[51] NJ Admin. Code § 10A:71-3.53 (n) (2); *id.* at (p).
[52] Jean Mikle, *Health Care Costs for Older Inmates Skyrocket*, USA TODAY, Mar. 31, 2013, https://www.usatoday.com/story/news/nation/2013/03/31/health-care-costs-for-older-inmates-skyrocket/2038633/
[53] *Id.*
[54] *Id.*

corrections department."[55] Thirty-nine percent of all Department of Corrections inmates were sentenced to total terms of ten years of more, as of January 2018.[56] Of the total, six percent are serving life sentences with parole eligibility and eighty-one offenders are serving life sentences without parole.[57] However, terminal illnesses do not discriminate simply based on age. Prisoners, just like free persons, may be the victim of a terminal illness at any point in their lives.

## IX. Cost of Death with Dignity

When participating in physician-assisted suicide, there is no one specific drug that is prescribed.[58] However, most patients are prescribed an oral dosage of barbiturate (pentobarbital or secobarbital).[59] The cost of the medications "varies based on medication type and availability as well as the protocol used (additional medications must be consumed prior to the lethal medications at an extra cost)."[60] Prior to 2012, the cost of pentobarbital was as low as $500 for a liquid dose. Since then the price has rose to between $15,000 and $25,000.[61] As a result, users have begun utilizing the powder form, which costs between $400 and $500. The cost of secobarbital (brand name Seconal), the other medication commonly prescribed under death with dignity laws, is between $3,000 to $5,000. As a result of the price increases in the medications, there have been alternative mixtures created in Washington State in an effort to bring down prices. "The phenobarbital/chloral hydrate/morphine sulfate mix produces a lethal dose that is similar in effect to Seconal. The cost of this alternate mix is approximately $450 to $500. A second alternative, consisting of morphine sulfate, Propranolol (Inderal), Diazepam (Valium),

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[55] *Id.*
[56] *Frequently Asked Questions*, STATE OF N.J. DEP'T OF CORRECTIONS, https://www.state.nj.us/corrections/pages/FAQ.html (last visited Dec. 2, 2019).
[57] *Id.*
[58] *Frequently Asked Questions*, DEATH WITH DIGNITY, https://www.deathwithdignity.org/faqs/ (last visited Dec. 2, 2019).
[59] *Id.*
[60] *Id.*
[61] *Id.*

Digoxin and a buffer suspension costs about $600."[62] The alternative mixture could be prepared by any compounding pharmacy.

X. Competing Costs

Based on the competing data, the cost of keeping an inmate over the age of fifty alive is nearly 300% more than the cost of prescribing the most expensive form of medication used in physician-assisted death. However, correctional facilities have the advantage of negotiating and cutting deals with pharmaceutical companies and would likely be able to find a much more affordable option ranging closer to $400 to $600. From an economic standpoint, allowing voluntary terminal inmates to end their lives through the use of medical aid in death would bring down the amount of money spent on housing inmates and would allow the State to reallocate their money to other needs. The State's interest in preserving life is important; however, with more money revolving in the budget, the State could potentially focus on creating better health care for those inmates who do not have a death sentence.

XI. *Jack Kevorkian*

Jack Kevorkian was an American physician who led a controversial movement of mercy killings of terminally ill patients. Through the use of self-made inventions, which would administer a lethal dose of medication, he would help end the lives of willing and desperate patients. Kevorkian typically would not administer the drug to the patients; the patients would administer the mixture of drugs themselves, by the pressing of a trigger, the pulling of a knob, or the pulling of a clip. However, in an attempt to elicit a response from the United States Supreme Court, Kevorkian assisted in "active euthanasia." Kevorkian escaped conviction for the acts of

[62] *Id.*

physician-assisted suicide four times [63]; however, he was charged guilty with murder in the second degree and delivery of a controlled substance for his participation in the active euthanasia case. Kevorkian's divisive legacy may be reduced to physician-assisted death, but there was another reason he was a proponent of it. Kevorkian's specific use of a lethal dose of mixed medicine, that suppressed the respiratory system, allowed for one's organs to be recovered and usable for donation purposes.[64]

XII. *Organ Donation*

Organ donation, like medical aid in dying, has been highly debated and is ethically complex. It is not only imperative, but also required, that both donors and recipients be carefully examined in order to qualify for a transplant. Another necessity of the transplantation process is protecting the rights of both parties involved, as well as making sure the decisions are made voluntarily and based off of factual information. This helps ensure that any possible conflicts of interests are minimized.[65] While organ and tissue donations have become generally accepted,[66] viable organs are scarce. Nationally, there are more than 98,000 people awaiting life-saving organ transplants. Of those 98,000 people, more than 4,000 people reside in New Jersey.[67] Some of the many medical obstacles that surround the successful transplantation of organs and tissue include: 1) determining when, how and on whom such procedures can be performed; 2) finding suitable donors for proper matching with the intended donee; 3) time constraints in organ

[63] Keith Schneider, *Dr. Jack Kevorkian Dies at 83; A Dr. Who Helped End Lives,* THE N.Y. TIMES, June 3, 2011, https://www.nytimes.com/2011/06/04/us/04kevorkian.html.
[64] YOU DON'T KNOW JACK (HBO 2010).
[65] Bette-Jane Crigger, PhD., *AMA Code of Med. Ethics' Opinions Relevant to Organ Transplantation & Procurement*, 18:2 [J]AMA ETHICS 122, 122, (February 2016).
[66] *AMA Code of Medical Ethics' Opinion on Organ Transplantation*, 14:3 [J]AMA ETHICS 204, 204-214 (March 2012).
[67] 48 N.J.S.A. § 26:6-67.

preservation; and, 4) locating available organs.[68] The Uniform Anatomical Gift Act (UAGA) of 1968 is the uniform organ donation law and acts a guideline for the donation of organs, tissues, and other human body parts in the United States. The UAGA was revised in 2006 and has been adopted entirely, or in part, in forty-five States. New Jersey is one of the States that have adopted the Revised Uniform Anatomical Gift Act.[69] The statute permits a person, or if deceased, the agent, spouse, adult child, parent, adult sibling, other adult related by blood, person acting as a guardian, or any other person with authority to dispose of the decedent's body, to make an anatomical gift during or after the life of the donor.[70] "The shortage in human organs for transplantation purposes continues to challenge the medical and legal community to create new ways to meet the growing demand for organs."[71]

*a. Manner of Making an Anatomical Gift*

In preparation of death, a donor may make an anatomical gift by authorizing a statement on a driver's license or identification card, in a will, or through any form of communication addressed to at least two adults, at least one of whom shall be a disinterested witness if during the course of a terminal illness or injury of the donor.[72]

b. *Cadaver versus "Nearly Dead Donors"*

The primary source of organs, for regenerative and non-regenerative organs transplants, comes from deceased persons or "nearly dead" donors. While the use of a cadaver is the least problematic alternative, both legal and medical complications can arise which threaten the use of the organs. The most prevalent issue with utilizing cadaver organs is locating the organs in a

[68] Gloria J. Banks, *Legal & Ethical Safeguards: Protection of Soc'y's Most Vulnerable Participants in a Commercialized Organ Transplantation System,* 21 AM. J.L. & MED. 45, 45 (1995).
[69] N.J.S.A. § 26:6
[70] N.J.S.A. § 26:6-85
[71] Banks, *supra* note 70, at 64.
[72] N.J.S.A. § 26:6-81(a)

timely manner. Organs must be located, identified and transported quickly because the organ itself, risks death. A "nearly dead" donor is a person whose body has been kept alive through the use of extraordinary measures: respirators, ventilators, etc., for the purpose of organ transplantation. There are many legal issues that arise when attempting to utilize the organs of a "nearly dead" donor. One issue that may arise is the Doctor's inability to separate the interest of the "nearly dead" person and the person who has a chance of survival, dependent on the "nearly dead" persons organ removal. One of the most common controversies is the use of an unauthorized organ or tissue.

c. *Organ Transplant and Terminally Ill Patients*

Organ donations face further obstacles when coming from donors suffering from terminal illnesses who wish to participate in physician-assisted aid in death. The primary concern is the desperation and vulnerability of terminally ill patients. Namely, that those who are terminally ill will feel a pressure to end their lives sooner in order to satisfy the donation. Arguably, if one is going to participate in medical aid in dying, then it would not be the donation of organs which would cause the donor's death. Instead, it is the act of suicide which would create the availability of a viable organ. Medical aid in dying provides patients with a medically suitable way to terminate their lives without compromising the viability of their organs.

*XIII. Connection of Jack Kevorkian, Interests and Organ Donations*

Jack Kevorkian had a greater purpose in mind when challenging the law and assisting in the death of terminally ill persons. His ideologies would be well implemented in a policy allowing inmates to participate in aid in death. While a policy could not force those, who participate in aid in death, to donate their organs, it could certainly present the opportunity to do so. Practically speaking, the organs of inmates might not be suitable for donation. Many inmates

are suffering from diseases such as Hepatitis[73] or have utilized drugs to the point of ineligibility for organ donation. Organ donation is a commonly associated risk factor of Hepatitis C, thereby limiting an infected person eligibility.[74] Recent studies have acknowledged a heighted rate of incarcerated persons suffering from Hepatitis C, as well as the heightened risk of transmission[75] associated with incarceration due to the correctional systems lack of incorporation of Hepatitis C screenings or prevention programs.[76] However, for those with healthy and transferable organs, allowing them to donate under a Medical Aid in Dying for the Terminally Ill Inmate Policy would help the greater good. An opportunity such as this would advance the prisoner's interest by allowing him to attempt doing good. Furthermore, a statue such as this would advance the State's interests, as there would be one less incarcerated person serving a lengthy sentence behind bars, which would result in less money being spent on housing and caring for a terminal inmate. Lastly, society and third-party interests will be furthered, as innocent persons could benefit from an inmate's voluntary participation in both Medical Aid in Dying for the Terminally Ill Inmate Policy and organ donation.

**Proposed Approach to Prison Inmate's Medical Aid in Dying**

There are many attainable ways to implement a policy such as aid in dying in correctional facilities. The primary issues stem from morality, not practicality. Most persons do not want to

[73] *New Jersey Strategic Plan for Hepatitis C Prevention & Control*, N.J. HEPATITIS C ADVISORY BOARD, Jan. 2005, at 4, https://www.nj.gov/health/cd/documents/topics/hepatitisc/hepatitisc_strategic_plan.pdf.
[74] William W. Latimer, PhD, MPH, Sarra L. Hedden, PhD, Leah Floyd, PhD, April Lawson, MA, Alexander Melnikov, MSC, S. Geoffrey Severtson, PhD, MA, Anne-Gloria Moleko, PhD, & Kristin Cole, MSW *Prevalence & Correlates of Hepatitis C Among Injection Drug Users: The Significance of Duration of Use, Incarceration & Race/Ethnicity*, 39:4 J DRUG ISSUES 893, 893 (Sept. 1, 2009) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2867351/
[75] *Id.*
[76] *Id.* (*"*A growing base of empirical research strongly suggests that the absence of such programming represents a lost opportunity to improve public health within society as a whole as well as among inmates and those released from incarceration. When an estimated 30% to 90% of drug users with a history of incarceration are seropositive for HCV, the utility of providing systematic screening and prevention efforts within jails and correctional facilities is clear.")

give prisoners the right to escape their sentences or "cheat the system." However, the implementation of a policy such as this can satisfy both the prisoner and those who want to hold prisoners accountable for their crimes.

A Medical Aid in Dying for the Terminally Ill Inmate Policy should be structured similar to that of free persons. First, the patient wishing to receive a prescription for a life-ending medication shall be required to make two oral requests and one written request [77] to the attending physician, all with a fifteen-day waiting period in between each request and a minimum forty-eight hour waiting period between the attending physician's receipt of the written request and the writing of a prescription for medication.[78] Any and all requests may be revoked at any time.[79]

The Act requires that a valid written request shall be in a form substantially similar to the one set forth in the bill and that the written request "be signed and dated by the patient and witnessed by at least two individuals who attest, in the patient's presence, that, to the best of their knowledge and belief, the patient is capable and act voluntary." While this may be significantly more difficult for incarcerated persons, it is not impossible. [80] Similar to the way that prisoners obtain information and forms regarding medical parole, they will have access to the laws, information, and forms necessary to apply for medical aid in dying. As a protective measure for the requesting prisoner, the State, correctional officers, healthcare providers, and State actors, it would be best practice to require the witnesses to be persons outside of the prison structure. Such a requirement would best ensure the intent and voluntariness of the requesting inmate. Obtaining the signatures of two witnesses may prove difficult for those lacking a support system outside the

[77] N.J.S.A. § 26:16-1.
[78] N.J.S.A. § 26:16-10.
[79] N.J.S.A. § 26:16-10(b).
[80] *Bounds v. Smith*, 430 U.S. 817, 828, 97 S. Ct. 1491, 1498, 52 L. Ed. 2d 72 (1977); *see also id.* at 830.

correctional facility. However, that burden would rest upon the requesting inmate and not the State.[81]

Another way to address a freely participating Medical Aid in Dying for the Terminally Ill Inmate Policy would be by offering inmates the opportunity to create an advance health care directive upon admission to the correctional facility. This would address end-of-life practices at the beginning of their sentence in anticipation of terminal illnesses. The execution of such a document could be also be accomplished by involving someone outside the prison structure.[82]

Furthermore, the requesting inmate shall be required to consult with two physicians: an attending physician and a consulting physician to verify the diagnosis and the voluntariness of the decision to participate in aid in death.[83] If the inmate is approved for medical aid in dying, the dispense portion of the law would have to differ from the Medical Aid in Dying for the Terminally Ill Act. In order to effectively prescribe a lethal medication to a prison inmate, there would have to be extra security measures set forth to ensure that the medication is either being utilized or disposed of according to Federal and Statutory laws.

The only sensible conclusion is to confine the approved inmate to isolation under twenty-four-hour supervision. While this seems overdramatic and cruel, it is the only way to guarantee the safety of the other prisoners and persons inside the prison walls. The original statute gives approved patients up to thirty days to either utilize the medication or dispose of it lawfully, but this is not feasible in a prison setting.[84] As a result of approved inmates being confined during this period of the aid in dying process, the time frame should be reduced to fifteen days, as opposed to thirty days. Being that the access to this medication is a privilege, one which is

[81] N.J.S.A. § 26:16-5(b))
[82] Dubler, *supra* note 20, at 153.
[83] N.J.S.A. § 26:16-6.
[84] N.J.S.A. § 26:16-13.

voluntary and not imposed upon the prisoner, this is a stipulation they would have to agree to prior to the request of participation. Should an approved inmate change his or her mind during the isolation period, the drug shall be disposed of lawfully and the prisoner must return to his or her prison sentence. Furthermore, the law should encompass a provision prohibiting any federal or statutory challenges to a violation of his or her rights for the period of confinement.

## Conclusion

Due to the complexity and moral ambiguity associated with assisting another human with expediting their own death, the law on death and dying is continuously evolving. It is of paramount importance that the laws of incarcerated persons are also considered along this complex journey. While the rights of free persons are thought to be of the upmost importance, it is those who are lost in the system, forgotten about as a result of their crimes, that are in need of their rights being considered. Simply put, becoming an incarcerated person should not strip one from receiving any and all compassion and empathy and should certainly not strip one of his or her human rights. Incarcerated persons deservingly lose the most fundamental of rights, such as freedom and privacy; however, there is little to no harm in allowing an incarcerated person the dignity of taking their own life sooner than an illness can. Most terminally ill prisoners are or have been incarcerated for life, or for the better part of their life, and it is likely that these persons will reach their death during their prison sentence. Prohibiting prisoners from aid in death and allowing them to suffer through a terminal illness is cruel, inhumane, and a fate worse than the death penalty. Incarcerated persons of this nature are utilizing State tax dollars every day they remain behind bars. This simple mercy will not give an incarcerated person back their freedom. While there are certain religions may believe they will obtain freedom and forgiveness in the afterlife, but no one knows for sure. On Earth, in his or her physical, human form, an

incarcerated person granted aid in dying will still die an incarcerated person and, thus, will never cheat or manipulate the system.

Medical aid in dying has the potential to further the best interest of all relevant parties. First, the prisoners' interest will be satisfied by allowing them the opportunity to end their suffering. Second, the States' interests would be no more compromised than it already is under the New Jersey Medical Aid in Dying for the Terminally Ill Act. Third, the medical profession would be no more compromised under the New Jersey Act than it is currently. Lastly, a Medical Aid in Dying for the Terminally Ill Inmate Policy would further protect and help innocent third parties by allowing participants to donate their organs after death.

Moreover, as a result of their illnesses, these persons require continuous medical care, if and until they exercise their constitutional right to refuse medical treatment. At this point, they should be permitted to just end their life sooner than allowing their illness to progress and ultimately chose to refuse treatment. This will produce an effective way of making more room in the prison system, for other criminals. Additionally, a policy of this nature will allow the State to reallocate their taxes more wisely, which in turn benefits the law-abiding citizens, as opposed to those who break the law. For the foregoing reasons, I do not see the harm in extending New Jersey's Medical Aid in Dying for the Terminally Ill Act to terminally ill, incarcerated persons.

In conclusion, the benefits of prisoner access to aid in death outweigh any potential harms or conflicting State interests. However, this law shall be adopted with specific stipulations, setting forth bright line qualifications of eligible persons, illnesses, and jail sentences. Furthermore, all eligible accounts of aid in death are subject to denial based on refusal by physician. Physician-assisted death for terminally ill inmates is not a death sentence. Instead, it provides ample opportunities to impact the prisoners' autonomy in their last days of life, the

State's ability to better allocate their money in funding correctional facilities, and the lives of many persons on the organ donation list.