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Locked Up They Won't Let Me Out: Giving Prisoners the Right to Die with Dignity in Oregon

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On November 4, 1994, voters in Oregon elected to pass Measure 16, Oregon Death with Dignity ("Dignity Act"), making it the first state in the country[1] to legalize physician-assisted suicide.[2] The future of Oregon's Dignity Act would be uncertain until a few years later because of the many legal delays provoked by the controversy of legalizing physician-assisted suicide.[3] Physician-assisted suicide goes by many other names such as: aid in dying, right to die, end of life, and death with dignity. Oregon opted for the latter. Death with dignity has gained some steam as of recent.[4] Even though more states have passed such legislation, the debate on physician-assisted suicide continues to spark heated discussion.[5]

Nonetheless, some seek expansion of this new end-of-life option, including certain segments of our incarcerated population. While prisoners lose some rights when they are convicted, the question always persists as to the scope of rights they should retain. Those in

[1] *See* David Brown, *Assisted Suicide Law Splits Oregon Doctors: Tough Rules Limit Use of Lethal Doses*, CHI. SuN-TIMEs, Nov. 14, 1994, at 22 ('[E]nactment ... of Oregon's 'Death with Dignity Act' represents a legal acceptance of physician-assisted suicide that is without precedent in the United States.").
[2] Or. Rev. Stat. Ann. § 127.800.
[3] Oregon Death with Dignity Act: A History - Physician-Assisted Death Oregon https://www.deathwithdignity.org/oregon-death-with-dignity-act-history/
[4] The other eight states with end of life statutes are California, Colorado, District of Columbia, Hawaii, Maine, Oregon, Vermont, and Washington. How to Access and Use Death with Dignity Laws, DEATH WITH DIGNITY, https:// www.deathwithdignity.org/learn/access/ (last visited Dec. 2, 2019). California and Colorado also have the death penalty with 732 and three inmates on death row respectively, however they currently have a gubernatorial moratorium on executions. Death-Row Prisoners by State, DEATH PENALTY INFO. CTR., http:// www.deathpenaltyinfo.org/death-row-inmates-state-and-size-death-rowyear?scid=9&did=188#state (last visited Oct. 18, 2019). District of Columbia, Hawaii, Vermont and Washington abolished the death penalty between the years 1972 and 2018. States with and Without the Death Penalty, DEATH PENALTY INFO. CTR., http://www.deathpenaltyinfo.org/states-and-without-death-penalty (last visited Dec. 2, 2019).
[5] *See* Brown, supra note 8, at 22 and accompanying text; Carey Goldberg, *Oregon Braces for New Right-to-Die Fight*, N.Y. TIMES, June 17, 1997, at A12 ("Oregon may become again, and with greater intensity, the principal arena in which the thorny ethical questions surrounding [physician-assisted suicide] are translated into a knock-down, drag-out political battle.").

prison should be able to make the same choice when it comes to being able to die with dignity. This will aid in maintaining the prison population as well.

The Supreme Court of the United States is silent on its ruling on access to aid in dying in prison. Due to the absence of binding precedent, our dialogue on the constitutionality of aid in dying in prisons is informed by how courts have treated withdrawal of medical technology and do not resuscitate orders, and how the Supreme Court has ruled on aid in dying.

This paper will examine the Dignity Act in Oregon and how to apply it to the incarcerated. The Dignity Act currently is silent on whether the Act covers the incarcerated.[6] It is understood that when one is sent to prison, they lose certain liberties and freedoms afforded to law-abiding citizens. Like for instance, the right to vote. Losing that right is much different than not having a say over your bodily autonomy. While nine states have enacted parallel "death with dignity" statutes, this paper will focus on Oregon's dying with dignity statute due to its place in right to die history, as the first state to have such legislation, as well as the constant battle the state has had over prisoner well-being.

This paper will proceed as follows. First, this paper will identify the problems of aging in prison. Next, it will discuss what death with dignity is and the details of Oregon's Dignity Act. Afterwards, distinguishing the constitutional rights afforded to prisoners and then balancing the states interests with the rights afforded to the incarcerated. The discussion of prison and the role that healthcare plays in the prison system will inform how the Act will apply to the incarcerated. Last, suggested legislation for addressing the incarcerated and their access to the Dignity Act.

Dying and Aging in Prison

[6] Or. Rev. Stat. Ann. § 127.800

TABLE 10

Average annual mortality rate per 100,000 state prisoners, by cause of death and selected decedent characteristics, 2001–2014

Characteristic	All causes	Illness					All other[a]	Suicide	Drug/alcohol intoxication	Accident	Homicide[b]
		Cancer	Heart disease	Liver disease	Respiratory disease	AIDS-related					
Total	256	69	66	25	16	10	42	16	3	3	5
Sex											
Male	263	71	68	26	16	10	42	16	4	3	5
Female	151	37	32	12	12	7	34	12	3	1	...
Race/Hispanic origin											
White[c]	367	105	97	38	25	6	53	26	7	4	6
Black/African American[c]	222	60	61	14	13	17	41	8	2	2	4
Hispanic/Latino[d]	174	35	32	30	9	7	32	16	5	2	5
Other[c,e]	129	30	27	16	6	3	19	19	5	2	3
Age											
17 or younger	51	5 !	5 !	3 !	3 !	0	3 !	28 !	0	3 !	3 !
18–24	33	2	4	--	2	1	4	13	2	1	3
25–34	55	5	9	1	3	4	8	16	4	1	4
35–44	139	23	33	11	7	14	23	16	5	2	4
45–54	457	125	107	70	22	21	77	18	6	4	6
55 or older	1879	639	561	150	146	19	311	19	4	11	10

Note: Data may have been revised from previously published statistics. Detail may not sum to total due to missing data. Mortality rates are based on a 1-day inmate custody count. See *Methodology* for details on custody counts, rates, illnesses, homicides, and Hispanic origin.

...Not available.

--Less than 0.5.

! Interpret with caution. Too few cases to provide a reliable rate.

[a]Includes other specified illnesses (such as cerebrovascular disease, influenza, and other nonleading natural causes of death) and unspecified illnesses.

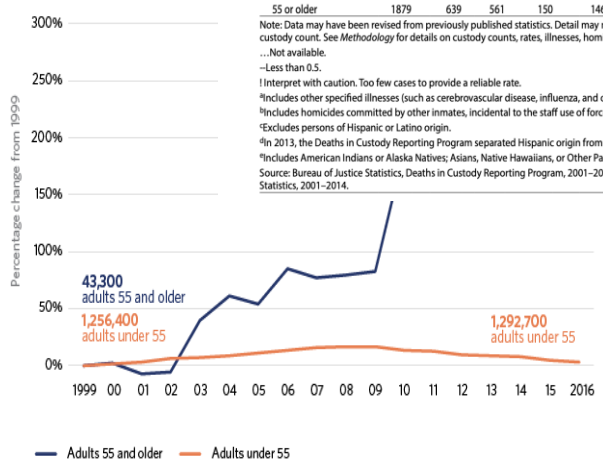
[b]Includes homicides committed by other inmates, incidental to the staff use of force, and resulting from assaults sustained prior to incarceration.

[c]Excludes persons of Hispanic or Latino origin.

[d]In 2013, the Deaths in Custody Reporting Program separated Hispanic origin from race. Comparisons with previous years should not be made.

[e]Includes American Indians or Alaska Natives; Asians, Native Hawaiians, or Other Pacific Islanders; and persons identifying two or more races.

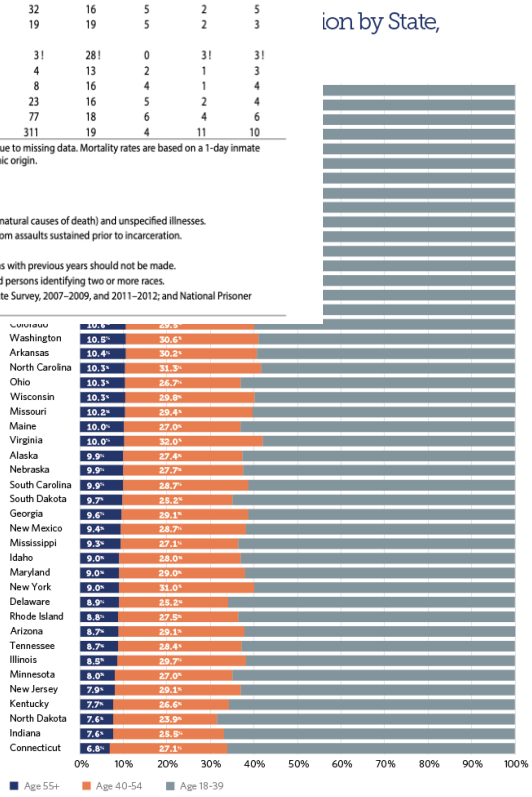
Source: Bureau of Justice Statistics, Deaths in Custody Reporting Program, 2001–2014; National Inmate Survey, 2007–2009, and 2011–2012; and National Prisoner Statistics, 2001–2014.



Note: The Bureau of Justice Statistics estimates the age distribution of prisoners using data from the Federal Justice Statistics Program and statistics that states voluntarily submit to the National Corrections Reporting Program. State participation in this program has varied, which may have caused year-to-year fluctuations in the Bureau's national estimates, but this does not affect long-term trend comparisons. From 2009 to 2010, the number of states submitting data increased substantially, which might have contributed to the year-over-year increase in the national estimate between those years.

Source: Bureau of Justice Statistics

Figure 1. The growth of older prisoners from 1999-2016.



Note: Three states (Alabama, Iowa, and Michigan) either did not track inmates by the age brackets surveyed or did not report data to Pew and Vera for fiscal 2015. Montana and Wyoming reported data only for the proportion of inmates 55 and older. New Hampshire provided no data. Percentages reflect all inmates under the jurisdiction of state departments of correction (i.e., those under the legal authority of the state, regardless of where the prisoner is held).

Figure 2.

Figure 3

There exists a term called the "silver tsunami,"[7] that reflects how the surging numbers of elderly inmates[8] raises significant moral, health, and fiscal implications deserving keen scrutiny. Prisoners are getting older and constitute an obvious population for potential early release. This "national human-made epidemic,"[9] is growing at a rapid rate and needs to be addressed. An aging inmate population—in part due to extended sentences—is one of the main drivers of increased cost of medical care in state prison systems. Looking at Figure 2[10] above, Oregon has one of the largest percentages of prisoners over the age of 55. Prisoners over the age of fifty 50 are the fastest growing population.[11] Research has even shown that those in prison age faster than those of the same age who are not in prison.[12] The cost of caring for these elderly inmates is five

[7] Martina E. Cartwright, *The Silver Tsunami: Aging Prisoners, Early Release, Guardianship and Prisoner Advocate Initiatives for Long Term Care Beyond the Prison Walls*, 1 TOURO L. CTR. J. AGING, LONGEVITY, L., & POL'Y 54, 54 (2016), *available*

[8] Matt McKillop & Alex Boucher, *Aging Prison Populations Drive Up Costs | The Pew Charitable Trusts* (2018), https://www.pewtrusts.org/en/research-and-analysis/articles/2018/02/20/aging-prison-populations-drive-up-costs. *at* https://digitalcommons.tourolaw.edu/cgi/viewcontent.cgi?article=1003&context=jallp [https://perma.cc/CB59-65WG]; *see* OSBORNE ASS'N, THE HIGH COSTS OF LOW RISK: THE CRISIS OF AMERICA'S AGING PRISON POPULATION 2 (Jul. 2014), *available at* http://www.osborneny.org/news/unite-for-parole-and-prison-justice/osborne-aging-whitepaper/ [https://perma.cc/7S8N-A3BP].

[9] OSBORNE ASS'N, *supra* note 7, at 2; *see also* Matthew Clarke, *Report Finds Fiscal Crisis of Increasing Low-Risk, High-Cost Older Prisoners*, PRISON LEGAL NEWS (Aug. 4, 2016), https://www.prisonlegalnews.org/news/2016/aug/4/report-finds-fiscal-crisis-increasing-low-risk-high-cost-older-prisoners/ [https://perma.cc/Z3YF-RY2U] (reacting to the Osborne Association report).

[10]

[11] 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=.4ffdcb077191 [http://perma.cc/F7DE-JFES].

[12] 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).

times greater in states with the greatest elderly population compared to those with the least amount of elderly inmates.[13] Prisoners have significantly higher rates of physical and mental illness than the general population[14] - including higher rates of communicable diseases such as HIV/AIDS,[15] Hepatitis B and C,[16] chronic diseases, and mental illness. Illness related deaths account for majority of the deaths among prisoners. Terminally ill diseases such as Alzheimer's and Dementia are prevalent among people 65 and older.[17] Among those 55 and older, they are the most susceptible to these illnesses and in turn are the age group with the most deaths, dying from illnesses and diseases (heart, liver, and respiratory).[18] Those in prison who fall within this age gap should be allowed to make use of the Dignity Act.

There are prisoners who are not elderly who also may succumb to terminal illness mentioned above. Enabling them to access the Act will prove helpful as well. Allowing anyone

[13] OFFICE OF THE INSPECTOR GEN., U.S. DEP'T OF JUSTICE, THE IMPACT OF AN AGING INMATE POPULATION ON THE FEDERAL BUREAU OF PRISONS 2, at ii, 51. (May 2015), https://oig.justice.gov/reports/2015/e1505.pdf.

[14] *See* John V. Jacobi, Prison Health, Public Health: Obligations and Opportunities, 31 Am. J.L. & Med. 447, 450 (2005) ("'The prevalence of chronic illness, communicable diseases, and severe mental disorders among people in jail and prison is far greater than among other people of comparable ages.'" (quoting The Report of the Re-Entry Policy Council: Charting the Safe and Successful Return of Prisoners to the Community 157 (2005))); Adrienne Lyles-Chockley, Transitions to Justice: Prisoner Reentry as an Opportunity to Confront and Counteract Racism, 6 Hastings Race & Poverty L.J. 259, 297-98 (2009) ("The prevalence of certain infectious diseases, substance abuse problems, and mental health disorders is significantly greater in inmate populations than in the general American population." (footnotes omitted)); Harold Pollack et al., Health Care Delivery Strategies for Criminal Offenders, 26 J. Health Care Fin. 63, 65 (1999) (describing how the prison population suffers from a "prevalence of mental health problems, infectious diseases, substance abuse, and other morbidities"); Michele Westhoff, An Examination of Prisoners' Constitutional Right to Healthcare: Theory and Practice, Health Law, Aug. 2008, at 1, 8-9 (noting the high rates of communicable diseases, substance abuse disorders, and mental illness in prison).

[15] A 2003 Department of Justice study found that 22,028 state inmates and 1631 federal inmates were infected with HIV, accounting for "1.1% of all federal inmates and 2.0% of state inmates, or 1.9% of the entire prison population in the United States." Kari Larsen, Deliberately Indifferent: Government Response to HIV in U.S. Prisons, 24 J. Contemp. Health L. & Pol'y 251, 251 (2008). The report also found that the rates of HIV varied significantly from state to state. In New York, for example, 7.6% of state **prisoners** were HIV positive. Id.

[16] Hepatitis B and Hepatitis C are grossly overrepresented in the prison population, with rates nine to ten times the national average. Westhoff, supra note 4, at 8.

[17] https://www.alzheimers.org.uk/about-dementia/types-dementia/who-gets-alzheimers-disease

[18] Margaret Noonan, *Mortality in State Prisons, 2001-2014 - Statistical Tables*, Table 10 (2016), https://www.bjs.gov/content/pub/pdf/msp0114st.pdf. (See Figure 3.).

who is terminally ill to make the choice to end their life with dignity will relieve the burden of an overcrowded prison situation and help to maintain balance.

Death with Dignity Act

Death with Dignity allows a person the opportunity to meet their ends quickly and painlessly, as an alternative to the long and painful process they would otherwise endure. Oregon's Death with Dignity Act enumerates the conditions patients and physicians must satisfy in order to take advantage of physician-assisted dying: the patient must be (1) an adult who is capable; (2) a resident of Oregon; and (3) diagnosed with a terminal illness.[19] There are many procedural safeguards contained within the legislation: the person seeking aid-in-dying medication must make three separate requests for medication for the purpose of ending his or her life, one written and two oral, to their attending physician, and the oral requests must be made fifteen days apart, the second reiterating the oral request to the physician.[20] The written request has to "be signed and dated, in front of at least two witnesses . . . ."[21] Then a consulting physician must examine the patient and his or her relevant medical records and confirm, in writing, the prior diagnosis of a terminal condition by the attending physician is accurate, and verify that the patient is capable, acting voluntarily and made a fully informed decision with awareness of other options.[22] If during the course of this process either physician believes that a

[19] *Id.* § 127.805 s.2.01.
[20] *Id.* § 127.840 s.3.06.
[21] *Id.* § 127.810 s.2.02.
[22] *Id.* § 127.820 s.3.02.

patient may be suffering from a psychiatric or psychological disorder or depression that will cause judgments to be impaired, either physician must refer the patient for counseling.[23]

The Dignity Act requires that the medical records contain the diagnosis and prognosis made by both physicians, all oral and written requests, the attending physician and consulting physician's diagnosis and prognosis and notes on capacity, and outcome and determinations made during counseling, if performed.[24] Even after going through the process, an individual can still make the decision to not take the medication.[25] However, they must self-administer the prescription if they do choose to follow through. This thorough legislation did not come overnight. It took years to develop and the history of right to die made it all possible.

History of "Right to Die"

The right to die is not constitutional. It is the state's choice to give their residents this option. Since Oregon allows this, the history of the right to die is imperative in developing an analysis that would explain why applying this to prisoners should be considered and implemented. In 1983, the right to die clash took the nation by storm when the Supreme Court agreed to hear *Cruzan v. Director, Missouri Department of Health*.[26] In Cruzan, Nancy was driving down the road when she lost control of the vehicle; the car toppled over, leaving her in a "persistent vegetative state," with severe injuries, including brain damage.[27] Nancy's husband

[23] *Id.* § 127.825 s.3.03.
[24] *Id.* § 127.855 s.3.09.
[25] OR. REV. STAT. ANN. *§* 127.845 s.3.07.
[26] 497 U.S. 261 (1990); *see also* In re Quinlan, 355 A.2d 647, 671 (N.J. 1976) (holding that the guardian of a young woman who was not competent had the legal right to withdraw life-sustaining treatment).
[27] Cruzan, 497 U.S. at 266.

consented to the initial insertion of feeding and hydration tubes.[28] Years later, Nancy's co-guardians requested a court order that the hospital to discontinue this life-sustaining treatment. The state hospital refused to remove the tubes. It demanded court approval, which was granted by the Missouri trial court.[29] The Supreme Court of the United States held that because the state has a legitimate interest in preservation of life,[30] its requirement of clear and convincing evidence that Nancy would have wanted the discontinuation of nutrition and hydration was not unconstitutional.[31]. This constitutional decision stated that there is a "liberty interest" that individuals possess that stems from the Due Process Clause of the Fifth and Fourteenth Amendments to the United States Constitution, that guarantees freedom from unwanted touching. This freedom is meant to include that of unwanted medical treatment, even if it is life-sustaining.[32] This constitutional decision was the first step towards a one of the most controversial topics.

In *Washington v. Glucksberg*, the Supreme Court upheld a statute which prohibited physician assisted suicide, finding that the state, in enacting the statute, was properly motivated by the four legitimate interests mentioned in Thor.[33] The Court also stated in dicta that states could choose, if they so wanted, to pass legislation allowing physician-assisted suicide.

The SCOTUS decision opened the gates for states to make their own legislation. In Oregon, although the first state to enact such legislation, they were met with opposition the same

[28] *Id*. at 266–68.
[29] *Id.*
[30] *Id*.
[31] *Id*.
[32] *Id.*
[33] 521 U.S. 702, 735–36 (1997); Thor, 855 P.2d at 382 ("Four state interests generally identify the countervailing considerations in determining the scope of patient autonomy: preserving life, preventing suicide, maintaining the integrity of the medical profession, and protecting innocent third parties.").

year of their enactment of the Dignity Act in 1994 with *Lee v. Oregon*.[34] The plaintiffs here included physicians, four terminally ill or potentially terminally ill patients, a residential care facility, and individual operators of residential care facilities.[35] The Oregon Death With Dignity Act (Measure 16) was challenged in the Ninth Circuit on the grounds that it violated the Equal Protection and Due Process Clauses of the Fourteenth Amendment, statutory and First Amendment rights of freedom to exercise religion and to associate, and the Americans with Disabilities Act. The court determined that "Measure 16 provides a means to commit suicide to a severely overinclusive class who may be competent, incompetent, unduly influenced, or abused by others."[36] The court held that the state interest was not rationally related to the disparate treatment, meaning the Dignity Act was unconstitutional.[37]

Prison and Healthcare

It is the Eighth Amendment that governs prison healthcare. The United States Constitution, by prohibiting cruel and unusual punishment, interpreted this amendment to require prisons to provide a minimum level of care for prisoners.[38] Currently in 2019, there are around 1,306,000 people serving sentences in state prisons within the United States.[39] These inmates account for about 57% of the total prison population of 2.3 million.[40] Healthcare is expensive and for inmates the cost of providing healthcare is increased. The factors that contribute to the increased costs are the "[p]revalence of infectious and chronic diseases, mental illness, and

[34] 891 F. Supp. 1429 (Ore. 1995).
[35] *Id*.
[36] *Id*. at 1437.
[37] *Id*.
[38] NOTE: PRISON HEALTH CARE AFTER THE AFFORDABLE CARE ACT: ENVISIONING AN END TO THE POLICY OF NEGLECT, 89 N.Y.U.L. REV. 700, 719.
[39] PETER WAGNER & WENDY SAWYER, MASS INCARCERATION: THE WHOLE PIE, at 1 (2019), https://www.prisonpolicy.org/reports/pie2019.html
[40] *Id*.

substance abuse among inmates, many of whom enter prisons with these problems." [41] The location of prisons plays a role in the situation as well. Prisons are not near hospitals and other providers, making it harder to provide emergency services.[42]

In *Estelle v. Gamble*,[43] the SCOTUS addressed the constitutional standard for medical treatment in the prison system. Gamble was an inmate who was denied prescribed treatment by guards, sent to solitary confinement, and put before the prison disciplinary committee.[44] The Court held that under the Eighth Amendment, it is unconstitutional if there is an indifference to the serious medical needs of the prisoner "whether the indifference is manifested by prison doctors in their response to the prisoner's needs[45] or by prison guards in intentionally denying or delaying access to medical care[46]or intentionally interfering with the treatment once prescribed. The Court found, in dicta, that the government has an "obligation to provide medical care for those whom it is punishing by incarceration."[47] Prisoners are unable to freely obtain the medical attention they need so the State is obligated to pay for it.[48]

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[41] Pew Charitable Tr., Managing Prison Health Care Spending supra note 29, at 4, 8. (2013), http://www.pewtrusts.org/~/media/legacy/uploadedfiles/pcs_assets/2014/pctcorrectionshealthcarebrief050814pdf.pdf [https://perma.cc/V3XM2YCX].

[42] *Id.*

[43] 429 U.S. 97 (1976).

[44] *Id.* at 101.

[45] *Id.* at 104-05. See, *e.g.*, *Williams* v. *Vincent*, 508 F. 2d 541 (CA2 1974)(doctor's choosing the "easier and less efficacious treatment" of throwing away the prisoner's ear and stitching the stump may be attributable to "deliberate indifference… rather than an exercise of professional judgment"); *Thomas* v. *Pate*, 493 F. 2d 151, 158 (CA7), cert. denied *sub nom. Thomas* v. *Cannon*, 419 U.S. 879 (1974) (injection of penicillin with knowledge that prisoner was allergic, and refusal of doctor to treat allergic reaction); *Jones* v. *Lockhart*, 484 F. 2d 1192 (CA8 1973) (refusal of paramedic to provide treatment); *Martinez* v. *Mancusi*, 443 F. 2d 921 (CA2 1970), cert. denied, 401 U.S. 983 (1971) (prison physician refuses to administer the prescribed pain killer and renders leg surgery unsuccessful by requiring prisoner to stand despite contrary instructions of surgeon).

[46] *Id.* See, *e.g.*, *Westlake* v. *Lucas*, 537 F. 2d 857 (CA6 1976); *Thomas* v. *Pate*, *supra*, at 158-159; *Fitzke* v. *Shappell*, 468 F. 2d 1072 (CA6 1972); *Hutchens* v. *Alabama*, 466 F. 2d 507 (CA5 1972); *Riley* v. *Rhay*, 407 F. 2d 496 (CA9 1969); *Edwards* v. *Duncan*, 355 F. 2d 993 (CA4 1966); *Hughes* v. *Noble*, 295 F. 2d 495 (CA5 1961).

[47] *Id*. at 130.

[48] *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

In *Wilson v. Seiter*,[49] the Supreme Court held that the deliberate indifference standard applies to all cases challenging conditions of confinement and defined acting with "deliberate indifference" as acting with a "sufficiently culpable state of mind."[50] In *Farmer v. Brennan*, the Supreme Court elaborated on the meaning of the term.[51] The petitioner argued that deliberate indifference was based on the objective standard for civil suits, but the Supreme Court rejected that argument.[52] The Court instead held that liability for a prison official under the Eighth Amendment for inhumane conditions of confinement is when the "official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference."[53] Though the Court did not clearly define the term in Gamble, it did provide some guidance. After reasoning that prisons were responsible for providing medical care because prisoners could not get care on their own, Justice Marshall wrote, "In the worst cases, such a failure [to provide medical care] may actually produce physical 'torture or a lingering death,' …. In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose."[54]

Some prisons contract physicians and although not directly working for the State, there still exists a standard of care that must be met. In *West v. Atkins*,[55] the Court held that "contracting out prison medical care does not relieve the State of its constitutional duty to

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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.").

[49] 501 U.S. 294 (1991).

[50] *Id*. at 298.

[51] 511 U.S. 825 (1994). Farmer was a conditions of confinement case. However, its treatment of the "deliberate indifference" standard is still relevant to cases that involve medical care because, after Wilson, all conditions of confinement cases use the "deliberate indifference" standard.

[52] *Id*. at 837.

[53] *Id*.

[54] Estelle v. Gamble, 429 U.S. 97, 103 (1976) (citing In re Kemmler, 136 U.S. 436, 447 (1890)).

[55] 487 U.S. 42

provide adequate medical treatment to those in its custody, and it does not deprive the State's prisoners of the means to vindicate their Eighth Amendment rights."[56]

Some courts say that prisoners have a "paramount" liberty interest in privacy and bodily integrity, while others, despite finding a liberty interest, allow prison officials to force medical treatment.[57] The State interests in maintaining prison order and security can at times outweigh the liberty interest of the prisoner.[58] Even when a healthy prisoner threatens these state interests, they can be subject to state intervention.[59] The groundbreaking case discussing this is *Commissioner of Corrections v. Myers*.[60]

Mr. Myers acquired a kidney disease that involved hemodialysis during his time at a correctional facility in Massachusetts.[61] His death would stem from a mixture of not receiving dialysis and his refusal to ingest required medication.[62] Given this information it would be correct to say that the medication and dialysis are life-saving treatments. It was after a year that Myers decided to reject the scheduled treatment.[63]

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[56] As the dissent in the Court of Appeals explained, if this were the basis for delimiting § 1983 liability, "the state will be free to contract out all services which it is constitutionally obligated to provide and leave its citizens with no means for vindication of those rights, whose protection has been delegated to 'private' actors, when they have been denied." 815 F. 2d, at 998.

[57] COMMENT: DEATH WITH DIGNITY FOR THE SEEMINGLY UNDIGNIFIED: DENIAL OF AID IN DYING IN PRISON, 109 J. CRIM. L. & CRIMINOLOGY 633, 648

[58] In re Caulk, 480 A.2d 93, 95 (N.H. 1984); Lantz v. Coleman, 978 A.2d 164, 169 (Conn. Super. Ct. 2008); ("The defendant did not completely forfeit his State constitutional right to privacy by reason of his incarceration, but rather subjected himself to State interests unique to the prison."). See also State ex rel. Schuetzle v. Vogel, 537 N.W.2d 358, 360 (N.D. 1995) (holding that a prison could force a diabetic inmate to take insulin where he was refusing in an effort to manipulate and blackmail the prison).

[59] *Id*. at 99 (Douglas, J., dissenting) (describing the testimony of the prison doctor as to how the inmate was forcibly fed through a tube that "passed down through the nasal passages into the stomach . . .").

[60] 399 N.E.2d 452 (Mass. 1979).

[61] *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*.

[62] *Id*. at 454.

[63] *Id*.

Following this action by Myers, the Commissioner of Correction brought suit in the Superior Court, for a declaratory judgment that would allow him to compel Myers to undergo the treatment he was previously doing.[64] The Court went over a few possibilities for why Myers refused treatment such as the effects of the treatment, religious objections, or a general desire to die and ultimately discovered it was a way of him protesting against being placed in a medium instead of a minimum-security prison.[65] Among the considerations the superior court examined were the amount of pain Myers would endure from dialysis, where he was on the kidney transplant list, and how old he was. After examining these aspects, the court determined he would be able to live a normal life.[66] The court recognized precedent that there is a strong interest in being free from a non-consensual invasion of bodily integrity that a person in addition to a constitutional privacy right in preventing unwanted medical treatment.[67] The Court balanced the prison's interest in "upholding orderly prison administration" against the constitutional right of Mr. Myers. The former outweighed the latter.[68] The Court recognized that although "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."[69] The Court upheld the appeals court's decision that prison officials can use "reasonable force" to restrain Mr. Myers during his dialysis and other life-saving treatment.[70]

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[64] *Id*. at 453.
[65] *Id*. at 454.
[66] *Id.*
[67] *Id*. at 455-56.
[68] *Id*. at 457. The Commissioner argued that preservation of the prison's internal order and discipline and maintaining institutional security was what the prison had an interest in. *Id.* He argued "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.*

[69] *Id.*
[70] *Id*. at 453, 457-58.

Washington v. Harper changed the precedent for state courts. Before 1990 courts had a fairly unrestricted freedom in determining when a prisoner was forced to undergo medical treatment.[71] After serving a sentence at Washington State Penitentiary from 1976-1980, Mr. Walker Harper was diagnosed with manic-depressive disorder and housed in a special correctional institute that diagnosed and treated prisoners with serious mental health illnesses.[72] Under Policy 600.30 a person may be involuntarily treated with medication "if the person (1) suffers from a "mental disorder" and (2) is "gravely disabled" or poses a "likelihood of serious harm" to himself, others, or their property."[73]

Walker said yes to the treatment at first but then refused to continue the medication.[74] In an effort to medicate Mr. Harper despite his refusing treatment, a committee held a hearing with Mr. Harper present that concluded he was a danger to others as a result of a mental illness, and approved the involuntary administration of antipsychotic drugs.[75] A few years later Mr. Harper brought an action under 42 U.S.C. § 1983[76] claiming that his Fourteenth Amendment right to

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[71] 494 U.S. 210 (1990).
[72] *Id*.
[73] The Policy's definitions of the terms "mental disorder," "gravely disabled," and "likelihood of serious harm" are identical to the definitions of the terms as they are used in the state involuntary commitment statute. See App. to Pet. for Cert. B-3. "Mental disorder" means "any organic, mental, or emotional impairment which has substantial adverse effects on an individual's cognitive or volitional functions." Wash. Rev. Code § 71.05.020(2) (1987). "Gravely disabled" means "a condition in which a person, as a result of a mental disorder: (a) is in danger of serious physical harm resulting from a failure to provide for his essential human needs of health or safety, or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety." § 71.05.020(1). "Likelihood of serious harm" means "either: (a) [a] substantial risk that physical harm will be inflicted by an individual upon his own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on one's self, (b) a substantial risk that physical harm will be inflicted by an individual upon another, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm, or (c) a substantial risk that physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others." § 71.05.020(3).
[74] Harper at 214.
[75] *Id.* at 217.

[76] § 1983. Civil action for deprivation of rights- Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in

Due Process was violated because the committee failed to provide a hearing before prison officials administered his drugs without his consent.[77] The Supreme Court of the United States acknowledged that Harper had a "significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause."[78] In addition, they found that "[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."[79] The Court, using the decision in *Turner v. Safley*,[80] which established the standard of review for constitutional claims brought by prisoners.[81] The *Turner* precedent articulated the Due Process Clause warrants prison officials to "treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will."[82]

The standards and resources available for those in prison compared to those who are not is clear. There are rights that people who do not spend their time behind bars have available to them that those that do, although may be recognized, still may not invoke. Bodily autonomy is not something that prisoners have full control over if the interest of the state is more important. This is a drastic difference from *Cruzan*, finding a competent person has the liberty to refuse medical care.

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equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

[77] *Id.*

[78] *Id*. at 221-22.

[79] *Id.*

[80] 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: (1) a "valid, rational connection" between the regulation and the purported legitimate interest; (2) whether there are alternative means of exercising the right that are an avenue by which the prisoner can exercise his asserted right; (3) the impact that the accommodation will have on the prison community and institutional resources; and (4) "the absence of ready alternatives is evidence of the reasonableness of a prison regulation." *Id*. at 89-90.

[81] *Id.* at 223-24.

[82] *Id.* at 227.

An incarcerated individual's inability to refuse medical treatment highlights a case where courts treat prisoners' autonomy different than non-incarcerated individuals. The ability of prison officials to force feed inmates is also demonstrates how courts treat incarcerated and nonincarcerated individuals' autonomy differently. Based on the holding in *Cruzan*--that a competent person has a Fourteenth Amendment liberty interest in withdrawing medical care--prisoners should be able to starve themselves under the Fourteenth Amendment and autonomy principles.[83] Notwithstanding a ruling by the Supreme Court weighing in on a constitutional right to starve, several state court cases are informative on the issue. Cases involving prisoners' refusal to eat help elucidate the expanse of prisoners' constitutional rights as weighed against the state's interests.

In *Zant v. Prevatte*,[84] Mr. Prevatte, as a form of protest, decided to stop eating.[85] After about a month the doctors opined that Mr. Prevatte would not live longer than three weeks if he did not receive nutrition.[86] The State believed it had a "duty to protect the health of those who are incarcerated in the state penal system; and that there is a compelling state interest to preserve human life."[87] In disagreeing, The Supreme Court of Georgia held that a competent prisoner, with no dependents, maintained a right to privacy and therefore the State could not override his decision to starve, even though feeding would likely save his life.[88] The Supreme Court of

[83] *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.").
[84] 286 S.E.2d 715 (Ga. 1982).
[85] *Id.*
[86] *Id.* Ketosis is a normal metabolic process. When the body does not have enough glucose for energy, it burns stored fats instead; this results in a build-up of acids called ketones within the body.
[87] *Id.*

[88] *Id*. at 717.

Georgia was one of many other courts who held this standard.[89] Other states have refused to recognize a protected liberty interest in the right to starve.[90]

Oregon cases contribute to our analysis as well. *Atiyeh v. Capps* addressed the relationship between healthcare and prison population in terms of proper medical care.[91] The district court found that the overcrowding in prison "exceeds the level of applicable professional standards; has increased the health risks to which inmates are exposed; has impinged on the proper delivery of medical and mental health care; has reduced the opportunity for inmates to participate in rehabilitative programs; has resulted in idleness; has produced an atmosphere of tension and fear among inmates and staff; and has reduced the ability of the institutions to protect the inmates from assaults."[92] Although freedom from overcrowding is not a constitutional right, it leads to inadequate healthcare which is.

The cases discussed above as well as those being discussed below address prisoners' access to healthcare and suggest that there is a level of care prisoners should have, driven by the Constitution and that a competent prisoner who chooses to refuse food and treatment should be allowed to do so. The Supreme Court of California in *Thor v. Superior Ct.*,[93] held that an informed prisoner (Andrews) possessed a fundamental right to deny or demand retraction of medical treatment of any kind, despite the risk of mortality, which normally outweighed any countervailing state interest.[94] The State argued that Andrews did not possess the same degree of debilitation of others which chronic pain and dependence made life hopeless and "intolerable,"

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[89] *Id. See* Lane v. Candura, 6 Mass. App. Ct. 377 (376 NE2d 1232) (1978); In Re Quackenbush, 156 N.J. Super. 282 (383 A2d 785) (1978); In Re Yetter, 62 Pa. D. & C. 2d 619 (1973). *See in general* 93 ALR3d 67, anno.
[90] *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).
[91] 449 U.S. 1312 (1981); Capps v. Atiyeh, 559 F. Supp. 894 (holding the milk pasteurization process and fire alarm system were constitutional deficiency in the provision of medical care.)
[92] *Id*. at 1350.
[93] 5 Cal. 4th 725 (Cal. 1993).
[94] *Id*. at 749.

constituting a proportionately smaller measure of control over bodily intrusions.[95] The court found the argument "misapprehends the intensely individual nature and broadly based scope of the right to personal autonomy, which simply will not accommodate the kind of parsing petitioner invites.[96] It is the individual who must live or die with the course of treatment chosen or rejected, not the state.[97]

In *Billings v. Gates*[98] Billings sought relief from the pain he suffered as a result of high arches that were not accommodated by the shoes he was provided, causing enough pain to keep him from walking.[99] The State argued that under Gamble, Billings was receiving "constitutionally adequate" care and should be denied relief.[100]The Oregon Supreme Court concluded that deliberate indifference to serious medical needs of prisoners constitutes the unnecessary and wanton infliction of pain, whether the indifference is manifested by prison doctors in their response to a prisoner's serious medical needs or by prison guards in intentionally denying or delaying access to medical care, or in intentionally interfering with prescribed treatment.[101] *Delker v. Maass*,[102] utilized the deliberate indifference standard as well.[103] Delker had an inguinal hernia that was never taken care of because it was deemed not an emergency according to the physician he went to see while incarcerated.[104] Despite being told he was on a waiting list for surgery, plaintiff continued to state how he was in pain and continued to

[95] *Id*. at 741.
[96] *Id*.
[97] *Id*.
[98] 323 Or. 167 (1996).
[99] *Id*. at 169.
[100] *Id*.
[101] *Id*. at 181. That claim is comparable to others that we have held were legally sufficient. *See, e.g.,* Voth v. Maass, 120 Ore. App. 574, 852 P.2d 969 (1993) (foot problem aggravated by defendant's confiscation of prescribed orthopedic footwear and refusal to provide replacement footwear); Jorgenson v. Schiedler, *supra* (edema in ankles).
[102] 843 F. Supp. 1390, 1398 (D. Or. 1994)
[103] *Id*. at 1401.

[104] *Id*. at 1393-95.

receive no treatment.[105] The State and prison officials made two assertions: 1. The court cannot question a professional medical opinion, and 2. the Eighth Amendment duty to provide medical care is limited to conditions that are life-threatening or will cause permanent disability.[106] The court in Thor found that while precedent before and after Cruzan acknowledged a right to forgo medical treatment, that right is qualified by four state interests: "preserving life, preventing suicide, maintaining the integrity of the medical profession, and protecting innocent third parties."[107] None of these interests applied to this case.[108]The court held that defendant was deliberately indifferent to plaintiff's complaints of pain and restricted capacity, and his obvious anxiety. This indifference resulted in the unnecessary infliction of pain, suffering, and anxiety upon plaintiff. Plaintiff has established the necessary elements of his claim and is entitled to prevail.[109]

We must examine the role of prison healthcare when discussing how aiding in dying and incarceration work. The standards as discussed above vary. The prison system cannot be wrangled into one category because the way that states proportion the resources for prisons differ. Regardless, the standard developed by the Eighth Amendment stays the same throughout.

Death with Dignity for Oregon Prisoners

[105] *Id*. ("An inguinal hernia occurs when there is a small opening in the lining of the abdominal wall, and part of the intestine pokes through this hole. A hernia is "easily reducible" if, when the peritoneum bulges through the outer abdominal wall, the patient can restore the hernia sac to its proper position without the assistance of a doctor by either pressing on the sac or laying down. An inguinal hernia can become acutely incarcerated. An acutely incarcerated hernia that is not treated within 6 to 8 hours may become strangulated (i.e., the intestinal loop protruding through the abdominal wall becomes constricted), a condition that may result in serious injury or even death. An acutely incarcerated hernia also causes severe pain. Even an unincarcerated hernia can cause pain and limit activity in some patients.")
[106] *Id*. at 1398.
[107] *Id*. at 382 (citing Bouvia v. Superior Court, 179 Cal. App. 3d. 1127, 1142 (Cal. Ct. App. 1986); Brophy v. New England Sinai Hosp., Inc., 497 N.E.2d 626, 634 (Mass. 1986); In re Conroy, 486 A.2d 1209, 1223 (N.J. 1985)).
[108] *Id*. at 384. Interestingly, the court in Thor stated, in dicta, that "the state has expressed a limited interest at best [in preventing suicide] since it imposes no criminal or civil sanction for intentional acts of self-destruction." Id. at 385.
[109] *Id*. at 1401.

Overcrowding is still an issue in Oregon prisons today.[110] This is an issue that does not seem to be relieved anytime soon.[111] Over 700 inmates were released earlier due to overcrowding.[112] When prisoners are released most of them lack the resources to be able to fend for themselves. Oregon is one such state that releases terminally ill prisoners from prison and lets someone else handle it, whether it be a hospital or family member.[113] Although Oregon State Penitentiary does have a hospice program for men,[114]this hospice care does not offer death with dignity services,[115] just palliative care for inmates who are suffering from serious illnesses.[116]

The cases above demonstrate that prisoners have a right to proper medical care, a liberty interest, and a right to privacy established in the Constitution. Implicit amongst these rights should be the right to die with dignity. Oregon should also inform prisoners who are suffering from terminal illnesses of the option to utilize the Dignity Act as an alternative end of life treatment. However, since inmates are a vulnerable population due to the lack of sufficient medical care there needs to be additional safeguards for them. For instance, Prisoners with mental health issues may not be the best candidates for death with dignity. Many prisoners enter prison with mental health issues and others develop mental health issues as a result of prison life. [117] Severe mental health disorders are more prevalent among the prison population versus the

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[110] Nina Mehlhaf, *Hundreds of inmates released in metro area due to overcrowding.* (2018). [https://www.kgw.com/article/news/investigations/hundreds-of-inmates-released-in-metro-area-due-to-overcrowding/283-517966521]
[111] *Id*.
[112] *Id*.
[113] B. Jaye Anno, Ph.D., C.C.H.P.–A. et al., U.S. Department of Justice, *Addressing the Needs of Elderly, Chronically Ill, and Terminally Ill Inmates* (2004).
[114] *Id*. at 38. They do have criteria for the hospice program.
[115] *Id.* at 39. The only criteria for receiving hospice care are that two practitioners must have determined that the inmate has less than a year to live and that the inmate elects to receive hospice services. The inmate's diagnosis, level of functioning, and type of crime are not considered.
[116] *Id.*
[117] Linda A. Teplin, *Psychiatric and Substance Abuse Disorders Among Male Urban Jail Detainees*, 84 Am. J. Pub. Health 290, 292 (1994) [hereinafter Teplin, Psychiatric and Substance Abuse Disorders].

general, non-incarcerated population.[118] Studies have shown that 7.2% of the jail population has a serious mental disorder.[119]Prolonged lengths of incarceration in correctional settings aggravate the mental and physical health of inmates with severe mental disorders even further and render both treatment and adjudication virtually indefinite.[120] This means that they will constantly be undergoing treatment until they die. This increases costs for the state institutions that could be avoided if inmates were given the option to end their life pursuant to the Dignity Act.

The Dignity Act already lays out the steps for prisoners to access life ending medication. Oregon's Dignity Act already has in place, a clause that allows physicians to refer a person to psychological or psychiatric counseling if they deem necessary.[121] Due to the lack of sufficient care in prison systems additional safeguards just need to be in place so that the fully informed decision that is required is actually one sufficient to qualify for the medication. There should be a mandatory counseling session for any prisoner choosing to access the Dignity Act.

Conclusion

Allowing the incarcerated to die with dignity will not only aid in overall prison healthcare but will also help to maintain the prison population. The prison system has not always been kind to those they must protect. Giving them the option to die with dignity will give them autonomy over their bodies as well as allowing for individuals who are facing terminal illnesses in prison to be able to end their life. This will also alleviate some of the issues that come with overcrowding, freeing up the prison population.

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[118] Ron Jemelka et al., *The Mentally Ill in Prisons*, 40 Hosp. & Community Psychiatry 481, 486 (1989).
[119] E. Fuller Torrey et al., *Criminalizing the Seriously Mentally Ill: The Abuse of Jails as Mental Hospitals* 13 (1992). The survey represented 41% of all U.S. jails and 60% of all jail inmates. The survey defined a serious mental illness as schizophrenia, manic-depressive illness, and related conditions. *Id*. at 14.
[120] Robert D. Miller & Jeffrey Metzner, *Psychiatric Stigma in Correctional Facilities*, 22 Bull. Am. Acad. Psychiatry L. 621, 626 (1994).
[121] Or. Rev. Stat. Ann. *§* 127.825 s.3.03.