

5-1-2014

# Simple Yet Serious: A Discussion Of The Obstacles To The Reasonable Administration Of End-Of-Life Care In United States Correctional Facilities

Christopher V. Raupers

Follow this and additional works at: [https://scholarship.shu.edu/student\\_scholarship](https://scholarship.shu.edu/student_scholarship)

---

## Recommended Citation

Raupers, Christopher V., "Simple Yet Serious: A Discussion Of The Obstacles To The Reasonable Administration Of End-Of-Life Care In United States Correctional Facilities" (2014). *Law School Student Scholarship*. 551.  
[https://scholarship.shu.edu/student\\_scholarship/551](https://scholarship.shu.edu/student_scholarship/551)

**SIMPLE YET SERIOUS:**  
**A DISCUSSION OF THE OBSTACLES TO THE REASONABLE ADMINISTRATION**  
**OF END-OF-LIFE CARE IN UNITED STATES CORRECTIONAL FACILITIES**

CHRISTOPHER VINCENT RAUPERS

**I. INTRODUCTION**

“Prisoners compose the segment of adult society with perhaps the least freedom of choice about the course of treatment for terminal illnesses and, ultimately, their own deaths.<sup>1</sup>” In this manner, one of the most revealing reflections of a society is way in which it meets the medical needs of prisoners. With standards of care ranging from those that border human rights violations to those that are hospitable; there is little global indicia of the extent to which a society is expected to ameliorate the suffering of those who are imprisoned. This writing focuses on an increasingly important and costly component of prison medical services: the quality of “end-of-life care.”

In this area of health care, the difficulties associated with weighing the costs and benefits of treating those that are already an economic and behavioral burden to the state are exacerbated in the case of end-of-life care. The aging of the inmate population,<sup>2</sup> longer sentences and higher rates of incarceration suggest that prisons have become a critical frontier for end-of-life care,

---

<sup>1</sup> Marjorie P. Russell, *Too Little, Too Late, Too Slow: Compassionate Release of Terminally Ill Prisoners-Is the Cure Worse Than the Disease?*, 3 WIDENER J. PUB. L. 799, 804 (1994).

<sup>2</sup> Timothy Curtin, *The Continuing Problem of America's Aging Prison Population and the Search for A Cost-Effective and Socially Acceptable Means of Addressing It*, 15 ELDER L.J. 473, 478 (2007).

particularly for poor, urban men and women.<sup>3</sup> It is also clear from scholarly data collections, accounts from prison officials and reports from concerned interest groups that the current system of end-of-life care administration must be tailored to meet the demands of an increasingly elderly prison population, coupled with rising prison health care costs. State and federal legislatures must work together to develop realistic sentencing guidelines, push for the adoption of compassionate release programs, and allow for inmate-operated hospice programs in order to more effectively administer end-of-life care to American inmates.

## **II. WHAT IS END-OF-LIFE CARE?**

An understanding of the practices and procedures comprising end-of-life care is essential to a determination of their appropriate administration. End-of-life care encompass a broad range of medical treatments and options aimed at lessening the suffering of terminally ill patients. This type of care can include access to advanced directive forms, the adoption of pain management regimens,<sup>4</sup> living space accommodations for additional comfort, therapy to combat mental and physical deterioration,<sup>5</sup> counseling of close family members, and spiritual guidance, among others. Unfortunately for prisoners, not all of these services may be available, affordable or deemed necessary by the clinical practice guidelines adopted in their particular correctional facility. The end-of-life care phase may last for weeks, months or years, depending on the individual and their particular terminal illness.

End-of-life care can also be very difficult to conceptualize because it is too frequently reduced to palliative care or hospice care, which represents an under-inclusive understanding of

---

<sup>3</sup> Nancy B. Mahon, *Introduction: Death and Dying Behind Bars - Cross-Cutting Themes and Policy Imperatives*, 27 J.L. MED. & ETHICS 213 (1999).

<sup>4</sup> Gina Castellano, *The Criminalization of Treating End of Life Patients with Risky Pain Medication and the Role of the Extreme Emergency Situation*, 76 FORDHAM L. REV. 203, 211 (2007).

<sup>5</sup> *Laube v. Campbell*, 333 F. Supp. 2d 1234, 1259 (M.D. Ala. 2004).

end-of-life care, which also seeks to provide care for family members outside of the immediate patient.

Palliative care is treatment administered to a patient with an illness that probably will take his life over a short, definite period of time, and simply intended to make the patient feel more comfortable. While nearly all end-of-life services are inherently satisfied by this definition, much palliative care would not be considered end-of-life care as there is no need that the patient be terminal, or that the illness even be capable of causing the patient to perish. Hospice care encompasses services provided to a terminally ill individual, such as nursing care, physician's services, short term in-patient care, and counseling.<sup>6</sup> This definition is very similar to what we have come to consider as being end-of-life care, but is sometimes improperly used as a synonym of end-of-life care.

In its "State-of-Science Conference Statement on Improving End-of-Life Care," the National Institutes of Health (NIH) stated that a precise definition of the interval referred to as "end-of-life" is not supported by available scientific evidence, as data demonstrates that the scientific community is not capable of accurately predicting an individual's time of death by any reasonable measure of certainty. The NIH did establish that evidence supports the definitional inclusion of "the presence of a chronic disease(s) or symptoms or functional impairments that persist but may also fluctuate" and "the symptoms or impairments resulting from the underlying irreversible disease that require formal (paid, professional) or informal (unpaid) care and can lead to death."<sup>7</sup>

Whatever confusion attributed to the conceptualization of end-of-life care is certainly not an issue regarding its cost. The Centers for Medicare and Medicaid Services estimate that more

---

<sup>6</sup> 42 U.S.C.A. § 1395x (West).

<sup>7</sup> *NIH State-of-the-Science Conference Statement on Improving End-of-Life Care*, 21 NIH CONSENSUS & STATE-OF-THE-SCIENCE STATEMENTS 1, 10 (2004).

than twenty-five percent of Medicare spending goes towards the five percent of beneficiaries that pass away each year.<sup>8</sup> This amounts to spending for persons in their last year of life that is six times greater than the cost for a survivor.<sup>9</sup> For example, in 2006 Medicare spent an average of \$38,975 per decedent compared to \$5,993 for other beneficiaries.<sup>10</sup>

### III. LEGAL FOUNDATIONS OF PRISONER ACCESS TO MEDICAL CARE

An understanding of the legal foundations of the American prisoner's right to medical care is important to a discussion of the proper administration of end-of-life care in the United States. Lawful incarceration brings about necessary withdrawals or limitations of many privileges and rights, and while the State has constitutional authority to deny a convicted felon those basic civil rights, such as the right to vote and to serve on jury, to a person convicted of felony, convicted prisoners do not forfeit all constitutional protections by reason of conviction and confinement.<sup>11</sup>

Inmates do not forfeit their constitutional rights upon imprisonment, as the United States Supreme Court's 1974 ruling in *Wolff v. McDonnell* declared that "a prisoner is not wholly stripped of constitutional protections when he is imprisoned for crime. There is no iron curtain drawn between the Constitution and the prisons of this country."<sup>12</sup>

Under the Eighth Amendment of the United States Constitution, correctional officials subject prisoners to cruel and unusual punishment prohibited by the 8<sup>th</sup> amendment if their acts or omissions are sufficiently harmful to evidence deliberate indifference to an inmate's serious

---

<sup>8</sup> Helen Adamopoulos, *The Cost and Quality Conundrum of American End-of-Life Care*, THE MEDICARE NEWSGROUP, June 3, 2013 at (2013), <http://www.medicarenewsgroup.com/context/understanding-medicare-blog/understanding-medicare-blog/2013/06/03/the-cost-and-quality-conundrum-of-american-end-of-life-care>; (Citing Gerald Riley & James Lubitz, *Long-term Trends in Medicare Payments in the Last Year of Life.*, 45 HEALTH SERVICES RES. 565, 565-576 (2010)).

<sup>9</sup> *Id.*

<sup>10</sup> *Id.*

<sup>11</sup> *Singletary v. Costello*, 665 So. 2d 1099, 1104 (Fla. Dist. Ct. App. 1996).

<sup>12</sup> *Wolff v. McDonnell*, 418 U.S. 539, 555 (1974).

medical need.<sup>13</sup> This requirement remains a necessity regardless of whether that medical care is administered by a government employee working in the prison or by a private medical worker under contract with the government.<sup>14</sup>

Some factors that the courts have identified in determining whether a "serious medical need" is at issue are "(1) whether a reasonable doctor or patient would perceive the medical need in question as important and worthy of comment or treatment; (2) whether the medical condition significantly affects daily activities; and (3) the existence of chronic and substantial pain."<sup>15</sup> Courts have also found a serious medical need is said to be present where the failure to treat a prisoner's condition could result in further significant injury or the unnecessary and wanton infliction of pain.<sup>16</sup> Such a condition does not even have to be life threatening in order to constitute as a serious medical need, as fact that a condition does not produce objective symptoms does not entitle the medical staff to ignore it.<sup>17</sup>

Even if a correctional facility fails to undertake a particular medical treatment with potentially devastating results to the inmate, there are financial limits to the facility's duties as well, depending on the jurisdiction. In the first circuit, although an inmate may deserve adequate medical care, he or she cannot insist that their institutional host provide the most sophisticated care that money can buy.<sup>18</sup> This distinction is of the utmost importance to terminally ill inmates within that jurisdiction because end-of-life treatments are extremely costly.

Similar to medical care providers outside of a correctional setting, prison medical facilities must adopt clinical practice guidelines. Practice guidelines are defined as

---

<sup>13</sup> Estelle v. Gamble, 97 S.Ct. 285, 292 (1976).

<sup>14</sup> 42 U.S.C.A. § 1983 (West).

<sup>15</sup> Brock v. Wright, 315 F.3d 158, 162 (2d Cir. 2003).

<sup>16</sup> Clement v. Gomez, 298 F.3d 898, 904 (9th Cir. 2002).

<sup>17</sup> Greeno v. Daley, 414 F.3d 645, 655 (7th Cir. 2005).

<sup>18</sup> United States v. DeCologero, 821 F.2d 39, 42 (1st Cir. 1987).

“systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.<sup>19</sup>” These guidelines are meant to mirror modern healthcare standards, as the American Bar Association’s “Standard’s on the Treatment of Prisoners” relates that “Hospitals and infirmaries operated by or within correctional facilities should meet the licensing standards applicable to similar, non-prison hospitals or infirmaries.<sup>20</sup>” The “Bureau of Prisons' Program Statement” regarding staff and inmate health services and clinical practice guidelines are internal statements of Bureau of Prison policies that can be altered at will, and do not create entitlements enforceable under the Administrative Procedure Act.<sup>21</sup>

The thousands of available Clinical practice guidelines are not standardized by jurisdiction or created by one organization, but “the field is dominated by standards formulated by 3 organizations: the American Public Health Association (APHA); the National Commission on Correctional Health Care (NCCHC), which drew on the work of the APHA and the American Medical Association; and the American Correctional Association (ACA).<sup>22</sup>”

If a prison’s clinical practice guidelines, as chosen by the managed care provider, do not allow for an end-of-life treatment that an inmate requests, there are several options available. First, the prisoner must exhaust the series of appeals and hearings that are available in their particular state or federal prison system, by pleading their case for treatment before an administrative body within their correctional facility. After exhausting the various administrative options, an inmate may then file a claim for *habeus corpus* relief, under the theory established in

---

<sup>19</sup> Jeremy Grimshaw & Ian Russel, Achieving Health Gain Through Clinical Guidelines. I: Developing Scientifically Valid Guidelines, 2 Quality in Health Care 243 (1993).

<sup>20</sup> ABA STANDARDS FOR CRIMINAL JUSTICE: TREATMENT OF PRISONERS 165 (3rd ed. 2011).

<sup>21</sup> Robinson v. Sherrod, 631 F.3d 839, 843 (7th Cir. 2011).

<sup>22</sup> Marc F. Stern, *Patient Safety: Moving the Bar in Prison Health Care Standards*, 100 AM. J. OF PUB. HEALTH 2103, 2103 (2010).

*Estelle* that their prison's managed care provider was deliberately indifferent to a serious medical need in denying the treatment requested by the prisoner.<sup>23</sup>

*Habeas corpus* actions were traditionally used to review the lawfulness of a person's imprisonment, but in modern times, state *habeas corpus* actions can be used to review the legality of prison conditions, even if the person who is complaining about the conditions is not challenging the validity of his or her underlying criminal or civil commitment.<sup>24</sup> These claims can be based on any rights guaranteed by the federal or state constitutions, statutes or regulations. Prisoners can also use state habeas corpus to seek proper health care.<sup>25</sup>

In regards to prisoner autonomy, "the right to refuse medical treatment is squarely grounded in the act of consent: everyone, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment."<sup>26</sup> This is extremely important to inmates facing end-of-life care decisions, because so long as they are shown to have capacity they may remain in control of the deeply personal medical decisions that often accompany terminal illness.

Prisoners have reduced rights in regards to notice of rights of self-determination. The baseline requirements for free citizens under government funded health care such as Medicare and Medicaid are elevated from what inmates can expect. For example, under the *Patient Self-Determination Act*, a citizen's doctor must provide written information to each such individual concerning "an individual's rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept

---

<sup>23</sup> *Gamble*, 429 U.S. 97, 104 (1976).

<sup>24</sup> Donald Specter, *State Habeas Corpus Procedure: A Manual for California Prisoners* 1, 2 (Prison Law Office 2008), <http://www.prisonlaw.com/pdfs/STATEHABEAS2008.pdf>.

<sup>25</sup> *Id.*

<sup>26</sup> *Blouin ex rel. Estate of Pouliot v. Spitzer*, 356 F.3d 348, 360 (2d Cir. 2004).

or refuse medical or surgical treatment and the right to formulate advance directives.<sup>27</sup>” Incarcerated inmates enjoy comparatively sparse rights relating to such notice.

One study of health care providers at the University of Connecticut and the Connecticut Department of Corrections assessing knowledge of, prevalence of, and procedures for completion of advance directives within a correctional setting, researchers found that fewer than 1% of inmates have advance directive discussions and even less complete an advance directive form.<sup>28</sup> The challenge of consenting in the prison system generates a set of unique problems, as prison settings have been viewed as “the most coercive environment in which a patient can be treated.<sup>29</sup>” Some health professionals believe that the environment in which prisoner’s advance directives are signed can impose significant pressures on the inmate, perhaps from prison staff or other inmates.

#### **IV. PRISONER ACCESS TO MEDICAL SERVICES**

The majority of prisons in the United States currently provide their medical services through the use of outsourced, for-profit corporations. After the Supreme Court’s 1976 holding in *Estelle v. Gamble* validated a prisoner’s right to humane confinement, indifference to medical needs rose to the level of cruel and unusual punishment prohibited by the Eighth Amendment,<sup>30</sup> and privatization in prison medical services grew rapidly.<sup>31</sup> This is because “*Estelle* was instrumental in challenging the old tradition of the ‘hands-off’ doctrine, in which courts deferred to prison administrators’ internal actions and decisions within prison facilities.<sup>32</sup>”

---

<sup>27</sup> 42 U.S.C.A. § 1395cc(e)(A)(i) (West).

<sup>28</sup> Susan Franzel Levine, *Improving End-of-life Care of Prisoners*, 11 J. OF CORRECTIONAL HEALTH CARE 317 (2011).

<sup>29</sup> Thomas DL & Watson JM, *Advance Directives in a Correctional Setting*, 4 PSYCHOLOGY, PUB. POL’Y & L. 878, (1998).

<sup>30</sup> *Gamble*, 429 U.S. 97, 103 (1976).

<sup>31</sup> Brittany Bondurant, *The Privatization of Prisons and Prisoner Healthcare: Addressing the Extent of Prisoners’ Right to Healthcare*, 39 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 407, 416 (2013).

<sup>32</sup> Michael Cameron Friedman, *Cruel and Unusual Punishment in the Provision of Prison Medical Care: Challenging the Deliberate Indifference Standard*, 45 VAND. L. REV. 921, 928 (1992).

After *Estelle*, “the number of prisoners and the cost of healthcare both skyrocketed, forcing the prison systems to seek out alternatives to excessive healthcare costs,” making health care the most common outsourced prison service.<sup>33</sup> This rise in the number of inmates and health care costs which contributed to the rise in outsourced private medical programs were aided by the fact that many prisons that did not outsource their health care services faced significant challenges in hiring quality medical personnel. This is because correctional facilities are not attractive workplaces to many doctors due to the negative social stigma of working with convicts, difficulty establishing a professional reputation, and generally lower pay scale than that of doctors in the same field of medicine in the outside community.<sup>34</sup>

In the current correctional setting, privatized health care services are best described as a managed care system. “‘Managed care’ is an administrative and medical treatment practice motivated by the desire or need to improve the quality, efficiency, and cost effectiveness of healthcare.<sup>35</sup>” The three major components of an outsourced managed healthcare system are the managed care organization, the healthcare provider, and the health plan patient. While the providers and patients are simply the doctors and prisoners at play, the managed care organization is usually a for-profit organization that balances low healthcare costs with expectations of quality prison healthcare. This creates an inherently problematic conflict of interest where managed care organizations have an incentive to minimize high-cost treatments, such as specialist visits, adequate testing, or emergency room care, while still providing quality care to the prisoners.<sup>36</sup>

---

<sup>33</sup> Doug Jones, *A Cruel and Unusual System: The Inherent Problems of the Practice of Outsourcing Health Care of Prisons and Jails*, 27 CHICANA/O-LATINA/O L. REV. 179, 181 (2008).

<sup>34</sup> Friedman, *supra* note 32, at 933.

<sup>35</sup> Bondurant, *supra* note 31, at 418.

<sup>36</sup> Ira P. Robbins, *Managed Health Care in Prisons As Cruel and Unusual Punishment*, 90 J. CRIM. L. & CRIMINOLOGY 195, 214 (1999).

A relatively small number of privatized healthcare companies meet the needs of America's correctional facilities.<sup>37</sup> One particularly massive industrial player is Corizon Healthcare. This company is the product of a merger which combined Prison Health Services, which had fifty-seven contracts in 150 jails over nineteen states, and Correctional Medical Services which served 250,000 inmates in nineteen states.<sup>38</sup> Corizon now provides healthcare to approximately 271,100 inmates in twenty-nine states at over 285 correctional facilities across the country.<sup>39</sup>

Much like their in-house predecessors and those prison-funded health care providers that have survived, private health care providers are held liable for constitutional violations against prisoners under their care.<sup>40</sup> In this manner, a managed care organization under contract with a municipality to provide health care services to inmates could be found liable for unconstitutional care.

## **V. CHANGING PRISONER DEMOGRAPHICS AFFECTING END-OF-LIFE CARE**

Another issue that complicates the reasonable administration of end-of-life services for incarcerated inmates is the changing demographics of American prisoners. It is particularly troubling that aging men and women are the most rapidly growing group in US prisons.<sup>41</sup> The average age of a prisoner in the United States has grown for years as a result of numerous factors such as the increase in the average age of American citizens, higher arrest rates, mandatory minimum sentences, and habitual offender laws. The rising average age of prisoners contributes

---

<sup>37</sup> Lynette Holloway, *The Root: Inmate Healthcare Another Kind of Prison*, NPR (June 8, 2011), <http://www.npr.org/2011/06/08/137055836/the-root-inmate-health-care-another-kind-of-prison>.

<sup>38</sup> Bondurant, *supra* note 31, at 419.

<sup>39</sup> *Id* at 419.

<sup>40</sup> Robbins, *supra* note 36, at 412.

<sup>41</sup> *Number of Aging Prisoners Soaring: Corrections Officials Ill-Prepared to Run Geriatric Facilities* (Human Rights Watch 2012), <http://www.hrw.org/news/2012/01/26/us-number-aging-prisoners-soaring>.

directly to an increase in need for end-of-life care because death rates consistently climb as individuals progresses beyond the age of twenty-five.<sup>42</sup>

All known data suggests that the older population of the United States has seen a marked rise from previous generations. In the most recent census performed in 2010, more people were 65 years and over than in any previous census, with 40,300,000 Americans at or above the age of sixty-five years old.<sup>43</sup> Also, between the years 2000 and 2010, the United States population of individuals aged 65 and over increased at a faster rate than the total population, growing at a rate of just over fifteen percent.<sup>44</sup> This marks an increase of 5,300,000 over the Census in 2000, when this population numbered 35,000,000.

The percentage of the population 65 years and over also increased from 2000 to 2010. In 2010, the older population represented 13.0 percent of the total population, an increase from 12.4 percent found in 2000. When compared with the number and percentage of older Americans in the past, the number of individuals 65 years and over has notably increased over time.

The rise in the average age of Americans can be reasonably attributed to an increase in the age, and thus end-of-life medical needs for incarcerated Americans as well. According to the Bureau of Justice Statistics under the United States Justice Department, the United States prison population has quintupled since the year nineteen-eighty, with an increase from roughly 319,000 to 1,571,013 in the onset of 2013.<sup>45</sup> Unfortunately, this gain that is only accompanied by a mere thirty-six percent increase in population through 2010.<sup>46</sup>

---

<sup>42</sup> Donna L. Hoyert & Jiaquan Xu, *Deaths: Preliminary Data for 2011*, 61 NAT'L VITAL STAT. REP. 1 (2012).

<sup>43</sup> U.S. Department of Commerce Economics and Statistics Administration: *The Older Population: 2010: Census Briefs 1, 1-12* (Bureau of the Census 2011), <http://www.census.gov/prod/cen2010/briefs/c2010br-09.pdf>.

<sup>44</sup> *Id.*

<sup>45</sup> John Tierney, *Prison and the Poverty Trap*, The New York Times, Feb. 18, 2013, <http://www.nytimes.com/2013/02/19/science/long-prison-terms-eyed-as-contributing-to-poverty.html>.

<sup>46</sup> Bureau of the Census, *supra* note 43.

Although elderly persons make up a small proportion of initial offenders in Federal and State prisons, “current crime trends suggest an aging offender population.<sup>47</sup>” The number of prisoners over the age of fifty is on the rise due to mandatory minimum sentences, three strikes laws, higher arrest rates, and an increased average age for Americans in general. In accordance with this, the number of sentenced state and federal prisoners age 65 or older grew at 94 times the rate of the overall prison population between 2007 and 2010.<sup>48</sup> The number of sentenced prisoners age 55 or older also grew at six times the rate of the overall prison population between 1995 and 2010.<sup>49</sup>

While an individual is normally considered a senior citizen at the age of sixty-five, an inmate is generally considered elderly at the age of fifty.<sup>50</sup> Correctional officials have suggested that the typical inmate in his fifties has a physical appearance of at least 10 years older.<sup>51</sup> In addition, the declining health of many inmates contributes to them being “elderly” before their time.<sup>52</sup> Under this industry definition, an even larger number of incarcerated persons are currently approaching old age, posing a large financial burden to the prison system. For example, the confinement of inmates over 55 costs state and federal governments a mammoth \$2.1 billion annually.<sup>53</sup> A 2005 report by California Legislative Analyst's Office similarly relates that elderly inmates cost two to three times more to care for than do younger ones.<sup>54</sup>

---

<sup>47</sup> Mike Males & Dan Macallair, *Striking Out: The Failure of California's "Three Strikes and You're Out" Law*, 11 STAN. L. & POL'Y REV. 65 (1999).

<sup>48</sup> *Old Behind Bars: The Aging Prison Population in the United States* 4, 6 (Human Rights Watch 2012), [http://www.hrw.org/sites/default/files/reports/usprisons0112webwcover\\_0.pdf](http://www.hrw.org/sites/default/files/reports/usprisons0112webwcover_0.pdf).

<sup>49</sup> *Id.* At 7.

<sup>50</sup> Ronald H. Aday, Ph.D., *Golden Years Behind Bars: Special Programs and Facilities for Elderly Inmates*, 58 FED. PROBATION 47, 48 (1994).

<sup>51</sup> *Id.*

<sup>52</sup> *Id.*

<sup>53</sup> *Vulnerable Older Adults: Health Care Needs and Interventions* 1-304 (Patricia M. Burbank ed., 1st ed. Springer Publ'g 2006).

<sup>54</sup> Brian Brown, Greg Jolivet &, *A Primer: Three Strikes - the Impact After More Than a Decade* (Cal. Legislative Analysts Office 2005), [http://www.lao.ca.gov/2005/3\\_strikes/3\\_strikes\\_102005.htm](http://www.lao.ca.gov/2005/3_strikes/3_strikes_102005.htm).

Nearly 45 percent of the federal prison population is over the age of 51, and the number of prisoners older than forty-one grew by 750% between 1991 and 2011.<sup>55</sup> These substantial changes in the age of prisoners have contributed to a dramatic increase in the need for end-of-life medical services for these aging prisoners, some of which will inevitably require end-of-life care.

Longer prison sentences brought about by the switch from an indeterminate sentencing model to a determinate sentencing model are another major factor which drives up the number of elderly inmates in America. Modern federal sentencing guidelines under the determinate sentencing system result in longer sentences and a greater proportion of defendants sent to prison.<sup>56</sup>

This paradigm shift resulted in a rapid expansion of both the prison population and the percentage of long-term incarcerated inmates.<sup>57</sup> Currently, 9.6 percent of state prisoners are serving a life sentence, and an additional 11.2 percent have sentences longer than twenty years.<sup>58</sup> In response to this change in sentencing models, prisons were forced to terminate many rehabilitation programs and special programs in favor of a “warehousing approach” to meet the sudden influx of prisoners.<sup>59</sup>

The growth in prevalence of “habitual offender laws,” otherwise known as “three strikes laws” is yet another significant catalyst to modern increases in prisoner sentence length and age. These statutes have the effect of forcing state courts to impose harsher sentences on individuals who are convicted of three or more serious criminal offenses. For example, qualifying crimes in

---

<sup>55</sup> Jonathan Turley, *Testimony on Prison Reform and Older Prisoners before the House Judiciary Committee* (December 6, 2007) <http://jonathanturley.org/2007/12/06/testimony-on-prisoner-reform-and-older-prisoners-before-the-house-judiciary-committee/>.

<sup>56</sup> *Id.*

<sup>57</sup> *Id.*

<sup>58</sup> *Number of Aging Prisoners Soaring: Corrections Officials Ill-Prepared to Run Geriatric Facilities* (Human Rights Watch 2012), <http://www.hrw.org/news/2012/01/26/us-number-aging-prisoners-soaring>.

<sup>59</sup> Turley, *supra* note 55.

California are murder, rape, robbery, aggravated assault, lewd acts with a child, kidnapping, arson, bombing, providing hard drugs to a minor, and residential burglary with a weapon; as would be the case in California.<sup>60</sup>

Federal courts, as well as twenty-seven states have some form of habitual offender law to the extent that a life sentence without parole is mandatory upon conviction of at least one specified offense.<sup>61</sup> This change in state and federal sentencing law has a major effect on the number of elderly prisoners in need of prison health services.

An understanding of these changing demographics and their underlying catalysts is essential to a determination of how and why the demand for end-of-life care will continue to grow in United States correctional facilities. If anything can be gleaned from these changes in prison demographics in regards to long term structural preparations, it is that regardless of the legislatures plans to deal with the growing number of elderly prisoners, “prison systems will have to invest in an even greater number of specialized facilities for aging inmates.”<sup>62</sup>

## **VI. RECURRING CHARACTERISTICS OF END-OF-LIFE CARE FOR PRISONERS**

Certain end-of-life care issues appear to be universal across American correctional facilities. For example, concerns about drug abuse regularly diminish efforts to provide adequate pain management and symptom control,<sup>63</sup> fear of 8<sup>th</sup> amendment litigation often incentivizes aggressive treatment even when not elected,<sup>64</sup> and treatment plans are frustrated by crowding, issues of inmate classification and budgetary concerns<sup>65</sup>.

---

<sup>60</sup> Cal. Penal Code § 667.5(c) (West 1998).

<sup>61</sup> Ashley Nellis, *Throwing Away the Key: The Expansion of Life Without Parole Sentences in the United States*, 23 FED. SENT'G REP. 27, 28 (2010).

<sup>62</sup> Curtin, *supra* note 2, at 478.

<sup>63</sup> Margaret Ratcliff, 2 *Dying Inside the Walls: Innovations in End-of-Life Care*, AN INT'L J. OF LEADERS IN END-OF-LIFE CARE (2000), <http://www2.edc.org/lastacts/archives/archivesmay00/editorial.asp#7>.

<sup>64</sup> *Id.*

<sup>65</sup> *Id.*

The use of syringes for the delivery of medicines and narcotic pain relievers is a critical issue in the administration of end-of-life services because the presence of these syringes brings about a serious risk that incarcerated patients will allow their medical device to double as a means of intravenous drug, a deadly weapon, or a tattoo gun.<sup>66</sup> This forces increased regulation of all syringes in the facility, and in some cases, monthly inventory of such items to ensure that inmates have not stolen them for other, non-medical uses.

On the other end of the spectrum, a lack of available needles in a correctional medical setting can also lead to undesirable medical outcomes. This was once the case, when a New Jersey physician was charged with twelve counts of involuntary manslaughter after accidentally causing the death of fifteen patients by using improperly sanitized and re-used needles<sup>67</sup>.

In regards to the fear of litigation bringing about over-aggressive treatments, this is also a valid concern regarding the administration of end-of-life correctional care. With the sheer number of Eighth Amendment lawsuits for insufficient medical treatment, doctors have an incentive to be able to say that they pursued any and all avenues to a better outcome; regardless of whether those avenues were initially warranted under the circumstances of the patient's infirmity.

The recurring issues shared by end-of-life correctional medical providers across the country are examined in "the GRACE Project." This collaboration between correctional and hospice organizations, led by Volunteers of America, collected information on formal end-of-life care programs in the Federal Bureau of Prisons and 14 state departments of corrections in an effort to better understand the intricacies of an ever-growing need for end-of-life correctional

---

<sup>66</sup> Kari Larsen, *Deliberately Indifferent: Government Response to HIV in U.S. Prisons*, 24 J. CONTEMP. HEALTH L. & POL'Y 251, 260 (2008).

<sup>67</sup> *State v. Weiner*, 41 A.2d. 21, 22, (N.J. 1963).

medical care.<sup>68</sup> Throughout its rigorous investigation, the GRACE Project identified various recurring issues for prison end-of-life care programs. The most challenging recurring issues that were identified were pain and symptom management, involvement and visitation by the inmate families, difficulties associated with staff training, the isolation of inmates, the involvement of volunteers, and prisoner attitudes.<sup>69</sup>

## **VII. ISSUES OF AUTONOMY IN END-OF-LIFE PRISONER CARE**

Questions of autonomy are increasingly relevant to prisoner decisions regarding end-of-life care, as those inmates who are terminally ill have an inherent interest in choosing whether or not they wish to pursue an end-of-life treatment option that is available to them. This issue continues to grow in importance, as the number of inmates die while incarcerated is rising. In its Deaths in Custody Reporting Program, The Bureau of Justice Statistics reinforced this assertion, announcing that the number of deaths in state prisons rose from 2,877 to 3,452 between 2001 and 2008; a twenty percent increase.<sup>70</sup>

“Individuals who are subject to criminal confinement are by definition not free to make choices for themselves. Yet some decisions are so fundamental and important to human existence that even an inmate is, or should be, allowed some degree of personal autonomy. Determining the medical treatment an individual should receive is one such decision.”<sup>71</sup>

In some instances, terminally ill inmates have more autonomous choice regarding end-of-life medical care than one would think. For example, the Supreme Court of the United States has

---

<sup>68</sup> Elizabeth Craig, Margaret Ratcliff &, *The GRACE Project: Guiding End-of-Life Care in Corrections 1998–2001*, 7 J. OF PALLIATIVE MED. 373, (2004).

<sup>69</sup> *Id.*

<sup>70</sup> Margaret E. Noonan & E. Anne Carson, *Prison and Jail Deaths in Custody, 2000-2009 - Statistical Tables* (U.S. Dep't of Justice, Bureau of Justice Statistics 2011), <http://bjs.gov/content/pub/pdf/pjdc0009st.pdf>.

<sup>71</sup> Christopher Quinn, *The Right to Refuse Medical Treatment or to Direct the Course of Medical Treatment: Where Should Inmate Autonomy Begin and End?*, 35 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 453 (2009).

determined that under the presumption that the right to self-determination is of major importance, incarcerated persons have a due process right to refuse medical treatment.<sup>72</sup>

In *Thor v. Superior Court*, a quadriplegic California inmate who had shattering his cervical vertebrae in a fall, fought an injunction brought by his physician which would allow for the inmate to be fed and medicated via surgical tube against his wishes. After finding that the prisoner was of sound mind, the court ruled that once a competent, informed adult patient has declined further medical intervention, a physician's duty to provide such care ceases.<sup>73</sup>

By holding that a competent, informed adult, in the exercise of self-determination and control of bodily integrity, has the right to direct the withholding or withdrawal of life-sustaining medical treatment, even at the risk of death, *Thor* is of primary importance on the issue of prisoner autonomy at end-of-life. In upholding the patient's fundamental right of self-determination in medical decisions, the court looked to balance the right of an inmate to self-determination in regards to medical care against California's penal code, which relates that a prisoner may ... be deprived of such rights ... as is necessary in order to provide for the reasonable security of the institution in which he is confined and for the reasonable protection of the public.<sup>74</sup> In balancing these concerns, the court reasoned that even though a custodial environment demands administrative control to curtail the effect of disruptive conduct, the need for denial must be demonstrably "reasonable" and "necessary," not a matter of conjecture.<sup>75</sup> In this instance, there was no reasonable or necessary need to deny the prisoner's requested course of treatment.

---

<sup>72</sup> *Washington v. Harper*, 494 U.S. 210 (1990).

<sup>73</sup> *Thor v. Superior Court*, 5 Cal. 4th 725, 734 (Cal. Super. 1993).

<sup>74</sup> Cal. Penal Code § 2600 (West).

<sup>75</sup> *Thor supra* note 73, at 744.

In dealing with these tumultuous scenarios, some courts have come to use an analysis, in which four different state interests must be considered and balanced against the individual's right to refuse medical treatment.<sup>76</sup> These interests include “(1) the preservation of life; (2) the protection of the interests of innocent third parties; (3) the prevention of suicide; and (4) the maintenance of the ethical integrity of the medical profession.<sup>77</sup>”

In *Commission of Correction v. Myers*, The court the court used a similar balancing approach in upholding the authority of the Commissioner of Correction and the Department of Public Health to compel an unconsenting, competent adult prisoner to submit to medications and to hemodialysis, when such measures are reasonably necessary to save his life.” After weighing the relevant interests of the state and the individual, this court restricted the inmate's ability to refuse dialysis.

By applying the state interest factors, the court concluded that although individuals have a constitutional right to privacy, arising from a high regard for human dignity and self-determination, and this right may be asserted to prevent unwanted infringements of bodily integrity, this right is not absolute and may be enforced only in appropriate circumstances; what set of circumstances will be deemed “appropriate” for the exercise of this privacy right depends on the proper balancing of applicable state and individual interests.<sup>78</sup> The *Myers* court reasoned that “although the fact of defendant's incarceration did not per se divest him of his right of privacy and interest in bodily integrity, it did impose limitations on those constitutional rights in terms of the state interests unique to the prison context.<sup>79</sup>”

## **VIII. COMPASSIONATE RELEASE AND END-OF-LIFE CARE**

---

<sup>76</sup> Quinn *supra* note 71, at 453.

<sup>77</sup> *Id.* at 459.

<sup>78</sup> *Id.*

<sup>79</sup> *Comm'r of Correction v. Myers*, 379 N.E.2d 255, 264 (Mass. 1979)

One response to the growing cost of end-of-life care in American prisons is the compassionate release program. These controversial programs which are applied in both federal and state prisons, grant inmates an early release from incarceration when the prisoner's circumstances are deemed extraordinary and compelling; a distinction often reserved for the terminally ill.

The aim of these programs is primarily to alleviate the negative economic impact that terminally ill inmates pose to the prison system, as well as the government budget at large. By qualifying terminally ill prisoners for compassionate release, prisons in the United States can effectively shift the elevated economic burden associated with end-of-life care from the "health" budget function to the "administration of justice" budget function.<sup>80</sup>

Compassionate release programs are authorized under federal statute, demanding that the Director of the Bureau of Prisons secure compassionate release where an inmate's circumstances are deemed "extraordinary and compelling,"<sup>81</sup> although this statute is largely "a tool for the Bureau of Prisons to use and not an alternative available to the prisoner himself."<sup>82</sup> In the comments for its Sentencing Guidelines for November of 2007, the United States Sentencing Commission first defined 'extraordinary and compelling' circumstances as including terminal illness, debilitating physical conditions that prevent inmate self-care, and the death or incapacitation of the only family member able to care for a minor child.<sup>83</sup> The Bureau of Prisons has largely ignored the broader statutory language as well as its own regulations by limiting

---

<sup>80</sup> Christopher Wlezien, Stuart N. Soroka & , *Measures and Models of Budgetary Policy*, 31 THE POL'Y STUD. J. 273, 277 (2003).

<sup>81</sup> 18 U.S.C.A. § 3582 (West).

<sup>82</sup> Russel, *supra* note 1, at 816.

<sup>83</sup> William W. Berry III, *Extraordinary and Compelling: A Re-Examination of the Justifications for Compassionate Release*, 68 MD. L. REV. 850, 853 (2009).

application of compassionate release to prisoners who are terminally ill,<sup>84</sup> which federal statute defines as an individual with “a medical prognosis that the individual's life expectancy is 6 months or less.”<sup>85</sup>

In its 2005 “Program Statement 6010.02” on health services administration, the Federal Bureau of Prisons mandated several guidelines to be used in the application of compassionate release programs to federal correctional facilities.<sup>86</sup> These guidelines require that information regarding a request for sentence reduction under the doctrine of compassionate release must be gathered from several departments within the institution.<sup>87</sup> For example, the Health Services Unit must provide a comprehensive medical summary including an estimate of life expectancy or a statement that life expectancy is indeterminate, the level or degree of functionality; all relevant test results, all relevant consultations, referral reports or opinions from which the medical assessment was made, and the level of self-participation in activities of daily living.<sup>88</sup> Other information regarding the inmates present condition that the report cites as potentially helpful include whether they are in a hospice program, the type and frequency of pain medication required to treat the inmate, weight loss, frequency of hospitalization, mental status, mobility status, and requirement for supplemental oxygen.<sup>89</sup>

Medical eligibility criteria for compassionate release programs used in federal and state institutions can be divided into two approaches.<sup>90</sup> One model, such as that used in New York, asks both whether the patient is terminally ill as well as to what degree the patient is disabled or

---

<sup>84</sup> *Id.*

<sup>85</sup> 42 U.S.C.A. § 1395x(dd)(2)(3A) (West).

<sup>86</sup> Harley G. Lappin, *Program Statement 6010.02* 1, 1-38 (Fed. Bureau of Prisons 2005), [http://www.bop.gov/policy/progstat/6010\\_002.pdf](http://www.bop.gov/policy/progstat/6010_002.pdf).

<sup>87</sup> *Id.* At 22.

<sup>88</sup> *Id.* At 4.

<sup>89</sup> *Id.* At 23.

<sup>90</sup> John A. Beck, *Compassionate Release from New York State Prisons: Why Are so Few Getting Out?*, 27 THE J. OF LAW, MED. & ETHICS 216, 223 (1999).

incapacitated due to that illness.<sup>91</sup> A clear purpose of these criteria is to minimize the risk associated with releasing an inmate and to delay release until the very last stages of a patient's illness.<sup>92</sup> A second model focuses on the life expectancy of the inmate, emphasizing survivability.<sup>93</sup> This model is primarily concerned with whether it is safe and appropriate to release the inmate.<sup>94</sup>

Among the states, the number of jurisdictions providing early release to inmates due to health status or advanced age continues to grow. While not identical to compassionate release under federal law, forty states have some type of medical release program in their jurisdiction. For example, in the state of New York, the eligibility requirements for what has been termed “medical parole” are overly restrictive, disqualifying some terminally ill inmates from the program or deferring their eligibility until it is nearly impossible to complete the review process before they die.<sup>95</sup>

The New York Medical Parole Law states that the state’s Board of Parole:

“shall have the power to release on medical parole any inmate serving an indeterminate or determinate sentence of imprisonment who, pursuant to subdivision two of this section, has been certified to be suffering from a significant and permanent non-terminal condition, disease or syndrome that has rendered the inmate so physically or cognitively debilitated or incapacitated as to create a reasonable probability that he or she does not present any danger to society.”<sup>96</sup>

---

<sup>91</sup> *Id.* at 223.

<sup>92</sup> *Id.* at 225.

<sup>93</sup> *Id.* at 225.

<sup>94</sup> *Id.* at 225.

<sup>95</sup> *Id.* at 216.

<sup>96</sup> N.Y. Exec. Law § 259-s (McKinney)

In its first six years of existence, New York's Medical Parole Law resulted in the parole of 215 inmates since the law's enactment, but paroling such a small number of terminally ill inmates due to their medical conditions, when compared with the 2,000 inmates that died in custody during the same time period, suggests that obstacles are impeding the program's effectiveness.<sup>97</sup>

The upside of compassionate release is twofold; terminally ill prisoners get the chance to live out the rest of their lives with increased dignity outside of prison walls and the correctional medical budget is reduced to the extent that it would have been forced to care for those terminally ill inmates would they not have been released.

Those in favor of compassionate release have enumerated various reasons supporting their position, such as overcrowding due to record prison population levels,<sup>98</sup> the increasingly high cost of housing elderly and ill prisoners,<sup>99</sup> the belief that terminally ill prisoners no longer present a threat to society,<sup>100</sup> the fact that most if not all prisons are not designed as long-term healthcare facilities,<sup>101</sup> and the fact that by keeping these inmates incarcerated, the state has to provide for their medical care.<sup>102</sup> Many prisoner advocates acknowledge “that the cost of caring for a terminally ill person at home is about half that of treating them while they are incarcerated.<sup>103</sup>” In this manner, “Once prisoners are released, their medical bills are shared by the federal and state governments.<sup>104</sup>”

Proponents of compassionate release programs are quick to point out that the current prison system maintains low-risk, high-cost inmates by refusing to release terminally ill

---

<sup>97</sup> *Id.*

<sup>98</sup> Jason S. Ornduff, *Releasing the Elderly Inmate: A Solution to Prison Overcrowding*, 4 *ELDER L.J.* 173, 174 (1996)

<sup>99</sup> *Id.* at 175.

<sup>100</sup> Susan Sward, *Groups Decry Veto of Bill to Hasten Releases of Dying Inmates / Evaluation System Works As It Is, Governor Says*, *S.F. Chron.*, Oct. 19, 1995.

<sup>101</sup> *Compassion in the Prisons: The Dying Should Be Freed, for Fiscal As Well As Humane Reasons*, *L.A. Times*, Aug. 9, 1996, at B8.

<sup>102</sup> Gamble, 429 U.S. 97, 103 (1977).

<sup>103</sup> Cynthia Hubert, *Bill Aims to Ease Release of Terminally Ill Inmates*, *Sacramento Bee*, Apr. 27, 1996, at A1.

<sup>104</sup> See *id.* at A1.

prisoners, and not leaving room for younger, more dangerous offenders. Those that support compassionate release programs also allege that current laws in place in most jurisdictions take too long to process an inmate for discharge.<sup>105</sup>

Even with the rise of compassionate release programs and many individuals and lobbyists, such as the American Civil Liberties Union, calling for such programs, compassionate release programs that are already in existence are infrequently used due to bureaucratic and social obstacles.

Opponents of compassionate release of terminally ill inmates frequently argue that such programs are not tough enough on crime,<sup>106</sup> to the extent that illness should not warrant the release of imprisoned convicts.<sup>107</sup> Some legislatures oppose compassionate release legislation under the belief that it would render the current system of dealing with terminally ill prisoners more cumbersome and would unlikely result in the release of more terminally ill prisoners.<sup>108</sup>

Many of those who are opposed to compassionate release take issue with the release of inmates who are terminally ill as a result of Acquired Immune Deficiency Syndrome (AIDS). These individuals argue that AIDS is a disease that is difficult to predict,<sup>109</sup> and that doctors have difficulty accurately determining how long an infected person actually has to live.<sup>110</sup> Some opponents of compassionate release for inmates with terminal AIDS have even suggested that such legislation poses a threat to the public by allowing for the spread of the illness.<sup>111</sup>

---

<sup>105</sup> Tracy Dell'Angela, *Edgar Wary of Granting Clemency to Inmate Dying of AIDS; Action Backfired on Him in the Past*, Chi. Trib., Dec. 22, 1995, at 1.

<sup>106</sup> Russell, *supra* note 37, at 804.

<sup>107</sup> *Id.*

<sup>108</sup> Hubert, *supra* note 103, at A1.

<sup>109</sup> Diane Hirth, *Parole is Denied for AIDS Patient; Wife Batterer's Health Improves*, Sun-Sentinel, Aug. 31, 1996.

<sup>110</sup> Amy Linn, *Death Sentence; Why Are Prisoners with AIDS Dying for Release?*, S.F. Wkly., Nov. 15, 1995.

<sup>111</sup> Jon Kerr, *California Measure Easing Early Release of Terminally-Ill Prisoners Advances*, West's Legal News, 1996.

Another distressing aspect of compassionate release that opponents are quick to note is the unfortunate truth regarding an inmate's chances for economic stability after being released. The majority of inmates leave prison with no savings, no immediate entitlement to unemployment benefits, and few employment prospects.<sup>112</sup> One year after release, as many as 60 percent of former inmates are not employed in the regular labor market, and there is increasing reluctance among employers to hire ex-offenders.<sup>113</sup> A survey in five major U.S. cities found that 65 percent of all employers said they would not knowingly hire an ex-offender, and between 30 and 40 percent had checked the criminal records of their most recent employees.<sup>114</sup>

Given the enormous cost of end-of-life services, it is extremely unlikely that a paroled inmate with a terminal illness would be capable of either finding a job that could support their medical care needs, or being physically strong enough to work that job. Once released from their respective correctional institutions under the doctrine of compassionate release, economically disadvantaged prisoners would be forced to seek help from their state and federal governments in order to fund their end-of-life health care needs. This relief could only come in the form of Medicare or Medicaid.

Medicare is a federal health insurance program for people who are ages sixty-five and over, or individuals of any age receiving Social Security Disability Insurance benefits.<sup>115</sup> Medicare does not pay for services for a person who is incarcerated in jail or prison, but individuals who are eligible for supplemental security income benefits can apply for reinstatement while incarcerated, with benefits to begin upon release.<sup>116</sup> Reinstatement of

---

<sup>112</sup> Joan Petersilia, *When Prisoners Return to Communities: Political, Economic, and Social Consequences*, 2 SENT'G & CORRECTION 1, 5 (2000), <https://www.ncjrs.gov/pdffiles1/nij/184253.pdf>.

<sup>113</sup> *Id.* at .

<sup>114</sup> Holzer, H. *What employers want: Job prospects for less-educated workers*. (Russell Sage Foundation 1996).

<sup>115</sup> MEDICARE AND INCARCERATION 1, 2 (Judge David L. Bazelon Ctr. for Mental Health Law 2013).

<sup>116</sup> *Id.* at 1.

benefits only applies if the inmate's benefits have been suspended and not terminated, which occurs after one year in jail or prison.<sup>117</sup> This distinction is problematic for terminally ill inmates who have served long convictions and successfully petitioned for compassionate release because they will likely be ineligible for Medicare assistance.

Medicaid is the health insurance partnership between the federal and state governments which provides health care coverage for impoverished Americans. Under federal law, states must provide Medicaid to children, pregnant women and disabled adults who fall below certain income thresholds.<sup>118</sup> Starting in January of 2014, a number of the 650,000 inmates released from prison each year will be eligible for health care by way of Medicaid,<sup>119</sup> under the Medicaid expansion provisions of the Affordable Care Act.<sup>120</sup>

Since most recently released prisoners are not pregnant or disabled, the vast majority of them do not have Medicaid or health insurance of any kind.<sup>121</sup> As a result, studies show that many do not receive treatment for chronic conditions or continue on medications prescribed in prison.<sup>122</sup> If not for the aforementioned Medicaid expansion, many recipients of compassionate release could be exposed to more dire circumstances than they had suffered in their respective prison health care centers.

It comes as no surprise that compassionate release for terminal inmates has become such an intensely debated topic when one considers the polarizing arguments in favor and dissent of such programs. These issues of when and under what circumstances to release terminally ill

---

<sup>117</sup> *Id.* at 1.

<sup>118</sup> 42 U.S.C.A. § 1396d (West)

<sup>119</sup> Michael Ollove, *Ex-Felons Are About to Get Health Coverage*, 2013 The Pew Charitable Tr. (2013), <http://www.pewstates.org/projects/stateline/headlines/ex-felons-are-about-to-get-health-coverage-85899465889>.

<sup>120</sup> 42 U.S.C.A. § 1396a (West)

<sup>121</sup> Michael Ollove, *Ex-Felons Are About to Get Health Coverage*, The Pew Charitable Tr. (2013), <http://www.pewstates.org/projects/stateline/headlines/ex-felons-are-about-to-get-health-coverage-85899465889>.

<sup>122</sup> *Id.*

prisoners can only grow as the average age of prisoners and cost of end-of-life medical care continue to rise.

## **IX. INMATE-OPERATED PRISON HOSPICE PROGRAMS**

Another approach to lessening the economic burdens associated with providing end-of-life care to inmates is inmate-operated hospice programs. One manner in which prison hospice programs save money is by diverting terminally ill patients from more expensive treatments such as chemotherapy and radiation to pain management regimens, which are exponentially less expensive.<sup>123</sup> The availability of these alternatives allows for terminally ill inmates to treat their pain and suffering instead of potentially adding to their woes by pursuing aggressive treatment options with a miniscule chance of success.

American correctional facilities have begun to train healthy inmates to assist in caring for those that are terminally ill. These programs provide a valuable way to administer a better quality of end-of-life care while saving money on staffing costs. As of 2009, roughly 75 federal prisons had started hospice programs, half of them using inmate volunteers, according to the National Hospice and Palliative Care Organization.<sup>124</sup>

State jurisdictions have just begun to follow suit, albeit in much smaller numbers. In response to the number Colorado inmates serving life sentences more than doubling from 2001 to 2012 and the state's prison medical costs rising from \$15.9 million to \$77.6 million between 1994 and 2012, one Colorado correctional facility instated the first state prison hospice program

---

<sup>123</sup> Kirk Mitchell, *Colorado Prison Hospice Program Helps Inmates Die with Dignity*, The Denver Post, Feb. 17, 2013 at , [http://www.denverpost.com/ci\\_22607208/colorado-prison-hospice-program-helps-inmates-die-dignity](http://www.denverpost.com/ci_22607208/colorado-prison-hospice-program-helps-inmates-die-dignity).

<sup>124</sup> John Leland, *Fellow Inmates Ease Pain of Dying in Jail*, The New York Times, Oct. 17, 2009 at , [http://www.nytimes.com/2009/10/18/health/18hospice.html?\\_r=0](http://www.nytimes.com/2009/10/18/health/18hospice.html?_r=0).

in the nation.<sup>125</sup> “Inmates of the Colorado Territorial Correctional Facility in Canon City are trained to care for fellow prisoners” as they succumb to terminal illness.<sup>126</sup>

One unintended and useful benefit of inmate-run prison hospice programs are the byproducts of the bond that inmate volunteers can form with their patients. Not only can inmate-caregivers be more affectionate with their patients than is permissible for prison employees, but the effects of their involvement can be life-changing.<sup>127</sup> Prison hospice programs have the effect of confronting prisoners with their mortality, teaching them compassion for others, and sometimes putting their crimes in perspective. When confronted with the death of his “patient,” one convicted murderer at Coxsackie Correction Facility in New York revealed that the event had made a lasting impression, forcing the inmate to ask himself, “Who were you to do this to somebody else?”<sup>128</sup>,

Despite the many positives associated with inmate-operated hospice programs there are some opponents to this course of action. For example, Joan Smith, deputy superintendent of health services at the Coxsackie prison recalled that their own hospice program was initially met with resistance from prison guards, who resented the fact that those inmates would be receiving better medical treatment.<sup>129</sup>

Another such issue that has arisen among opponents of inmate-operated hospice programs is that some terminally ill patients will divert their pain medication to their volunteer aides or other patients, who abuse it or sell it.<sup>130</sup> This issue is inherently problematic due to the

---

<sup>125</sup> Mitchell, *supra* note 123.

<sup>126</sup> *Id.*

<sup>127</sup> *Id.*

<sup>128</sup> *Id.*

<sup>129</sup> Leland, *supra* note 124.

<sup>130</sup> *Id.*

predatory nature of the prison system,<sup>131</sup> but this serious concern could potentially be minimized by increased internal regulation and organization regarding prison hospice programs.

The use of inmates in correctional hospice programs is a positive response to the problems posed by the rising cost of providing end-of-life care for an increasingly elderly prison population. These programs have few substantial drawbacks and also serve a secondary rehabilitative purpose for those healthy inmates that choose to get involved.

## **X. CONCLUSION**

The factors weighing against effective administration of end-of-life correctional medical services show no signs of leniency. The average age of Americans is growing, as is the average age of the American prisoner. Health care costs in the United States continue to inflate, as do the number of inmates and their sentences. In order to once again meet the needs of America's terminally ill inmates in a meaningful way, state and federal legislatures must make one or both of the following simple yet serious decisions; either stop incarcerating individuals at a rate that is economically unsustainable or start releasing terminally ill inmates at a rate that alleviates the growing strain on the system. Applying both principles would be preferable in terms of expected return on state action, but this would be altogether too large of a change to ask of any governing body.

In regards to curtailing the number of prisoners that are entering the system, this approach seems less likely to be undertaken, but some progress can definitely be made in the manner of sentencing reforms. A switch from the determinate sentencing model back to the indeterminate sentencing model would be extraordinarily helpful under these circumstances, but altogether unlikely given the course that sentencing law has taken over the past twenty years.

---

<sup>131</sup> *Id.*

This is not to say that inmate-operated hospice programs cannot have a significant effect on the administration and budget for end-of-life care, but this action alone is unlikely to combat the underlying issues regarding the advanced aging of the United States population, and the fact that individuals are being imprisoned for longer than ever. Even with expansive hospice programs with inmate inclusion across every correctional facility in the state, there is only so much money that can be saved.

In regards to the release of prisoners that are no longer a large risk to society at large, this is probably the most viable manner in which the current legislatures can humanely meet the needs of dying prisoners in its care. Widespread adoption of compassionate release should and could be an enormous ally in the struggle for more adequate end-of-life services and budgets. The current systems of compassionate release must be greatly expanded in order to have any significant effect, as under the current status quo prisoners are only being considered for release in the most dire of circumstances.

Although there are definitely reasons to be concerned for the future of end-of life care in American prisons, the growth and slow acceptance of such programs as compassionate release and inmate-inclusive hospice programs means that there is hope for the future. With increased acceptance of programs to alleviate numbers of elderly prisoners and more creative sentencing infrastructure, there may be a more promising future for future inmates in need of end-of-life care.