

A RIGHT TO DIE IN PRISON: PROPOSED PROCEDURAL SAFEGUARDS UNDER THE END OF LIFE OPTION ACT FOR TERMINALLY ILL INMATES IN CALIFORNIA

Nicole Espin

INTRODUCTION

On October 5, 2015, the California Legislature enacted Assembly Bill X2-15, known as the End of Life Option Act (“the Act”).¹ The Act gives qualifying adults the right to request a prescription for life-ending medication, to be self-administered.² This Commentary focuses on the application of that law, codified as section 443 of the California Health & Safety Code,³ to persons currently incarcerated in California’s prisons. The Act is silent on its application to incarcerated or otherwise institutionalized persons.⁴ However, incarcerated persons represent a particularly vulnerable population, as this Commentary will demonstrate,⁵ and, as such, special consideration should be made regarding prisoners’ rights under the Act. While other states have similar “death with dignity” legislation, this Commentary focuses on California because of its large inmate population and well-documented history of inadequate prison medical care.⁶ There are over one hundred thousand

1. Assemb. B. X2-15, 2015 Leg., Reg. Sess. (Cal. 2015).

2. *See id.* (“This bill would provide a person, except as provided, immunity from civil or criminal liability solely because the person was present when the qualified individual self-administered the drug . . .”).

3. CAL. HEALTH & SAFETY CODE § 443 (West 2018).

4. *See id.*

5. See *infra* notes 90–98 & accompanying text, for a discussion comparing the rate of mental illness in the California inmate population to the general population of California.

6. The other three states with end of life statutes are Oregon, Washington and Vermont. *How to Access and Use Death with Dignity Laws*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/learn/access/> (last visited Apr. 9, 2018). Oregon and Washington also have the death penalty with thirty-three and eight 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-row-year?scid=9&did=188#state> (last visited Apr. 9, 2018). Vermont abolished the death penalty in 1964. *States With and Without the Death Penalty*, DEATH PENALTY INFO. CTR.,

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inmates serving time in California's state prison system.⁷ There are also unique problems caused by the over seven hundred inmates on death row in California, the highest number of any state in the nation.⁸ Florida, holding the second highest, has just under four hundred.⁹

For these reasons, the Legislature should adopt additional procedural safeguards to protect the inmate population. This paper suggests that the California Legislature adopt additional provisions, such that when an inmate requests the aid-in-dying drug under the End of Life Option Act, mental health screening is mandatory. Moreover, the Legislature should adopt a provision that an independent physician, who is not employed by the prison, must provide a certification that the medical needs of the inmate are being met by the prison medical staff, and that the inmate's pain and suffering, and terminal prognosis, are not a result of inadequate healthcare, in addition to fulfilling all other requirements a consulting physician is currently assigned under the Act.¹⁰

THE END OF LIFE OPTION ACT

In California, under the End of Life Option Act, an individual seeking aid-in-dying must: (1) be an adult; (2) have "the capacity to make medical decisions"; and (3) have a terminal illness.¹¹ There are many procedural safeguards already contained within the legislation: the individual seeking aid-in-dying medication must make two separate oral requests to their attending physician, at least fifteen days apart, and a written request.¹² This written request has to "be signed and dated, in the presence of two witnesses . . ."¹³ The attending physician and a consulting physician must both determine "[w]hether the requesting adult has the capacity to make medical decisions," is making the decision

<http://www.deathpenaltyinfo.org/states-and-without-death-penalty> (last visited Apr. 9, 2018).

7. Justin Goss & Joseph Hayes, *California's Changing Prison Population*, PUB. POL'Y INST. OF CAL., http://www.ppic.org/main/publication_show.asp?i=702 (last visited Apr. 13, 2018). As of July 1, 2017, California had 746 inmates serving capital sentences. *Death-Row Prisoners by State*, *supra* note 6.

8. *Death-Row Prisoners by State*, *supra* note 6.

9. *Id.*

10. CAL. HEALTH & SAFETY CODE § 443.6.

11. *Id.* § 443.2.

12. *Id.* § 443.3.

13. *Id.*

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voluntarily and not under coercion, and is aware of treatment alternatives.¹⁴ Where there is an indication of a “mental disorder,” the physician must refer the individual to a mental health specialist.¹⁵ The statute requires that the individual’s medical record contain all oral and written requests, the attending physician and consulting physician’s diagnosis and prognosis and finding of capacity, the mental health specialist’s report, where applicable, and the offer to withdraw.¹⁶ It is important to note that under the Act, the physician merely prescribes the life-ending medication, and the requesting individual self-administers this medication.¹⁷ The entire process takes at least three weeks.¹⁸ Once the individual obtains a prescription, they are still free to choose not to take the drug.¹⁹

HISTORY OF THE “RIGHT TO DIE”

The national debate surrounding the “right to die” gained speed following the Supreme Court’s decision in *Cruzan v. Director, Missouri Department of Health*.²⁰ In 1983, Nancy Cruzan lost control of her car; the vehicle overturned, causing her severe injuries, including brain damage, and leaving her in a “persistent vegetative state.”²¹ Her husband consented to the insertion of feeding and hydration tubes, however, her parents instructed the hospital to discontinue this life-sustaining treatment.²² The hospital would not remove the tubes without first gaining court approval, which the Missouri trial court granted.²³ Nancy

14. *Id.* § 443.6.

15. *Id.*

16. *Id.* § 443.8.

17. *Id.* § 443.1(p) (“‘Self-administer’ means a qualified individual’s affirmative, conscious, and physical act of administering and ingesting the aid-in-dying drug to bring about his or her own death.”).

18. Carol Parrot, *Preparing for the California End of Life Option Act: How to Get Started If You Think You Might Qualify*, DEATH WITH DIGNITY (Apr. 27, 2016), <https://www.deathwithdignity.org/news/2016/04/preparing-california-end-life-option-act/> (explaining that three weeks is the minimum time period to obtain the aid-in-dying drug under the law, and the process usually takes an average of forty-five to fifty days).

19. CAL. HEALTH & SAFETY CODE § 443.4(a).

20. 497 U.S. 261 (1990); see also *In re Quinlan*, 355 A.2d 647, 671 (N.J. 1976) (holding that the father of a young girl had the legal right to withdraw life-sustaining treatment).

21. *Cruzan*, 497 U.S. at 266.

22. *Id.* at 266–68.

23. *Id.* at 268 (“The [trial] court also found that Nancy’s ‘expressed thoughts at age twenty-five in somewhat serious conversation with a housemate friend that if sick or

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Cruzan's husband appealed this decision, and the case eventually made its way to the United States Supreme Court.²⁴ The Court held that while a competent adult has the right to refuse life-sustaining medical treatment,²⁵ the State has a legitimate interest in preserving life and, as such, the Missouri trial court could require a showing of clear and convincing proof that Nancy Cruzan would have wanted the nutrition and hydration removed before allowing the hospital to discontinue treatment.²⁶ The Court reasoned that under the common law of battery, individuals have a "liberty interest" under the Due Process Clause of the Fifth and Fourteenth Amendments to the United States Constitution, to be free from unwanted touching, which includes freedom from unwanted medical treatment, even where that treatment is life-sustaining.²⁷

In California, the right to refuse life-sustaining medical treatment was extended to incarcerated individuals in 1993 by the California Supreme Court's decision in *Thor v. Superior Court*.²⁸ The real party at interest in *Thor*, Howard Andrews, was an inmate, facing a life sentence, when he fell—or possibly jumped—from a wall, and was paralyzed.²⁹ Andrews was subsequently transferred to the Vacaville Medical Facility,³⁰ run by the California Department of Corrections, and he was

injured she would not wish to continue her life unless she could live at least halfway normally suggests that given her present condition she would not wish to continue on with her nutrition and hydration." (quoting App. to Pet. for Cert. A97–A99)).

24. *Id.* at 268–69 ("The Supreme Court of Missouri reversed by a divided vote. The court recognized a right to refuse treatment embodied in the common-law doctrine of informed consent, but expressed skepticism about the application of that doctrine in the circumstances of this case.").

25. *Id.* at 277. The Court did not hold that the right to refuse unwanted medical treatment extends to incompetent persons, through their surrogates. However, it held that, where the State recognizes the right of a surrogate to act on behalf of an incompetent person by withdrawing treatment, the State can also establish procedural safeguards to ensure the surrogate is acting in accordance with the patient's will. *Id.* at 280.

26. *Id.* at 284.

27. *Id.* at 276–78 ("[T]he common-law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment." (citing *McConnell v. Beverly Enters.-Conn., Inc.*, 553 A.2d 596 (Conn. 1989); *In re Estate of Longeway*, 549 N.E.2d 292 (Ill. 1989); *In re Westchester Cty. Med. Ctr.*, 531 N.E.2d 607 (N.Y. 1988)).

28. *Thor v. Superior Court*, 855 P.2d 375 (Cal. 1993).

29. *Id.* at 379. The Court fails to detail the circumstances of the incident that left Mr. Andrews paralyzed. *See id.*

30. The California Medical Facility in Vacaville, California ("Vacaville" or "CMF") is still in operation. In 2017, the facility housed between 2,400 and 2,600 inmates. CAL. DEPT OF CORR. & REHAB., COMPSTAT STATISTICAL REPORT NO. SB601 (Feb. 12, 2018). *See infra* notes 64–65 & accompanying text for the current state of medical care at Vacaville.

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kept alive via medication and a feeding tube.³¹ The plaintiff in the case, Daniel Thor, was a staff member at the medical facility where Andrews was held, who sought an order allowing him to forcibly feed and medicate Andrews after he refused medical treatment.³²

The court in *Thor* found that while precedent before and after *Cruzan* established 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.”³³ The court subsequently found that none of these interests were offended in the present case.³⁴

Moreover, the court concluded that Andrews’ status as a state prison inmate did not restrict his ability to exercise the right to refuse life-sustaining medical treatment.³⁵ Previous case law held that states may legally deprive inmates of rights they would usually enjoy outside of confinement—even constitutionally protected rights such as freedom of association—where such restrictions are necessary “to provide for the reasonable security of the institution . . . and for the reasonable protection of the public.”³⁶ The court held that, unlike in cases of hunger strikes and refusal to take psychiatric medication, the State of California has no legitimate security interest for refusing to honor an individual inmate’s right to forgo life-sustaining medical treatment.³⁷

The court grappled with a concern this Commentary addresses: whether the inmate’s choice to die, in this case by refusing life-sustaining treatment, can really be “voluntary” where the prison is providing inadequate medical and psychological support services to inmates.³⁸

31. *Thor*, 855 P.2d at 379.

32. *Id.* at 379–80.

33. *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)).

34. *Id.* at 384. Interestingly, in dicta, the court in *Thor* stated 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.

35. *Id.* at 388. The court also found that there was no nexus between the degree of pain of an individual and his or her right to refuse treatment. *Id.* at 385 (“For self-determination to have any meaning, it cannot be subject to the scrutiny of anyone else’s conscience or sensibilities. It is the individual who must live or die with the course of treatment chosen or rejected, not the state.”).

36. *Id.* at 380 (quoting CAL. PENAL CODE § 2600 (West 1993)).

37. *Id.* at 384. The court, in dicta, indicates that advances in medicine and technology are driving the need for patients to have a right to refuse treatment. *Id.* at 383–84.

38. *Id.* at 386.

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Though the court acknowledged the potential danger of its decision, it ultimately rejected the proposal made by amicus curiae of a mandatory judicial intercession to “assess the adequacy of the prisoner’s environment on the prisoner’s capacity to make a ‘rational’ choice” when an inmate wished to refuse life-sustaining treatment.³⁹ The court reasoned that such a process would actually serve to reduce the inmate’s autonomy, by replacing the “medical paternalism” involved when a medical professional decides to administer forced feeding and medication, with a form of “legal paternalism” where a judge can do the same.⁴⁰ The court also noted that all decisions to forego medical treatment are influenced by external circumstances, such as income and familial obligations; and that this threat is not as imminent as it may seem because inmates have the ability to challenge the adequacy of their medical care through administrative proceedings.⁴¹

As alluded to earlier, an inmate’s right to forgo unwanted medical treatment is not absolute.⁴² Such rights are limited by the State’s interest in maintaining prison order and security.⁴³ Courts have held that inmates can be forcibly fed, even through the insertion of a feeding tube, in cases when they are otherwise healthy and starve themselves⁴⁴; this usually happens when inmates are involved in hunger strikes.⁴⁵ In *in re Caulk*, for example, the court found that the inmate was “manipulat[ing] the [prison] system and disrupt[ing] the order” by refusing to eat.⁴⁶ Thus, the court held, the State had a legitimate security interest in forcibly

39. *Id.* at 389.

40. *Id.*

41. *Id.* at 390 (internal citations omitted).

42. *Lantz v. Coleman*, 978 A.2d 164, 169 (Conn. Super. Ct. 2008); *In re Caulk*, 480 A.2d 93, 95 (N.H. 1984) (“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).

43. *See, e.g.*, *Washington v. Harper*, 494 U.S. 210, 222 (1990); *Lantz*, 978 A.2d 164 at 169; *Caulk*, 480 A.2d at 96.

44. *See Caulk*, 480 A.2d 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 . . .”).

45. *See e.g.*, *Lantz*, 978 A.2d at 167 (finding that inmate was refusing food to protest the prison’s refusal to let his children visit him and other prison conditions). *But see Caulk*, 480 A.2d at 94 (finding that inmate’s only reason for refusing food was to cause his own death, and he was making no religious or political statement and had made no demands on the prison).

46. *Caulk*, 480 A.2d at 96.

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feeding the inmate.⁴⁷ Additionally, inmates can be forced to take psychiatric medication.⁴⁸ In *Washington v. Harper*, the Supreme Court held that an inmate's right to be free from unwanted medical treatment is not absolute, and that, in instances where allowing an inmate to refuse psychiatric medication would pose a threat to prison security, the State's interest in prison security outweighs the inmate's interest in freedom from unwanted treatment.⁴⁹

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*.⁵⁰ The Court also stated in dicta that states could choose, if they so wanted, to pass legislation allowing physician-assisted suicide.⁵¹ Since the Court announced its decision in *Glucksberg*, four states have passed such legislation, and there have been efforts to do so in other parts of the country.⁵² These statutes give terminally ill persons a legal right to obtain life-ending medicine, while also placing specific restrictions on the process.⁵³ The End of Life Option Act is one of these statutes.⁵⁴

HEALTHCARE IN CALIFORNIA PRISONS

In *Brown v. Plata*, the Supreme Court ordered the State of California to reduce its prison population to 137 percent capacity.⁵⁵ At the time, the prison system had been operating at 200 percent capacity.⁵⁶ This extreme holding was determined by the Court to be a necessary remedy for the constitutional violations of the prison's inmates' rights to adequate medical care.⁵⁷ Justice Kennedy, writing for the majority of the Court,

47. *Id.* at 97.

48. *Harper*, 494 U.S. at 222 ("The extent of a prisoner's right under the Clause to avoid the unwanted administration of antipsychotic drugs must be defined in the context of the inmate's confinement.").

49. *Id.* at 226. *See, e.g.*, *Thor v. Superior Court*, 855 P.2d 375, 384 (Cal. 1993).

50. 521 U.S. 702, 735–36 (1997); *Thor*, 855 P.2d at 382.

51. *Glucksberg*, 521 U.S. at 735–36.

52. *How to Access and Use Death with Dignity Laws*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/learn/access/> (last visited Apr. 14, 2018).

53. *See* CAL. HEALTH & SAFETY CODE § 443.2.

54. *See id.*

55. 563 U.S. 493, 501 (2011).

56. *Id.* at 502.

57. *Id.* at 499–501. *See also* 18 U.S.C. § 3626(a)(1)(A) (2012).

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stated that “[f]or years the medical and mental health care provided by California’s prisons has fallen short of minimum constitutional requirements and has failed to meet prisoners’ basic health needs.”⁵⁸

The Court noted that the extreme overcrowding in California’s prisons had adverse effects for both mentally and physically ill inmates.⁵⁹ The prison’s medical facilities, it explained, were (obviously) only designed to operate at 100 percent capacity.⁶⁰ The Court also detailed some of the tragic and horrific deaths and injuries that occurred while people waited for health care, including inmates who were left suffering from constant pain for hours, even days, as they waited to see a doctor.⁶¹

Since then, the CDCR has complied with the Court’s ruling in *Plata*, and has been decreasing the prison population. As of 2015, the prison population was at approximately 136 percent capacity.⁶² It is important to note, however, that this means the hospital’s medical staff is still operating over the intended capacity by 36 percent. While under the standards announced in *Plata*, the prison system no longer “fall[s] short of minimum constitutional requirements,” it is still extremely overcrowded and understaffed.⁶³ In fact, in September 2016, the state inspector general released a report stating the Vacaville Medical Facility—the same facility where the events in *Thor* took place—still provides inadequate medical care to inmates.⁶⁴ Moreover, the inspector noted that one third of the twenty-two California state prisons inspected were providing inadequate healthcare.⁶⁵ It is unclear what standards the inspector used to decide the adequacy of care, and how, if at all, these standards differed from those applied by the Supreme Court in *Brown v. Plata*.

58. *Plata*, 563 U.S. at 501.

59. *Id.* at 502.

60. *Id.* at 504.

61. *Id.* at 504–06.

62. Ryken Grattet & Joseph Hayes, *California’s Changing Prison Population*, PUB. POL. INST. OF CAL. (Apr. 2015), http://www.ppic.org/content/pubs/jtff/JTF_PrisonsJTF.pdf.

63. *Plata*, 563 U.S. at 501; see also Grattet & Hayes, *supra* note 62 (stating that as of March 2015 the California prison system was operating at 135.8 percent capacity).

64. ASSOCIATED PRESS, *Report: California Prison Medical Facility Provides Inadequate Care*, FOX 40 (Sept. 19, 2016, 3:48 PM) <http://fox40.com/2016/09/19/report-california-prison-medical-facility-provides-inadequate-care/>; Don Thompson, *Review: California Prison Medical center inadequate*, ORANGE COUNTY REG. (Sept. 20, 2016, 5:00 AM), <http://www.ocregister.com/articles/medical-729509-care-prison.html>.

65. Thompson, *supra* note 64.

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It is also important to note that the inmate population in California is aging, even as the overall prison population decreases.⁶⁶ The number of prisoners over the age of fifty was only 4 percent in 1990; by 2013, that number had increased to 21 percent.⁶⁷ This could have further implications for the healthcare system within the CDCR, as it is generally safe to assume that as the inmate population—like any population—ages, the medical needs of those inmates are likely to become more numerous, and meeting those needs will require a greater number of resources.

As the overall California state prison population has decreased, the percentage of mentally ill inmates, or at least the percentage of inmates diagnosed with mental illnesses, has grown.⁶⁸ In 2013, 24.5 percent of inmates in the state prison system suffered from a mental illness.⁶⁹ As of February 2016, mentally ill inmates make up 29 percent of the state prison population.⁷⁰ The prison system has failed to adequately address the needs of this growing population, as is evidenced by court orders following the decision in *Brown v. Plata*. On February 3, 2015, in *Coleman v. Brown*, a companion case to *Plata*, a federal judge for the Eastern District of California ordered the California Department of Corrections to adopt new suicide prevention recommendations.⁷¹ On May 15, 2015, the court found that California failed to provide adequate mental healthcare, and to maintain an adequate number of medical staff, and ordered the state to revise its hiring policies.⁷²

HOW A “RIGHT TO DIE” IMPACTS INMATE AUTONOMY

Two areas in which legal, medical, and social science scholars challenge the concept of autonomy in the prison system are informed

66. Goss & Hayes, *supra* note 7.

67. *Id.*

68. Abby Sewell, *Mentally Ill Inmates are Swamping the State's Prisons and Jails. Here's One Man's Story*, L.A. TIMES (June 16, 2016, 3:00 AM), <http://www.latimes.com/local/california/la-me-mentally-ill-inmate-snap-story.html>.

69. *Id.*

70. *Id.*

71. 2015 U.S. Dist. LEXIS 12737, at *20–21 (E.D. Cal. Feb. 3, 2015).

72. *Coleman v. Brown*, 2015 U.S. Dist. LEXIS 65419, at *59 (E.D. Cal. May 15, 2015) (finding that the prison system did not employ a sufficient mental health staff).

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consent and patient choice.⁷³ Generally speaking, when non-incarcerated persons seek medical care, they can—at least to some extent—choose where to receive that care.⁷⁴ This choice does not exist in prison.⁷⁵ Most medical care is provided inside the prison, by medical personnel employed by the prison, or through private contracts with for-profit healthcare systems.⁷⁶ When care is inadequate, prisoners must go through the prison administration to seek redress.⁷⁷ Visits with medical professionals can be unpleasant and traumatic, and some individuals avoid seeking care altogether to avoid interaction with doctors.⁷⁸

When inmates require medical treatment, they are often not given all possible medical options, nor provided with information that would allow them to give informed consent.⁷⁹ This problem is explained by Nancy Dubler in an article she wrote for the Health Affairs blog:

In correctional settings this relationship is further deformed from the idealized, but rarely realized, norm on the outside by the additional barriers to physicians and other medical practitioners having all of the medical alternatives available to the inmate. The doctrine of informed consent envisions the interaction of two moral agents, one with superior knowledge and skill who desires to empower the other as patient. The patient

73. See Nancy Dubler, *Ethical Dilemmas in Prison and Jail Health Care*, HEALTHAFFAIRS (Mar. 10, 2014), <https://www.healthaffairs.org/doi/10.1377/hblog20140310.037605/full/>.

74. Margaret O. Hayes, *Prisoners and Autonomy: Implications for the Informed Consent Process with Vulnerable Populations*, 2 J. FORENSIC NURSING 84, 86–87 (2006), <https://www.ncbi.nlm.nih.gov/pubmed/17073068>.

75. Gérard Niveau, *Relevance and Limits of the Principle of “Equivalence of Care” in Prison Medicine*, 33 J. MED. ETHICS 610, 611 (2007) (“[P]risoners may refuse the care offered by the doctors of the prison medical services, they may sometimes be visited by an external doctor or, on occasion, attend a consultation outside the prison, but they cannot undertake regular treatment from a doctor whom they would have chosen outside the prison.”).

76. Dubler, *supra* note 73.

77. See Prison Litigation Reform Act (PLRA) 42 U.S.C. § 1997e(a) (2012) (stating that inmates must exhaust all administrative relief before filing a civil claim).

78. See Dubler, *supra* note 73; HUMAN RIGHTS PROGRAM AT JUSTICE NOW, *Prisons as a Tool of Reproductive Oppression*, 685 STAN J.C.R. & C.L. 309, 328 (2009); Niveau, *supra* note 76, at 611.

79. For a discussion of reproductive oppression in prisons and the failure to get informed consent for sterilization procedures, see HUMAN RIGHTS PROGRAM AT JUSTICE NOW, *supra* note 79, at 321.

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brings to the encounter a history with medical interventions, individual values and beliefs, and personal likings and dislikes.

This sharing of authority and responsibility is undercut by every rule and custom of correctional institutions. The provider-patient relationship must survive the devaluing and undermining of the sense of individual worth and moral agency that correctional settings are designed to extinguish. The options offered are generally not all those that medicine could and should provide given the condition of the inmate and what is really in his/her best interest. Surprisingly, sometimes real sharing actually happens, fostered by a committed physician and a courageous patient.⁸⁰

PROPOSED LEGISLATION

In *Thor*, the court recognized the vulnerability of inmates who wish to end their lives, but rejected putting procedural safeguards in place when an inmate chooses to refuse life-sustaining treatment.⁸¹ The court ultimately struck down the suggestion of judicial intervention, finding “no basis for assuming [incarceration] inherently jeopardizes the voluntariness” of refusing life-saving treatment.⁸²

Under the End of Life Option Act, there already exist safeguards in place to ensure voluntariness: two physicians must examine the patient and, where the attending physician deems it is necessary, a mental health specialist must determine that the patient is mentally healthy.⁸³ Thus, the California Legislature was concerned with ensuring voluntariness. In California prisons, due to the external forces that reduce patient choice and informed consent, and the documented history of inadequate provision of medical care, these safeguards are not enough to ensure that terminally ill inmates are not being coerced into choosing to end their lives.⁸⁴

80. Dubler, *supra* note 73.

81. *Thor v. Superior Court*, 855 P.2d 375, 388 (Cal. 1993).

82. *Id.* at 389–90. It has been suggested that “Death with Dignity” laws themselves are a form of medical paternalism. See Annette Clark, *Autonomy and Death*, 71 TUL. L. REV. 45, 137 (1996).

83. CAL. HEALTH & SAFETY CODE § 443.3.

84. There is also a concern, perhaps more sinister, that inmates who are not in fact terminally ill, will be given such a prognosis.

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The threat of inadequate medical care is much higher for inmates than for the general population, and California has a long history of providing inadequate healthcare to its inmate population, as evidenced by court orders and state inspection reports, and at times has provided care so inadequate it fell below minimum constitutional standards.⁸⁵ Although the prison system has greatly reduced capacity since required to do so by the Supreme Court in *Plata*, recent reports show that it is still not providing adequate care.⁸⁶ The inmates who are suffering from this inadequate care have limited options for improving their conditions.⁸⁷

Under the Act, when an attending physician believes it to be necessary, they may refer an individual who requests life-ending drugs to a mental health professional.⁸⁸ The Legislature should adopt mandatory, rather than discretionary, mental healthcare screening when an inmate requests aid-in-dying, because the state prison population is particularly vulnerable to mental illness and California has a documented history of failing to provide adequate mental healthcare to inmates in the state prison system.⁸⁹

Prisoners in California are at a higher risk of mental illness than the general population. In California, 29 percent of the prison population suffers from a mental illness,⁹⁰ while approximately 16 percent of non-incarcerated adults suffer from a mental illness.⁹¹ In the United States, 18.5 percent of adults suffer from a mental illness.⁹² The threat of depression and suicidal thoughts are even higher for those on death row than other prisoners and much higher than that of the general prison

85. See *supra* notes 55–72 & accompanying text.

86. See *supra* notes 62–65 & accompanying text.

87. See Gary Hunter, *California Supreme Court Rules in Prisoner's Favor in Compassionate Release Denial*, PRISON LEGAL NEWS (May 5, 2016), <https://www.prisonlegalnews.org/news/2016/may/5/california-supreme-court-rules-prisoners-favor-compassionate-release-denial/>. See also *supra* notes 82–83 and accompanying text.

88. CAL. HEALTH & SAFETY CODE § 443.5.

89. See discussion *supra* pp. 7–8.

90. Sewell, *supra* note 68.

91. *Mental Health Care in California: Painting a Picture*, CALIFORNIA HEALTH CARE FOUND. (Jul. 16, 2013), <http://www.chcf.org/publications/2013/07/mental-health-california>.

92. *Mental Health by the Numbers*, NAT'L ALL. ON MENTAL ILLNESS, <http://www.nami.org/Learn-More/Mental-Health-By-the-Numbers> (last visited Apr. 14, 2018). California state prisons are only 4 percent higher than the average of 24 percent. L.E. Glaze & D.J. James, *Mental Health Problems of Prison and Jail Inmates*, BUREAU OF JUSTICE STATISTICS SPECIAL REPORT, U.S. DEP'T OF JUSTICE (2006).

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population.⁹³ This is especially pertinent in California, where a large number of inmates are being held on capital sentences, with indefinite fates ahead of them.⁹⁴ Thus, when a terminally-ill inmate requests life-ending drugs, it is nearly twice as likely that the inmate is suffering from an underlying mental health condition as it is when a non-incarcerated person requests them.⁹⁵

Moreover, the State of California has continually failed to provide adequate mental healthcare to its inmate population. In 2011, the United States Supreme Court found that the provision of both physical and mental healthcare in the state prison system fell below constitutionally acceptable standards.⁹⁶ In 2015, in two separate orders, a federal court found that the prison system needed new suicide prevention protocols and new hiring policies of mental health care specialists.⁹⁷ Given the continued failure to employ a sufficient number of mental healthcare providers, if mental health screening is discretionary, there is serious risk that an individual would not receive much-needed mental health screening after requesting aid-in-dying drugs, due to a lack of resources.

For the foregoing reasons, mental health screening should be mandatory, not discretionary, when a California state prisoner requests aid-in-dying drugs. This would prevent mental health problems from being overlooked, and would remove discretion from the attending physician, who may fail to notice mental health problems, or fail to refer these problems to a mental health care specialist.

Under the End of Life Option Act, when an individual requests life-ending drugs, two physicians must certify that this individual is both terminally ill and mentally competent.⁹⁸ In the case of inmates, the State Legislature should adopt an additional procedural safeguard to ensure that the individual who requests life-ending drugs is receiving adequate medical care. In the prison system, after the two physicians make this certification—and after mental health screening—an independent physician, or a physician who is not an employee of the prison, should certify that the patient is receiving adequate medical care and that the

93. See Meredith Rountree, *Criminal Law: Criminals Get All the Rights: the Sociolegal Construction of Different Rights to Die*, 105 J. CRIM. L. & CRIMINOLOGY 149, 202 (2015).

94. See *Death-Row Prisoners by State*, *supra* note 6 & accompanying footnote text.

95. See *infra* note 94 & accompanying text.

96. *Brown v. Plata*, 563 U.S. 493, 501–02 (2011).

97. *Coleman v. Brown*, 2015 U.S. Dist. LEXIS 65419, at *59 (E.D. Cal. May 15, 2015); *Coleman v. Brown*, 2015 U.S. Dist. LEXIS 12737, at *20–21 (E.D. Cal. Feb 3, 2015).

98. CAL. HEALTH & SAFETY CODE § 443.6.

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inmate's pain and suffering and prognosis would not be significantly altered by better medical care.

The court in *Thor* correctly noted that the decision to end one's life—in that case by refusing life-saving treatment—is always influenced by outside factors, including inadequate medical care.⁹⁹ While it is possible that some individuals in the general population who request aid-in-dying are receiving inadequate care, for the state prisoners in California, inadequacy of care is a matter of documented fact; the record in *Brown v. Plata* clearly showed that the healthcare provided by the California state prison system was unconstitutionally inadequate.¹⁰⁰ In September 2016, the California inspector general released a report stating the Vacaville Medical Facility, run by the California Department of Corrections, continues to provide inadequate medical care to inmates and that one third of the twenty-two prisons inspected were providing inadequate healthcare.¹⁰¹

The increased risk that an individual requesting life-ending drugs in prison is not receiving adequate medical care calls for increased procedural safeguards. There is a real need to prevent the California prison system's inadequate care from coercing inmates into killing themselves. In *Brown v. Plata*, the Court discussed an inmate who suffered from testicular cancer, and died as the result of inadequate medical treatment after seventeen months of extreme pain.¹⁰² As the End of Life Act currently stands, there is nothing to protect such inmates from ending their lives by physician-assisted suicide to prevent the pain and suffering that is caused by their illness and exacerbated by inadequate healthcare.¹⁰³

Moreover, two key components underlying patient autonomy, informed consent and patient choice, are minimized in the prison settings. An independent physician could reduce the effects of institutionalization on patient autonomy by providing a check on prison doctors. Inmates receive their healthcare from the prison.¹⁰⁴ When care is inadequate, prisoners must go through the prison administration to

99. See *Thor v. Superior Court*, 855 P.2d 375, 388 (Cal. 1993).

100. *Brown v. Plata*, 563 U.S. 493, 501–02 (2011) (noting that any long-term gains were eroded by the effects of “severe and pervasive overcrowding”).

101. *California Prison Medical Facility Provides Inadequate Care*, *supra* note 64; Thompson, *supra* note 64.

102. *Plata*, 563 U.S. at 505.

103. See generally CAL. HEALTH & SAFETY CODE § 443.

104. Dubler, *supra* note 73.

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seek redress.¹⁰⁵ Where an inmate is requesting aid-in-dying drugs, there needs to be a safeguard in place to ensure the decision is not caused by inadequate healthcare.

The threat of corruption for suicide-assistance laws is greater for vulnerable populations.¹⁰⁶ The prison population is made up of many individuals who were already vulnerable outside of prison, such as low-income individuals, people of color, victims of sexual assault and mentally ill individuals.¹⁰⁷ This raises a serious concern that the End of Life Option Act could be used as a tool to carry out euthanasia in the prison system. The Human Rights Program at Justice Now has suggested that prisons are used as a “Tool of Reproductive Oppression,” and that prison doctors have failed to get meaningful informed consent from patients before performing medical procedures that leave inmates infertile.¹⁰⁸ Failure by doctors inside the prison to provide medical information, give alternative treatment plans, and provide adequate care can lead to a system of euthanasia in prisons if inmates are given life-ending drugs without a serious inquiry into their medical care.

The Legislature was already concerned about the threat of corruption when it drafted the End of Life Option Act and put safeguards in place. In prisons, this Commentary has illustrated, informed consent is not always meaningfully achieved in the doctor-patient relationship and the medical professionals within the prison are not reliable enough shields to protect terminally ill inmates. Therefore, an independent physician should be required to certify that the inmate’s healthcare needs are adequately met before a terminally ill inmate can access life-ending drugs. The physician should find, based on accepted medical standards, that the inmate is receiving adequate health care and that their decision to seek life-ending drugs is not a result of pain and suffering caused by a failure to provide adequate care or by a prognosis that is the result of inadequate care options.

105. Niveau, *supra* note 75, at 611.

106. See Richard E. Coleson, *The Glucksberg & Quill Amicus Curiae Briefs: Verbatim Arguments Opposing Assisted Suicide*, 13 ISSUES L. & MED. 3, 19 (1997); Richard Huxtable, *Splitting the Difference? Principled Compromise and Assisted Dying*, 28 BIOETHICS 472, 473 (2014) (discussing the need to protect vulnerable populations from involuntary euthanasia).

107. See, e.g., HUMAN RIGHTS PROGRAM AT JUSTICE NOW, *supra* note 79, at 328 (discussing how inadequate reproductive health care and long prison sentences have led to reducing the fertility of minority women’s populations);

108. See *id.* at 319.

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CONCLUSION

The California Legislature has decided to afford residents of the state the right to physician-assisted suicide. However, the arguments against assisted suicide—the possibility of corruption by physicians, the risk of suicide, and the belief that external pressures will coerce the decision—are exacerbated in the prison setting, and even further heightened for those on death row. With high rates of depression and suicide attempts, a lack of meaningful choice of care, and a documented history of receiving inadequate mental and physical healthcare, this population needs to be protected from these deep concerns. Accordingly, when a death row inmate requests aid-in-dying drugs under the End of Life Option Act, the Legislature should adopt the procedural safeguards proposed in this Commentary: mandatory mental health screening, and a certification that the inmate’s healthcare needs are adequately met.