

# LIFE WITHOUT PAROLE AS DEATH WITHOUT DIGNITY

*Brittany L. Deitch*

INTRODUCTION .....328

I. LIFE WITHOUT PAROLE IN THE UNITED STATES .....332

    A. *Historical Background of LWOP* .....333

    B. *Theories of Punishment Applied to LWOP*.....337

II. DEATH WITH DIGNITY.....342

    A. *The Debate*.....343

    B. *Death-with-Dignity Laws*.....346

        1. *Passage*.....347

        2. *Protocols and Procedures*.....348

            a. *Patient Profile* .....348

            b. *Request for Medication*.....349

            c. *Drugs*.....350

    C. *Who Exercises Death with Dignity?*.....351

III. DEATH WITH DIGNITY FOR LWOP INMATES .....352

    A. *Prisoners’ Constitutional Rights* .....353

    B. *End-of-Life Care in Prisons* .....356

    C. *Suffering as Part of the Punishment* .....358

CONCLUSION .....362

## LIFE WITHOUT PAROLE AS DEATH WITHOUT DIGNITY

*Brittany L. Deitch\**

*When prisoners serving life without parole (LWOP) sentences become terminally ill, may the state prohibit them from experiencing a dignified death?*

*Prisoners serving LWOP sentences know with practical certainty that they will die in prison. The ten U.S. jurisdictions that allow individuals with terminal illnesses to die through physician-assisted death ground their laws in human-rights conceptions of autonomy and dignity. However, these jurisdictions prohibit prisoners from enjoying this right to self-determination in end-of-life decisions. Although the blanket ban applies to all prisoners, it disproportionately impacts LWOP prisoners, many of whom will die from painful terminal illnesses. Through evaluation of the history and nature of LWOP sentences, the rationales for death-with-dignity laws, the constitutional rights of prisoners to receive and refuse medical treatment, and the major theories of punishment, this Article argues that categorically prohibiting prisoners from exercising death-with-dignity statutory rights constitutes unjustified additional punishment.*

### INTRODUCTION

“A life sentence [without parole] is just a death penalty in disguise.”<sup>1</sup>

Life without parole (LWOP) is called “death by incarceration”<sup>2</sup> because the sentence carries the implication that death in prison is inevitable. Although the sentence implies the location of the inmate’s death, may an LWOP sentence also authorize the state to exercise control over how and when prisoners serving LWOP die?

Physician-assisted death, also called “death with dignity,” offers terminally ill patients a choice in the terms of their impending death. However, of the U.S. jurisdictions authorizing death with dignity, those jurisdictions that have spoken on the issue categorically bar prison inmates from exercising this option. Although the exclusion of prisoners from death with dignity applies to all

---

\* Visiting Assistant Professor of Law, Villanova University Charles Widger School of Law (2019–2021); J.D. Case Writing Fellow, Harvard Law School (2017–2019). I would like to thank Teri Ravenell, Michelle Dempsey, Nadia Banteka, Orli Oren-Kollbinger, Brett Frischmann, Andrew Lund, Tuan Samahon, Michael Risch, David Caudill, Jocelyn Kennedy, AJ Blechner, Matt Lamkin, Stephen Galoob, Russell Christopher, and Daniel Fryer for their comments and contributions at various stages of this project. I also owe a debt of gratitude to my wonderful research assistants, Alex Ator, Ronald Avila, and Karina Norwood, for their research and thoughtful discussions with me on this topic.

1. Pope Francis, Bishop of Rome, Address to the Delegates of the International Association of Penal Law (Oct. 23, 2014), [http://www.vatican.va/content/francesco/en/speeches/2014/october/documents/papa-francesco\\_20141023\\_associazione-internazionale-diritto-penale.html](http://www.vatican.va/content/francesco/en/speeches/2014/october/documents/papa-francesco_20141023_associazione-internazionale-diritto-penale.html).

2. See, e.g., Joseph Dole, *Is Life Without Parole Worse Than a Death Sentence?*, PRISON WRITERS, <https://prisonwriters.com/is-life-without-parole-worse-than-a-death-sentence> (last visited Oct. 6, 2020) (“Instead of being sentenced to death by execution, I was sentenced to death by incarceration or Life-Without-Parole (LWOP), the invisible death row . . . Had the judge ordered me executed, I probably would have been much better off.”); Robert Johnson & Sandra McGunigall-Smith, *Life Without Parole, America’s Other Death Penalty: Notes on Life Under Sentence of Death by Incarceration*, 88 PRISON J. 328, 333 (2008).

incarcerated persons, the ban disproportionately impacts LWOP prisoners, who know with practical certainty that they will die in prison. The states' preclusion of inmates from enjoying the freedom of choice, autonomy, and dignity that nonincarcerated citizens are entitled to exercise over the time and manner of their deaths constitutes an additional, unjustifiable condition of punishment.

LWOP sentences have become increasingly common in recent decades. To understand why, it is necessary to look at its relationship to capital punishment. The death penalty was long considered the most severe imposable punishment in the United States, and many have devoted scholarship and advocacy to advance its abolition, often noting that other Western civilizations do not use capital punishment.<sup>3</sup> With mounting criticisms and the Supreme Court's temporary moratorium on capital punishments,<sup>4</sup> lawmakers sought alternative harsh punishments for heinous offenses. By 1990, thirty-two states and the District of Columbia had adopted LWOP statutes.<sup>5</sup> Today, all U.S. jurisdictions but one authorize LWOP, and the use of LWOP sentences has increased so exponentially that they have replaced the death penalty as the "distinctive American punishment."<sup>6</sup> Even after the death penalty's resurrection,<sup>7</sup> LWOP sentences have remained a popular solution for "unlikely bedfellows"<sup>8</sup>—death penalty abolitionists who view LWOP as a viable response to the practice of capital punishment<sup>9</sup> and "tough-on-crime" politicians who want to ensure that

---

3. See, e.g., *Death Penalty in 2018: Facts and Figures*, AMNESTY INT'L (Apr. 10, 2019), <https://www.amnesty.org/en/latest/news/2019/04/death-penalty-facts-and-figures-2018> (providing data on the death penalty's use globally); see also *Policy Issues: International*, DEATH PENALTY INFO. CTR., <https://deathpenaltyinfo.org/policy-issues/international> (last visited Oct. 6, 2020).

4. *Furman v. Georgia*, 408 U.S. 238 (1972) (holding that the imposition of the death penalty in some cases constituted cruel and unusual punishment in violation of the Eighth Amendment). This case caused state and federal legislatures to revisit their capital punishment statutes to ensure that they were drafted to avoid capricious or discriminatory applications. See Evan J. Mandery, *It's Been 40 Years Since the Supreme Court Tried To Fix the Death Penalty—Here's How It Failed*, MARSHALL PROJECT (Mar. 30, 2016), <https://www.themarshallproject.org/2016/03/30/it-s-been-40-years-since-the-supreme-court-tried-to-fix-the-death-penalty-here-s-why-it-failed>.

5. ASHLEY NELLIS, SENTENCING PROJECT, *LIFE GOES ON: THE HISTORIC RISE IN LIFE SENTENCES IN AMERICA* 3 tbl.A (2013).

6. Craig S. Lerner, *Life Without Parole as a Conflicted Punishment*, 48 WAKE FOREST L. REV. 1101, 1102 (2013).

7. *Gregg v. Georgia*, 428 U.S. 153, 168–87 (1976).

8. Lerner, *supra* note 6, at 1118 ("Unlikely bedfellows began touting the virtues of LWOP. On the one hand were law-and-order advocates, generally on the political right, and on the other hand were death penalty abolitionists, generally on the political left."); see also Note, *A Matter of Life and Death: The Effect of Life-Without-Parole Statutes on Capital Punishment*, 119 HARV. L. REV. 1838, 1838–39 (2006) [hereinafter *Matter of Life and Death*] ("The result has been a strange pairing of death penalty abolitionists with pro-incarceration activists and legislators, joining to push life-without-parole statutes through state legislatures. Working together, they have been remarkably successful.")

9. RICHARD C. DIETER, DEATH PENALTY INFO. CTR., *SENTENCING FOR LIFE: AMERICANS EMBRACE ALTERNATIVES TO THE DEATH PENALTY* 25 (1993).

criminals are punished harshly, even if their juries refuse to impose capital punishment.<sup>10</sup>

As LWOP sentences have become more prolific in the United States, scholars and activists have begun challenging LWOP's alleged humaneness.<sup>11</sup> For some, life sentences are worse than death.<sup>12</sup> Prisoners serving LWOP express psychological trauma,<sup>13</sup> and those on death row comment that they prefer death row to LWOP.<sup>14</sup> It is easy to see why. From a legal perspective, death row inmates have more opportunities to appeal than LWOP prisoners, which gives factually or legally innocent prisoners a glimmer of hope.<sup>15</sup> Psychologically, it is difficult to overstate the ongoing traumatic impact on the LWOP inmate.<sup>16</sup> Each day, LWOP prisoners bear the weight of knowing that society has banished them and condemned them to die in prison.<sup>17</sup> Simply stated, a LWOP sentence functions as society's expression that a person is beyond redemption and has no hope for rehabilitation.

LWOP prisoners do not merely know that they will die in prison; they can also make statistical determinations about the likeliest manner of death. Although reliable data on the causes of death specifically for those serving LWOP sentences are unavailable, the Bureau of Justice Statistics (BJS) publishes general statistics on prisoner deaths. In its most recent publication on prisoner death statistics, the BJS compiled reports from state and federal

10. NELLIS, *supra* note 5, at 4; see Jeffrey M. Jones, *Americans Now Support Life in Prison Over Death Penalty*, GALLUP (Nov. 25, 2019), <https://news.gallup.com/poll/268514/americans-support-life-prison-death-penalty.aspx>.

11. See, e.g., Charles J. Ogletree, Jr. & Austin Sarat, *Lives on the Line: From Capital Punishment to Life Without Parole*, in *LIFE WITHOUT PAROLE: AMERICA'S NEW DEATH PENALTY?* 1, 6 (Charles J. Ogletree, Jr. & Austin Sarat eds., 2012); Katie Reade, *Life Imprisonment: A Practice in Desperate Need of Reform*, PENAL REFORM INT'L (June 11, 2018), <https://www.penalreform.org/blog/life-imprisonment-a-practice-in-desperate-need-of> (describing the "bleak picture" of life imprisonment and urging further research at an international level).

12. See, e.g., Ross Kleinstuber et al., *Into the Abyss: The Unintended Consequences of Death Penalty Abolition*, 19 U. PA. J.L. & SOC. CHANGE 185, 186 (2016) ("[LWOP prisoners] have less access to the courts and less ability to challenge the accuracy or legality of their convictions and are therefore in a worse position than those who have been sentenced to death."); J.C. Oleson, *Swilling Hemlock: The Legal Ethics of Defending a Client Who Wishes to Volunteer for Execution*, 63 WASH. & LEE L. REV. 147, 159–60 (2006) (discussing death row inmates volunteering for execution and the ethical considerations for attorneys representing such clients); Dole, *supra* note 2; *Matter of Life and Death*, *supra* note 8, at 1853 ("Unlike death sentences . . . life-without-parole sentences receive no special consideration from appellate tribunals . . .").

13. See Johnson & McGunigall-Smith, *supra* note 2, at 333.

14. See Bob Egelko, *Death Row Inmates Oppose Prop. 34*, SFGATE (Apr. 30, 2014), <https://www.sfgate.com/news/article/Death-Row-inmates-oppose-Prop-34-3891122.php> (revealing that most death row inmates in California opposed the 2014 ballot initiative to abolish the death penalty, which would also reduce their sentences to life).

15. See, e.g., *Glossip v. Gross*, 576 U.S. 863, 895 (2015) (Scalia, J., concurring).

16. See generally Margaret E. Leigey & Michael A. Ryder, *The Pains of Permanent Imprisonment: Examining Perceptions of Confinement Among Older Life Without Parole Inmates*, 59 INT'L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 727, 732–38 (2014) (empirically examining and expanding upon twenty issues associated with long-term imprisonment).

17. *Id.* at 738 ("LWOP inmates, similar to other types of long-term inmates, find the deprivations associated with their removal from society to be more painful than the deprivations inherent within the prison.").

prisons and indicated that, in 2014, 87% of prisoner deaths were caused by illness.<sup>18</sup> Thus, LWOP prisoners, who expect to be among those who die in prison, are statistically likely to die by succumbing to a terminal illness.

Meanwhile, nine states and Washington, D.C. have authorized death with dignity<sup>19</sup> through legislative and judicial processes.<sup>20</sup> In these jurisdictions, when a nonincarcerated person is diagnosed with a terminal illness, they<sup>21</sup> may be entitled to exercise the option of following carefully constructed procedures to end their life on their own terms, with the assistance of their physician. Presently, four of these jurisdictions expressly exclude prisoners from the exercise of these procedures.<sup>22</sup>

Some have argued generally that prisoners should be afforded an opportunity to choose physician-assisted death.<sup>23</sup> Others note an “apparent paradox that the socially powerless death row prisoner has a right to assistance in dying where the innocent and ill do not” because death row inmates may seek to hasten their executions upon discovering they are seriously ill, whereas most nonincarcerated individuals may not.<sup>24</sup>

This Article shows that the LWOP prisoner in jurisdictions authorizing death with dignity without extending that right to prisoners suffers a punishment even harsher than death by incarceration. Undeniably, LWOP inmates are condemned to die in prison. However, these death-with-dignity jurisdictions impose the additional punishment of prohibiting these prisoners

18. MARGARET E. NOONAN, U.S. DEPT’T JUST., MORTALITY IN STATE PRISONS, 2001-2014 STATISTICAL TABLES 5 tbl.3 (2016). Of these, 30% of prisoner deaths were attributable to cancer, 25.6% to heart disease, 9% to liver disease, 6.8% to respiratory disease, 1.8% were AIDS-related, and the remaining were due to other natural illnesses. *Id.*

19. Death with dignity is a broad term, but this Article uses death with dignity as the term for physician-aided death, which is also referred to as physician-assisted death, physician-assisted suicide, physician aid in dying, aid in dying, aid in death, assisted death, and other terms describing the practice of medical doctors assisting terminally ill patients in dying. However, medical, health policy, and mental health professionals recognize the term “assisted suicide” as “inaccurate, biased, and pejorative in this context.” Kathryn L. Tucker & Peter Ubel, *A Debate on Death with Dignity*, FORBES (Sept. 11, 2013), <https://www.forbes.com/sites/peterubel/2013/09/11/a-debate-on-death-with-dignity/#3de3d12a6a0e>.

20. Montana authorized death with dignity through a state supreme court decision, whereas the other states have passed legislation authorizing the practice. *See infra* Part II.B.

21. The singular “they” is deliberately used throughout this Article as a gender-neutral pronoun to promote inclusivity and diversity. Although traditionally grammatically incorrect, growing support for this practice suggests that the modern trend is to embrace the singular “they” in an effort to promote diversity and inclusion in writing. *See* Heidi K. Brown, *We Can Honor Good Grammar and Societal Change Together*, ABA J. (Apr. 1, 2018), [http://www.abajournal.com/magazine/article/inclusive\\_legal\\_writing](http://www.abajournal.com/magazine/article/inclusive_legal_writing).

22. The four jurisdictions which have spoken to the issue of prisoners’ eligibility to exercise death with dignity are Oregon, Washington, Colorado, and California, which enacted death-with-dignity laws in 1997, 2009, 2016, and 2016, respectively. Kathleen S. Messinger, *Death with Dignity for the Seemingly Undignified: Denial of Aid in Dying in Prison*, 109 J. CRIM. L. & CRIMINOLOGY 633, 657–58 (2019). The remaining jurisdictions, most of which authorized death with dignity either more recently than these four jurisdictions or outside of legislative means, are silent on the issue of prisoners’ eligibility for death with dignity.

23. *Id.* at 670–73.

24. Meredith Martin Rountree, *Criminals Get All the Rights: The Sociolegal Construction of Different Rights to Die*, 105 J. CRIM. L. & CRIMINOLOGY 149, 154 (2015); *see also* Bryan Robinson, *Death-Row Inmates Prefer Death to Life*, ABC NEWS (Jan. 7, 2006), <https://abcnews.go.com/US/story?id=90935&page=1>.

from exercising autonomy in their death. Instead, these prisoners will suffer as they succumb to a terminal illness. In other words, “life in prison” in these jurisdictions includes stripping the prisoner of the dignity that free citizens enjoy.

Part I introduces the historical background of LWOP and describes the meteoric rise in prevalence of the sentence. This Part also briefly introduces the dominant theories or justifications of punishment and applies those theories to LWOP. Part II provides an overview of death with dignity in the United States, beginning with a history of the arguments and theories underlying the ongoing debate of its appropriateness. This Part also describes the protocols and procedures required when a free patient decides to exercise this option.

Part III argues that denying prisoners the opportunity to exercise death with dignity, solely on the basis of their incarceration status, constitutes an unjustifiable additional punishment. None of the major theories of punishment can support the blanket exclusion of prisoners from exercising self-determination in their deaths. Moreover, precluding prisoners from exercising death with dignity contradicts the prisoners’ constitutional rights to receive and refuse medical treatment. This Part also explains the status of end-of-life care in prisons to support the proposition that prisoners might rationally choose to exercise death with dignity if given the opportunity.

This Article concludes that categorically denying prisoners the opportunity to pursue death with dignity—to the same extent they could if they were free—constitutes an untenable added penalty. A sentence to die in prison does not entitle the state to exercise dominion over the extent to which the prisoner suffers in death.

## I. LIFE WITHOUT PAROLE IN THE UNITED STATES

A brief overview of life without parole in the United States will suffice for purposes of this Article. LWOP sentences have been part of the American justice system for nearly a century, often as a sentence imposed upon habitual offenders through so-called “three-strike laws.”<sup>25</sup> States began enacting LWOP statutes in the 1970s.<sup>26</sup> However, it was not until the 1980s that LWOP sentences became commonplace.<sup>27</sup> The upward trend in LWOP sentences has continued ever since. Between 1992 and 2016, the LWOP population in the

---

25. Ogletree & Sarat, *supra* note 11, at 2.

26. *Id.*

27. *Id.*

United States increased by 328%.<sup>28</sup> Indeed, LWOP is “today the distinctive American punishment.”<sup>29</sup>

#### A. Historical Background of LWOP

The United States’ embrace of LWOP sentences can be traced to *Furman v. Georgia*,<sup>30</sup> which imposed a temporary moratorium on capital punishment. In response to this prohibition of executions, state legislatures sought a satisfactory alternative to the death penalty in punishing serious crime.<sup>31</sup> LWOP was the popular solution.<sup>32</sup> Even after the Supreme Court lifted the moratorium, states retained their LWOP statutes and continued to punish criminals under these acts. In fact, death sentences have decreased during the period of time LWOP sentences have increased, leading scholars and commentators to directly attribute the successes death-penalty abolitionists have enjoyed to the prevalence of LWOP.<sup>33</sup>

The American public, by and large, supported the LWOP solution.<sup>34</sup> Tough-on-crime politicians and constituents praised LWOP as being a suitable alternative to the death penalty for situations in which jurors would reject capital punishment.<sup>35</sup> Opponents of the death penalty extolled LWOP as a sentencing option that would discourage jurors from imposing capital punishment.<sup>36</sup> Data

28. ASHLEY NELLIS, SENTENCING PROJECT, STILL LIFE: AMERICA’S INCREASING USE OF LIFE AND LONG-TERM SENTENCES 24 (2017).

29. Lerner, *supra* note 6, at 1102–03 (explaining the uniqueness of LWOP as a punishment and contrasting the prevalence of life sentences in the U.S. with those in European nations).

30. See *Furman v. Georgia*, 408 U.S. 238, 239–40 (1972); Mandery, *supra* note 4.

31. I. Bennett Capers, *Defending Life, in LIFE WITHOUT PAROLE: AMERICA’S NEW DEATH PENALTY?* *supra* note 11, at 167, 169 (“[Th]e connection between death and life without parole is perhaps most evident in the response to *Furman v. Georgia*, which effectively invalidated all existing death penalty sentencing regimes. Prior to *Furman*, the punishment of life without parole was rare.” (footnotes omitted)). Before *Furman*, only seven states—Maine, Massachusetts, Michigan, Mississippi, Nevada, Pennsylvania, and West Virginia—had LWOP sentencing. Now, the only state without LWOP is Alaska. *Year That States Adopted Life Without Parole (LWOP) Sentencing*, DEATH PENALTY INFO. CTR. (Aug. 2, 2010), <https://deathpenaltyinfo.org/stories/year-that-states-adopted-life-without-parole-lwop-sentencing>.

32. James Ridgeway & Jean Casella, *What Death Penalty Opponents Don’t Get*, MARSHALL PROJECT (Nov. 30, 2014), <https://www.themarshallproject.org/2014/11/30/what-death-penalty-opponents-don-t-get> (“In many states, the expansion—and the very existence—of life without parole sentences can be directly linked to the struggle to end capital punishment.”).

33. Adam Liptak, *No Way Out: Serving Life, with No Chance of Redemption*, N.Y. TIMES (Oct. 5, 2005) (quoting James Lieberman), <https://www.nytimes.com/2005/10/05/us/serving-life-with-no-chance-of-redemption.html>.

34. See Lerner, *supra* note 6, at 1116; see also *Matter of Life and Death*, *supra* note 8, at 1838–39.

35. See Judith Lichtenberg, *Against Life Without Parole*, 11 WASH. U. JURIS. REV. 39, 45 (2018).

36. For an example of a juror stating that they opted for death only because LWOP was not on the table, see Bill Rankin, *Inmate To Be Executed for Crime That No Longer Gets Death Penalty*, ATLANTA J. CONST. (Jan. 16, 2020), <https://www.ajc.com/news/local/inmate-executed-for-crime-that-longer-gets-death-penalty/Co5BxehAhR8mcsySEr3v3L>.

suggests that this latter argument may be true because, empirically, the increase in LWOP sentences correlates to a decrease in death sentences.<sup>37</sup>

The death penalty has long been criticized as a “barbaric”<sup>38</sup> practice with no place in a modern Western civilization. LWOP, on the other hand, was for a long period celebrated as a victory by those who opposed the death penalty.<sup>39</sup> Recently, however, growing doubt about the humaneness of LWOP sentences has come to the forefront.<sup>40</sup> Modern technology allows greater access to the inmates serving these sentences. Through various projects that give inmates a platform for making their challenges known to the outside world, public awareness of the unique struggles and anguish inmates serving LWOP experience is increasing.<sup>41</sup>

Inmates have expressed immense psychological pain from being completely cast out from society and being deemed beyond hope of redemption.<sup>42</sup> LWOP constitutes an absolute rejection of rehabilitation. Locked

37. See Lichtenberg, *supra* note 35.

Death penalty opponents point to studies showing that support for it drops drastically among jurors and the general public when LWOP is an option. It stands to reason that people who fear that abolishing the death penalty means letting dangerous criminals go free, or dispensing less punishment than they deserve, may be reassured by life-without-parole sentences.

*Id.* at 45; see also NELLIS, *supra* note 5, at 4 (“The upward creep in life sentences has accelerated in recent decades as an element of the ‘tough on crime’ political environment . . . [of] the 1980s.”). This trend in favor of LWOP has continued, and according to a recent Gallup poll, a majority of Americans favor LWOP to the death penalty. See Jones, *supra* note 10 (“For the first time in Gallup’s 34-year trend, a majority of Americans say that life imprisonment with no possibility of parole is a better punishment for murder than the death penalty is.”).

38. Cass R. Sunstein & Adrian Vermeule, *Is Capital Punishment Morally Required? Acts, Omissions, and Life-Life Tradeoffs*, 58 STAN. L. REV. 703, 704 (2005) (“Many people believe that capital punishment is morally impermissible. In their view, executions are inherently cruel and barbaric.”).

39. See, e.g., Carol S. Steiker & Jordan M. Steiker, *Opening a Window or Building a Wall? The Effect of Eighth Amendment Death Penalty Law and Advocacy on Criminal Justice More Broadly*, 11 U. PA. J. CONST. L. 155, 175 (2008) (“Apart from the focus on innocence, current abolitionist advocacy tends to reinforce rather than question increasingly punitive sanctions. This dynamic is most evident in death penalty opponents’ support for harsh incarceration sanctions (including LWOP) as a way of undermining support for the death penalty.”); Ridgeway & Casella, *supra* note 32 (“Death penalty opponents often accept—and even zealously promote—life without parole as a preferable option, in the process becoming champions of a punishment that is nearly unknown in the rest of the developing world.”).

40. See Ogletree & Sarat, *supra* note 11, at 6 (“Nonetheless, some recent research raises questions about the wisdom of the abolitionist embrace of LWOP.”); Reade, *supra* note 11.

41. See, e.g., PRISON WRITERS, prisonwriters.com (last visited Oct. 6, 2020); *Our Mission*, THE OTHER DEATH PENALTY PROJECT, www.theotherdeathpenalty.org/documents/2065\_001.pdf (last visited Oct. 6, 2020) (founded and operated by inmates serving LWOP with the intent to raise awareness about the “long, slow, dissipating death sentence without any [of] the legal or administrative safeguards rightly awarded to those condemned to the traditional forms [of] execution”); *Life Inside*, MARSHALL PROJECT, https://www.themarshallproject.org/tag/life-inside (last visited Oct. 6, 2020) (“a weekly series of first-person essays from people who live or work in the criminal justice system”).

42. Johnson & McGunigall-Smith, *supra* note 2.

One source of evidence on the extent of pain associated with a life sentence is provided by condemned prisoners who tell us point blank that a life sentence is worse than a death sentence. These are not just empty words. A remarkable 123 prisoners—11% of the 1,099 executions carried out at the time of this writing—have dropped their appeals and allowed themselves to be killed.

in a cage for life with fewer opportunities to appeal than if they were sentenced to death, many inmates have expressed that they wished they were on death row instead.<sup>43</sup>

Based on the view of LWOP as a more humane alternative to capital punishment, or even as an equitably harsh penalty for serious crimes that would be penalized by death, one might expect that the convictions resulting in LWOP sentences are tantamount to death-eligible offenses. Statistically, however, this is not the case, and many people serving LWOP sentences were convicted of less serious offenses. Despite an overall decrease in serious, violent crimes, LWOP sentences have continued to increase.<sup>44</sup> Although it is true that LWOP sentences are now “used regularly as a sentence in murder cases,”<sup>45</sup> only 60.3% of LWOP inmates were convicted of first-degree murder in 2016.<sup>46</sup> Nearly a quarter were convicted of drug offenses, crimes against property, and other nonhomicide offenses, including robbery and aggravated assault.<sup>47</sup>

In total,<sup>48</sup> between 2001 and 2016, 59,036 inmates died in state and federal prisons.<sup>49</sup> Inmates serving LWOP expect to be among those whose fate includes death in prison. The leading cause of death in U.S. federal and state prisons is illness. Eighty-eight percent of inmate deaths in state and federal prisons from 2001 through 2016 resulted from illnesses, including cancer, heart disease, liver disease, AIDS-related causes, respiratory diseases, and other illnesses.<sup>50</sup> That inmates typically die of natural causes, or more precisely of diseases, is significant for purposes of analyzing their eligibility for death with dignity. Because death-with-dignity laws in the United States only apply to

---

*Id.* at 333.

43. See, e.g., Liptak, *supra* note 33.

Mr. Arroyo realized he had just become a lifer, and that was the last thing he wanted. Lifers, he said, exist in a world without hope. ‘I wish I still had that death sentence,’ he said. ‘I believe my chances have gone down the drain. No one will ever look at my case.’

*Id.*; see also Dole, *supra* note 2; Egelko, *supra* note 14 (describing that death row inmates, who are ineligible to vote in California, opposed the ballot initiative that would abolish the death penalty because they would “rather gamble and have the death penalty dangling there but be able to fight to right a wrong” than have “the courthouse doors . . . slammed forever”); *Glossip v. Gross*, 576 U.S. 863, 895 (2015) (Scalia, J., concurring) (“The reality is that any innocent defendant is infinitely better off appealing a death sentence than a sentence of life imprisonment.”).

44. See NELLIS, *supra* note 5, at 1 (“[T]he number of prisoners serving life sentences continues to grow even while serious, violent crime has been declining for the past 20 years and little public safety benefit has been demonstrated to correlate with increasingly lengthy sentences.”).

45. Ogletree & Sarat, *supra* note 11, at 2.

46. NELLIS, *supra* note 28, at 12 tbl.3.

47. In 2016, 7.2% of LWOP inmates were sentenced to LWOP after being convicted of sex offenses; 10.5% resulted from aggravated assault, kidnapping, or robbery convictions; 4.6% resulted from drug offenses; 0.7% were property offenses; 0.9% are categorized as “other,” and exclude murder convictions, which account for the remaining 75.8% of LWOP sentences. *Id.*

48. No reliable data is available to narrow the scope of this statistic to include only those prisoners serving LWOP.

49. See E. ANN CARSON & MARY P. COWHIG, U.S. DEP’T JUST., MORTALITY IN STATE AND FEDERAL PRISONS, 2001-2006 – STATISTICAL TABLES 2 (2020).

50. *Id.* at 5 tbl.1.

persons who are terminally ill, the high rates at which inmates die from terminal illnesses suggest that LWOP prisoners may often become eligible for physician-aided death.

Overcrowding in prisons,<sup>51</sup> the exorbitant cost of caring for aged and ill inmates,<sup>52</sup> and the diminished risk to public safety<sup>53</sup> have all been cited by prison-reform advocates as reasons for abolishing LWOP and other life sentences.<sup>54</sup> From the parsimonious taxpayer's perspective, the cost to incarcerate an aging prison population is high.<sup>55</sup> Life sentences cost in the range of \$1 million per adult prisoner, and the cost to incarcerate after the age of forty increases tremendously.<sup>56</sup> Unsurprisingly, there is an inverse relationship between age and recidivism rates.<sup>57</sup> As inmates age, they become decreasingly likely to commit future crimes or to pose a danger to society.<sup>58</sup> Thus, as the price of incarceration increases for the community, the public safety justifications for imprisonment decrease.

As the United States prison population increases, so too does the population of aging and aged prisoners.<sup>59</sup> Recent reforms have been

---

51. Susan Lundstrom, *Dying To Get Out: A Study on the Necessity, Importance, and Effectiveness of Prison Early Release Programs for Elderly Inmates Suffering from HIV Disease and Other Terminal-Centered Illnesses*, 9 *BYU J. PUB. L.* 155, 157 (1994) (discussing the national crisis of overcrowding in U.S. prisons and arguing for a closer examination of the problems that arise with an aging prison population).

52. See Maura Ewing, *When Prisons Need To Be More Like Nursing Homes*, MARSHALL PROJECT (Aug. 27, 2015), <https://www.themarshallproject.org/2015/08/27/when-prisons-need-to-be-more-like-nursing-homes> (noting that older prisoners cost taxpayers two to four times more than younger offenders to incarcerate, primarily due to healthcare costs).

53. Dana Goldstein, *Too Old To Commit Crime?*, *N.Y. TIMES* (Mar. 20, 2015), <https://www.nytimes.com/2015/03/22/sunday-review/too-old-to-commit-crime.html>; Marc Mauer, *Long-Term Sentences: Time to Reconsider the Scale of Punishment*, 87 *UMKC L. REV.* 113, 121 (2018) (“[L]ong-term sentences produce diminishing returns for public safety as individuals ‘age out’ of the high-crime years.”); KIM STEVEN HUNT & BILLY EASLEY II, *U.S. SENT’G COMM’N, THE EFFECTS OF AGING ON RECIDIVISM AMONG FEDERAL OFFENDERS* 30 (2017) (“The Commission found that older offenders are substantially less likely to recidivate following release compared to younger cohorts.”).

54. NELLIS, *supra* note 28, at 6; see also Leigey & Ryder, *supra* note 16 (empirically examining and expanding upon twenty issues associated with long-term imprisonment).

55. The cost of incarceration has recently been publicized more by those seeking to end mass incarceration. For example, Philadelphia District Attorney Larry Krasner, who is widely viewed as the nation's most progressive prosecutor, implemented a policy requiring the prosecutors in his office to disclose the cost of incarceration to the sentencing judge, based on the cost of \$42,000 to \$60,000 per prisoner annually. See Alicia Victoria Lozano, *Philadelphia Prosecutors Must Share the Cost of Prison Time Inside Court During Case Sentencing*, *NBC PHILA.* (Mar. 15, 2018), <https://www.nbcphiladelphia.com/news/local/philadelphia-prosecutors-must-include-cost-of-prison-time-during-sentencing/175626>.

56. NELLIS, *supra* note 28, at 26; see also ACLU, *AT AMERICA'S EXPENSE: THE MASS INCARCERATION OF THE ELDERLY* (2012), [https://www.aclu.org/sites/default/files/field\\_document/elderlyprisonreport\\_20120613\\_1.pdf](https://www.aclu.org/sites/default/files/field_document/elderlyprisonreport_20120613_1.pdf).

57. See HUNT & EASLEY, *supra* note 53.

58. *Id.*

59. See ACLU *supra* note 56, at 5 (estimating prisoners aged fifty-five years and older will increase by 4,400% from 1981 to 2030 and projecting that by 2030, prisoners aged fifty-five years and older will account for one-third of the total prison population, totaling over 400,000); see also Chris Feliciano Arnold, *The Dying American Prisoner*, *ATLANTIC* (Dec. 23, 2019), <https://www.theatlantic.com/politics/archive/2019/12/>

implemented, which expand opportunities for compassionate release or medical parole for inmates who are aged, terminally ill, or both, including the opportunity to finish their prison terms at home under supervision.<sup>60</sup> It is too early to indicate the success of the First Step Act, and particularly, whether it does enough to ensure that the released persons' healthcare needs are met.<sup>61</sup> Regardless of this federal action, state prisons house the majority of the United States prison population, and many states expressly forbid granting compassionate release or medical parole to certain categories of prisoners, including those serving LWOP.<sup>62</sup>

In sum, as LWOP sentences have increased, the population of aging prisoners has also increased, drawing attention to unique issues surrounding the incarceration of a large elderly population. Notably, a majority of these prisoners can reasonably expect to die of natural causes or terminal illnesses.

### B. *Theories of Punishment Applied to LWOP*

Modern societies have developed away from the state of nature in which individuals righted wrongs through personal revenge.<sup>63</sup> By participating in

---

compassionate-release-lets-prisoners-die-free/603988 (“[T]he number of older inmates has nearly tripled since 1999.”).

60. First Step Act of 2018, Pub. L. No. 115-391, 132 Stat. 5194 (2018).

61. The First Step Act, in part, seeks to expand eligibility and avenues for elderly and terminally-ill prisoners to seek early release (sometimes called Compassionate Release, Reduction in Sentence, or Medical Parole). Previously, compassionate release was only available through the Bureau of Prisons, which set its own criteria for determining eligibility and authorizing release. From 2013 through 2017, the Bureau of Prisons approved only 6% of the 5,400 applications it received. *See* Christie Thompson, *Old, Sick and Dying in Shackles*, MARSHALL PROJECT (Mar. 7, 2018), <https://www.themarshallproject.org/2018/03/07/old-sick-and-dying-in-shackles>.

Prisoners facing this prospect were required to make difficult, time-sensitive decisions regarding their healthcare if they were fortunate to be in the minority of applicants who were granted early release. While in prison, incarcerated persons are constitutionally entitled to receive medical care. However, nonincarcerated U.S. citizens enjoy no right to healthcare. Thus, if an ill inmate remains incarcerated, they would receive medical care, but if they are released, they would no longer have a guarantee to medical care. Timing the release with their application for Medicaid to ensure that they would have effective health coverage immediately upon release posed a unique challenge. Under the new law, which received bipartisan support, more applications for release are being approved. *First Step Act Already Shows Success*, AM. BAR ASS'N (Aug. 15, 2019), [https://www.americanbar.org/advocacy/governmental\\_legislative\\_work/publications/washington\\_letter/august\\_2010\\_WL/first\\_step\\_act\\_article](https://www.americanbar.org/advocacy/governmental_legislative_work/publications/washington_letter/august_2010_WL/first_step_act_article). However, there is insufficient information at this time as to the impact on healthcare coverage.

62. MARY PRICE, *FAMILIES AGAINST MANDATORY MINIMUMS, EVERYWHERE AND NOWHERE: COMPASSIONATE RELEASE IN THE STATES* 14 (2018) (“Many states categorically exclude certain kinds of prisoners from consideration . . . South Carolina and a number of other states will not consider prisoners who are sentenced to life without parole or death for compassionate release.”).

63. The “state of nature” refers to a philosophical hypothetical about what humankind was like prior to civilized society. *See generally* THOMAS HOBBES, *LEVIATHAN* (Oxford Univ. Press 1st ed. 1909) (1651) (defining the state of nature essentially as the human condition without a government); JOHN LOCKE, *SECOND TREATISE OF CIVIL GOVERNMENT AND A LETTER CONCERNING TOLERATION* (C. H. Wilson & R. B. McCallum eds., Basil Blackwell Oxford 1948) (1689); BARON DE MONTESQUIEU, *THE SPIRIT OF THE LAWS* (Thomas Nugent trans., 1959) (1748); DAVID HUME, *A TREATISE OF HUMAN NATURE* (David Fate

society, we have entered into a social contract in which we rely on the government to use its systems and processes to punish wrongdoers.<sup>64</sup> There is an expectation that the government will act in accordance with the accepted norms and values of the society in which it operates. When a punishment is imposed, it must be justified because, at its core, punishment is the infliction of suffering upon an individual for violating a law.<sup>65</sup> Several prominent theories, or justifications, of punishment offer frameworks for analyzing the moral permissibility of a given punishment. Though hybrids, modifications, and variations of each of these theories have recently emerged, often overlapping with the long-standing justifications, it is only necessary here to sketch out the broad definitions of the following prevailing, relevant theories: rehabilitation, deterrence, incapacitation, and retributivism.

Rehabilitation is one of the more ambiguous justifications of punishment, in that identifying with precision the metrics to use for considering the rehabilitative goal satisfied presents challenges.<sup>66</sup> Simply put, the theory expects that, through punishment, wrongdoers will learn from their mistake and refrain from committing a future crime.<sup>67</sup> In the United States, rehabilitative justifications of punishment are most often seen in the context of the juvenile system. Rehabilitation is distinct from the seemingly similar specific deterrence rationale, in that rehabilitation anticipates that a person will have a change of heart<sup>68</sup> and will no longer have the impulse to commit crimes, whereas specific deterrence merely anticipates that the fear of the punishment itself will deter the individual from committing future crimes.

Rehabilitation clearly cannot be used to justify LWOP. In fact, LWOP may be viewed as the ultimate rejection of rehabilitation. Regardless of whether the

---

Norton & Mary J. Norton eds., 2007) (1739) (critiquing Hobbes' version of the state of nature for ignoring humankind's natural inclination toward socialness).

64. JEAN JACQUES ROUSSEAU, *THE SOCIAL CONTRACT AND DISCOURSES* 57–58 (G.D.H. Cole ed., London and Toronto: J.M. Dent and Sons 1923) (1761)

65. See H. L. A. Hart's five-element definition of punishment:

- (i) It must involve pain or other consequences normally considered unpleasant.
- (ii) It must be for an offence against legal rules.
- (iii) It must be of an actual or supposed offender for his offence.
- (iv) It must be intentionally administered by human beings other than the offender.
- (v) It must be imposed and administered by an authority constituted by a legal system against which the offence is committed.

H. L. A. HART, *PUNISHMENT AND RESPONSIBILITY: ESSAYS IN THE PHILOSOPHY OF LAW* 4–5 (1968); see also HOBBS, *supra* note 63, at 244 (“For Punishment is only for Transgression of the Law, and therefore there can be no Punishment of the Innocent.”).

66. See Lichtenberg, *supra* note 35, at 48–49 (“The concept of rehabilitation is . . . ambiguous. Does it mean simply becoming a person who can live in society without creating a risk of injury to others? Or does it include some notion of repentance or change of heart?”).

67. See, e.g., Leo Katz et al., *Humanitarian or Scientific Alternatives to Punishment: The Rehabilitative Ideal*, in *FOUNDATIONS OF CRIMINAL LAW* 96, 97 (1999) (“The question raised by criminal behavior is thus not one of retributive justice and punishment but rather one of how to rehabilitate the criminal out of his condition . . . . [T]he animating goal is that of distributive justice, to make the less well off better off . . . .”).

68. *Id.* at 96–97.

purpose of punishment under a rehabilitative theory is to rehabilitate an individual in preparation for their reentry into society or to rehabilitate the prisoner for paternalistic or altruistic reasons, LWOP cannot effectuate the goals of rehabilitation. LWOP expresses the belief that some criminals are completely beyond hope of redemption and are culpable to such a high degree that they should be absolutely barred from reentry into society.<sup>69</sup> Moreover, even if the purpose of punishment under a rehabilitative justification is simply to cure a wrongdoer of their immoral thinking patterns for mere paternalistic or altruistic reasons without an expectation of reentry, “the prospect of eventual freedom would serve as an incentive for an incarcerated person to change.”<sup>70</sup>

While rehabilitative theories sit in striking opposition to LWOP and can be dispensed with quickly as a potential justification, deterrence, retributivism, and incapacity are often used to justify the penalty. However, enough time has elapsed since LWOP’s increased use to cast serious doubt on the deterrent value, retributive efficacy, and incapacitation rationales of LWOP.

Deterrence is a subset of utilitarian theories of punishment that seeks to justify punishment by touting its utility in preventing future crimes.<sup>71</sup> LWOP’s deterrent value has been questioned in several ways. First, general deterrence has three prerequisites which must be met to fairly justify harsh sentencing.<sup>72</sup> The prospective criminal must be aware of the punishment, the prospective criminal must be able to rationally calculate the risk, and the prospective criminal must actually engage in the cost-benefit analysis and conclude that the risk outweighs the benefits of the crime.<sup>73</sup> As Paul Robinson argues, LWOP fails to successfully deter LWOP-eligible crimes, because the evidence shows that prospective criminals: (1) are unaware of their jurisdiction’s laws and sentencing practices; (2) “are less inclined . . . to think carefully about the future consequences of their conduct;” and (3) tend to underestimate the likelihood of punishment and tend to “discount future detriments.”<sup>74</sup>

Second, on a more theoretical level, John Stuart Mill argued in favor of the death penalty over life sentences from a deterrent perspective. Mill suggested that prospective criminals would be more readily able to comprehend and be deterred by a death sentence than a life sentence.<sup>75</sup> In other words, the public

---

69. See Lerner, *supra* note 6, at 1103–04; see also Lichtenberg, *supra* note 35, at 59.

70. Lichtenberg, *supra* note 35, at 49.

71. See, e.g., James W. Child, *Deterrent Rationale*, in 1 THE PHILOSOPHY OF LAW: AN ENCYCLOPEDIA 201, 201–02 (Christopher Berry Gray ed., 1999) (“One of the traditional theories of punishment is deterrence. The theory is that when effective social situ[at]ions for inflicting punishment exist, people will commit fewer crimes, knowing that they will be punished if they do . . .”).

72. Paul H. Robinson, *Life Without Parole Under Modern Theories of Punishment*, in LIFE WITHOUT PAROLE: AMERICA’S NEW DEATH PENALTY?, *supra* note 11, at 138, 140 (“For [general deterrence] to work, three prerequisites must be satisfied.”).

73. *Id.* at 140–41.

74. *Id.* at 141–42.

75. John Stuart Mill, *April 1868 Speech on Capital Punishment*, in UTILITARIANISM 65, 65–72 (George Sher 2d. ed., 2001).

can imagine death as a horrible sentence, but they cannot meaningfully conceptualize life in prison to a degree of accuracy that would deter them from committing a crime. To many, life sentences are perceived as a more merciful alternative to death sentences.

Third, studies have shown that the certainty of punishment, rather than severity of punishment, is more likely to deter prospective criminals.<sup>76</sup> The temporal gap and the complex nature of the steps between commission of a crime and imposition of the punishment are so great that it is doubtful that prospective criminals engage in a cost-benefit analysis prior to committing an offense. Even if they do, it is unlikely that they can accurately assess the consequences of the action they consider taking.<sup>77</sup>

Retributivism<sup>78</sup> commonly justifies the imposition of harsh sentences for serious crimes in the United States.<sup>79</sup> Rooted in vengeance,<sup>80</sup> just desert,<sup>81</sup> and *lex talionis*,<sup>82</sup> retributivism is often likened to Old Testament views of

76. VALERIE WRIGHT, SENT'G PROJECT, DETERRENCE IN CRIMINAL JUSTICE: EVALUATING CERTAINTY VS. SEVERITY OF PUNISHMENT 2 (2010) (“[S]ince most crimes, including serious ones, do not result in an arrest and conviction, the overall deterrent effect of the certainty of punishment is substantially reduced.”).

77. See Lichtenberg, *supra* note 35, at 47–48.

78. Joel Feinberg, *The Classic Debate*, in PHILOSOPHY OF LAW 646, 646 (Joel Feinberg & Hyman Gross eds., 4th ed. 1991) (“Punishment is justified only on the ground that wrongdoing merits punishment.”); MICHAEL MOORE, PLACING BLAME: A THEORY OF THE CRIMINAL LAW 92 (1997) (“[R]etributivism asserts that punishment is properly inflicted because, and only because, the person deserves it. That some people deserve punishment on such a theory, is both a necessary and a sufficient condition justifying criminal sanctions.”); Russell L. Christopher, *Deterring Retributivism: The Injustice of “Just” Punishment*, 96 NW. U. L. REV. 843, 845 n.1 (2002) (“Retributivism is a theory, or justification, of punishment.”). For an overview of the debate between retributivist and consequentialist theories of punishment, see generally *id.* at 855–65.

79. Rachel E. Barkow, *Life Without Parole and the Hope for Real Sentencing Reform*, in LIFE WITHOUT PAROLE: AMERICA’S NEW DEATH PENALTY?, *supra* note 11, at 190, 197 (stating that retribution is an accepted theory of punishment in the United States and arguing that “[t]here is . . . no universal consensus on what crimes deserve what punishments” and some retributivists believe that there are sufficiently heinous crimes to justify LWOP, while other retributivists believe that “everyone deserves the opportunity to reform”).

80. Christopher, *supra* note 78, at 848 (“From its roots in vengeance, bloodlust, revenge, retaliation, and an eye for an eye, retributivism is pitched as the only theory which, in justifying punishment, does justice . . . .” (footnote omitted)).

81. Talia Fisher, *Conviction Without Conviction*, 96 MINN. L. REV. 833, 875–76 (2012) (“Retributivists are concurrently committed to two fundamental principles: punishing the guilty and not punishing the innocent. Deviation from either one of these outcomes is considered a departure from the principles of just desert.” (footnote omitted)).

82. IMMANUEL KANT, THE METAPHYSICS OF MORALS 130 (Mary Gregor trans., Cambridge Univ. Press 1996) (1797) (equality between the crime and the punishment is referred to as *lex talionis* or an eye for an eye); Russ Shafer-Landau, *The Failure of Retributivism*, 82 PHIL. STUD. 289, 299 (1996) (“The classic accompaniment to retributivism is *lex talionis*. *Lex* requires imposing a harm on a criminal identical to the one he imposed on his victim.”); see also Edwin L. Rubin, *Just Say No to Retribution*, 7 BUFF. CRIM. L. REV. 17, 28 (2003) (“[I]hat the criminal should be paid back for the harm he did . . . inevitably suggests the famous *lex talionis* . . . .”). But see Dan Markel, *State, Be Not Proud: A Retributivist Defense of the Commutation of Death Row and the Abolition of the Death Penalty*, 40 HARV. C.R.-C.L. REV. 407, 412 (2005) (arguing that retributivists are mistakenly excessively “viewed as adherents to *lex talionis*”).

punishment.<sup>83</sup> Likewise, LWOP has been compared to the banishment of Cain from the Garden of Eden.<sup>84</sup> By exiling those wrongdoers whom our society deems unfit to participate, retributive justice is exacted because they are getting what they deserve. Some retributivists even argue that LWOP is preferable to the death penalty because LWOP forces the offender to live with what they have done.<sup>85</sup>

However, retributive justifications of LWOP have also been called into question.<sup>86</sup> First, retributive justice is ambiguous insofar as reasonable retributive minds may differ on what level of punishment is “deserved.” Retributivism is meant to be proportional to the crime committed. The punishment can only be justified under retributive theories by its proportionality to the severity of the crime committed. To the extent that the severity of the punishment exceeds what is proportionate to the crime, the excessive punishment is unjustified. Some argue that LWOP is always disproportionate to the crime committed because it is excessive in relation to any possible crime.<sup>87</sup> This argument suggests that there is no crime sufficiently heinous to justify the harshness of lifelong condemnation. Others argue that LWOP, even if appropriately proportionate to the crime, has no place in a civilized society and undermines the morality of the society imposing the punishment.<sup>88</sup> Still others argue that those who commit the most heinous crimes deserve harsh punishment but should always be eligible for release if they can demonstrate sufficient repentance and a “change of heart.”<sup>89</sup>

---

83. *Exodus* 21:23–24 (King James) (“And if *any* mischief follow, then thou shalt give life for life, eye for eye, tooth for tooth . . . .”); *Leviticus* 24:17-20 (King James) (“And he that killeth any man shall surely be put to death . . . . Breach for breach, eye for eye, tooth for tooth . . . .”).

84. Lerner, *supra* note 6, at 1127.

85. See Josh Bowers, *Mandatory Life and the Death of Equitable Discretion, in LIFE WITHOUT PAROLE: AMERICA’S NEW DEATH PENALTY?*, *supra* note 11, at 25, 44 (“Capital punishment may satiate a retributive hunger, but it concurrently provides . . . a quicker way out. By contrast, a death-in-prison term [such as LWOP] forces bad actors to live with themselves and their transgression.” (footnotes omitted)); see also Michael S. Moore, *The Moral Worth of Retribution, in RESPONSIBILITY, CHARACTER, AND THE EMOTIONS* 179, 213 (Ferdinand Schoeman ed., 1987) (arguing that, if Moore had committed a horrifically malicious crime, he “would feel guilty unto death . . . [and] couldn’t imagine any suffering that could be imposed upon [him] that would be unfair because it exceeded what [he] deserved,” concluding that “[s]uch deep feelings of guilt seem to me to be the only tolerable response of a moral being”); see generally Markel, *supra* note 82, at 547–68 (opposing the death penalty on retributive grounds).

86. See Lichtenberg, *supra* note 35, at 52–58.

87. See *id.* at 57–58.

88. See *id.* at 55–56.

89. See *id.*

Those who commit the worst crimes (and are morally responsible for committing them, i.e. are not legally insane or otherwise excused from punishment) deserve punishment and ought to be punished, but those who are no longer dangerous and have undergone a change of heart amounting to repentance must be evaluated for release after serving a reasonable and appropriate sentence that satisfies aims of punishment such as deterrence and respect for law and persons.

*Id.* at 57–58.

Incapacitation justifies punishment on the basis that the individual being punished is prevented from committing crimes during their incarceration. Although this may initially appear to be a strong justification for LWOP, it is surprisingly weak. First, incapacitation generally fails to recognize that prisoners can commit crimes within the prison walls. While incarcerated, the prisoner may commit crimes against fellow inmates or prison staff. Second, there is little evidence to suggest that perpetual incapacitation is necessary to prevent an offender from committing future crimes. Studies have shown that recidivism rates decline with age, so in most cases, an LWOP sentence would not be more effective in preventing the particular offender from committing future crimes than tailoring the sentence to provide for release at the point where the criminal “age[s] out” of crime.<sup>90</sup>

The main theories of punishment thus struggle to justify LWOP generally, at least not without becoming subject to strong criticism. Even if they could provide persuasive support for the practice as a whole, as discussed below, these theories struggle even more to support the additional punishment of prohibiting LWOP prisoners from exercising autonomy and dignity in their death when they are properly diagnosed with a terminal illness.

## II. DEATH WITH DIGNITY

An explanation of terminology may be necessary for clarifying the meaning of the perhaps ambiguous phrase death with dignity. For purposes of this Article, the term death with dignity refers to physician-aided death for terminally ill individuals who wish to exercise autonomy in their deaths by obtaining and administering death-hastening prescription drugs, rather than naturally succumbing to their illness.<sup>91</sup> As used here, the term does not encompass palliative care, hospice care, or suicide. Further, death with dignity is separate and distinct from refusal of medical treatment or withdrawal of medical support.

---

90. Goldstein, *supra* note 53.

91. The phrase “death with dignity” was selected because this is the language that advocates and legislatures supporting the practice use. Other terms deemed acceptable by supporters of death-with-dignity laws include assisted dying, assisted death, physician-assisted death, physician-assisted dying, aid in dying, physician aid in dying, and medical aid in dying. Proponents of death with dignity advise against using phrases which include the word “suicide,” noting that “suicide” is a “loaded,” “biased” term which may be hurtful or offensive to patients and their families and that death-with-dignity laws expressly state that the practice of death with dignity under the protocols of the acts “shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law.” Put another way, including “suicide” in the terminology is neither value-neutral nor legally precise, as exercising death with dignity is not suicide. *Terminology of Assisted Dying*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/terminology> (last visited Oct. 6, 2020).

*A. The Debate*

People have vigorously debated the morality and ethics of accelerating one's own death for centuries.<sup>92</sup> As applied to aid in dying, the arguments for and against the practice may be typified into several categories. Proponents' arguments generally fall into two broad categories: autonomy and dignity. Opponents' arguments usually amount to moral, religious, and skeptical rationales.

By and large, the most common argument in favor of death with dignity is an argument flowing from notions of autonomy. This argument suggests that allowing persons to make their own decisions about how their lives end respects their autonomy and affords them dignity.<sup>93</sup> Because death is certain, there is no question about whether we will die. The question instead is how we die. One characterization of this argument is as follows: "Simply put, if you are in favor of self-determination and against pain and suffering, then you must favor the legalization of physician-assisted [death]."<sup>94</sup> Some argue that the ideal is for everyone to die an "appropriate death."<sup>95</sup> An appropriate death is sometimes defined as a concurrence among the individual's physical death,<sup>96</sup> psychological death,<sup>97</sup> social death,<sup>98</sup> and anthropomorphic death.<sup>99</sup> Thus, a death occurring after a coma (psychological death preceding physical death) is an inappropriate death under this definition. Others have defined appropriate deaths as those in which a person plays a role in their own death.<sup>100</sup> If a person dies as a result of a natural disaster, that is an inappropriate death under this definition, whereas

---

92. See generally JENNIFER MICHAEL HECHT, *STAY: A HISTORY OF SUICIDE AND THE PHILOSOPHIES AGAINST IT* (2013); Elise P. Garrison, *Attitudes Toward Suicide in Ancient Greece*, 121 *TRANSACTIONS AM. PHILOLOGICAL ASS'N* 13 (1991); Robin E. Gearing & Dana Lizardi, *Religion and Suicide*, 48 *J. RELIG. HEALTH* 332, 332 (2009).

93. When asked for their reasons for choosing death with dignity, autonomy was the most common response, with 89.5% of Oregonian patients and 87% of Washingtonian residents naming autonomy as a primary reason for electing to act under the statute. In fact, autonomy outranked pain control and control over bodily functions. Inability to enjoy life and loss of dignity were the second and third most common responses. ORE. HEALTH AUTH., *OREGON DEATH WITH DIGNITY ACT: DATA SUMMARY 2016*, at 10 (2017); WASH. ST. DEP'T HEALTH, *WASHINGTON STATE: 2016 DEATH WITH DIGNITY ACT REPORT 2* (2017).

94. Giles R. Scofield, *Exposing Some Myths About Physician-Assisted Suicide*, 18 *SEATTLE U. L. REV.* 473, 476 (1995).

95. See RICHARD A. KALISH, *DEATH, GRIEF, AND CARING RELATIONSHIPS* (2d ed. 1985); see also David Lester, *Assisted Suicide for Prisoners*, 9 *SUICIDOLOGY ONLINE* 1, 1–2 (2018).

96. The moment the organs stop functioning.

97. The moment an individual loses self-awareness.

98. The moment when an individual is no longer included as part of their social community, "such as when [an] elderly relative is put in a home and forgotten by his family and friends." Lester, *supra* note 95, at 1.

99. The moment when an individual is cut off from the community and treated as if they no longer exist.

100. See generally Ludwig Binswager, *The Case of Ellen West: An Anthropological-Clinical Study*, in *EXISTENCE: A NEW DIMENSION IN PSYCHIATRY AND PSYCHOLOGY* 237 (Rollo May et al. eds., 1958).

a death by suicide would be an appropriate death. Under either definition, physician-aided death would be considered “appropriate” and ideal.

Another argument for autonomy suggests simply that the government should not meddle in the doctor-patient relationship or in a person’s decision to end their suffering on their own terms.<sup>101</sup> Under this argument, patients and their physicians should be afforded privacy in their end-of-life care decisions. So long as sufficient procedural restrictions are put in place to ensure that the decision is informed and the patient is competent to make the choice to end life on their terms, the government has no legitimate interest in a patient’s private medical decision.

The arguments against death with dignity are somewhat predictable, and many of them mirror arguments opposing suicide more broadly. A Kantian argument notes there is a duty owed to society that is breached when a life is ended before its natural expiration through suicide. Each member of society owes a duty to society and electing to end one’s life violates that duty. Kant further likens even the mere attempt of suicide to “discard[ing one’s] humanity.”<sup>102</sup> Once a person attempts suicide, according to Kant, they “ha[ve] no respect for human behavior, mak[ing] a thing of himself.”<sup>103</sup> For Kant, ending one’s life is a termination of rationality that results in that person’s inability to engage in future moral acts. Moreover, because death prevents future morality, suicide constitutes a deliberate prevention of future morality and cannot itself be moral.<sup>104</sup>

Religious morality typically opposes suicide, as well. St. Augustine, for example, proclaims that humans ought not have autonomy in their deaths because the time and manner of death is a decision to be made by a divine order or God’s plan.<sup>105</sup> Ending one’s own life, thus, violates the divine law against killing and rejects the plan that God has established for us humans.<sup>106</sup> For Augustine, “whoever kills a man, either himself or another, is implicated in the

---

101. Kevin M. Simmons, Note, *Suicide and Death with Dignity*, 5 J. L. & BIOSCIENCES 436, 437 (2018) (noting that the language in death-with-dignity acts commonly reference “choice” and “option”).

102. Paul Edwards, *Kant on Suicide*, PHIL. NOW (May/June 2007) (quoting IMMANUEL KANT, THE METAPHYSICS OF MORALS (1797)), [https://philosophynow.org/issues/61/Kant\\_On\\_Suicide](https://philosophynow.org/issues/61/Kant_On_Suicide).

103. *Id.*

104. KANT, *supra* note 82, at 38–39.

105. See AURELIUS AUGUSTINE, 1 THE CITY OF GOD 18 (Rev. Marcus Dods ed., trans., 1871) (“They, then, who are destined to die, need not be careful to inquire what death they are to die, but into what place death will usher them.”).

[B]ecause life is God’s gift to man, and is subject to His power, Who kills and makes to live. Hence whoever takes his own life, sins against God, even as he who kills another’s slave, sins against that slave’s master, and as he who usurps to himself judgment of a matter not entrusted to him. For it belongs to God alone to pronounce sentence of death and life, according to Deut[eronomy] 32:39, ‘I will kill and I will make to live.’

ST. THOMAS AQUINAS, SUMMA THEOLOGICA 3330 (Fathers Eng. Dom. Province trans., Benzinger Bros. ed. 1947).

106. AUGUSTINE, *supra* note 105, at 31.

guilt of murder.”<sup>107</sup> The argument says that our bodies are not actually our own but rather are, in a sense, leased from a divine being. Under this belief, humans have an obligation and responsibility as stewards of our bodies, and our autonomy does not extend to decisions about destroying, mutilating, or otherwise damaging our bodies. Likewise, it is antithetical of the notion that our lives belong to a divine creator to permit some humans to aid in the termination of another’s life because no distinctions should be drawn between this practice and any other homicide. Thus, under this view, suicide and homicide are absolutely impermissible without exception.<sup>108</sup>

The Roman Catholic Church’s official position on aid in dying is that all killing, regardless of the context, violates divine law and *offends* the dignity of the person. Similarly, the Orthodox Jewish position is that “Judaism places the highest importance on palliation of pain, particularly in the case of terminal patients,” and “Judaism teaches that suicide is an offense against the Deity who is the Author of life.”<sup>109</sup> The Qur’an instructs Muslims, “[T]ake not life, which Allah hath made sacred, except by way of justice and law.”<sup>110</sup> This has been interpreted as follows: “Since we did not create ourselves we do not own our bodies . . . . Attempting to kill oneself is a crime in Islam as well as a grave sin . . . . The concept of life not worthy of living does not exist in Islam.”<sup>111</sup> In short, under the strictest views of the world’s major religions, a formal position has been taken that indicates that our bodies belong to God, and we humans have a duty owed to preserve our bodies and the lives of others. Thus, humans do not possess as much autonomy over our bodies as death-with-dignity proponents suggest.

Some physicians refuse to provide aid in dying to their patients. There are non-faith-based reasons for their opposition to the practice. First, some cite the Hippocratic Oath’s famous “do no harm” clause as a reason for refusing to aid a patient in dying.<sup>112</sup> Second, some argue that a false dichotomy has been at the

107. *Id.* at 32.

108. Augustine discusses and rejects five possible defenses to suicide: (1) to escape temporal troubles; (2) to avoid another’s sin; (3) out of despair for past sins; (4) to attain a better life after death; and (5) to avoid falling into sin out of pleasure or fear. *See generally id.* at 32–34.

109. *Pain Relief Promotion Act: Hearing Before the Comm. on the Judiciary U.S. S.*, 106th Cong. 59–63 (2000) (statement of J. David Bleich, Rabbi, Union Orthodox Jewish Congregations Am.).

110. Qur’an 17:33 (Sahih International).

111. *Euthanasia, Is There a Right to Suicide?*, ISLAMICITY, <http://www.islamicity.com/Science/euthanasia.shtml> (last visited Oct. 7, 2020). But see the Islamic Medical Association of America (IMANA) statement that “When death becomes inevitable, as determined by physicians taking care of terminally ill patients, the patient should be allowed to die without unnecessary procedures.” *Euthanasia, Assisted Dying, Suicide, and Medical Ethics*, BBC (Oct. 21, 2012), <https://www.bbc.co.uk/religion/religions/islam/islamethics/euthanasia.shtml#:~:text=According%20to%20the%20Islamic%20Medical,to%20die%20without%20unnecessary%20procedures.%22>.

112. The Hippocratic Oath does not include an oath to do no harm, contrary to popular belief. The original Hippocratic Oath, however, expressly states, “I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan.” Hist. Med. Div. Nat’l Libr. of Med., *Greek Medicine*, NAT’L INSTS. HEALTH (Feb. 7, 2012), [https://www.nlm.nih.gov/hmd/greek/greek\\_oath.html](https://www.nlm.nih.gov/hmd/greek/greek_oath.html). For a discussion on the do-no-harm

root of the death-with-dignity debate. The palliative-care world provides many options for ensuring a comfortable transition during the final stages of life. These advocates suggest physicians make efforts to find alternatives for patients who are considering physician-assisted death. When a patient approaches a physician to seek the death-with-dignity option, the physician should inquire into why the terminally ill patient wants to end their life. If the physician can identify other means—including, for example, comprehensive hospice care or prescription medications—for allowing for a more peaceful transition, that would provide death with dignity without requiring such an extreme treatment. The solution for these physicians is to expand palliative and end-of-life care, not to authorize or promote death with dignity. Third, some physicians indicate that physician-aided death undermines trust between the physician and patient. The rationale for the erosion-of-trust argument simply states that patients seek to become well and expect their physicians to assist in their healing and well-being. Thus, the argument proposes, a physician should not assist in facilitating death because it could undermine the physician's integrity and result in a loss of patient trust.<sup>113</sup>

### B. *Death-with-Dignity Laws*

As of the time of this writing, ten United States jurisdictions expressly allow death with dignity. A brief overview of the passage and content of these laws may be helpful.

---

myth, see Robert H. Shmerling, *First, Do No Harm*, HARV. HEALTH BLOG (June 22, 2020, 12:00 AM), <https://www.health.harvard.edu/blog/first-do-no-harm-201510138421>.

113. These three arguments come from an article categorizing and expanding upon a 2015 secular debate held at Vanderbilt University School of Medicine in which physicians discussed their reasoning for opposing what they referred to as “physician-assisted suicide.” See Daniel P. Sulmasy et al., *Non-Faith-Based Arguments Against Physician-Assisted Suicide and Euthanasia*, 83 LINACRE Q. 246 (2016). Other secular arguments opposing death-with-dignity laws express concern over potentially disparate impacts on vulnerable populations, including those who are disabled but not terminally ill, the elderly, and women. See, e.g., Margaret K. Dore, *“Death with Dignity”: A Recipe for Elder Abuse and Homicide (Albeit Not by Name)*, 11 MARQ. ELDER’S ADVISOR 387 (2010); Katrina George, *A Woman’s Choice? The Gendered Risks of Voluntary Euthanasia and Physician-Assisted Suicide*, 15 MED. L. REV. 1 (2007); Mary Crossley, *Ending-Life Decisions: Some Disability Perspectives*, 33 GA. ST. U. L. REV. 893 (2017). However, some argue that minor children, a potentially vulnerable population that is not permitted to exercise death with dignity, should be permitted to do so. See, e.g., Anne Compton-Brown, *Examining Patient Integrity and Autonomy: Is Assisted Death a Viable Option for Adolescents in the United States?*, 23 ANNALS HEALTH L. ADVANCE DIRECTIVE 86 (2014); Neelam Chhikara, Note, *Extending the Practice of Physician-Assisted Suicide to Competent Minors*, 55 FAM. CT. REV. 430 (2017); Sydni Katz, *A Minor’s Right to Die with Dignity: The Ultimate Act of Love, Compassion, Mercy, and Civil Liberty*, 48 CAL. W. INT’L L.J. 219 (2018). These arguments suggest that perhaps implementing greater safeguards for vulnerable populations would be preferable to banning all death with dignity because of potential abuse of vulnerable populations.

1. *Passage*

In 1997, the state of Oregon was the first U.S. jurisdiction to enact a death-with-dignity act.<sup>114</sup> The Oregon Death with Dignity Act “transformed the crime of assisted suicide into a medical treatment if the assistance is provided by a physician.”<sup>115</sup> Now, nine other U.S. jurisdictions—California,<sup>116</sup> Colorado,<sup>117</sup> Washington, D.C.,<sup>118</sup> Hawaii,<sup>119</sup> Maine,<sup>120</sup> Montana,<sup>121</sup> New Jersey,<sup>122</sup> Vermont,<sup>123</sup> and Washington<sup>124</sup>—have followed suit, implementing their own rules. Most of the jurisdictions permitting physician-aided death imitate Oregon’s method and rationale, enacting statutes that decriminalize assisted suicide if performed by a physician and codify express procedural rules with which medical providers must comply.<sup>125</sup> In these jurisdictions, the local political figures have lauded some legislative measures as “[a]llowing terminally ill and dying residents the dignity to make end-of-life decisions according to their own consciences”<sup>126</sup> and protecting individuals from governmental overreach into their private lives and decisions.<sup>127</sup>

Montana, however, authorized death with dignity through the quieter judicial process rather than the legislative process. In *Baxter v. State*, medical providers and a terminally ill patient challenged “the application of Montana homicide statutes to physicians who provide aid in dying to mentally competent, terminally ill patients.”<sup>128</sup> The Montana Supreme Court held that it is not a crime for a physician to aid such a patient in dying. Relying on Montana

---

114. Oregon Death with Dignity Act, OR. REV. STAT. §§ 127.800–897 (2018).

115. *Assisted Suicide Laws in the United States*, PATIENTS RTS. COUNCIL (Jan. 6, 2017), <http://www.patientsrightscouncil.org/site/assisted-suicide-state-laws>.

116. End of Life Option Act, CAL. HEALTH & SAFETY CODE § 443 (West 2016).

117. Colorado End-of-Life Options Act, COLO. REV. STAT. §§ 25-48-101 to -123 (2016).

118. Death with Dignity Act, D.C. CODE §§ 7-661.01–.17 (2017).

119. Our Care, Our Choice Act, HAW. REV. STAT. ANN. § 327L (West 2019).

120. Maine Death with Dignity Act, ME. STAT. tit. 22, § 2140 (2019).

121. *Baxter v. State*, 224 P.3d 1211 (Mont. 2009).

122. Medical Aid in Dying for the Terminally Ill Act, N.J. STAT. ANN. § 26:16 (West 2019).

123. Patient Choice at End of Life Act, VT. STAT. ANN. tit. 18, §§ 5281–93 (2013).

124. Washington Death with Dignity Act, WASH. REV. CODE § 70.245 (2009).

125. See End of Life Option Act, CAL. HEALTH & SAFETY CODE § 443 (West 2016); Death with Dignity Act, D.C. CODE § 7-661.01–.17 (2017); Our Care, Our Choice Act, HAW. REV. STAT. ANN. § 327L (West 2019); Maine Death with Dignity Act, ME. STAT. tit. 22, § 2140 (2019); Patient Choice at End of Life Act, VT. STAT. ANN. tit. 18, § 5281 (2013); Washington Death with Dignity Act, WASH. REV. CODE § 70.245.901 (2009).

126. Press Release, Phil Murphy, N.J. Governor, Statement on Medical Aid in Dying for the Terminally Ill Act (Mar. 25, 2019), <https://www.nj.gov/governor/news/news/562019/approved/20190322d.shtml>.

127. See Press Release, Janet Mills, Maine Governor, Governor Mills Signs Death with Dignity Act (June 12, 2019), <https://www.maine.gov/governor/mills/news/governor-mills-signs-death-dignity-act-2019-06-12> (“It is not up to the government to decide who may die and who may live, when they shall die or how long they shall live . . .”).

128. *Baxter v. State*, 224 P.3d 1211, 1214 (Mont. 2009).

statutes (especially the Rights of the Terminally Ill Act) and public policy arguments, the Court emphasized respect for the terminally ill patient's autonomy<sup>129</sup> and privacy,<sup>130</sup> as well as deference to physicians' judgment.<sup>131</sup> Montana does not have a death-with-dignity act, but the ruling in *Baxter* legalizes the end-of-life option in Montana, relieving physicians from fear of civil or criminal liability<sup>132</sup> and giving patients suffering incurable diseases the option to have some control over the time and manner of their deaths during the final stages of their lives.

## 2. *Protocols and Procedures*

Each jurisdiction sets its own procedures for the exercise of death with dignity. These protocols can be conceptually categorized into two groups of rules: those pertaining to the profile of the patient and those describing the procedures for requesting physician-aided death to assure voluntary consent. While these two categories of procedures specifically set forth clear guidance on patients' eligibility and physicians' and pharmacists' obligations, there is a notable absence of detail with respect to the particular drugs that may be used in carrying out actions under the statutes.

### a. *Patient Profile*

In every jurisdiction authorizing death with dignity, the patient must meet certain eligibility requirements. First, the patient must meet age and capacity requirements. In all ten jurisdictions, the patient must be at least eighteen years of age and fully competent. Second, the patient must have been diagnosed by a physician with a terminal illness, defined as a prognosis of six months or less.

Third, the patient must be a resident of the jurisdiction in which they seek death with dignity. Each jurisdiction specifies its own means by which residency

---

129. *Id.* at 1217, 1220 (emphasizing that “the legislature’s intent [was] to give terminally ill patients . . . end-of-life autonomy, respect and assurance that their life-ending wishes will be followed” and that “the Act reflects legislative respect for the wishes of a patient facing incurable illness”).

130. *Id.* at 1216 (“[T]he act of a physician handing medicine to a terminally ill patient, and the patient’s subsequent peaceful and private act of taking the medicine, are not comparable to the violent, peace-breaching conduct that this Court and others have found to violate public policy.”); *see also id.* at 1217 (explaining that “[t]he patient’s subsequent private decision whether to take the medicine does not breach public peace or endanger others”).

131. *Id.* at 1220 (“The [Rights of the Terminally Ill] Act also indicates legislative regard . . . for a physician who honors his legal obligation to the patient.”).

132. *Id.* at 1222 (“We therefore hold . . . a terminally ill patient’s consent to physician aid in dying constitutes a statutory defense to a charge of homicide against the aiding physician when no other consent exceptions apply.”); *see also id.* at 1217 (analogizing aid in dying to withholding or withdrawing life-sustaining treatments with patients’ consent).

may be established.<sup>133</sup> Jurisdictions setting forth which documents suffice for purposes of establishing residency indicate that residency may be established through possession of a state-issued driver's license or identification card, voter registration, or evidence of owning or leasing property in the jurisdiction.<sup>134</sup> Some jurisdictions also allow the filing of an income tax return in that state for the most recent year<sup>135</sup> or permit physicians to rely on any government record that the physician reasonably believes to demonstrate the individual's current residency.<sup>136</sup> Further, Oregon's and Washington's statutes expressly state that the forms of documentation identified in the statute are inexhaustive.<sup>137</sup>

*b. Request for Medication*

After a patient has established that they meet the basic eligibility requirements to exercise their rights under the statute, they must proceed to the next phase: requesting the medication. Before a physician is authorized to write a prescription for the medication, the patient must meet certain statutory requirements, which vary by jurisdiction.

All jurisdictions with death-with-dignity statutes require that the request for the medication be made to a physician twice orally and once in writing. Each state requires either a fifteen- or twenty-day period between the initial oral request and the final oral request.<sup>138</sup> The purpose of this requirement is to ensure that the patient's decision is voluntarily and freely made. To further assure voluntariness, some jurisdictions mandate that the written request be witnessed by two competent adults.<sup>139</sup> Some jurisdictions grant an exception to

133. D.C.'s and Vermont's statutes impose a residency requirement, but the Acts do not specify the means through which a patient may establish residency. *See* Death with Dignity Act, D.C. CODE §§ 7-661.01–.17 (2017); Patient Choice at End of Life Act, VT. STAT. ANN. tit. 18, § 5281 (2013).

134. *See* End of Life Option Act, CAL. HEALTH & SAFETY CODE § 443.2(a)(3) (West 2016); Colorado End-of-Life Options Act, COLO. REV. STAT. § 25-48-102(14) (2016); Our Care, Our Choice Act, HAW. REV. STAT. ANN. § 327L-13 (West 2019); Maine Death with Dignity Act, ME. STAT. tit. 22, § 2140(15) (2019); Medical Aid in Dying for the Terminally Ill Act, N.J. STAT. ANN. § 26:16-11 (West 2019); Oregon Death with Dignity Act, OR. REV. STAT. § 127.860 (2018); Washington Death with Dignity Act, WASH. REV. CODE § 70.245.130 (2009).

135. *See* OR. REV. STAT. § 127.860(4); N.J. STAT. ANN. § 26:16-11(c); HAW. REV. STAT. ANN. § 327L-13(4); COLO. REV. STAT. § 25-48-102(14)(d); CAL. HEALTH & SAFETY CODE § 443.2(a)(3)(d).

136. *See* N.J. STAT. ANN. § 26:16-11(d).

137. *See* OR. REV. STAT. § 127.860; WASH. REV. CODE § 70.245.130. Brittany Maynard famously moved to Oregon expressly for the purpose of exercising death with dignity under Oregon's Death with Dignity Act. *See generally* *About Brittany Maynard*, COMPASSION & CHOICES, <http://thebrittanyfund.org/about> (last visited Oct. 8, 2020).

138. Hawaii is the only jurisdiction requiring a minimum of twenty days. HAW. REV. STAT. ANN. § 327L-11. All other death-with-dignity statutory jurisdictions require a minimum of fifteen days. *See* CAL. HEALTH & SAFETY CODE § 443.3(a); COLO. REV. STAT. § 25-48-104(1); ME. STAT. tit. 22, § 2140(13); N.J. STAT. ANN. § 26:16-10(a)(1); OR. REV. STAT. § 127.840(1); WASH. REV. CODE § 70.245.090; D.C. CODE § 7-661.02(a)(1); VT. STAT. ANN. tit. 18, § 5283(a)(2) (2013).

139. *See, e.g.*, ME. STAT. tit. 22, § 2140(5)(c).

the fifteen-day requirement if the physician determines that the patient is likely to die within fifteen days.<sup>140</sup>

After the physician has written the prescription, some states impose a waiting period before the medication is made available to the patient. Washington, D.C., Hawaii, New Jersey, Oregon, Vermont, and Washington require the doctor to wait forty-eight hours after the patient's final request before writing the prescription. Washington requires physicians at the time of the second oral request to inform patients that they may rescind the request.<sup>141</sup> Moreover, California and Hawaii require the patient to complete a Final Attestation Form within forty-eight hours prior to taking the medication.<sup>142</sup>

Finally, all jurisdictions require the patient to self-administer the medication. Medical professionals and loved ones may not assist in the administration of the death-hastening medication. Aiding the patient in this way undermines the apparent voluntariness of the act and exposes the assistant to civil and criminal liability.

### *c. Drugs*

None of the death-with-dignity jurisdictions' statutory schemes require physicians to prescribe any particular drug. Physicians are thus free to prescribe the drug of their choosing, which may vary due to cost and availability.

Most physicians who participate in death with dignity prescribe an oral dosage of a barbiturate, but compound medications have also been prescribed.<sup>143</sup> The two barbiturates widely considered as the best death-hastening drugs are pentobarbital and secobarbital.<sup>144</sup>

Pentobarbital exists in both liquid and powder form. The Danish pharmaceutical company Lundbeck produces the only liquid form of pentobarbital approved for sale in the United States.<sup>145</sup> Lundbeck refuses to distribute pentobarbital to U.S. prisons that carry out the death penalty by lethal injection. Hospitals and treatment centers, however, still have access to the drug, but the purchaser must sign an agreement not to redistribute without authorization from Lundbeck.<sup>146</sup>

---

140. See, e.g., OR. REV. STAT. § 127.850(2).

141. WASH. REV. CODE § 70.245.090.

142. See HAW. REV. STAT. ANN. § 327L-24(b); CAL. HEALTH & SAFETY CODE § 443.11(c).

143. *Frequently Asked Questions*, DEATH WITH DIGNITY NAT'L CTR., <https://www.deathwithdignity.org/faqs> (last visited Oct. 8, 2020).

144. Jennie Dear, *The Doctors Who Invented a New Way To Help People Die*, ATLANTIC (Jan. 22, 2019), <https://www.theatlantic.com/health/archive/2019/01/medical-aid-in-dying-medications/580591>.

145. Brandi Grissom, *A Drug Used in Executions Becomes Very Hard To Get*, N.Y. TIMES (Feb. 5, 2011), <https://www.nytimes.com/2011/02/06/us/06ttdrug.html>.

146. Press Release, Lundbeck, Lundbeck Overhauls Pentobarbital Distribution Program to Restrict Misuse (July 1, 2011), <https://investor.lundbeck.com/news-releases/news-release-details/lundbeck-overhauls-pentobarbital-distribution-program-restrict>.

In 2012, Lundbeck increased the price of liquid pentobarbital, making it cost prohibitive for many. Prices increased to \$15,000–\$25,000 per dose.<sup>147</sup> Powdered pentobarbital, on the other hand, is much more affordable at a price of \$400–\$500 per dose.<sup>148</sup> However, pentobarbital powder, which became the main life-terminating drug after the price hike for liquid pentobarbital, disappeared from the U.S. market around 2015.<sup>149</sup>

In 2015, with powdered pentobarbital's unavailability and liquid pentobarbital's high cost and unavailability, secobarbital became the only accessible drug. At that time, secobarbital's price doubled overnight, and the drug currently costs between \$3,000 and \$5,000 per lethal dose.<sup>150</sup>

Due to these unpredictable pharmaceutical company decisions governing the price and availability of life-ending drugs, a team of researchers in Seattle set out to develop a new, affordable, and accessible life-terminating drug.<sup>151</sup> Through research and trials with volunteer subjects, the team developed a compounded drug called DDMP2, which costs roughly \$500 per lethal dose.<sup>152</sup> As of 2019, DDMP2 is commercially available for U.S. patients seeking to exercise death with dignity.<sup>153</sup>

### C. *Who Exercises Death with Dignity?*

Oregon's Death with Dignity Act precedes the other jurisdictions' enactments by nearly two decades. As the state with the most longevity, Oregon is the state most useful for gathering data and statistics. At the twenty-year mark, state reports were published, and the data were synthesized by researchers hoping to understand how the Act has been used.

In the period from 1998 through June 2017, 1,857 Oregonians obtained a lethal prescription from their physician.<sup>154</sup> However, only 1,179 people chose

147. *Frequently Asked Questions*, *supra* note 143.

148. See Roxanne Nelson, *When Dying Becomes Unaffordable*, MEDSCAPE (Nov. 9, 2017), <https://www.medscape.com/viewarticle/888271>.

149. *Id.*

150. *Id.*

151. Dear, *supra* note 144.

152. *Id.*

153. *Id.* For states recommending or referencing DDMP2 as a drug option, see *Frequently Asked Questions, Our Care, Our Choice Act 3*, HAW. DEPT. HEALTH (Apr. 11, 2019), <https://health.hawaii.gov/opppd/files/2018/12/FAQ-OCOC-final-.pdf>; OR. HEALTH AUTH., OREGON DEATH WITH DIGNITY ACT 2018 DATA SUMMARY 7 (2018), <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf>.

154. Lynne Terry, *20 Years of Oregon's Death with Dignity Act*, OREGONIAN (May 17, 2019) (citing Katrina Hedberg & Craig New, *Oregon's Death with Dignity Act: 20 Years of Experience To Inform the Debate*, ANNALS INTERNAL MED. (Sept. 19, 2017), <https://olis.oregonlegislature.gov/liz/2019R1/Downloads/CommitteeMeetingDocument/187787>), [https://www.oregonlive.com/health/2017/10/20\\_years\\_of\\_oregons\\_death\\_with.html](https://www.oregonlive.com/health/2017/10/20_years_of_oregons_death_with.html).

to use the lethal dose.<sup>155</sup> Of those, the vast majority of the patients were seniors, and the median age was seventy-two years.<sup>156</sup> Seventy-seven percent of the patients who died from the lethal dose were cancer patients.<sup>157</sup> Lou Gehrig's disease was the next most common illness, representing 8% of patients.<sup>158</sup>

Among those who exercised death with dignity in Oregon were Charlie and Francie Emerick, a couple who was married for sixty-six years. Both were terminally ill and planned a simultaneous death in their bed at home in April 2017. Their family described them as “grateful to have the option” of managing their deaths after suffering from painful illnesses.<sup>159</sup> The Emericks also wanted to “help . . . change the way [people] think about dying” and allowed filming of their conversations and preparations.<sup>160</sup> Other stories similarly emphasize the gratitude the people who choose death with dignity feel for being able to die on their own terms.<sup>161</sup>

Thus, a majority of those who exercise death with dignity are elderly. All are terminally ill due to statutory requirements. Those who exercise death with dignity are grateful for the opportunity to exercise autonomy over their bodies and enjoy dignity in their deaths.

### III. DEATH WITH DIGNITY FOR LWOP INMATES

This Part begins with the argument that, although prisoners lose many rights during their period of incarceration, they still enjoy some constitutional protections, particularly when the prisoners' desired protections invoke notions of autonomy, dignity, and bodily integrity. This Part then shows the inadequacy of end-of-life care for prisoners in the current system. Finally, this Part shows that prohibiting prisoners from enjoying the death with dignity they would enjoy if they were free constitutes an additional punishment that is unjustified by the major theories of punishment.

---

155. *Id.*

156. *Id.* Of those who died from the lethal dose, 1,073 were patients fifty-five years of age or older. *Id.*

157. *Id.*

158. *Id.*

159. Jonel Aleccia, *This Couple Died by Assisted Suicide Together. Here's Their Story*, TIME MAG. (Mar. 6, 2018), <https://time.com/5179977/assisted-suicide-couple-death>. A documentary was created and released, titled *Living & Dying: A Love Story*. *Id.* The Emericks are the only known couple to exercise death with dignity together. *Id.*

160. *Id.*

161. Christina Derwey, *I Want To Have the Choice*, DEATH WITH DIGNITY NAT'L CTR., <https://www.deathwithdignity.org/stories/christina-derwey-choice> (last visited Oct. 8, 2020) (contrasting her stepfather's death from cancer with her mother's death through death with dignity and concluding, “I thank God every day that Oregon was a pioneer in humanitarianism by passing the Death With Dignity Act”); Lisa Vigil Schattinger, *The Peace that Death with Dignity Brings*, DEATH WITH DIGNITY NAT'L CTR. (Oct. 2015), <https://www.deathwithdignity.org/stories/lisa-vigil-schattinger-peace> (describing her grandfather's exercise of physician-aided death and writing that “[t]he opportunity to die at his own time of choice, with medication prescribed under the Oregon Death with Dignity Act gave him great peace of mind”).

*A. Prisoners' Constitutional Rights*

By virtue of incarceration, society renders prisoners dependent upon the government to meet basic needs, including food, water, shelter, clothing, and medical care. Although prisoners lose certain fundamental liberty rights, the state may not deprive prisoners of “the essence of human dignity inherent in all persons.”<sup>162</sup> The Eighth Amendment to the U.S. Constitution prohibits the government from inflicting “cruel and unusual punishments.”<sup>163</sup> The Punishment Clause’s “essential principle” is that the state must “respect the human attributes even of those who have committed serious crimes.”<sup>164</sup> This principle extends beyond physical torture and “embodies ‘broad and idealistic concepts of dignity, civilized standards, humanity, and decency.’”<sup>165</sup>

In analyzing whether a particular sentencing practice or prison condition constitutes cruel and unusual punishment, the Supreme Court looks to “evolving standards of decency that mark the progress of a maturing society.”<sup>166</sup> In applying this flexible test over the past several decades, the Court has expressed its preference for relying upon “objective indicators.”<sup>167</sup> Empirical analysis of twenty-four majority and plurality decisions applying the “evolving standards of decency” test from 1958 to 2012 shows the authoring justices relied most often on jury verdicts and legislative actions as indicators of society’s standards of decency.<sup>168</sup>

The Court has also considered public opinion polls,<sup>169</sup> expert opinions,<sup>170</sup> and international law.<sup>171</sup> According to a recent Gallup poll, 72% of Americans

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

163. U.S. CONST. amend. VIII; *Robinson v. California*, 370 U.S. 660 (1962) (incorporating the Punishment Clause to the states).

164. *Graham v. Florida*, 560 U.S. 48, 59 (2010); *see also Atkins v. Virginia*, 536 U.S. 304, 311 (2002) (“The basic concept underlying the Eighth Amendment is nothing less than the dignity of man.” (quoting *Trop v. Dulles*, 356 U.S. 86, 100 (1958))).

165. *Estelle v. Gamble*, 429 U.S. 97, 102 (1976) (quoting *Jackson v. Bishop*, 404 F.2d 571, 579 (8th Cir. 1968)).

166. *Trop v. Dulles*, 356 U.S. 86, 101 (1958); *see Miller v. Alabama*, 567 U.S. 460 (2012); *Gregg v. Georgia*, 428 U.S. 153 (1976); *Weems v. United States*, 217 U.S. 349 (1910); *Moore v. Texas*, 137 S. Ct. 1039 (2017); *Estelle*, 429 U.S. 97. For a more complete background of the transition from a static, historical analysis to the fluid, progressive “evolving standards of decency” analysis, *see* Matthew C. Matusiak et al., *The Progression of “Evolving Standards of Decency” in U.S. Supreme Court Decisions*, 39 CRIM. JUST. REV. 253 (2014).

167. *Coker v. Georgia*, 433 U.S. 584, 603 (1977); *see also Graham*, 560 U.S. at 48; *Miller*, 567 U.S. at 462; *Hall v. Florida*, 572 U.S. 701, 714 (2014); *Moore*, 137 S. Ct. at 1052.

168. Matusiak et al., *supra* note 166, at 262; *see also Atkins*, 536 U.S. at 312 (explaining that legislative actions are a useful objective indicator); *Enmund v. Florida*, 458 U.S. 782, 788–89 (1982) (explaining that jury decisions are a useful objective indicator).

169. *See Atkins*, 536 U.S. at 316 n.21.

170. *Id.*; *Hall*, 572 U.S. at 710; *see also* Bidish J. Sarma, *How Hall v. Florida Transforms the Supreme Court’s Eighth Amendment Evolving Standards of Decency Analysis*, 62 UCLA L. REV. DISCOURSE 186, 193 (2014); Messinger, *supra* note 22, at 659.

171. Matusiak et al., *supra* note 166, at 258.

support physician-aided death for terminally ill persons.<sup>172</sup> Unsurprisingly, the language of the polling question impacts the responses significantly. When asked whether “doctors should or should not be allowed by law to assist the [terminally ill] patient to commit suicide if the patient requests it,” 65% of Americans answered affirmatively.<sup>173</sup> As for expert opinions, physicians representing twenty-nine specializations increasingly favor legalization of physician-aided death for terminally ill patients.<sup>174</sup> As of now, looking to international law practices is not particularly helpful, though that may be subject to change. Switzerland is the nation with the most liberal death-with-dignity laws,<sup>175</sup> and its authorization of assisted death has existed since the 1980s.<sup>176</sup> Its laws governing the practice of aid in dying have resulted in a phenomenon called “suicide tourism.”<sup>177</sup> Switzerland requires equality in healthcare between prisoners and nonincarcerated persons.<sup>178</sup> However, it is presently unclear whether assisted dying is available to Swiss prisoners. In January 2020, a prisoner petitioned to exercise his right to die, but the case is presently unresolved.<sup>179</sup>

On balance, these objective indicia are likely insufficient to unequivocally settle the issue of whether our society’s standards of decency are such that the denial of physician-aided death to prisoners would constitute cruel and unusual punishment under the Eighth Amendment. However, there are other considerations that might offer some guidance.

---

172. Megan Brenan, *Americans’ Strong Support for Euthanasia Persists*, GALLUP (May 31, 2018), <https://news.gallup.com/poll/235145/americans-strong-support-euthanasia-persists.aspx>.

173. *Id.* For a more thorough discussion of public opinion polls on aid in dying and on the public’s conceptualization of life, autonomy, and dignity, see Messinger, *supra* note 22.

174. According to a MedScape poll of “more than 5200 physicians in over 29 specialties,” 58% of physicians supported legalization of death with dignity in 2018. Keith L. Martin, *Medscape Ethics Report 2018: Life, Death, and Pain*, MEDSCAPE (Dec. 12, 2018), <https://www.medscape.com/slideshow/2018-ethics-report-life-death-6011014>. Previous figures include: 57% in 2016, 54% in 2014, and 46% in 2010. *Id.* These figures include only “yes” votes, excluding physicians who voted “no” or “it depends.” *Id.*

175. Terminal illness is not a prerequisite for exercising aid in dying in Switzerland. Samia A. Hurst & Alex Mauron, *Assisted Suicide and Euthanasia in Switzerland: Allowing a Role for Non-Physicians*, 326 *BMJ* 271, 271 (2003).

176. *Id.*; Schweizerisches Strafgesetzbuch [StGB] [Criminal Code] Dec. 21, 1937, SR 311, art. 115 (Switz.) (prohibiting assisted or incited suicide only if the actor does so with selfish motives).

177. *The Suicide Tourist*, PBS FRONTLINE (Mar. 2, 2010), <https://www.pbs.org/wgbh/frontline/film/suicidetourist>.

178. David M. Shaw & Bernice S. Elger, *Assisted Suicide for Prisoners? Stakeholder and Prisoner Perspectives*, 40 *DEATH STUD.* 479, 479 (2016) (noting that the “principle of equivalence of care” requires that prisoners must receive the same care as those in the general community).

179. In January 2020, news outlets reported that an incarcerated, ill person has requested authorization to “benefit from Switzerland’s liberal assisted suicide laws” to the same extent a free person would. *Will Switzerland Allow Assisted Suicide for Its Prisoners?*, LOCAL (Jan. 6, 2020), <https://www.thelocal.ch/20200106/will-switzerland-allow-assisted-suicide-for-its-prisoners>. An official decision on the case is due in the coming months. Commenting on the story, Swiss ethics professor Celine Ehrwein noted that denying the prisoner’s request would be “a form of torture.” *Id.* The article also notes, “[M]ost legal and criminal justice experts in Switzerland believe that assisted suicide rights do extend to convicts.” *Id.*

The Punishment Clause imposes duties on the state officials to provide necessities, including medical care.<sup>180</sup> In *Estelle v. Gamble*, the landmark case for prisoners' right to medical treatment, the Court held that prison authorities must provide adequate medical care for an inmate when necessary because the inmate has no ability to obtain treatment outside the prison walls.<sup>181</sup> It further held that "deliberate indifference to serious medical needs of prisoners" violates the Eighth Amendment Punishment Clause.<sup>182</sup> The Court later expanded prisons' constitutional obligation by requiring medical treatment of prisoners where a possible risk of medical issues may arise in the future if their current conditions continue.<sup>183</sup>

Whether prisoners have a right to die or to refuse unwanted medical treatment is a murkier subject. As a preliminary matter, courts generally view the right to die or refuse medical treatment solely as a liberty interest, but some describe it as a "right of self-determination, autonomy, the right to bodily integrity, right of privacy or a liberty interest."<sup>184</sup> In analyzing whether a prisoner may enjoy the right to die or refuse medical treatment, courts have employed a balancing test, weighing the legitimate penological objectives of the state against the prisoner's liberty interest. Courts have generally recognized a prisoner's right to die or refuse medical treatment, so long as the state's interest in protecting innocent third parties, preventing suicide, maintaining the ethical integrity of the medical profession, or preserving life is not sufficiently compelling to override the prisoner's right to forego medical treatment.<sup>185</sup> Sometimes, the prisoner's motivation informs the constitutionality of a prison's decision to impose unwanted medical treatment on prisoners. For example, if a desire to manipulate administrative decisions regarding placement within the prison system motivates the prisoner to refuse treatment for a medical condition, then the state's interest in maintaining the orderly administration of justice will supersede the prisoner's right to refuse medical treatment.<sup>186</sup>

As applied to death with dignity, courts have not yet settled the matter of whether there is a bona fide constitutional right to death with dignity for either free or incarcerated persons. Physician-aided death for terminally ill persons is distinct from medical treatment and the refusal of unwanted medical treatment. However, the underlying rationales for these rights may provide some insight. The underlying rationale for the right to medical care in prison is simple:

---

180. *Farmer v. Brennan*, 511 U.S. 825, 832 (1994).

181. *Estelle v. Gamble*, 429 U.S. 97, 103–04 (1976).

182. *Id.* at 104.

183. *Helling v. McKinney*, 509 U.S. 25, 35 (1993).

184. Arlene McCarthy, Annotation, *Prisoner's Right To Die or Refuse Medical Treatment*, 66 A.L.R.5th 111 2a (1999).

185. See, e.g., *Thor v. Superior Ct.*, 855 P.2d 375 (Cal. 1993); *Singletary v. Costello*, 665 So. 2d 1099 (Fla. Dist. Ct. App. 1996); *Zant v. Prevatte*, 286 S.E.2d 715 (Ga. 1982); *Stouffer v. Reid*, 993 A.2d 104 (Md. 2010).

186. *Comm'r of Corr. v. Myers*, 399 N.E.2d 452, 457–58 (Mass. 1979).

prisoners have no ability to see physicians outside the prison system. The underlying rationale for the right to refuse medical treatment in prisons echoes the rationales supporting death with dignity in general—that is, a respect for a person’s autonomy, dignity, and self-determination.

Prohibiting a prisoner from obtaining medical care and expressing their dignity and autonomy when they are terminally ill undermines the rationales for the prisoner’s analogous healthcare rights. In a jurisdiction authorizing death with dignity, free persons would have access to physicians and pharmacies to help them achieve a dignified death. Denying prisoners access to this form of medical care in a jurisdiction in which free persons are entitled to access such care constitutes an additional condition of punishment. For persons serving LWOP sentences, this limitation is especially damaging. Prisoners serving LWOP sentences know with practical certainty that they will die in prison. A majority of these prisoners will die from a terminal illness. If they were free in jurisdictions permitting death with dignity, they would be entitled to die on their own terms and ensure a dignified death. By virtue only of their status as incarcerated persons, they are prohibited from enjoying this self-determination, and instead, they must succumb to their illness on the prison’s terms.

### B. *End-of-Life Care in Prisons*

Even in jurisdictions permitting death with dignity, four of these jurisdictions’ departments of corrections have adopted policies prohibiting prison officials from facilitating prisoners’ death-with-dignity requests.<sup>187</sup> Thus, the jurisdictions that have expressly supported the practice of physician-aided death for the terminally ill on the basis of promoting autonomy, dignity, and self-determination have categorically denied prisoners this dignity and autonomy interest.

Empirical analysis shows that a majority of inmates in poor health thought about dying in prison on a regular basis.<sup>188</sup> Many prisoners who knew someone who died in prison experience higher “death anxiety,” which is related to poor physical and mental health.<sup>189</sup> For prisoners who anticipate dying in prison, as those serving LWOP sentences do, the stigma associated with dying in prison is a particular concern, “especially in terms of how it might negatively affect

---

187. See, e.g., 1 CAL. CORR. HEALTH CARE SERVS., END OF LIFE OPTION ACT: EXEMPTION POLICY (2016); COLO. DEP’T CORR., ADMIN. REG. NO. 700-27(1V)(G), OFFENDER HEALTH SERVICES: MEDICAL DECISIONS AND ADVANCE DIRECTIVES (2018); OR. ADMIN. R. 291-124-0005(3)(e) (2017); HEALTH SERVS. DIV., DEP’T CORR. WASH. ST., 600-HA001, WASHINGTON DOC HEALTH PLAN 5 (2019). The remaining six jurisdictions are silent on the issue of prisoners exercising death with dignity. Three of these six jurisdictions enacted death with dignity in 2019. One authorizes death with dignity through judicial means, without the involvement of the legislature.

188. See Ronald H. Aday, *Aging Prisoners’ Concerns Toward Dying in Prison*, 52 OMEGA 199, 208–09 (2006).

189. *Id.*

family members.”<sup>190</sup> Some perceived death in prison as an “escape’ [from] . . . their suffering, pain, loneliness, and diminished social status.”<sup>191</sup> In a study of whether prospect theory influences end-of-life medical decisions, inmates serving life sentences were more likely to choose palliative-care interventions than life-prolonging treatment.<sup>192</sup> Moreover, if diagnosed with cancer, prisoners expressed a desire to forgo life-prolonging treatment.<sup>193</sup>

Unlike in community-based hospice programs, prison end-of-life care occurs without specific legislative regulations, and practices vary across prisons.<sup>194</sup> More than half of prisons offer hospice services to inmates.<sup>195</sup> Eligibility determinations vary across prisons, as do requirements upon entry into an end-of-life care program. That said, there has been considerable research on prison end-of-life care, which offers some insight into the treatment of an increasingly significant portion of the aging population.<sup>196</sup> For example, some, but not all, prisons require inmates to have do-not-resuscitate (DNR) orders in place before admission into a hospice program. Some, but not all, require inmates to terminate curative treatment prior to admission. Some prison hospice programs require a life expectancy of six months or less; others allow admission for life expectancy up to one year; some have no life expectancy requirement.<sup>197</sup> Care providers include both trained healthcare professionals and volunteer inmates.<sup>198</sup> Some prisons additionally provide social workers who will advocate for the prisoner’s compassionate release and counsel inmates when their release requests are denied.<sup>199</sup>

Prison end-of-life care includes a range of services, aimed at addressing inmates’ physical, psychological, spiritual, and social needs. Administrators in the department of corrections of one state offering hospice care for inmates “emphasiz[e] the notion that prison becomes home for prisoners with long or lifetime sentences who age and die in the system.”<sup>200</sup> Volunteer inmates are typically charged with duties such as housekeeping, letter writing,

---

190. Rachel K. Wion & Susan J. Loeb, *End-of-Life Care Behind Bars: A Systematic Review*, 116 AM. J. NURSING 24, 31 (2016).

191. *Id.*

192. See Lauren L. Phillips et al., *Care Alternatives in Prison Systems: Factors Influencing End-of-Life Treatment Selection*, 36 CRIM. JUST. & BEHAV. 620, 630 (2009).

193. Wion & Loeb, *supra* note 190, at 33.

194. See Janice A. Cichowlas & Yi-Ju Chen, *Volunteer Prisoners Provide Hospice to Dying Inmates*, 19 ANNALS HEALTH L. 127, 129 (2010).

195. Wion & Loeb, *supra* note 190, at 26.

196. See, e.g., Svetlana Yampolskaya & Norma Winston, *Hospice Care in Prison: General Principles and Outcomes*, 20 AM. J. HOSPICE & PALLIATIVE CARE 290 (2003); Wion & Loeb, *supra* note 190.

197. Wion & Loeb, *supra* note 190, at 26.

198. *Id.*; see Cichowlas & Chen, *supra* note 194, at 129.

199. See Kevin N. Wright & Laura Bronstein, *An Organizational Analysis of Prison Hospice*, 87 PRISON J. 391, 400 (2007). Some have called for greater uniformity in compassionate release procedures, including the American Bar Association. Fleet Maull, *The Prison Hospice Movement*, 1 EXPLORE 477, 478 (2005).

200. Wion & Loeb, *supra* note 190, at 30.

companionship, protection from abuse or theft, bodily fluid management, transportation within the prison, and bathing.<sup>201</sup> Prison administrators generally agree that volunteer-inmate hospice programs successfully enrich the volunteers by providing them with greater compassion and respect for others.<sup>202</sup> However, some prison officials resist hospice and end-of-life care for retributive reasons. Notably, one study found that correctional officers expressed concern that such end-of-life care undermines the punitive function of prison.<sup>203</sup> Three studies have identified a “lack of compassion for dying inmates and negative attitudes toward inmates expressed by corrections staff and prison health care providers” and recognized this as a “barrier to quality [end-of-life] care” in prisons.<sup>204</sup>

Given the lack of consistency in end-of-life hospice care for inmates—along with systemic, economic, and sociocultural hurdles in ensuring that end-of-life care is dignified and respectful—it stands to reason that many rational, terminally ill LWOP inmates seeking death with dignity would prefer physician-aided death to the uncertainty of hospice care.

### C. *Suffering as Part of the Punishment*

Prohibiting LWOP prisoners from exercising death with dignity to the same extent a similarly situated free person would constitutes the imposition of additional punishment on the prisoner. The state not only incarcerates the prisoner for the duration of their life, but also exercises control over the length of the prisoner’s life and the degree to which they suffer in death.

In addition to the long term of incarceration, prisoners serving LWOP sentences suffer from psychological trauma, which is at least partly attributable to the looming anxiety of knowing to a practical certainty that they will die in prison.<sup>205</sup> Physically, prisoners suffer from ailments to a greater degree than their free counterparts, due at least in part to inadequate medical care.<sup>206</sup> A

---

201. *See id.* at 29; Cichowlas & Chen, *supra* note 194, at 131.

202. *See* Wion & Loeb, *supra* note 190, at 29–30.

203. *Id.* at 30; *see also* Laura R. Bronstein & Kevin Wright, *The Impact of Prison Hospice: Collaboration Among Social Workers and Other Professionals in a Criminal Justice Setting that Promotes Care for the Dying*, 2 J. SOC. WORK END LIFE PALLIATIVE CARE 85, 93 (2007).

204. Wion & Loeb, *supra* note 190, at 33; *see also* Bronstein & Wright, *supra* note 203; Susan J. Loeb et al., *Care and Companionship in an Isolating Environment: Inmates Attending to Dying Peers*, 9 J. FORENSIC NURSING 35, 40 (2013); Susan J. Loeb et al., *Who Wants to Die in Here? Perspectives of Prisoners with Chronic Conditions*, 16 J. HOSPICE PALLIATIVE NURSING 173, 177 (2014).

205. *See generally* Margaret E. Leigey & Michael A. Ryder, *The Pains of Permanent Imprisonment: Examining Perceptions of Confinement Among Older Life Without Parole Inmates*, 59 INT’L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 726 (2014) (examining and expanding upon twenty issues associated with long-term imprisonment); *see also* Johnson & McGunigall-Smith, *supra* note 2, at 333.

206. *See* Ashley Hurst et al., *Deliberate Indifference: Inadequate Health Care in U.S. Prisons*, 170 ANNALS INTERNAL MED. 563, 563 (2019) (“[T]here is a growing epidemic of inadequate health care in U.S. prisons. Shrinking prison budgets, a prison population that is the highest in the world, and for-profit health care contracts all contribute to this epidemic.”); John F. Linder & Frederick J. Meyers, *Palliative Care for Prison*

prisoner's physiological age averages ten to fifteen years older than their actual age.<sup>207</sup> By adding the prohibition of exercising death with dignity upon diagnosis of a terminal illness, states include yet another component of punishment to the LWOP prisoner's sentence.

This additional layer or component of punishment cannot be justified by any of the theories of punishment discussed above. The fatal nature of the punishment precludes rehabilitation, incapacitation, and specific deterrence. Excluding these theories leaves only retributivism and general deterrence, which also fail to provide satisfactory justification for the imposition of suffering in natural death.

Retributivism is a desert-based theory of punishment,<sup>208</sup> which does not consider external beneficial effects on society in justifying the infliction of punishment.<sup>209</sup> Under the retributivist view, punishment is only justified to the degree the offender deserves.<sup>210</sup> Retributivists must justify not only the issue of *whether* the punishment is morally justified, but also the question of *how much* punishment is justified. Given that the prisoner has already been sentenced to

*Inmates: "Don't Let Me Die in Prison,"* 298 JAMA 894 (2007); Blake Ellis & Melanie Hicken, CNN (June 25, 2019), <https://www.cnn.com/interactive/2019/06/us/jail-health-care-ccs-invs> ("Across the country . . . doctors and nurses have failed to diagnose and monitor life-threatening illnesses and chronic diseases. [Correct Care Solutions] employees have denied urgent emergency room transfers. They have failed to spot or treat serious psychiatric disorders and have allowed common infections and conditions to become fatal."). For more information about a major private health care contractor's failure to provide adequate medical treatment to prisoners, see Beth Schwartzapfel, *How Bad is Prison Health Care? Depends on Who's Watching*, MARSHALL PROJECT (Feb. 26, 2018), <https://www.themarshallproject.org/2018/02/25/how-bad-is-prison-health-care-depends-on-who-s-watching> (describing lawsuits leveled against Corizon Health, alleging it cooperated with state departments of corrections to "gam[e] a system put in place to ensure adequate health care for . . . prisoners"). For more information about state healthcare expenditures for prisoners, see PEW CHARITABLE TRS., PRISON HEALTH CARE COSTS AND QUALITY (2017), <https://www.pewtrusts.org/en/research-and-analysis/reports/2017/10/prison-health-care-costs-and-quality> (providing a forty-nine-state report and analysis on prison healthcare spending).

207. Messinger, *supra* note 22, at 656 ("Research has shown that a prisoners' physiological age averaged ten to fifteen years older than their chronological age."); see also Brie A. Williams et al., *Aging in Correctional Custody: Setting a Policy Agenda for Older Prisoner Health Care*, 102 AM. J. PUB. HEALTH 1475, 1477 (2012).

208. See MOORE, *supra* note 78, at 92; Joel Feinberg, *The Classic Debate*, in PHILOSOPHY OF LAW *supra* note 78, at 646; Kent Greenawalt, *Punishment*, in 4 ENCYCLOPEDIA OF CRIME AND JUSTICE 1336, 1338 (Sanford H. Kadish ed., 1983) ("Briefly stated, a retributivist claims that punishment is justified because people deserve it . . .").

209. See George P. Fletcher, *The Place of Victims in the Theory of Retribution*, 3 BUFF. CRIM. L. REV. 51, 52 (1999) ("[R]etributivism is a jealous theory in the sense that whatever the beneficial side-effects of punishment, if it is not deserved it cannot possibly be justified.").

210. Some commentators have equated the degree of desert with the biblical "eye for an eye" proportionality. See, e.g., KANT, *supra* note 82, at 169 ("[W]hat is done to [the offender] in accordance with penal law is what he has perpetrated on others . . ."); JAMES Q. WILSON & RICHARD J. HERRNSTEIN, CRIME AND HUMAN NATURE 496 (1985); IGOR PRIMORATZ, JUSTIFYING LEGAL PUNISHMENT 12 (1989) ("Punishment ought to be proportionate to the offense (the *lex talionis*)." (emphasis omitted)); G.W.F. HEGEL, ELEMENTS OF THE PHILOSOPHY OF RIGHT 127 (Allen W. Wood ed., H. B. Nisbet trans., Cambridge Univ. Press 1991) (1821) ("[W]hat the criminal has done should also happen to him."). But see MOORE, *supra* note 78, at 88 (asserting that retributivism is less concerned with questions of proportionality and more concerned with justifying punishment at the outset). It is also worth noting that the Eighth Amendment to the United States Constitution addresses proportionality by prohibiting "cruel and unusual punishments." U.S. CONST. amend. VIII.

LWOP, the issue of whether to punish is already resolved at the relevant point in time. That is, the prisoner is serving an LWOP sentence—which may or may not be justified in itself<sup>211</sup>—and has become terminally ill. The question now is whether prohibiting the prisoner from exercising physician-aided death is justified.

For a retributivist, several proportionality theories are available to assist in answering the *how much* punishment inquiry.<sup>212</sup> Common views of proportionality among retributivists are Kant's *lex talionis* theory,<sup>213</sup> Hegel's annulment theory,<sup>214</sup> and Jean Hampton's expressive theory.<sup>215</sup> Many theorists also look to the victim's suffering and seek to achieve an equilibrium between the suffering of the victim and the suffering of the offender.<sup>216</sup> In the case of prisoners serving LWOP sentences, looking to the victim's suffering to determine whether there is a proportional justification for stripping a prisoner of the opportunity to exercise death with dignity is often unhelpful.<sup>217</sup> Similar problems arise in attempting to apply the other proportional punishment theories, such as *lex talionis* or annulment, because the moral culpability of each individual prisoner must be assessed on a case-by-case basis. Many LWOP

211. See *supra* Part I.B.

212. See Larry Alexander, *You Got What You Deserved*, 7 CRIM. L. & PHIL. 309, 315 (2013) (“The ‘how much is deserved’ question has many facets, some of which have been copiously debated.”).

213. See KANT, *supra* note 82, at 169.

214. See HEGEL, *supra* note 210, at 127 (establishing the principle that the offender's suffering should be proportionate to the value of the crime and that “what the criminal has done should also happen to him”).

215. Jean Hampton, *Correcting Harms Versus Righting Wrongs: The Goal of Retribution*, 39 UCLA L. REV. 1659, 1686 (1992). Hampton sets forth the “expressive” theory of retribution and advocates for equality between the suffering of the criminal and the suffering he caused the victim:

[A] response to a wrong that is intended to vindicate the value of the victim denied by the wrongdoer's action through the construction of an event that not only repudiates the action's message of superiority over the victim but does so in a way that confirms them as equal by virtue of their humanity.

*Id.*; see also Adam J. Kolber, *The Comparative Nature of Punishment*, 89 B.U. L. REV. 1565, 1595 (2009) (“Moreover, if we want to punish proportionally, then we have to calibrate punishments to reflect the suffering that offenders actually experience or are expected to experience as a result of being punished.”).

216. See, e.g., ARISTOTLE, NICOMACHEAN ETHICS 120–21 (Martin Ostwald trans., 1962) (c. 350 B.C.E.).

It makes no difference whether a decent man has defrauded a bad man or vice versa, or whether it was a decent or a bad man who committed adultery. The only difference the law considers is that brought about by the damage: it treats the parties as equals and asks only whether one has done and the other has suffered wrong, and whether one has done and the other has suffered damage. As the unjust in this sense is inequality, the judge tries to restore the equilibrium. When one man has inflicted and another received a wound, or when one man has killed and the other has been killed, the doing and suffering are unequally divided; by inflicting a loss on the offender, the judge tries to take away his gain and restore the equilibrium.

*Id.* Fletcher, *supra* note 209, at 58 (“[T]he position and dignity of the victim are rendered equal relative to the aggressor.”).

217. See Adam J. MacLeod, *All for One: A Review of Victim-Centric Justifications for Criminal Punishment*, 13 BERKELEY J. CRIM. L. 31, 42 (2008) (“Fletcher's conception of punishment as a means to restore balance between victim and offender is criticized as inconsistent with retributivism . . . Fletcher acknowledges some of the difficulties . . . for example, that many crimes involve no dominance over a readily-identifiable victim.”).

prisoners received their sentences for offenses without identifiable victims, due to three-strikes laws and harsh penalties for drug offenses. Similarly, not all LWOP prisoners are serving their sentences for offenses reflecting a high level of moral culpability, due to sentencing laws permitting the imposition of LWOP sentences for merely *malum prohibitum* offenses, such as drug offenses.<sup>218</sup>

Taken together, perhaps the general imposition of LWOP sentences without clear retributive justification presents difficulty in attempting to justify the added component of requiring suffering in the event of death by terminal illness. At the very least, in a system that punishes crimes reflecting various degrees of culpability with equally harsh sentences, jurisdictions imposing the additional punishment as a blanket rule violates retributive theories of proportionality. Moreover, the blanket policy prohibiting prisoners from exercising physician-aided death disparately impacts different groups of prisoners without regard to the prisoners' respective levels of culpability. Rather, the determining factor for whether a prisoner will suffer from this additional punishment is based on whether the person has the misfortune of developing a terminal illness during their incarceration. Imposing additional suffering on a prisoner based upon their misfortune or bad luck undermines retributivism's chief principle of basing punishment on desert or moral culpability. Retributivism requires consideration of proportional punishment on a case-by-case basis, using the culpability of the individual offender or the damage to the victim as the guide. Universally applicable penalties that disproportionately impact offenders based on their health—rather than their moral or legal desert—are antithetical to the entire retributivist theory.

General deterrence seeks to justify punishment on the basis that punishment deters prospective criminals from committing their contemplated criminal acts.<sup>219</sup> This theory fails to justify the jurisdictions' deprivation of death-with-dignity rights for LWOP prisoners. As explained above, general deterrence works when three prerequisites are satisfied. The prospective criminal must: (1) be aware of the punishment; (2) be able to rationally calculate the risk; and (3) actually engage in a cost-benefit analysis.<sup>220</sup> Whether prospective criminals accurately consider, comprehend, or calculate the potential penalty for their contemplated criminal conduct is questionable. People fail to sufficiently appreciate the gravity or likelihood of the

---

218. Doug Bandow, *Drug Prohibition: Destroying America To Save It*, 27 CONN. L. REV. 613, 616 (1995) (“[M]ost drug ‘crimes,’ which now account for a large percentage of arrests, convictions, and imprisonments, are crimes only because of legislative decree, not because there is an unwilling victim as in such crimes as theft, rape, and murder (*malum prohibitum* versus *malum in se*) . . . .”); see also Christopher Ingraham, *It's Not Just Alice Marie Johnson: Over 2,000 Federal Prisoners are Serving Life Sentences for Nonviolent Drug Crimes*, WASH. POST (June 6, 2018), <https://www.washingtonpost.com/news/wonk/wp/2018/06/06/its-not-just-alice-marie-johnson-over-2000-federal-prisoners-are-serving-life-sentences-for-nonviolent-drug-crimes>.

219. See Child, *supra* note 71.

220. Robinson, *supra* note 72, at 140–41.

consequences for their actions until after they have decided to act.<sup>221</sup> LWOP itself is difficult to imagine, as is death in prison. The additional punishment of losing one's autonomy and dignity in end-of-life decision-making is likely even more difficult to fully appreciate. Because of the attenuated and distant nature of the penalty for the probably young prospective criminal, this suffering is unlikely to deter the contemplated conduct.<sup>222</sup>

When the state strips a prisoner of their right to self-determination, autonomy, and dignity that they would enjoy if they were free, this constitutes an unjustifiable punishment. It constitutes punishment because it is state-sanctioned suffering imposed upon an offender for an offense against legal rules.<sup>223</sup> This punishment is unjustifiable under any major theory of punishment.

### CONCLUSION

Unlike many other prisoners, those serving LWOP sentences know with practical certainty that they will die in prison. Most will die from terminal illness. In ten U.S. jurisdictions, but for their status as incarcerated, these people would be entitled to exercise death with dignity when they become terminally ill. These same jurisdictions that use autonomy and dignity rationales to support passage of death-with-dignity laws also prohibit incarcerated persons from exercising this right to self-determination. This additional layer or component of punishment on prisoners is inconsistent with prisoners' constitutional rights to receive and refuse medical treatment. Moreover, none of the major theories or justifications of punishment can support the state-imposed suffering via categorical exclusion of prisoners from exercising death with dignity. Thus, a sentence of "life" cannot legally or morally justify the state's exercise of control over the time and manner of a person's death.

---

221. See Lichtenberg, *supra* note 35, at 47.

222. See Goldstein, *supra* note 53.

223. HART, *supra* note 65.