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Are You (Still) My Great and Worthy Opponent Compassionate Release of Terminally Ill Offenders

Jalila Jefferson-Bullock
ARE YOU (STILL) MY GREAT AND WORTHY OPPONENT?: COMPASSIONATE RELEASE OF TERMINALLY ILL OFFENDERS

Jalila Jefferson-Bullock*

“Is it you? My great and worthy opponent?”
— Captain Hook to an adult Peter Pan1

I. INTRODUCTION

Compassionate release is rooted in the notion that changed circumstances post-conviction may render a criminal sentence inhumane, excessive, unjust, and, therefore, unwarranted. Compassionate release provides for the early release of prisoners for “extraordinary and compelling” reasons, which may include terminal illness, debilitating medical condition, age, and unique family caregiving duties.2 When a prisoner becomes terminally ill, compassionate release allows him to spend his last days on earth, in his own home, surrounded and supported by family and friends. In such situations, the justice system recognizes that radically changed circumstances have transformed the offender into a shadow of his former self, a less worthy opponent, with whom battle is neither fair nor necessary.

In the movie, Hook, Captain Hook attempts to vindicate himself and restore his reputation by finally defeating his mortal enemy, Peter Pan, in an epic battle for the ages. Captain Hook sojourns through space and time, abducts Peter Pan’s children and removes them to Neverland, confident that his nemesis, Peter Pan, will fly to Neverland to rescue them. Hook knows he has the advantage—after all, he has Peter Pan’s prized possession: his children. Peter Pan loves his children dearly, and voyages to Neverland, desperate to save them. Elated, Hook is primed for what he believes will be the war of the century.

It bears remembrance that Captain Hook’s abhorrence of Peter Pan is not unmerited. For years, Pan and Hook sparred for the same purpose as other storybook foes—because that is what heroes and villains do. However, their rivalry becomes intensely personal when Pan disobeyed the rules of decency,

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1 HOOK (Amblin Entertainment 1991).
order, and basic humanity by cutting off Hook’s hand and feeding it to a menacing crocodile. Peter Pan further insults Hook by leaving Neverland to grow up. From then on, Hook swears to avenge his physical and reputational loss by obliterating Peter Pan. When Peter Pan arrives in Neverland to save his children, Hook finally has his opportunity.

However, when Hook beholds Peter Pan, he is dreadfully disappointed. Time stands still in Neverland, but the clock continues to tick in the real world where Peter Pan has been. Many years have passed since Peter Pan defeated Hook, and Pan has grown much older and rounder. He cannot fly or crow, and most of all, he does not even remember that he was once Peter Pan. Peter Pan has grown up! Hook cannot fathom that this plump, middle-aged man standing before him is the magnificent Peter Pan. Hook cannot believe that this adult man, so unlike the incomparable Peter Pan who once confounded him, is the same character that he has romanticized conquering for all these years. Incredulous, Hook peers into adult Peter Pan’s eyes and says, “Is it you? Are you my great and worthy opponent?”

The movie takes a most delightful turn when Pan eventually remembers who he once was, recovers his powers, and soundly defeats Hook. Over a period of days, adult Peter Pan trains vigorously with the Lost Boys, restores his imagination, finds his happy thought, and develops into a worthwhile rival for his adversary, Captain Hook. With fairy dust and imagination, he transforms into Hook’s great and worthy opponent once again, and becomes the stuff of legends.

This is a fairy tale. Without the assistance of magic pixie dust and child-like fancy, adult Peter Pan could never have redeemed his former faculties—he could never have become the real Peter Pan. He would have remained a shadow of his former self, flightless, unable to crow, and totally devoid of imagination. The circumstances of life would have permanently transformed him into a most unworthy opponent, ill-equipped to battle the mighty Captain Hook.

A great and worthy opponent is a formidable foe, interested in and capable of accessing tools to engage in robust combat. The fight is equal, and a great and worthy opponent, if beaten, has lost fairly. In Hook, Peter Pan was not a great and worthy opponent until he overcame his changed circumstances. That possibility does not exist for terminally ill prisoners. The adversarial relationship between the government and the ultimately convicted is complex and lengthy, lasting far beyond sentencing and incarceration. While it is arguable that the criminal justice system is ever fair to certain marginalized groups, it is always unfair to terminally ill prisoners. Because they are shadows of their former selves, incarceration of the terminally ill is no longer adequately justified by any theory of punishment. Likewise, prison medical facilities for the severely

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3 In the movie, Captain Hook refused to fight Peter Pan until he regained all of his faculties. He insisted upon engaging in a fair fight. See Hook, supra note 1.
4 See generally infra Part III; Michelle Alexander, The New Jim Crow: Mass Incarceration in the Age of Colorblindness 59 (2010).
ill are woefully inadequate, such that continued incarceration is constitutionally prohibited and cost-prohibitive. Finally, the Bureau of Prisons-controlled compassionate release process strips terminally ill prisoners of their power to access relief. Together, these factors render terminally ill prisoners the most unworthy opponents, who should be discharged from battle and released from prison.

Compassionate release doctrine offers a re-assessment of justice, and permits judges to review prisoners’ sentences to determine whether, upon a terminal prognosis, they remain just. In such situations, the granting of compassionate release relies on a determination that impending death extinguishes any threat that an otherwise dangerous offender might levy upon release, and on a basic, fundamental belief that, due to the inmate’s altered circumstances, humanity and decency demand early release. Compassionate release is justified by two philosophies: one legal and one medical. The legal justification is that impending death has cancelled a terminally ill prisoner’s debt to society, thereby re-harmonizing the scales of justice so that release, prior to the completion of the prisoner’s sentence, is warranted. The medical virtue of compassionate release is grounded in basic humanity, and commands that we treat dying prisoners as people, worthy of a dignified death. When compassionate release is granted, achieving the traditional goals of the penal system are outweighed in favor of realizing compassion for the sick or injured. However, despite much larger numbers of prisoners who die in prison from terminal illnesses, only 0.01 percent of prisoners receive compassionate releases annually in the federal system. This is because the Bureau of Prisons has chosen to usurp court power, and only grant compassionate release in the most narrow of circumstances.

Incarceration of terminally ill prisoners is legally, ethically, and financially unsound. It is not supported by any theory of punishment, does not comply with the Eighth Amendment ban on cruel and unusual punishment, and is financially unsustainable. 18 U.S.C. § 3553(a) sets forth purposes of federal criminal punishment: retribution, deterrence, incapacitation, and rehabilitation. These theories only operate effectively if the inmate’s circumstances post-

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6 Id. at 805.
7 Id. at 826-27.
8 Id.
10 See Berry, supra note 9, at 869.
conviction do not change. In the case of terminally ill prisoners, enforcing
sentences based on these factors appears illogical, unnecessary, and unfair.
Likewise, granting compassionate release comports with current medical
literature and practice, which suggests that effective end-of-life care requires a
carefully constructed blend of physical treatment, mental health therapy, and the
preservation of essential familial and social systems. For a myriad of reasons,
prison physicians are not equipped to provide end-of-life care in accordance with
evolving standards of decency and humanity recognized by the Eighth
Amendment. Finally, scholars, practitioners, judges, lawmakers, policy leaders,
and others lament the enormous, unsustainable cost of incarceration. Expanding compassionate release can potentially realize cost savings of at least
$5.8 billion annually.

This article explores the legal and medical validations of compassionate
release, and ultimately argues that narrowly applied federal compassionate
release policies must be reformed so that compassionate release is granted to all
terminally ill prisoners for three principal reasons: (1) incarceration of the
terminally ill does not serve any retributive or deterrent purpose of punishment;
(2) incarceration of the terminally ill violates the Eighth Amendment prohibition
against cruel and unusual punishment; and (3) incarceration of the terminally ill
is fiscally unsound. This work ultimately proposes a new compassionate release
model that allows the terminally infirm to spend their last days in their homes,
surrounded by loved ones. This article submits that doing so is directly aligned
with the underlying purposes of federal criminal punishment, and with
constitutionally required evolving medical standards of decency.

Following this Introduction, Part II outlines the Bureau of Prisons-
controlled compassionate release process and identifies its critical flaws. Part III

12 Nancy Dubler, Ethical Dilemmas in Prison and Jail Health Care, HEALTH AFFAIRS BLOG (Mar.
10, 2014), http://healthaffairs.org/blog/2014/03/10/ethical-dilemmas-in-prison-and-jail-health-
care/; Nancy Neveloff Dubler, The Collision of Confinement and Care: End-of-Life Care in Prisons
and Jails, 26 J.L. MED. & ETHICS 149, 150 (1998); INST. MED. NAT’L ACAD’S, DYING IN AMERICA:
IMPROVING QUALITY AND HONORING INDIVIDUAL PREFERENCES NEAR THE END OF LIFE (2014),
[hereinafter DYING IN AMERICA].
13 See URB. INST., STEMMING THE TIDE: STRATEGIES TO REDUCE THE GROWTH AND CUT THE COST
14 See Memorandum from the U.S. Inspector General, supra note 13.
explores retributive and deterrent theories of punishment, applies them to current compassionate release practices, and concludes that realization of theories of punishment requires a broader application of compassionate release. Part IV analyzes prisoners’ constitutional right to health care, and suggests that narrowly applied compassionate release processes violate the Eighth Amendment prohibition against cruel and unusual punishment. Further, Part IV compares the state of prison end-of-life care to that of the general population to determine whether prison health care comports with evolving standards of decency. Part V examines the cost of incarcerating the terminally ill, and concludes that fiscal fitness requires compassionate release. Finally, Part VI proposes an alternative model of compassionate release that simultaneously preserves community safety and human dignity. The battle must cease so that the terminally ill can die with dignity.

II. THE COMPASSIONATE RELEASE PROCESS IS CRITICALLY FLAWED

Between 1999 and 2008, 2,902 prisoners died in federal prison from illness. However, only 0.01% of dying prisoners receive compassionate releases annually. The most compelling reason for such disturbingly low numbers of approved compassionate release requests is that the Bureau of Prisons has manufactured an unduly burdensome and time-consuming administrative process that terminally ill prisoners do not often live long enough to complete. The Bureau of Prisons (BOP) has apprehended the compassionate release system by creating an internal review process that is contrary to both statutory language and congressional intent. Terminally ill prisoners must prevail through four, strict, time-consuming layers of BOP review before their case may be brought before a judge. 18 U.S.C § 3582(c) gives courts the power to reduce or end a prisoner’s sentence of incarceration for “extraordinary or compelling reasons that warrant reduction,” subject to 3553(a) factors, if applicable, and guidelines established by the Sentencing Commission. 18 U.S.C. § 3553(a) sets forth purposes of federal punishment, while United States Sentencing Guidelines, §1B1.13 offers a policy statement providing four examples of extraordinary and compelling circumstances for which compassionate release is appropriate. Neither the § 3553(a) factors nor the Guidelines warrant incapacitation of terminally ill prisoners. While the authority rests with the courts, the BOP resolves compassionate release requests, absent

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16 See Berry, supra note 9, at 868.
judicial oversight. The BOP has robbed terminally ill prisoners of their tools to fight. This unduly burdensome process must be reformed to ensure that every medically-eligible compassionate release request is granted.

A. The Tragedy of Mark Jones and Others

By August of 2010, Mark Jones was a shadow of his former self. Before his illness, Jones maintained an impressive 6 feet, 4 inch tall, 350 pound frame, which he referred to as “hugging size.” Jones’ personality matched his stature, and he commanded every room that he entered. He was a political power-broker and a master negotiator, who solved problems and brokered deals with ease, finesse, savvy, and detail. He was dependable, timely, personable, and kind. He was a friend to all. At the end of his life, however, he lay dying in a prison hospice, 863 miles away from his hometown. He struggled to breathe, endured constant, agonizing pain, and weighed a mere 180 pounds at his death. Worst of all, he was completely and utterly alone.

A year prior, Jones was convicted of various bribery related offenses, and was sentenced to a ten-year prison sentence. During his trial, prosecutors portrayed him as a career criminal and one head of a political crime ring. He was accused of bribing school board officials in exchange for lucrative education-based contracts. At trial, he mounted a vigorous defense, after countless attempts by prosecutors at a plea deal. Even after being convicted by a jury of his peers, Jones publicly maintained his innocence. Prosecutors successfully persuaded a jury, beyond a reasonable doubt, that Jones was a menace to society for whom incapacitation was the only effective deterrent. The court reasoned that a ten-year sentence was appropriate retribution for Jones’ crimes. Though unsuccessful in court, Jones was a worthy opponent.

Approximately five months after reporting to prison, Jones complained of searing leg pain, but was denied the right to medical treatment. Over several weeks, Jones’ leg pain became excruciating, yet treatment was firmly refused. Jones was finally granted medical care when, as he limped into court for another matter, a concerned magistrate inquired about his health. Medical tests revealed that Jones had stage IV lung cancer that had already metastasized to his leg. His prognosis was terminal, and he was given less than six months to live.

As soon as he learned of his prognosis, Jones filed a request for a compassionate release with the Warden of his institution, but was informed that his request was denied because he was a co-defendant in a separate federal case. According to the Warden, Jones remained a threat to society, although Jones’

20 While his name has been changed, “Mark Jones” is a close relative of the author. The facts were personally related to her.
terminal prognosis was undisputed. The judge in the second case had already
determined that Jones was too ill to stand trial. The prosecutors in both cases
joined forces to oppose Jones’ compassionate release. They remembered him as
they believed him to once be. Extracting language from the evidence used to
prosecute him, the prosecutors labeled him as the ringleader of a criminal
enterprise who, despite being stricken with a painful, terminal illness, would
most assuredly commit more crimes from his deathbed. However, he was not the
same great and worthy opponent.

In their analysis, the Bureau of Prisons and prosecutors failed to account
for the changed circumstances of Jones’ existence. Jones labored to breathe, he
could not walk, and his pain was immobilizing. The deterrent and retributive
values in incapacitating Jones were no longer just. Further, the medical staff
treated Jones as a prisoner instead of as a patient. Jones lay in pain for long
periods of time throughout the day, and was spoken to “like an animal, like a
dog.” He waited an agonizing few weeks to learn the disposition of his
compassionate release request, only to be told in the last two months of his life
that his request was denied and that the decision was not appealable.

The Bureau of Prisons cheated Jones of the opportunity to die with
dignity. The jailers acted as judge, and deprived Jones of the occasion to prove
the extraordinary and compelling reasons for his release to an impartial judge.
Cancer literally sucked the life out of Jones, and his last days on earth were spent
separated from family and friends, receiving substandard medical care in a prison
hospice. For humanity’s sake, Jones should have been granted a compassionate
release. Sadly, Jones’ story is not uncommon among terminally ill prisoners.
Despite hundreds of applications in process annually, only twenty-four federal
inmates were granted a compassionate release between 2006 and 2011.21

Under federal process, after a prisoner has completed a series
of administrative hurdles, the Director of the Bureau of Prisons may make a motion
to the Court on their behalf to secure a compassionate release for “extraordinary
and compelling” reasons.22 This onerous administrative process begins when the
prisoner files a written request with the Warden of his institution, who
unilaterally investigates the prisoner’s claim and determines whether it contains
sufficiently “extraordinary and compelling” reasons to forward a positive written
recommendation to the Regional Director.23 Upon receipt of a positive
recommendation from the Warden, the Regional Director may forward a
supportive, written recommendation to the General Counsel of the Bureau of
Prisons.24 The General Counsel must then determine if the request warrants
approval by consulting with the Medical Director of the Correctional Division

21 See U.S. Office of the Inspector General, supra note 9, at iii.
22 See Berry, supra note 9, at 869.
24 Id.
and the prosecuting Assistant United States Attorney. If approval is granted at this level, only then will the request be forwarded to the Director for a final decision of whether to file a petition on the prisoner’s behalf. This entire process may take months, and the Director’s decision is not appealable. Most commonly, requests for compassionate release never reach the court for judicial review. In disposing of compassionate release requests without judicial intervention and review, the Director of the Bureau of Prisons inappropriately acts as judge.

B. The Original Intent of Compassionate Release

Congress authorized compassionate release in the “precedent shattering” Comprehensive Crime Control Act of 1984’s Sentencing Reform Act (SRA). The primary object of the SRA was to ensure uniformity and fairness in sentencing by eliminating the free and full authority that judges enjoyed in federal criminal sentencing. Prior to the passage of the SRA, “there was a broad and rising level of concern in Congress regarding problems with the federal criminal code, particularly with the serious problems of sentencing disparity,” and a belief that “federal sentencing practices provide[d] neither rationality nor fairness.” The SRA required prison sentences to be determinate in length, abolished parole, and rendered release subject to good time credits only. To fulfill its mission and remedy sentencing disparities, the SRA created the Sentencing Commission, whose mission was to establish guidelines for judges regarding the appropriate form and severity of punishment for offenders convicted of federal crimes. The Sentencing Commission’s directive was in the following areas: (1) structuring “the previously unfettered sentencing discretion accorded federal trial judges;” (2) making “the administration of punishment . . . more certain;” and (3) targeting “specific offenders . . . for more serious

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25 Id.
26 Id. An expedited compassionate release process may take anywhere from five to sixty-five days. Appeals of the Warden’s or Regional Director’s decisions may take five months to complete. U.S. Office of the Inspector General, supra note 9.
27 See Russell, supra note 5, at 817.
28 Jalila Jefferson-Bullock, The Time is Ripe to Include Considerations of the Effects on Families and Communities of Excessively Long Sentences, 83 UMKC L. Rev. 73, 80 (2014).
penalties.”33 It is notable, then, that despite “precedent-shattering,” Sentencing Commission reforms, motivated by a desire to increase uniformity in sentencing, compassionate release survived.

The legislative record indicates that while Congress intended the SRA to place strict limits on judges’ “unfettered discretion” in sentencing, they concurrently agreed to preserve a measure of that judicial power. Congress sought to maintain judicial sentence reduction authority in “the unusual case in which a defendant’s circumstances are so changed . . . that it would be inequitable to continue . . . confinement.”34 Changed circumstances constitute situations where the defendant or the defendant’s family “may have suffered a catastrophe.”35 Congress ensured that “adequate post-sentencing procedures . . . be maintained to give relief in those and similar situations.”36 Congress’ clear intent was to maintain then-existing judicial sentencing authority in compassionate release situations.

That then-existing judicial sentence reduction authority is expressed in 18 U.S.C. § 3582 (c), which provides, in part, that:

The Court may not modify a term of imprisonment once it has been imposed except that in any case the court, upon motion of the Director of the Bureau of Prisons, may reduce the term of imprisonment (and may impose a term or probation or supervised release with or without conditions that do not exceed the unserved portion of the original term or imprisonment), after considering the factors set forth in §3553(a) to the extent that they are applicable, if it finds that extraordinary and compelling reasons warrant such a reduction. . . . and that such a reduction is consistent with applicable policy statements issued by the Sentencing Commission.37

The aforementioned “policy statement” of the Sentencing Commission appears in the form of the Sentencing Guidelines Manual, which states in its commentary that as long as the defendant is not “a danger to the safety of any other person or the community, as provided in 18 U.S.C. § 3142(g),” extraordinary and compelling reasons may exist that require a judicial sentence reduction if “the defendant is suffering from a terminal illness.”38 The referenced

34 Baker, supra note 31, at 5.
36 Id.
38 SENTENCING GUIDELINES MANUAL, supra note 18.
§ 3553(a) factors offer the goals of federal punishment, which include deterrence, retribution, incapacitation, and rehabilitation.39 All relevant statutes clearly state that it is the intent of Congress to reserve this authority to judges. Nevertheless, the Bureau of Prisons has unjustly appropriated this judicial function. Contrary to legislative intent, the Bureau of Prisons has commandeered the compassionate release system so that as few prisoners utilize it as possible. The BOP has succeeded in structuring the application process so that prisoner success is exceedingly improbable.

C. The Unduly Burdensome Nature of the Process

Title 28 of the Code of Federal Regulations, § 570.60-64 (G) and the BOP’s Program Statement establish specific procedures that further impede terminally ill prisoners’ opportunity for release.40 These procedures clearly illustrate the extent of the Bureau of Prisons’ appropriation of the compassionate release process.41 According to both, the compassionate release review process for terminally ill prisoners involves the heavy-handed participation of two major decision makers: the Bureau of Prisons and the Assistant United States Attorney.42 Both participants are invested in controlling prisoners through incapacitation, and therefore represent interests counter to those of prisoner-patients. Neither party is positioned to formulate the type of neutral decisions that judges were intended to render in compassionate release situations.

The Bureau of Prison’s Program Statement and 28 C.F.R. § 570.60-64(G) set forth the government-controlled, time-consuming, bureaucratically-obstacled process on which terminally ill prisoners must rely. This process requires four stages of Department of Justice scrutiny. The compassionate release review process begins when an inmate submits a request to the Warden of his institution, which must include the “extraordinary and compelling circumstances that the inmate believes merit consideration;” a plan for where the inmate will reside if released; and how he or she will support him or herself if released.43 The request must also contain detailed information concerning where the inmate will receive medical care, what the cost of medical care will be, and how that cost will be covered.44 The Warden then reviews the request, and, if he believes it merits approval, forwards an approval recommendation to the

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40 28 C.F.R. §§ 571.60-64(G).
41 Id.
42 Id. In the case of compassionate release for non-medical reasons, the Office of the Deputy Attorney General is a major decision maker as well.
43 Id. at 571.61(a)(1)(2). It is noteworthy that the majority of terminally ill prisoners are not aware that compassionate release is a possibility. U.S. OFFICE OF THE INSPECTOR GENERAL, supra note 9, at 54.
44 28 C.F.R. § 571.62(a).
Regional Director.45 If the request is denied, a written explanation of denial is sent to the prisoner, who may appeal through the Bureau of Prisons’ Administrative Remedy Program.46 The Regional Director conducts a second merit review, after which, if approved, a written recommendation for approval is referred to the Bureau of Prisons Office of General Counsel.47 If the request is denied at this level, the Regional Director informs the inmate in writing of the reasons for denial, and of available administrative remedies.48 The third level of examination requires analysis by three entities: (1) the BOP Central Office General Counsel; (2) the BOP Medical Director; and (3) the prosecuting Assistant United States Attorney.49 The General Counsel then submits approval recommendations from the Warden and Regional Director and the opinions of the Medical Director and the Assistant United States Attorney to the BOP Director for a final decision.50 The decision of the BOP Director is not appealable. If the BOP Director denies the request, the prisoner is informed within twenty working days.51 If the request is granted, the BOP Director entreats the prosecuting United States Attorney’s Office to petition the sentencing court for a compassionate release.52 Shockingly, the petition only receives legislatively-intended judicial review at this fifth and final stage. Most requests do not survive beyond stage two.53 Jones’ request did not endure past stage one. Though stripped of weapons, his battle continued.

III. INCARCERATION OF THE TERMINALLY ILL DOES NOT FULFILL ANY GOAL OF CRIMINAL PUNISHMENT

For Jones and others, incarceration does not fulfill any theory of criminal punishment. Several situations exist where punishment loses its intended utility. In such situations, punishment should be revisited and perhaps extinguished. In The Theory of Legislation, Professor Jeremy Bentham offers that punishment should not be exacted in four specific situations: (1) when it would be

45 Id. at § 571.62(a)(1).
46 Id. at § 571.63(a).
47 Id. at § 571.62(a)(3).
48 Id. at § 571.63(c).
49 Id. at § 571.62(a)(3).
50 See id. at § 573.63. While the General Counsel had the authority to approve or deny compassionate release requests, they never exercise this power. See Office of the Inspector General, supra note 9, at 2. It must also be noted that “if the original sentence included a term of supervised release to follow the initially imposed term of imprisonment, the warden must have included in the referral to the BOP Director confirmation that the release plans were approved by the appropriate U.S. Probation Office.” Id. at n. 15.
51 28 C.F.R. § 571.63(c).
52 Id. at § 571.62(a)(3).
misapplied; (2) when it is inefficacious; (3) when it is superfluous; and (4) when it is too expensive. The writer defines an inefficacious punishment as one that has “no power to produce an effect upon the will . . . and no tendency towards the prevention of like acts.” Restrictive laws that continue to incapacitate the terminally ill are exceedingly inefficacious. Theories of punishment do not justify sustained incarceration for prisoners who are “too ill or cognitively impaired to be aware of punishment, too sick to participate in rehabilitation, or too functionally compromised to pose a risk to public safety.”

The goals of federal punishment are expressed in the provisions of 18 U.S.C. § 3553(a), which melds utilitarian and retributivist theories of punishment. This hybrid approach purports to punish offenders for both a larger societal benefit and to justly penalize moral blameworthiness. Among the governing principals of punishment enumerated in the statute are deterrence of specific offenders, incapacitation, crime prevention, distribution of just punishment and effective offender rehabilitation. Utilitarian and retributivist theories of punishment differ in their punishment goals. The goal of the utilitarian theory of punishment is to prevent or reduce future crime, while that of retribution is to ensure the offenders receive their “just desserts.” Neither the goal of crime prevention nor the “eye for an eye” value is satisfied by narrowly applied compassionate release policies.

A. The Problem with Deterrence

The utilitarian principle of deterrence is rooted in the proposition that punishment is necessary for the general protection of society. Deterrence has long been criticized as a punishment tool because it is grounded in three unpersuasive assumptions: (1) that criminal offenders know the law; (2) that criminal offenders “perceive the cost of violation [of the law] as greater than the perceived benefit”; and (3) that criminal offenders “bring such knowledge to bear

55 Id.
56 See infra Part IV. Narrowly applied compassionate release policies are also too expensive.
57 See Williams et al., supra note 53.
59 Id.
60 Id.
62 Id.
on [their] conduct decision at the time of the offense.”64 According to Professor Paul H. Robinson, all three of these assumptions are erroneous because

most people do not know the law . . . even [] career criminals who have a special incentive to know it do not, and that even when people think they know the law they are frequently wrong….As to the perceived net-cost hurdle, the possibilities of deterrent effects are weakened by the difficulties in establishing a punishment rate that would be meaningful to potential offenders . . . there are a host of conditions that interfere with rational calculation of self-interest by potential offenders.65

Professor Robinson’s analysis accurately deduces that any criminal punishment model based in deterrence is inherently flawed because it lacks true meaningfulness—meaningfulness in both the actual punishment itself and meaningfulness in the expectation of apprehension.

Meaningfulness is of critical importance in a deterrence based model because deterrence’s ultimate goal is crime prevention. In drafting deterrence-based sentences, legislators are intimately concerned with the notion of “behavioral control reasoning,”66 and fundamentally believe that “the rule they adopt will translate into influence over decisions on the street.”67 However, if a potential offender cannot appreciate that his criminal conduct may be detected and that punishment will be severe, or is not even aware of the punishment associated with his conduct, the expected deterrent effect of the punishment is lost.68 Professor Robinson’s work criticizes deterrence as a principle for distributing punishment, and so focuses on the misguided efforts of legislative drafters to prevent crime by creating laws supported solely by deterrence. Robinson’s analysis can be extended, in certain situations, to judges who share this same delusion that their sentencing decisions will deter criminal behavior.69

The absence of meaningfulness in legislators’ deterrence-based drafting decisions and judges’ deterrence-based punishment decisions manifests differently. In deterrence-based legislative drafting, the absence of meaningfulness is evidenced pre-charge or pre-arrest, when offenders decide to engage in criminal behavior. At that moment, offenders have made careful calculations of the possibility and likely cost of getting caught, and then determined that the gamble is worthwhile.70 At that point, it is obvious that the law did not specifically deter crime in that particular situation. The absence of

65 Id. at 954, 999.
66 See ROBINSON, supra note 61, at 77.
67 Id. at 76.
68 See id. at 75.
69 See id. at 81.
70 GARY BECKER, CRIME AND PUNISHMENT: AN ECONOMIC APPROACH 3 (1974).
meaningfulness in deterrence-informed sentencing decisions is only realized post-conviction, and is most evident when prisoners’ circumstances change. In such situations, punishment is rendered meaningless because it no longer works to prevent crime. This is true when prisoners become terminally ill.

One critical quandary in a deterrence-centered sentencing model is that it assumes that conditions have not changed, and that what is deterrent at sentencing will remain so. General deterrence hopes that the public crime prevention message invoked at sentencing will remain the same throughout the sentence, thus deterring others from committing crime. Specific deterrence is persuaded that personalized punishment is necessary to prohibit future crimes of the offender. Neither of these factors is true in the case of terminally ill prisoners. When prisoners become terminally ill, the illness, not the punishment, is what deters them. The incapacitation believed, at sentencing, to be required to deter, is no longer useful or necessary. According to Professor Robinson, current deterrence models are flawed because they are unable to predict future conditions. In his words, “. . . not only does reliable deterrence analysis require information that is not now available and an understanding of the interrelation among the relevant factors that we do not now have, but it also requires a constant updating of the analysis because the relevant factors themselves are constantly in motion.” This disregard of change extinguishes any meaningfulness in deterrence-centered sentencing models. Further, such meaninglessness is glaringly evident when an offender becomes terminally ill.

71 It must be noted that in the modern criminal punishment context, specific deterrence and incapacitation may be used interchangeably. Incapacitation also assumes that physical confinement is necessary to stop the offender from engaging in prohibited behaviors. While incapacitation physically prohibits an offender from engaging in criminal behavior for a period of time, recent social science literature and legal scholarship demonstrates that it does little to prevent either the general public from committing crime or the specific offender from re-offending. Further, in the case of terminally ill patients, their illness is enough incapacitation—nothing else is required. See generally Jelani Jefferson Exum, Sentencing, Drugs, and Prisons: A Lesson from Ohio, 42 U. TOL. L. REV. 881, 882 (2011); see also Michelle Alexander, The New Jim Crow: Mass Incarceration in the Age of Colorblindness 59 (2010) (stating that the war on drugs targeted mostly low-level street dealers); Kate Stith & Steve Y. Koh, The Politics of Sentencing Reform: The Legislative History of the Federal Sentencing Guidelines, 28 WAKE FOREST L. REV. 223, 227 (1993); see also, generally Thomas Orsagh & Jong-Rong Chen, The Effect of Time Served on Recidivism: An Interdisciplinary Theory, 4 J. OF QUANTITATIVE CRIMINOLOGY 2, 155-71 (1988) ("[W]hen prisoners serve longer sentences they are more likely to become institutionalized, lose pro-social contacts in the community, and become removed from legitimate opportunities, all of which promote recidivism.").

72 See Robinson, supra note 61, at 77.
B. Fairness and Desert-Based Sentencing

The theory of desert rests upon the idea that offenders should be punished based solely on moral blameworthiness.\textsuperscript{73} Vengeful desert is derived from the Old Testament command of “an eye for an eye,”\textsuperscript{74} and determines moral blameworthiness from the point of view of the victim. Under a vengeful desert regime, offenders are punished in a manner similar to the harm done to the victim.\textsuperscript{75} Deontological desert apportions moral blameworthiness based on the views of moral philosophers. Deontological desert is believed to transcend individual notions of morality by embodying “a set of principles derived from fundamental values and principles of right and good,” and will “thus produce justice without regard to the political, social, or other peculiarities of the situation at hand.”\textsuperscript{76} In this way, deontological desert relies on moral judgments made “from the point of view of the universe.”\textsuperscript{77} Finally, empirical desert assigns moral blameworthiness according to the community’s shared intuitions of justice.\textsuperscript{78} Unlike the other two forms of desert, empirical desert “avoids the resistance and subversion inspired by an unjust system, [it] gains compliance by prompting people to defer to it as a moral authority in new or grey areas . . . and it earns the ability to help shape powerful societal norms.”\textsuperscript{79} Of the three categories of desert, none justify the atrocious punishment that terminally ill offenders receive.

To many scholars, desert is a preferred distributive punishment principle, but only works if the general population is convinced of its fairness. Professor Robinson writes that “deviating from a community’s intuitions of justice can inspire resistance and subversion among participants—judges, juries, prosecutors, and offenders—where effective criminal justice depends upon acquiescence and cooperation” and that “liability and punishment rules that deviate from a community’s shared intuitions of justice undermine that reputation.”\textsuperscript{80} He further opines:

The system’s intentional and regular deviations from desert also undermine efficient crime control because they limit law’s access to one of the most powerful forces for gaining compliance: social influence. The greatest power to gain compliance with society’s rules of prescribed conduct may lie not in the threat of official sanction but

\textsuperscript{73} Id. at 91.
\textsuperscript{74} Id. at 137.
\textsuperscript{75} Id.
\textsuperscript{76} Id. at 139.
\textsuperscript{77} Id.
\textsuperscript{78} Id.
\textsuperscript{79} Id. at 140.
\textsuperscript{80} Id. at 95-96.
rather in the influence of the intertwined forces of social and individual moral control.\footnote{Id. at 96.}

While deterrence has proven to be a reliable goal of modern punishment, its reliability is governed strictly by fairness.

For desert to function properly, “[A]lmost without exception, all factors relevant to desert are known at the time a sentence is imposed.”\footnote{Id. at 15.} In a desert-based sentencing model, society has already “pre-determined the severity of the punishments it believes should accompany particular crimes.”\footnote{Michele Westhoff, \textit{An Examination of Prisoners’ Constitutional Right to Healthcare: Theory and Practice}, 20 \textit{Health Law.} 3, 10 (2008).} Further, studies reveal that:

The majority of offenses do not, in society’s opinion, merit sentences as harsh as the death penalty or even life in prison. Yet, by confining prisoners in an environment where they are at high risk for contracting communicable diseases, and where they lack access to care that would allow them to manage chronic health problems and avoid preventable consequences of certain diseases, society effectively imposes much stiffer penalties than were originally deemed appropriate by the legislature.\footnote{Id.}

Like deterrence, desert presupposes that conditions that could render the sentence unfair will not materialize while the sentence is being served. Once an offender no longer poses a threat to society, general deterrence considerations can no longer be justified. Likewise, when an offender is diagnosed with a terminal illness, his original sentence is no longer fair, and retributivist theories of punishment lose value. This is so because the punishment, a lonely, often agonizing death in a prison medical facility, no longer fits the crime. For terminally ill prisoners, “the judicial sentence they receive will be automatically converted to a sentence of life imprisonment without the possibility of parole.”\footnote{See Dubler, \textit{The Collision of Confinement and Care, supra} note 12, at 151.}

To remain fair, an effective desert-centered sentencing model must allow adequate safety valve provisions that permit judges to “look back” and amend sentences when appropriate. Unlike the current compassionate release process, safety valve provisions must function properly and provide prisoners with quantifiable relief. For terminally ill prisoners, receiving substandard end-of-life care in prison hospitals is not the punishment which was handed down at sentencing, and does not reflect that inmate’s degree of moral blameworthiness. Instead, the prisoner-patient is subject to unfair, harsher punishment than was anticipated at sentencing, without the benefit of judicial review.

\footnote{Id. at 96.}\footnote{Id. at 15.}\footnote{Id. at 15.}\footnote{Michele Westhoff, \textit{An Examination of Prisoners’ Constitutional Right to Healthcare: Theory and Practice}, 20 \textit{Health Law.} 3, 10 (2008).}\footnote{Id.}\footnote{Id.\footnote{See Dubler, \textit{The Collision of Confinement and Care, supra} note 12, at 151.}}
IV. INCARCERATION OF THE TERMINALLY ILL VIOLATES PRISONERS’ EIGHTH AMENDMENT RIGHT TO ADEQUATE HEALTH CARE

Failure to compassionately release terminally ill prisoners violates the constitutional prohibition against cruel and unusual punishment. It is well established that prisoners must be afforded a constitutional right to health care. In *Estelle v. Gamble*, the Court recognized that the government has an “obligation to provide medical care for those whom it is punishing by incarceration,” and that failure to do so, may result in an Eight Amendment violation. In accord with basic principles of humanity, decency, and order, *Estelle* allows a right to health care for prisoners because prison officials are solely responsible for their care and maintenance. According to the Court, “an inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met,” and would result in “pain and suffering” which no one suggests would serve any penological purpose.

Further, for prison health care to survive constitutional muster, it must be “adequate.”

Prison medical care is constitutionally inadequate because it fails to comply with evolving standards of decency. The decision in *Estelle* was premised upon the truth that standards of decency inevitably evolve over time. Two principal factors motivating the *Estelle* decision were the revelation of the grotesque conditions of prison medical care, and the subsequent prevailing notion that denial of medical care in prison is wholly incompatible with basic human decency. The *Estelle* court reasoned that as society evolves, so do standards of decency, and that prison medical care services must respond, within reason, to that evolution, in order to remain “adequate.” Since *Estelle*, courts have defined adequate medical care as “services at a level reasonably commensurate with modern medical science and of a quality acceptable within prudent professional standards.” According to these decisions, adequacy of medical care is a dynamic notion that must change continuously, as medical ethical and professional standards are modified. In *Hudson v. McMillan*, the court reasoned that “[t]he objective component of an Eighth Amendment claim is therefore

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86 U.S. CONST. amend. VIII.
88 *Id.* at 103.
89 *See id.* at 104-05.
90 *Id.* at 103.
91 *Id.* at 104.
92 *See id.* at 103-04.
93 *Id.*
contextual and responsive to ‘contemporary standards of decency.’

Hallmarks of appropriate prison medical care evolve concurrently with medicine and technology, and must constantly be reevaluated. Adequacy of care for prisoners is contingent upon and should mirror, current general population health care standards. Unfortunately, it does not. Despite the ethical and legal imperatives that prison and jail health care models must be determined by, depend upon, and reflect the standard of care in the general community, end-of-life care for the incarcerated almost always fails to reach that goal.

The Estelle court established that a determination of prison medical care inadequacy requires a finding that prison officials display a “deliberate indifference to serious medical needs of prisoners.” Nearly two decades later, in Farmer v. Brennan, the Supreme Court clarified that analysis of this standard must be divided into an objective and subjective prong of reasoning. Under the objective prong, a deprivation must be “objectively ‘sufficiently serious.’” The Farmer court explained that a prison health care model that provides care in a manner contrary to current standards of decency sufficiently satisfies the objective prong. According to the Court, medical treatment must be “reasonably commensurate with modern medical science and of a quality acceptable within prudent professional standards,” such that any deprivation will deny this “minimal civilized measure” of life’s necessities. The subjective prong requires that prison officials “know[] of and disregard[] an excessive risk to inmate health or safety.” To raise a successful constitutional claim, prisoners must “clearly demonstrate that they [have] been harmed by a significant medical failure that prison officials were aware of and could have addressed.” In delineating the subjective prong, the Court reasoned that awareness may be met if a substantial risk is amply obvious. The objective test requires an assessment of the state of prison health care and a comparison to general population medical care. The subjective test involves a probing of prison officials’ state of mind and degree of awareness.

Because of the inferior nature of prison health care, both the subjective and objective prongs of Eighth Amendment claims are satisfied when terminally ill prisoners are subjected to end-of-life care in prison medical facilities. The objective prong is met because prison health care falls far short of acceptable medical ethical and professional standards and guidelines. Despite best efforts

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96 See Dubler, The Collision of Confinement and Care, supra note 12, at 151.
97 Estelle, 429 U.S. at 104.
99 Id. at 834.
100 Id. at 834.
101 Id. at 837.
103 Farmer, 511 U.S. at 842.
by prison officials at “unawareness,” refusal of compassionate release satisfies the subjective prong as well because prison officials are cognizant of the exceedingly poor quality of prison health services, and deliberately disregard risks to terminally ill prisoners’ health. Consequently, prison health care is “at best inadequate and, at worst, an atrocity.”104

A. Prison End-of-Life Care is Objectively Inadequate

While no mandate exists that prison health care facilities be comfortable, they must be “adequate” to meet constitutional scrutiny.105 Because he has lost his liberty, a prisoner must rely solely on prison officials to care for him. If prison authorities fail to meet prisoners’ needs, those needs will not be met, and “any ‘deliberate indifference’ to the prisoner’s care constitutes ‘unnecessary and wanton infliction of pain.’”106 Estelle creates a constitutional claim “for prisoners who could clearly demonstrate that they had been harmed by a significant medical failure that prison officials were aware of and could have addressed.”107 In later cases, the Court explains that a serious medical need involves “an unreasonable risk of serious damage to . . . future health.”108 The ‘deliberate indifference to serious medical needs’ analysis for terminally ill prisoners, then, begins with an assessment of the standard of care offered in prison medical facilities.

Prison end-of-life medical care is objectively inadequate because it extinguishes three distinct relationships that are essential to effective medical care delivery: (1) the relationship between patient and physician; (2) the relationship between patients and medical licensing authorities; and (3) the relationship between patient, physician, and patient’s family. Obliteration of these fundamental affiliations produces a system of care that falls far short of adequate because patients’ serious medical needs are not met.

1. Prison End-of-Life Care Destroys the Physician-Patient Relationship

While the Supreme Court has recognized a right to correctional health care, that right has been established in a manner that is wholly inconsistent with general population health care delivery standards and models. In prison medical facilities, the “trusting alliance between care providers and patients” that is

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107 See Simon, supra note 102, at 272.
critical to any “decent end-of-life” care setting is non-existent.109 The health care model for the non-incarcerated envisions a physician-patient relationship between two autonomous, participating “moral agents,” who are laboring together to construct a treatment plan and achieve an improved health status for the patient.110 In general population end-of-life care, the physician-patient relationship is based on trust, where physicians “provide options that they judge are in the ‘best interest’ of the patient,” after which the patient “considers the diagnosis, prognosis, alternatives for treatment, and the possible consequences of refusing all interventions.”111 Each actor plays a vital role in this critical association. The doctor contributes “superior knowledge and skill” and “desires to empower the other,” while the patient provides “a history with medical interventions, individual values and beliefs, and personal likings and dislikes.”112 This sharing of “authority and responsibility” serves to enhance the bond of humanity between patient and physician, which is critical in health care service delivery. Sadly, the physician-patient relationship cannot exist in correctional facilities.

In prison, the goals of medical care and correction clash, to the detriment of patient-prisoners.113 Medical care’s mission is to “diagnose, comfort, and cure,” while prisons exist to “confine” and “punish.”114 These two systems are utterly incompatible. Federal prison officials exercise full control over inmates, which cannot coexist with a traditional physician-patient relationship. The prisoner “autonomy” and “participation” that is central to a traditional physician-patient relationship cannot survive in “inherently coercive” correctional facilities, which “for security reasons must exercise nearly total control over their residents’ lives and the activities within their confines.”115 Prison policies and procedures often “intrude on care plans.”116 Unlike on the outside, “access to health services flows through prison guards,”117 and medical orders are viewed as nuisances that interfere with correctionally-necessary prisoner routines and schedules.118 Instead of readily complying with medical orders, prison officials view them as hindrances and irritations. Worse, prisoner-patients do not have the authority to make critical decisions regarding their care. Rather, access to, quality of, and decisions regarding medical care are made solely by prison officials. The humanity of medical care is extinguished, as patients are prohibited from being full, active participants in their treatment.

109 See Dubler, The Collision of Confinement and Care, supra note 12, at 150.
110 See Dubler, Ethical Dilemmas, supra note 12.
111 Id.
112 Id.
113 Id.
114 Id.
115 Id.
116 Id.
117 See Dubler, The Collision of Confinement and Care, supra note 12, at 151.
118 Id.
The interests of the prison system and the prisoner-patient are even more diametrically opposed at the end of the prisoner-patient’s life.119 The prisoner-patient’s access to health care is controlled completely by prison guards and is “limited by whether a guard chooses to allow the inmate to seek treatment.”120 According to scholars,

. . . it is precisely at the end of life that the goals of medicine—to diagnose, comfort, and cure—and the mandate of corrections—to confine and punish—clash most directly. The antagonism, suspicion, and fear that have governed the relationship between the inmate and authorities prior to the last stage of illness continue to define and constrain that relationship during the inmate’s dying. 121

Despite the ethical and legal imperative that decent prison and jail health care reflect the standard of care in the general community, end-of-life care for the incarcerated almost always fails to reach that goal.122

The physician-patient relationship is further destroyed because of the quality of doctors that work as prison physicians. The prison health care system is “understaffed, poorly organized, and lacking in adequate equipment and facilities.”123 Studies prove that, for myriad reasons, physicians do not desire employment in prison facilities.124 First, prison work is viewed as less prestigious, low status work.125 Secondly, prison physicians implement care and treatment decisions subject to prison rules and regulations, and lack the professional “autonomy” that physicians in the general public enjoy.126 Additionally, prison physicians are often required to perform non-medical penal tasks requiring medical skills, including “working against the patient’s will . . . forced body searches, force feeding, and attendance at or even participation in executions.”127 For many physicians, these repugnant tasks do not accord with traditional standards of medical professional conduct, humanity, and dignity. Further, pay is low and prison medical facilities lack adequate supplies.128

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119 See id.
120 See Westhoff, supra note 83, at 8.
121 See Dubler, The Collision of Confinement and Care, supra note 12, at 151.
122 Id.
123 See Westhoff, supra note 83, at 5.
124 See Douglas C. McDonald, Medical Care in Prisons, 26 CRIME & JUST. 427, 436 (1999); See also Westhoff, supra note 83, at 5-6.
125 See McDonald, supra note 124, at 437; see Westhoff, supra note 83, at 5. Additionally, the Bureau of Prisons has reported facing challenges in recruiting professional medical staff because of non-competitive salaries. See NATHAN JAMES, CONG. RESEARCH SERV., R42937, THE FEDERAL PRISON POPULATION BUILDUP: OVERVIEW, POLICY CHANGES, ISSUES AND OPTIONS 9 (2014), available at https://www.fas.org/sgp/crs/misc/R42937.pdf.
126 See McDonald, supra note 124, at 438.
127 Id.
128 Id.
Finally, hospitals are often located in unappealing locales. According to prison health care scholars,

Prison medical facilities are frequently small, old, and crowded, and equipment and supplies are either unavailable or outdated. Support staff is often inadequate, security protocols may interfere with the physician’s medical decision making, prisoners often make for uncooperative and disrespectful patients, and some doctors fear for their own safety in prisons. What’s more, there is evidence that prison doctors lose status among their physician-colleagues.

Consequently, it is difficult for prison officials to recruit competent, qualified doctors.

On average, prison physicians represent some of the least qualified of physicians practicing in the United States, and are unable to secure more prestigious employment because they “lack specialized education, significant post-residency training, and specialty certification. . . .” Additionally, a recent study documenting the qualifications of prison doctors reads:

[] 33 percent of full time prison doctors were foreign medical graduates, as opposed to 20 percent of all physicians practicing in the U.S. This is significant because the majority of foreign medical graduates working in prison are not board certified, do not have advanced training, do not practice in any specialty, and have restricted state licenses . . . . Also troubling is the lack of specialty-trained and board-certified physicians in prison. No specialty was declared by 42 percent of prison doctors, compared with only 16 percent in the larger physician population. Furthermore, only 28 percent of prison physicians were board certified, as opposed to 49 percent of physicians working outside of prisons.

For this reason, “one cannot be sanguine about the quality of care the full-time prison physicians are likely to provide, since their profile indicates that a disproportionate number have characteristics associated with lower quality care.” Unlike more qualified physicians practicing in the general population, less competent prison doctors view themselves as extensions of prison officials, further destroying essential relationships between patients and physicians.

The physician-patient relationship is central to effective health care delivery, and its purposeful abandonment constitutes denial of a “serious medical

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129 Id. at 439.
130 See Westhoff, supra note 83, at 7.
131 Id.
132 Id. at 5-8.
133 See McDonald, supra note 124, at 442.
need.” 134 Under the prison health care model, prison officials make the kinds of decisions that properly belong in the hands of patients. This misappropriation of power renders prison end-of-life care abundantly less humane, and therefore woefully inadequate.

2. Prison End-of-Life Care Destroys the Patient-Licensing Authority Relationship

At the end of their lives, prisoner-patients should have the ability to appeal to independent authorities to challenge adequacy of care, and prison physicians should be accountable to patient-prisoners and their families. Unlike traditional patients, prisoner-patients are unjustly denied meaningful legal tools to ensure that the standard of care they are entitled to is properly enforced. Prisoners do not have the support or resources to request a second opinion, select an alternative medical provider, or air grievances regarding quality of medical treatment. 135 If a prisoner-patient wishes to challenge a health care decision made on his behalf by prison officials, he must follow the correctional institution’s administrative process. The prison medical grievance process occurs in-house, and the reviewer is often not a medical professional, but is a private contractor employee or prison administrator who represents the prison’s interest. 136 These biased reviewers are “not qualified to question the individual provider’s actions and usually defer to the provider’s medical judgment.” 137 The prison medical grievance process, then, “amounts to a rubber stamp for the provider’s choices.” 138

The judiciary is the only independent authority from which prisoner-patients can seek relief, but the courts have historically dismissed prisoners’ Eight Amendment claims pre-trial without allowing prisoners an opportunity for full presentation. 139 Moreover, “[e]ven when the claim survives the pleading stage, the prisoner plaintiff is unlikely to survive summary judgment.” 140 Most prisoner plaintiffs are indigent, rely on the labor of jailhouse lawyers, represent themselves pro se, are necessarily “[u]nskilled in discovery matters,” and are ill-equipped to “secure the production of supportive documents or testimony.” 141 Further, prisoners suffer exceedingly low literacy levels. 142 Together, all of the

136 Id. at 649.
137 Id.
138 Id. at 652.
139 Id.
140 Id. at 651.
141 Id.; see also JIM THOMAS, PRISONER LITIGATION: THE PARADOX OF THE JAILHOUSE LAWYER 156 (1988).
above factors create significant practical hurdles to plaintiff prisoner court access.143

Additionally, prisoners are regarded as inherently untrustworthy, and must rely solely on the testimony of expert witnesses to offer “an opinion about the adequacy of care and to rebut the providers’ claims.”144 A prisoner plaintiff’s sworn testimony concerning treatment received “without more, stands little chance against the records, affidavits, and expert opinions that the prison medical providers can generate.”145 Sadly, due to lack of resources, “[p]risoners generally lack the wherewithal to locate a willing expert and the funds to retain her as an expert witness.”146 Further, prisons have responded to rising health care costs by looking to private entities to provide health care at a lower cost.147 In utilizing private medical providers, prisons are able to better forecast and control costs by awarding contracts to the lowest bidder, who, in turn, is committed to providing care at the lowest cost possible.148 According to one scholar, “[w]hile CMS [Correctional Medical Services] is the nation’s largest provider of prison medicine, it is also the cheapest. Unlike conventional HMOs, however, which risk malpractice suits, CMS and similar companies have little reason to protect themselves because juries are reluctant to decide on behalf of convicts or award them damages.”149 The inability of a patient to petition effectively on his behalf destroys confidence in a system that, in the general population, relies heavily on accountability and sustained licensure.

Finally, the correctional health care model is “designed to avoid intruding on state malpractice litigation regarding adequacy . . . and standards of care.”150 Because the exercised standard of care for prisoner-patients is far below that of the general population, prisoner-patients are essentially legally prohibited from bringing malpractice claims against physicians, except in the most narrow of circumstances.151 According to scholars,

No single federal court decision, applicable to all prisoners in all prisons, has detailed all the specific services that must be provided. In general, the federal courts have established principles with specific examples, from which standards can be deduced. Moreover, not all court decisions apply equally to all categories of inmates. For example,

143 See Thompson, supra note 135, at 652-53; see also Thomas, supra note 141.
145 See Thompson, supra note 135, at 652-53.
146 Id. at 651-52.
147 Id. at 640.
148 Id. at 640-41.
150 See Dubler, Ethical Dilemmas, supra note 12.
151 See id.
some pertained only to civil commitments, or detainees, and not to convicted prisoners. Many court decrees were binding only on the specific litigants involved.”

Absence of reliable methods of appeal renders the system inadequate, less humane, and results in deprivations of serious medical needs involving “unreasonable risks of serious damage to future health.”

3. Prison End-of-Life Care Destroys the Patient-Family-Physician Relationship

Finally, correctional health care abolishes the indispensable relationship between the ill, their family, and treating physician(s). Medical studies demonstrate that effective end-of-life care requires the meticulous formation of a well-balanced relationship between the patient, their loved ones, and the patient’s medical team. Specifically, palliative care, which becomes “the main focus of care when disease-directed, life-prolonging therapies are no longer effective, appropriate, or desired,” demands the active participation of the patient’s family and loved ones. Palliative care is described as:

. . . a special kind of patient—and family—centered health care that focuses on effective management of pain and other distressing symptoms, while incorporating psychosocial and spiritual care according to patient/family needs, values, beliefs and cultures. The goals of palliative care are to anticipate, prevent, and reduce suffering and to support the best possible quality of life for patients and their families.”

According to the Institute of Medicine, “a focus on the family is part of the definition of palliative care; family members and caregivers both participate in the patient’s care and require assistance themselves.” Humane end-of-life care, then, must necessarily involve family participation.

Prevailing medical standards dictate that families must actively participate in end-of-life care both to provide comfort and also to assist in the decision making process when severely ill inmates become unable to self-

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152 See McDonald, supra note 124, at 437.
154 Michael H. Levy et al., Palliative Care, 10 Nat’l Comprehensive Cancer Network 1284, 1300 (2012), available at http://www.jnccn.org/content/10/10/1284.full.
155 Id.
156 Id.
157 See Dying in America, supra note 12.
advocate. Medical experts profess that advance care planning, accomplished with the patient and her family is essential to ensuring that end-of-life care wishes are honored. According to medical scholars, “medical advancements have created an area of compromised individual autonomy. . . . When persons become unconscious patients, their wishes are difficult to determine and act upon.”

Family participation is vital at this critical juncture. The movement away from a paternalistic approach to health care has dominated much of medical literature for the past three decades. Modern health care delivery service models advocate that patients are well-positioned to assist doctors in making care decisions, and that they should be involved in care and treatment plans. Families fulfill this role when prisoners are no longer able.

Advanced directives, such as living wills, health care agent appointments, and do-not-resuscitate orders are invaluable end-of-life care tools that “allow a capable individual to articulate treatment wishes to be honored at a future time when the ability to make decisions might be lost.” Medical scholars profess that advance care planning is a necessary component to end-of-life care that involves a collaborative effort between the patient, their family, and treating physicians. They write, “advance care planning should include an open discussion about palliative care options, such as hospice; personal values and preferences for end-of-life care; the congruence between the patient’s wishes/expectations and those of the family/health care team.” Further, “there is growing knowledge within medical and social care communities about how to better engage patients and families in advance care planning and shared decision making. . . .”

Current research demonstrates that terminally ill patients wish to experience a “good” or “peaceful” death, and, that patients, families, and physicians share a common understanding of what a “good” or “peaceful” death is. The National Palliative Care Council describes a peaceful death as one that is “in general accord with patient’s and family’s wishes . . . and consistent with clinical, cultural, and ethical standards.” Patients, physicians, and families regard such a death as one that is pain-free, where the patient is at spiritual peace,
and where family is present. A good death involves “an acceptance of the inevitable and a reconciliation with family and friends. . . .” According to scholars, however, “plans for a good death often run afoul of prison rules and regulations, and are complicated by the structure of the medical care organization, the distance of families, and the barriers to communication and affection that exist in the punitive correctional environment.” The crucial connection between patient, family and physician is simply unsustainable in the prison context.

During their last days, terminally ill prisoners are “frequently distanced from family or friends, impeding access to social support to navigate the [end-of-life] process.” Preserving family ties while incarcerated is a complicated task. A multitude of factors inhibit the forming and sustaining of family bonds during incarceration, including “intimidating security procedures, geographic distances between prison facilities and family residences, the time consuming nature of visits, and the general lack of visiting arrangements conducive to” healthy family interaction. Currently, 84% of federal offenders with families are housed in facilities more than 100 miles from the location of arrest, with only 5% housed fewer than fifty miles from their place of arrest.

Further, visiting prison facilities can be intimidating. Visitors are often subject to “long waits; body frisks; rude treatment; and hot, dirty and crowded visiting rooms. . . .” In addition, prison administrators have traditionally limited their role to operating safe and secure institutions, with little consideration given to issues personally affecting prisoners. As a result, many prison policies and practices actively discourage contact between incarcerated prisoners and their families, and some prison administrators view maintaining family relationships as beyond the scope of their mission.

The destruction of these three key relationships amounts to a significant decrease in a patient’s quality of care, and satisfies the objective prong of the ‘deliberate indifference to a serious medical need’ standard. These deprivations

166 Id.
167 See Dubler, The Collision of Confinement and Care, supra note 12, at 151.
168 Id.
169 See Williams et al., supra note 53, at 122-23.
are “sufficiently serious” to constitute an unconstitutional “wanton and
unnecessary infliction of pain.” 175 Unfortunately, prison officials’ treatment of
terminally ill prisoners satisfies the subjective deliberate indifference standard as
well.

B. Prison End-of-Life Care is Subjectively Deliberately Indifferent

The Supreme Court has chosen to frame the subjective prong of the
‘deliberate indifference to a serious medical need’ standard in much the same
way that criminal law has expressed its recklessness standard. For a criminal
defendant to act recklessly, she must be aware of, and disregard, a substantial risk
or harm. 176 According to Estelle’s deliberate indifference standard, a prisoner
must prove that prison officials disregarded a substantial risk of harm to the
prisoner’s health of which they were aware.177 Sadly, the deliberate indifference
standard provides a cloak under which prison officials can easily hide. This is
ture because prisoners lack resources to mount successful claims, courts have
decided not to second-guess medical judgment, and because it is nearly
impossible to probe the mind of a prison official.178

The deliberate indifference standard demands that prison officials are
“aware of facts from which the inference could be drawn that a substantial risk of
serious harm exists,” and, simultaneously, draw the inference.179 Courts and
administrative processes experience difficulty in deciphering between situations
where a prison official is motivated by safety concerns and where they are acting
deliberately indifferently. Further, “court rulings that the subjective prong
depends not on the conduct’s effect on the prisoner, but instead on the constraints
faced by the prison official, exacerbate this issue.”180 The standard’s ambiguity
invites exploitation.

According to scholars, this manipulation is systematic, and is manifested
in the exercise of four distinct policies that prison officials readily use: (1) do not
test; (2) test once and stop; (3) do not listen to others; and (4) do not consult
others.181 Together, these policies permit prison physicians to simultaneously cut
costs and formally escape the subjective deliberate indifference/recklessness test

176 MODEL PENAL CODE § 2.02(2)(c). Criminal recklessness is defined as follows: “A person acts
recklessly with respect to a material element of an offense when he consciously disregards a
substantial and unjustifiable risk that the material element exists or will result from her conduct.
The risk must be of such a degree and nature that, considering the nature and purpose of the actor’s
conduct and the circumstances known to him, its disregard involves a gross deviation from the
standard of conduct that a law-abiding person would observe in the actor’s situation.” Id.
178 See Thompson, supra note 135, at 639.
180 See Malave, supra note 104, at 722.
181 See Thompson, supra note 135, at 640-45.
by “chronically avoid[ing] gathering sufficient information about a patient.” An analysis of these “tests” illustrates that prison officials actually act subjectively deliberately indifferently.

The “do not test” policy allows prison officials to skirt the deliberate indifference standard by claiming that they were not aware of a medical condition requiring treatment. The “test once and stop” policy officially satisfies the Eighth Amendment directive because physicians can claim that they provided adequate treatment by doing something. In “test once and stop” scenarios, physicians fail to perform all of the tests that they normally would on non-incarcerated individuals. They test once, find nothing, and stop testing. Again, though their actions are deliberate, prison physicians can report that they were unaware of a serious medical need. Furthermore and unfortunately, courts have a long history of deferring to prison officials on issues of medical judgment.

The “do not listen to others” and “do not consult with others” policies operate similarly. Both deny prisoner-patients the opportunity, typical to and expected of non-incarcerated patients, to actively participate in their treatment. The “do not listen to others” policy presupposes that the prisoner is both untrustworthy and unintelligent. Under this model, the prisoner’s truthful statements about his current state of health and health history are ignored because physicians deem prisoners unreliable, and simply do not believe them. Prisoner accounts are also disregarded if they impose “a heavier burden on the prison medical provider.” Sadly, diagnoses from outside providers are often ignored for the same reasons. Under the “do not consult with others” policy, prison physicians “keep their heads buried in the sand” by purposely failing to contact specialists because “denying treatment for a known problem would be difficult to justify.”

The “do not listen to others” and “do not consult with others” policies ignore the doctrine of personal autonomy that is critical to health care delivery service models. According to the doctrine of personal autonomy, “[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others.”

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182 Id. at 642.
183 Id. at 643.
184 Id.
186 See Thompson, supra note 135, at 643-45.
187 See id. at 643-44.
188 Id.
189 Id. at 644.
190 Id. at 643-44.
191 Id. at 645.
192 See Neumann, supra note 160, at 307.
prison physicians’ acts do not adhere to this virtue, but instead, operate “in contravention of growing medical consensus that such conduct is an ethical violation.”

These four unjust policies result in an unconstitutional denial of care, where prisoners “run in place,” repeatedly undergoing the same procedures, with no result. At best, the result is a continuous cycle of non-treatment. At worst, the result is progression of a treatable condition into one that is untreatable. These policies allow prison physicians to undermine and manipulate the deliberate indifference standard. The consequence is that prisoners are virtually prohibited from raising Eighth Amendment claims.

Most courts agree that “while entitled to adequate medical care,” prisoners are not entitled to a “choice of treatment.” According to scholars, this language is a “shorthand” method of determining deliberate indifference, and is not part and parcel of the standard established in Estelle or Farmer. Because the standard disallows negligent and grossly negligent behavior, prison officials can claim that their actions are motivated by security, not indifference. This has serious consequences for the terminally ill, and results in an “early dismissal [of their claims] at the pleading stage,” before all of the facts are furnished to the judge. In other words, the deliberate indifference standard only pertains to a limited category of conduct.

While professional standards for prison health care have been created, there remains confusion regarding their content and application. The system is structured such that prison officials can “deny adequate care to prisoners but enable providers to claim otherwise.” Prison physicians regularly employ practices that facially meet the adequate care standard but fall far short substantively.

The deliberate indifference standard requires a showing of prison officials’ culpable state of mind, which has proven to be a high burden for prisoners to meet. However, ‘awareness’ of a ‘substantial risk of harm’ may be proven by “inferences from circumstantial evidence” demonstrating “the very fact that the risk [is] obvious.” A deeper, causal connection exists, then, between the objective and subjective prongs. If objective inadequacy is met by characterizing the ‘substantial risk of harm’ as failure to comply with evolving standards of decency, it may be argued that subjective deliberate indifference is

193 Id. at 318.
194 See Thompson, supra note 135, at 645.
195 Id. at 646.
196 Id. at 651.
197 See id.
198 Id.
199 See McDonald, supra note 124, at 436-37.
200 See Thompson, supra note 135, at 636.
201 See id. at 652.
also necessarily satisfied if such failure is glaringly obvious. It is clear that prison health care is administered in a manner that is contrary to current standards of decency.\textsuperscript{203} Prison officials’ disregard of this blatantly obvious substantial risk satisfies the subjective deliberate indifference standard. Fulfillment of the subjective and objective prongs of the ‘deliberate indifference to serious medical needs’ standard renders prison end-of-life care constitutionally inadequate and ripe for scrutiny. It remains so due to the enormous cost of prison medical care.

V. INCARCERATION OF THE TERMINALLY ILL IS FISCALLY IRRESPONSIBLE

Caring for an elderly, infirmed and terminally ill prison population is a costly endeavor that can be avoided. It is estimated that geriatric care can range from $60,000-$69,000 per year, while the cost of incarcerating a younger, more robust inmate is approximately $29,000 per year.\textsuperscript{204} Compassionate release programs could relieve the government’s financial burden by shifting care costs from the overburdened Department of Corrections to Medicare and Medicaid, where the costs would be “largely invisible.”\textsuperscript{205} As the non-incarcerated population grows older and lives longer, so does the prison population. Over the last two decades the number of older prisoners has increased by 750% nationwide.\textsuperscript{206}

The prison overcrowding phenomenon leads to strains on essential prisoner resources, including medical systems.\textsuperscript{207} In 1995, sentences for federal offenders were twice that of 1980,\textsuperscript{208} with a 300% increase in the prison population.\textsuperscript{209} In 1997, prison overcrowding hit its highest rate in many years, finally peaking at 41% above capacity in 2004.\textsuperscript{210} Between 1991 and 2007, 932,142 persons were incarcerated in the federal system, a 118% increase from 1991.\textsuperscript{211} Between 1980 and 2012, the federal prison population increased by a

\begin{footnotesize}
\begin{itemize}
    \item \textsuperscript{203} See \textit{infra} Part IV-A.
    \item \textsuperscript{204} See Duhl, The Collision of Confinement, \textit{infra} note 12, at 151; \textsc{James, supra} note 125.
    \item \textsuperscript{205} See Duhl, The Collision of Confinement, \textit{infra} note 12, at 154.
    \item \textsuperscript{206} See Williams et al., \textit{supra} note 53.
    \item \textsuperscript{207} State courts have recently made similar conclusions. For example, California courts have found prisons so overcrowded as to be deemed criminogenic, thereby ordering states to reduce prison populations. See Brown v. Plata, 131 S. Ct. 1910, 1914 (2011).
    \item \textsuperscript{210} See \textsc{James, supra} note 125.
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staggering 6100 inmates annually. The entire prison population has grown at a rate of 800% since 1980. By 2010, eight out of ten inmates were incarcerated for a drug or immigration-related offense, while far fewer were incarcerated for violent offenses. Regrettably, as a result of prison overcrowding, the condition of prison medical facilities has worsened.

As a direct result of prison overcrowding, the cost of funding corrections has risen exponentially. The Bureau of Prison’s Congressional appropriations grew from $330 million in FY 1980 to an astounding $6.64 billion in FY 2012. The average annual increase during those years was $197 million. Further, the per capita cost of incarcerating inmates is rising as well. From FY 2000 to FY 2012, the per capita cost of incarcerating inmates has increased by 34.4%, from $22,000 per inmate to more than $29,000 per inmate, resulting in an overall annual cost of $6.3 billion. This cost is many times that of the following federal programs combined: Science, Technology, Engineering, and Mathematics Programs (STEM); recruiting and training 100,000 high quality STEM teachers; Institute of Education Sciences research and development for investing in innovation; expansion of affordable housing to seniors and persons with disabilities; transformation of high poverty neighborhoods where distressed housing is located; math initiatives for the National Science Foundation; and development of comprehensive housing and transportation to lower energy costs and to reduce pollution. Included in the cost of housing offenders is the cost of food service, medical treatment, grounds upkeep, waste


212 This is an approximation. See generally JAMES, supra note 125. The majority of inmates in federal prisons are drug offenders. See id. Immigration violators follow closely behind. See id.; See BUREAU OF JUST. STAT., U.S. DEP’T OF JUST., FEDERAL CRIMINAL CASE PROCESSING STATISTICS, http://www.bjs.gov/fsrc/.


214 See generally JAMES, supra note 125. According to statistics, in 1998, approximately 12% of offenders in federal prison were imprisoned for a violent offense. This number decreased to 6.4% by 2010.

215 Due to mandatory minimum jail sentences, the federal prison population has increased. U.S. v. Blake, 89 F.Supp.2d 328, 346 (2000). According to a recent report, there are currently over two million people in the federal system. Id.

216 See generally JAMES, supra note 125.

217 See id.

218 See id. Additionally, the cost to states is more than $50 billion per year, second only to the spending amount of Medicaid. See Vigueirer, supra note 204.


220 Id. The annual cost is $80 million.

221 Id. at 94. The annual cost is $12 million.

222 Id. at 123. The annual cost is $154 million.

223 Id. The annual cost is $150 million.

224 Id. at 93.

225 Id. at 123. The annual cost is $100 million.
removal contracts, utility provisions, facility maintenance and repair, guard service, and personnel. It is noteworthy that the Bureau of Prisons’ appropriations grew by more than $3 billion from FY 1980 to FY 2012. Additionally, in fiscal year 2014, the BOP budget consisted of 25% of the entire DOJ budget, while it was only 20% of the budget in FY 2000. BOP’s rate of growth is twice that of the rest of the DOJ. Three primary “drivers” of increased prison costs are “expenditures on utilities, food, and medical care,” but none of these factors has been as “pronounced as the increase in the per capita cost of inmate medical care.” In 2008 alone, it cost $50 billion to fund prisons. Granting compassionate release to terminally ill prisoners would reduce the federal deficit greatly.

The precise reason for prison overcrowding may be attributed to several 1980-1990 era reform-related policies, including the institution of mandatory minimum sentences, sentencing enhancement policies for prior and/or subsequent offenses, the federalization of crimes previously handled by state and local governments, and prosecutorial charging decisions. For example, the number of federal offenses in the United States Code increased significantly from 1980-2008, and from 2000-2007, Congress enacted an average of 56.5 new

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226 See generally JAMES, supra note 125.
228 Id.
229 See generally JAMES, supra note 125.
230 G. Nicholas Wallace, The Real Lethal Punishment: The Inadequacy of Prison Health Care and How It Can Be Fixed, 4 FAULKNER L. REV. 265, 275 (2012); see generally JAMES, supra note 125.
231 The size of the federal docket has tripled in the last twenty years. The number of federal cases was 29,011 in 1990 and 83,946 by 2010. See U.S. SENTENCING COMM’N, Report to the Congress: Mandatory Minimum Penalties in the Federal Criminal Justice System 66 (2011), available at http://www.ussc.gov/sites/default/files/pdf/news/congressional-testimony-and-reports/mandatory-minimum-penalties/20111031-rtc-pdf/Chapter_04.pdf. Likewise, the number of federal offenders punished with a mandatory minimum sentence has risen from 6685 cases in 1990 to 19,896 cases in 2010. Id. Additionally, the number of mandatory minimum penalties has “more than doubled” since 1991 from 98 to 195. Id. at 71-72.
232 The most significant of these changes is found in the federalization of gun cases, a trend which began with Project Triggerlock in 1991, whose goal was to reduce “violent crime by imposing severe sentences on unlawful gun possessors,” cases which would ordinarily have been prosecuted in state court.” See U.S. SENT’G COMM’N, Report to the Congress: Mandatory Minimum Penalties in the Federal Criminal Justice System 65 (Oct. 2011), available at http://www.ussc.gov/Legislative_and_Public_Affairs/Congressional_Testimony_and_Reports/Mandatory_Minimum_Penalties/20111031_RtC_Mandatory_Minimum.cfm (citing David E. Patton, Guns, Crime Control, and a Systemic Approach to Federal Sentencing, 32 CARDOZO L. REV. 1427, 1440-41 (2011)).
federal crimes per year. The major culprit, however, is the gross expansion of mandatory minimum sentences. The effect that prison overcrowding has had on terminally ill prisoners can be explained as follows:

While Estelle and Farmer were shaping the civil rights of prisoners with regard to their medical care, other forces were shaping the actual delivery of such care. The prisoner population in this country skyrocketed during this period. Increased numbers of prisoners in jail and prisons created more demand for health care services, and thus higher costs. The prisoner population not only grew, it aged. Longer sentences and a decline in the number of prisoners granted parole led to a generation of prisoners who would grow old behind bars.

Criminal justice reforms triggered the aging of the prison population. Between 1981 and 1990, the number of elderly inmates doubled. In the last two decades, the number of elderly prisoners has risen by 750%. It must be noted that, due to lack of access to medical and dental facilities, poor diet, and other social factors, the rate of aging in prison is dramatically accelerated. According to medical professionals, “a prisoner aged fifty may be classified by society as middle-aged; he may, in fact, already be an elderly person if many of his years have been spent in the prison system." This is due to lack of care and frequent engagement in risky behaviors, which leads to premature aging. This escalation in physiological age may result in as much as a “ten-year aging differential” between prisoners’ rates of aging and those of the non-incarcerated population. Consequentially, as prisons become “grayer,” prison inmates’ medical problems increase exponentially as they mirror, though accelerated, age-related medical problems of the general population, including dementia, cardiac ailments, failing eyesight, high blood pressure, and cancer.


234 Id. This number does not account for the tens of thousands of criminal offenses found throughout the federal regulations.

235 Thompson, supra note 135, at 638-39.

236 See Williams et al., supra note 53.


238 See Berry, supra note 9, at 855.

239 See generally Dubler, The Collision of Confinement, supra note 12, at 150.

240 Id.


242 See Dubler, The Collision of Confinement, supra note 12, at 150.

243 Id.; See generally JAMES, supra note 125; Vestal, supra note 237.
Furthermore, an increasingly aging prison population triggers an upsurge in prison health care costs, especially for costs related to end-of-life care.\textsuperscript{244} Health care costs for elderly prisoners, who are more likely to experience chronic medical conditions and terminal illness, are “two to three times that of the cost for other inmates.”\textsuperscript{245} According to a recent Department of Justice Study, from FY 2010 to FY 2013, the population of inmates over the age of 65 in BOP-Managed facilities increased by 31 percent, from 2708 to 3555, while the population of inmates 30 or younger decreased by 12 percent, from 40,570 to 35,783. This demographic trend has significant budgetary implications for the Department because older inmates have higher medical costs. . . . Moreover, inmate health services costs are rising: BOP data shows that the cost for providing health services to inmates increased from $677 million in FY 2006 to $947 million in FY 2011, a 40 percent increase.\textsuperscript{246}

Additionally, prisons in the United States contain “an ever growing number of aging men and women. . . who are. . . suffering chronic illnesses, extremely ill, and dying.”\textsuperscript{247} The cost of housing and caring for terminally ill prisoners is simply unsustainable and irrational. According to analysts, it is estimated that releasing a category of infirmed prisoners could save correctional systems “$900 million in the first year alone,” and would not reduce public safety.\textsuperscript{248}

One response to rising prison health care costs is the privatization of health care. As prisons struggle under the weight of unsustainable budgets, they have begun seeking private entities to provide health care at a lower cost.\textsuperscript{249} In utilizing private medical providers, prisons are able to better forecast and control costs by awarding a contract to the lower bidder, who, in turn, is committed to providing care at the lowest cost possible.\textsuperscript{250} Cost, then, and not quality of care, drives prison health care systems. Since “some medical attention” will often satisfy the constitutional standard of “adequacy,” prison officials succeed in manipulating the system. As is stands, the Supreme Court has not ruled that cost can be a justification for failing to provide adequate care.

\textsuperscript{244} Vestal, \textit{supra} note 237.  
\textsuperscript{245} \textit{Id.}  
\textsuperscript{246} See Memorandum from the U.S. Inspector General, \textit{supra} note 13.  
\textsuperscript{249} See Thompson, \textit{supra} note 135, at 640.  
\textsuperscript{250} \textit{Id.}
VI. REMEDIES

For patients and their loved ones, no care decisions are more profound than those made near the end of life. For the millions of Americans who work in or with the health care sector—including clinicians, clergy, caregivers, and support-staff—high quality care for people who are nearing the end of life is a matter of professional commitment and responsibility. Health system managers, payers, and policy makers, likewise, have a responsibility to ensure that end-of-life care is compassionate, affordable, sustainable, and of the best quality possible.251

Prison end-of-life care is inherently inadequate. By its very nature, prison culture is strictly hierarchical; prison officials are viewed as superior, and prisoners are considered and treated as “subhuman.”252 The subhuman prisoner has, as a consequence of criminal behavior, surrendered all rights enjoyed by non-incarcerated humans.253 Unfortunately, this mentality is prevalent not only among prison officials, but spills over into the minds of prison physicians as well, creating a troublesome ethical dilemma. According to medical ethicists, “[d]octors, who take the Hippocratic Oath upon graduating from medical school, vow to use all measures required for the benefit of the sick. Those who take the classical version of the oath repeat, ‘Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice.’”254 However, “[t]he negative view of prisoners adopted by the public and by health care professionals ignores the spiritual laws of compassion, forgiveness, reconciliation, and responsibility,” values that are commonly at the forefront of medical practice, but are nevertheless absent in the practice of prison medicine.255 This ethical dilemma forms an impenetrable “barrier to the establishing of an effective interprofessional palliative care environment.”256

Prison hospice should be the environment where prisoner-patients can experience a dignified death, free from shackles and teeming with care and compassion. Researchers at the Institute of Medicine offer that:

Hospice is an important approach to addressing the palliative care needs of patients with limited life expectancy and their families. For people with a terminal illness or at high risk of dying in the near future, hospice is a comprehensive, socially supportive, pain-reducing, and

251 See Dying in America, supra note 12, at 4.
252 See Restum, supra note 149.
253 Id. at 1690.
254 Id.
255 Id.
256 Katie Stone et al., Establishing Hospice Care for Prison Population: An Integrative Review Assessing the UK and USA Perspective, 26 Palliative Med. 969, 977 (2011).
comforting alternative to technologically elaborate, medically centered interventions.257

However, the full benefits of hospice palliative care cannot exist in concert with prison officials’ safety and containment concerns. Prison hospices struggle to consider both comfort and overall prisoner safety, and safety always overrules comfort.258 The prison hospice environment is described in this way:

This locked and isolated medical unit provides no particular amenities or advantages other than basic nursing care and medical attention. Safety and security concerns mandate uncovered barred windows, bare walls and Spartan furnishings. Two heavy grey metal doors guard the entrance. Each medical cell does, however, have a television and radio.259

Further, terminally ill prisoners are isolated from people and resources. Hospice units traditionally have decreased access to spiritual and educational programming, the library, and other activities that make life more meaningful.260 Prison hospice care stands in stark contrast to traditional hospice, where there is a deliberate effort to pay special attention to patients’ specific comfort needs.261 Despite a movement to reform palliative care, an exorbitant number of patients still die in pain in traditional hospitals and medical centers.262 The inhumanity of dying in pain is even more prevalent in prison populations.263 Medical literature suggests and basic humanity demands that, once curing the prisoner is no longer an option, medical treatment should shift to palliative care, without regard for an inmate’s criminal history.264 In prison medical facilities, however, prison physicians utilize a conservative approach when prescribing pain-relieving medication, fearing that prescriptions will be smuggled into the larger prison population.265 As a result, terminally ill prisoner-patients are often left, inhumanely, in physical pain. According to a recent survey of prisoners undergoing cancer treatment, 81% of prison inmates reported a “pain score of 7 or above (severe pain) in the past 24 hours” and “forty-nine percent reported an average pain score of 7 or above in the past 24 hours.”266

257 See Dying in America, supra note 12, at 2.
258 See Stone et al., supra note 256, at 976.
259 Id.
260 See Dying in America, supra note 12, at 2.
261 Id.
262 See Dubler, The Collision of Confinement, supra note 12, at 149.
263 Id. at 151.
264 Id.
265 See Stone et al., supra note 256, at 975.
266 Id.
While prisoner end-of-life care should parallel that of the general population, the brutal reality is that “[c]ompassionate care for the terminally ill is a difficult paradigm to create in a prison environment.”\textsuperscript{267} This is so because “by definition, compassionate care requires deviation from the correctional norm whose goals are segregation, stigmatization, and punishment. Dying inmates need increased medical attention, expanded visiting hours with family and clergy, access to special foods, and relaxation of routine restrictions.”\textsuperscript{268}

Prison end-of-life-care reformers propose that quality of life in prison medical centers can be improved by implementing new care policies.\textsuperscript{269} They recommend the following types of improvements: education for correctional and health prison staff to enable them to view terminally ill prisoners as patients, implementation of effective palliative care protocols to ensure a pain-free experience, availability of appropriate medication with enhanced security precautions, special foods as needed, relaxed rules allowing flexible visiting hours for family/loved ones/clergy, assistance in strengthening family bonds, burial plans, and a firm no-shackling policy.\textsuperscript{270} Reformers earnestly believe that such amendments will render prison end-of-life care humane. They are simply incorrect. The rivalry between security and comfort in the prison health care model cannot be settled. The only truly humane way to treat terminally ill prisoners is to compassionately release them. Compassionate release procedures, then, must be reformed so that they effectively assist all terminally ill prisoners. This requires a complete overhaul of the compassionate release process.

In a report to Congress advocating for the broadening of compassionate release standards, the Congressional Research Service suggests that “Congress could reconsider modifications to the requirements for sentence reduction under 18 U.S.C. § 3582(c)(1)(A) to allow more inmates to have their sentences reduced.”\textsuperscript{271} A scathing 2013 Inspector General report chronicling the numerous flaws of the compassionate release process, recommends four major amendments to cure deficiencies. In order to ensure a fair process and humane application of compassionate release, the Bureau of Prisons must: (1) provide guidance to prison staff regarding appropriate compassionate release medical criteria; (2) provide timely responses to compassionate release requests and appeals; (3) create formal procedures to inform inmates about compassionate release; and (4) implement a system to track requests and denials in order to ensure proper oversight.\textsuperscript{272} In addition, the Bureau of Prisons should only screen compassionate

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\textsuperscript{267} See Dubler \textit{The Collision of Confinement and Care, supra note 12, at 153.}
\textsuperscript{268} Id. at 154.
\textsuperscript{270} Id.
\textsuperscript{271} JAMES, supra note 125.
\textsuperscript{272} See generally Memorandum from the U.S. Inspector General, supra note 13.
\end{flushright}
release requests to determine medical eligibility, and should allow judges to exercise the power lawfully granted to them. Together, implementation of all of these reforms will result in the preservation of both human dignity and cost. Human dignity will be protected because prisoners will be able to experience a “good” and “peaceful” death. According to the Inspector General, in “releasing 100 inmates with serious medical conditions from the medical referral centers each year, the BOP could potentially realize cost savings of at least $5.8 billion annually.”

A. Compassionate Release Procedures Must Clearly Define Eligible Medical Criteria

Governmental entities, policy leaders, academics, and medical experts all agree that the compassionate release system is ill-constructed. According to medical professionals, compassionate release procedures need to be reformed because they are “critically flawed” and because “procedural barriers may . . . limit their rational application.” In their words,

[w]e argue that the medical eligibility criteria of many compassionate-release guidelines are clinically flawed because of their reliance on the inexact science of prognostication, and additional procedural barriers may further limit rational application. Given that early release is politically and socially charged and that eligibility is based largely on medical evidence, it is critical that such medical evaluation be based on the best possible scientific evidence and that the medical profession help minimize medically related procedural barriers.

Compassionate release procedures fail to provide specific criteria and standards for evaluative purposes. As a result, BOP application has historically lacked uniformity. For example, at some institutions, only inmates with a life expectancy of six months or less were given consideration, while other facilities allowed prisoners with a twelve month or less life expectancy to apply. The BOP attempted to remedy this imbalance by issuing a 2013 Program Statement specifically stating that, compassionate release may be awarded to inmates “who have been diagnosed with a terminal, incurable disease and whose life expectancy is eighteen (18) months or less.” Despite the BOP’s effort, the program remains procedurally flawed.

274 See Memorandum from the U.S. Inspector General, supra note 13.
275 See Williams et al., supra note 53.
276 Id.
277 See Memorandum from the U.S. Inspector General, supra note 13.
278 Compassionate Release, supra note 19.
The “various clinical flaws” inherent in compassionate release procedures “reflect a fundamental tension between eligibility guidelines for compassionate release and the actual disease trajectories” of patients. The chief ill is that the compassionate release process relies on unverifiable prognoses. Medical professionals point out that prognostication is often difficult to establish in cases of illness where “functional trajectories” vary. In other words, it is difficult to determine when a patient, who no longer poses a safety risk, will substantially decline and die. Further, limiting inclusion to prisoners with a limited life expectancy excludes prisoners with severe, but not yet terminal medical conditions, whose sustained imprisonment incurs enormous cost and inhumanity analogous to that of terminally ill prisoners. Under the “improved” guidelines, BOP can consider inmates with debilitating medical conditions, but only under extraordinarily strict circumstances. Such inmates must be either completely disabled, or confined to a bed or chair for more than 50% of the day and exceptionally cognitively impaired. Limiting participation in this way does not sufficiently address the issues of humanity or cost.

An additional unjust procedural barrier that “invite[s] potential inequity” by denying compassionate release to “medically eligible” persons derives from prisoners’ inability to self-advocate. Severe illness is often accompanied by diminishing cognitive ability, and this type of functional reduction hampers patient advocacy participation. The compassionate release process requires patients to self-prepare petitions or request that another interested party petition on their behalf. According to medical professionals, “persons with profound incapacities (the majority of patients with advanced illness), could be incapable of completing a written petition” and are, therefore, unable to self-advocate. Architects of the compassionate release process seemingly attempt to account for this difficulty by allowing for petition filing by “another party on behalf of the inmate.” This “fix,” however, fails to consider that a severely ill prisoner may be so cognitively impaired that they are unable to decipher that petition filing is in their best interest. Also, it must be remembered that prisoner-patients are disassociated from supportive networks while incarcerated.

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279 See Williams et al., supra note 53 and accompanying text.
280 Id.
281 Id.
282 Id.
283 Id. See infra Part IV.
284 Compassionate Release, supra note 19.
285 Williams et al., supra note 53 and accompanying text.
286 Id.
287 See supra note 43.
288 See Williams et al., supra note 53 and accompanying text.
289 See supra note 43.
290 See Williams et al., supra note 53 and accompanying text.
B. Compassionate Release Procedures Must Provide Timely Responses to Prisoner Requests and Appeals

Reformers note that the BOP Program Statement declares that compassionate release requests must be processed timely, but that no clear time frame for compliance is given. According to a survey of federal prison officials, the time frame for review can range from five to sixty-five days, and a denial can take up to five months to complete. Even expedited requests were reported to take as long as up to thirty days to complete.  

Despite the Inspector General’s demands, the Bureau of Prisons refuses to create firm timelines for processing requests and appeals. Instead, the revised Program Statement retains the language that the Warden shall “promptly review” requests, and that medical requests shall be “expedited” with no further clarifying language. The BOP still retains enormous power to determine timeliness. It must be remembered that terminally ill prisoner-patients do not have an abundance of time. All compassionate release requests should be reviewed and processed within fourteen calendar days. Expedited requests should occur within seven calendar days. This time frame should not be difficult to adhere to. Medical documents and other pertinent files should already be in BOP’s possession.

C. The Bureau of Prisons Must Create Formal Procedures to Inform Inmates About Compassionate Release

Many medically eligible prisoners do not avail themselves of the compassionate release process because they are not aware that it exists. Staff are not required to inform eligible prisoners about the program and institution handbooks do not always reference the program. For handbooks that do discuss compassionate release, none specifically affirm eligibility criteria. According to the Inspector General’s report:

Neither the federal regulations establishing compassionate release nor the BOP’s compassionate release Program Statement specify how inmates are to be informed about the program. BOP institutions conduct admission and orientation (A&O) programs for new inmates to provide them with general information regarding institution-wide regulations, operations, and program opportunities. The BOP’s A&O Program Statement requires that specific information be discussed with inmates. We found, however, that the compassionate release program

291 Memorandum from the U.S. Inspector General, supra note 13.
292 Id.
293 Id.
was not one of the programs that is required to be discussed during A&O.294

This is highly inappropriate. Many prisoners are too uneducated to self-navigate through a complicated compassionate release process.295 Others, while educated, may find the system too cumbersome to effectively conquer without guidance.

“[F]ormal mechanisms to assign and guide a prisoner advocate have neither been universally accepted nor optimized,” and act as “functional barriers to a meaningful process and should be reformed along with medical eligibility criteria.”296 Upon a finding of medical eligibility, prison officials should be required to inform prisoners about the process, guide them through it, and encourage them to take advantage of it. Individual case workers should be assigned to every medically-eligible prisoner to help them determine how they will receive care, who will care for them, and how their care will be funded upon release.

D. The Bureau of Prisons Must Implement a System to Track Compassionate Release Requests, Denials, and Appeals

In order to ensure proper oversight, the Bureau of Prisons must monitor the number of compassionate release requests, denials, and appeals. Currently,

The BOP Central Office informally tracks only those inmate requests that have been forwarded to the Central Office for review by the BOP Director after they have been approved by both a Warden and a Regional Director. Therefore, the BOP does not know the total number of inmate requests for compassionate release. . . . In addition, the BOP cannot determine whether decisions made by the institution and Regional Office staff are consistent with each other or with BOP policy.297

Without oversight, the BOP’s power is unchecked. The BOP must be required to maintain accurate records of all requests, denials, reasons for denials, and appeals, and those records must be made part of the public record. Additionally, BOP institutions must employ continuing education and best practice sessions to ensure that monitoring systems work efficiently, and allow institutions to share information with each other.

294 Id.
295 See Williams et al., supra note 53 and accompanying text. It must be remembered that prisoners have the lowest literacy rates in the country. Id.
296 Id.
297 See Memorandum from the U.S. Inspector General, supra note 13.
E. Eligibility Determination Should be Placed Squarely in the Hands of Judges

Finally, the amount of power that the Bureau of Prisons wields was not envisioned by the Congress. The BOP has usurped the process, thereby prohibiting judges from determining whether an inmate’s circumstances are appropriately “extraordinary and compelling.” This authority properly belongs to judges, and must be returned to them. The Bureau of Prisons’ role should be limited to verifying medical eligibility only. Once a prison physician diagnoses a prisoner with a terminal illness, the Warden should contact the Medical Director for confirmation of the prognosis only. Upon receiving substantiation, the Warden should alert the Director of the BOP, who should automatically send the prisoner’s medical file to the sentencing judge for approval. Participation by the Regional Director and the prosecuting Assistant Attorney General is unjust and unwarranted. Given constitutional issues and issues of basic humanity and cost, the process should be simplified to ensure maximum participation of medically-eligible inmates.

VII. CONCLUSION

The goal of compassionate release is to permit judges to correct sentences, which, due to radically changed circumstances, are no longer just. Under a model compassionate release regime, every medically eligible prisoner would be released from prison and allowed to experience a “good” and “peaceful” death, surrounded by loved ones. However, compassionate release rarely achieves its intended goal. Ideally, compassionate release idealizes the notion that achieving the traditional goals of the penal system is less important than realizing compassion for the sick or injured. Unfortunately, in practice, compassionate release’s primary goals are thwarted by the Bureau of Prisons, and relief is only granted, in strict circumstances, where the BOP determines that an inmate no longer poses a threat to safety.

According to the Institute of Medicine, “a person-centered family-oriented approach that honors individual preferences and promotes quality of life through the end of life should be a national priority.” Such a practice promotes human dignity and humanity. This standard should be no different for

298 See infra Part II.
299 Id.
300 Id.
301 Id.
302 Id.
303 See DYING IN AMERICA, supra note 12, at 2.
304 Id.
305 Id.
prisoners. Though they have admitted culpability or been adjudged guilty, conviction does not render prisoners any less human. They should be afforded medical care in accordance with evolving standards of decency, including professionally and ethically sound end-of-life care. Less than adequate prison health care is unconstitutional, incredibly costly, and misaligned with any theory of punishment.\footnote{See infra Parts III and IV.}

Terminal illness transforms individuals into shadows of their former selves, for whom incarceration is wholly unjustified and completely unnecessary. To cure this ill, compassionate release policies must be broadened so that terminally ill prisoners can die with dignity. They are no longer worthy opponents, engaged in battle. They must be allowed to lay down their weapons and die with dignity.