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"Death Is Different": Limiting Health Care for Death Row Inmates

Michelle Masotto

"DEATH IS DIFFERENT": LIMITING HEALTH CARE FOR DEATH ROW INMATES

Michelle Masotto†

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INTRODUCTION

Robert Foley, like many Americans, needs a new hip.[1] However, unlike most Americans, he is a convicted murderer and currently sits on Kentucky's Death Row.[2] Mr. Foley was convicted of six murders

† J.D., 2014, Case Western Reserve University School of Law; B.A., Purdue University. Sincere thanks to Professor Michael Benza, Case Western Reserve University School of Law, for inspiring my interest in the legal issues surrounding prison healthcare. I am grateful to Professor Sharona Hoffman, Christina Petersen Greer, Sean Lee, and the Health Matrix Volume 24 staff for their support and hard work.

1. More than 285,000 hip replacements are performed every year in the United States. *Total Hip Replacement*, AM. ACAD. OF ORTHOPEDIC SURGEONS (Dec. 2011), http://orthoinfo.aaos.org/topic.cfm?topic=a00377.

2. *Death Row Inmates*, KY. DEP'T OF CORR., http://corrections.ky.gov/communityinfo/pages/deathrowinmates.aspx (last visited Apr. 19, 2014).

committed over a three-year period in Kentucky and is one the most prolific murderers in the state.[3]

Mr. Foley was under death warrant, meaning he had exhausted his appeals and the Kentucky Supreme Court had affirmed his execution.[4] All that remained was for the Kentucky Governor to set the execution date.[5] Then the Department of Corrections acknowledged Mr. Foley's need for a new hip.[6] Finding a facility willing to take on the heightened security standards that come with treating a death row inmate and locating a doctor to perform the procedure on a condemned man had proved to be an uphill battle.[7] Negative public opinion and possible political ramifications had affected the Kentucky Department of Corrections' actions. The Department of Corrections had to balance the constitutional requirement to provide care to inmates with the preservation of correctional system time, money, and resources on an individual whom the state might eventually kill.[8] In fact, the warden wrote that he would "contact [the medical director] to try to stop all medical procedures related to [Foley's] hip replacement" once an execution date was set.[9] While a non-institutionalized citizen may have to pay a significant amount of money out-of-pocket for such a procedure,[10] taxpayers' money is funneled through the state's Department of Corrections to fund inmate health care.

Mr. Foley's saga is not the only one to spark debate about costly and extraordinary care for death row inmates. David Long was convicted and sentenced to death for killing three women with a hatchet in their Texas home.[11] Mr. Long overdosed on drugs the night before his sched-

3. Brett Barrouquere, *Ky. Weighed Politics, Medicine in Inmate's Surgery*, ASSOCIATED PRESS (May 17, 2012), http://bigstory.ap.org/content/ky-weighed-politics-medicine-inmates-surgery.

4. KY. REV. STAT. ANN. § 431.218 (West 2013).

5. Barrouquere, *supra* note 3.

6. *Id.*

7. *Id.*

8. *Id.*

9. *Id.*

10. Even Medicare patients can be liable for thousands of dollars' worth of out-of-pocket expenses for surgeries. Lesley Alderman, *Knee and Hip Replacements: What You Need to Know*, CNN MONEY (Aug. 5, 2011), http://money.cnn.com/2011/08/05/pf/joint_replacement.moneymag/index.htm.

11. Press Release, Tex. Office of the Att'y Gen., David Martin Long Scheduled to Be Executed (Dec. 7, 1999), *available at* https://www.texasattorneygeneral.gov/newspubs/newsarchive/1999/19991207longadvsy.htm.

uled execution.[12] When he was found unresponsive in his cell, prison officials rushed him to the hospital where he was placed in the Intensive Care Unit (ICU).[13] The doctor recommended Mr. Long remain in the ICU for two more days but ultimately released him prior to his scheduled execution time on the condition that medical personnel transport him from the hospital to keep his condition stable.[14] The State of Texas took heroic measures to revive him immediately before his execution date, so the state could kill him on its own schedule.

Federal and state prison populations have exploded since 1980. In 1980 the federal Bureau of Prisons (BOP) had approximately 25,000 inmates in its custody.[15] By 2012 the inmate population had increased to almost 219,000 inmates.[16] Between 1980 and 2012 the average annual increase of inmates in the federal prison system was approximately 6,100 inmates per year. The state prison population has also risen dramatically. Approximately 500,000 inmates were housed in state prisons in 1985.[17] By 2011 the total population of state inmates had risen to almost 1.4 million inmates.[18]

Prison inmates are sicker than the non-institutionalized population and require more frequent care as a result.[19] Incarcerated individuals, whether in federal prison, state prison, or jails, are more likely than their non-institutionalized counterparts to have diabetes, hypertension, asthma, prior myocardial infraction (commonly known as a heart attack), and HIV/AIDS.[20] The drastic rise in the prison population coupled with the prison population's collective poor health causes a great strain on correctional department budgets.

Death row, reserved for those sentenced to death for the most heinous crimes, has also seen a population increase. In 2012, there were

12. Jim Yardley, *Texan Who Took Overdose Is Executed,* N.Y. TIMES (Dec. 9, 1999), http://www.nytimes.com/1999/12/09/us/texan-who-took-overdose-is-executed.html.

13. *Id.*

14. *Id.*

15. NATHAN JAMES, CONG. RESEARCH SERV., R42937, THE FEDERAL PRISON POPULATION BUILDUP: OVERVIEW, POLICY CHANGES, ISSUES AND OPTIONS 2 (2013).

16. *Id.*

17. BUREAU OF JUSTICE STATISTICS, CORRECTIONAL POPULATIONS IN THE UNITED STATES, 1997, at iii (2000), *available at* http://www.bjs.gov/content/pub/pdf/cpus97.pdf.

18. E. ANN CARSON & WILLIAM J. SABOL, BUREAU OF JUSTICE STATISTICS, PRISONERS IN 2011, at 6 (2012), *available at* http://www.bjs.gov/content/pub/pdf/p11.pdf.

19. *See* Andrew P. Wilper et al., *The Health and Health Care of US Prisoners: Results of a Nationwide Survey*, 99 AM. J. PUB. HEALTH 666, 669 (2009).

20. *Id.*

3,146 death row prisoners[21] in thirty-five states across the United States, including death row inmates held by the United States government and the United States military.[22] The death row population has exceeded 3,000 inmates per year since 1995,[23] and the average amount of time a death row inmate spends between sentencing and execution has been steadily increasing.[24] Currently, the average time between sentencing and execution is 178 months.[25]

The length of time between sentencing and execution has contributed to the rise in the average age of the death row population. In 2005 137 death row inmates were 60 years of age or older, compared to just 39 inmates in the same age group in 1995.[26] As inmates age, they become a bigger financial burden on the prison system, due to higher rates of illness and injury.[27] Prisons spend more money on death row inmate health care than on health care for the general inmate population because of compounding needs for more health care and greater security costs associated with treating death row inmates outside of the correctional facility.

The tension between an inmate's constitutional guarantee to receive health care, the public opinion that inmates should receive less care, and limited funds and resources makes it difficult for corrections officials to determine the proper course of action. On one hand, the prison system

21. *Size of Death Row by Year (1968-Present)*, DEATH PENALTY INFO. CTR., http://www.deathpenaltyinfo.org/death-row-inmates-state-and-size-death-row-year#year (last visited Mar. 21, 2014) [hereinafter *Size of Death Row*]. As of 2002, a total of 6,152 individuals had been sentenced to death since 1973, of which 899 had been executed. John H. Blume, *Killing the Willing: "Volunteers," Suicide and Competency*, 103 MICH. L. REV. 939, 1008 (2004).

22. *Size of Death Row*, *supra* note 21. New Mexico, Connecticut, and Maryland have abolished the death penalty, in 2009, 2012, and 2013 respectively, but the law was not made retroactive. As a result a total of eighteen inmates remain on death row between the three states. *Id.*

23. *Id.*

24. *Time on Death Row: Introduction*, DEATH PENALTY INFO. CTR.. http://www.deathpenaltyinfo.org/time-death-row (last visited Mar. 21, 2014).

25. U.S DEP'T OF JUSTICE, CAPITAL PUNISHMENT, 2010 – STATISTICAL TABLES 12 (2011), *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/cp10st.pdf.

26. *Time on Death Row: Aging Death Row Population*, DEATH PENALTY INFO. CTR., http://www.deathpenaltyinfo.org/time-death-row#aging (last visited Mar. 21, 2014).

27. *See generally* Anthony A. Sterns et al., *The Growing Wave of Older Prisoners: A National Survey of Older Prisoner Health, Mental Health and Programming*, CORRECTIONS TODAY, Aug. 2008, at 70 (noting that longer sentences have increased the population of elderly inmates in need of costly medical care).

must provide a minimum level of health care to inmates, but on the other hand, prison officials must effectively utilize their prisons' health care budgets.[28] In a survey of forty states, the total amount spent on prison health care in those states exceeded $335 million in 2011, and many of the states exceeded their prescribed budget.[29]

Case law and professional standards have established "the minimum standards to be followed – the floor below which service cannot legally fall – but not the upper limits on what the state is obligated to provide."[30] This Note will answer the question: Is the prison system required to provide death row inmates with expensive procedures after the inmates exhaust all appeals? The short answer to the question is no. Part I provides the historical context of the prison's duty to provide medical care to inmates under the Eighth Amendment. Part II argues that prisons are already able to limit inmate care in various ways. Part III recommends that death row inmates' care should be restricted to emergency and life-sustaining care after inmates have exhausted all appeals. Part IV will argue that limiting health care to death row inmates after all appeals have been exhausted would withstand Eighth Amendment and Fourteenth Amendment scrutiny. Part V will address potential criticisms of the proposed regulation.

I. THE DEVELOPMENT OF THE PRISON HEALTH CARE STANDARD

The Eighth Amendment ban on cruel and unusual punishment[31] is not a modern concept. The ban was originally implemented in the English Declaration of Rights of 1689 as an attempt to curb the government's use of torture and barbaric physical punishment.[32] This ban was

28. In California, the cost of health care per inmate per year is approximately $11,600 while Texas spends $2,920 per inmate per year for approximately the same inmate population size. Jasmine L. Kiai & John D. Stobo, *Prison Health Care in California*, UC HEALTH (Jan. 22, 2010), http://health.universityofcalifornia.edu/2010/01/22/prison-health-care-in-california.

29. CHRISTIAN HENRICHSON & RUTH DELANEY, VERA INST. FOR JUSTICE, THE PRICE OF PRISONS: WHAT INCARCERATION COSTS TAXPAYERS 6 (2012), *available at* http://www.vera.org/sites/default/files/resources/downloads/price-of-prisons-updated-version-021914.pdf.

30. Douglas C. McDonald, *Medical Care in Prisons*, *in* CRIME AND JUSTICE 427, 462 (Michael Tonry & Joan Petersilia eds., 1999).

31. U.S. CONST. amend. VIII ("Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.").

32. Michael Cameron Friedman, *Cruel and Unusual Punishment in the Provision of Prison Medical Care: Challenging the Deliberate Indifference Standard*, 45 VAND. L. REV. 921, 925 (1992).

subsequently adopted in the Eighth Amendment of the United States Constitution. Until the twentieth century, the Eighth Amendment was narrowly interpreted as *only* a prohibition against torture and barbaric punishments.[33] However, the Eighth Amendment standard for defining cruel and unusual punishment is dynamic and changes as society matures and evolves. The Constitution does not expressly require medical care for inmates. The 1976 Supreme Court case *Estelle v. Gamble* extended protection under the Eighth Amendment to include the state's affirmative duty of the state to provide proper medical care.[34]

In the *Estelle* decision, the Court held that the Eighth Amendment embodies "broad and idealistic concepts of dignity, civilized standards, humanity, and decency"[35] and the "evolving standards of decency . . . mark the progress of a maturing society."[36] The Court used these principles to establish the government's obligation to provide medical care to inmates since incarceration removes an inmate's ability to procure medical care on his own.[37] Further, the court held that denial of *all* medical care could result in pain and suffering that serves no penological purpose.[38] The Court formulated a two-prong test to determine if a state actor has violated the Eighth Amendment rights of a prisoner seeking medical care: the state actor must be deliberately indifferent and the medical need must be serious enough for a violation to exist.[39]

A. Deliberate Indifference Prong

The Supreme Court further defined what constitutes "deliberate indifference" in *Farmer v. Brennan*.[40] The Court ruled that deliberate indifference requires a more culpable mental state than negligence.[41] The Court also held that deliberate indifference could occur even in the absence of intent to cause harm or knowledge that harm would result.[42] The determination of a constitutional violation turns on whether the official "knows of and disregards an excessive risk to inmate health or safety; the official must both be aware of the facts from which the

33. *See* Estelle v. Gamble, 429 U.S. 97, 102 (1976).

34. *Id.*

35. *Id.* (quoting Jackson v. Bishop, 404 F.2d 571, 579 (8th Cir. 1968)).

36. *Id.* (quoting Trop v. Dulles, 356 U.S. 86, 101 (1958)).

37. *Id.* at 103.

38. *Id.*

39. *Id.* at 104.

40. Farmer v. Brennan, 511 U.S. 825, 835 (1994).

41. *Id.*

42. *Id.*

inference could be drawn that a substantial risk of serious harm exists, and he must also draw that inference."[43]

B. Serious Medical Need Prong

For an inmate to qualify for protection under the Eighth Amendment, the health issue must be serious. The definition of "serious medical need" is much more difficult to pinpoint and has been defined on a case-by-case basis.[44] If a physician determines that the condition is serious enough to warrant treatment and recommends a treatment, the condition is considered a serious medical need.[45] A serious medical need exists if a layperson could recognize the need for medical attention.[46] Many courts have found conditions to be serious if they cause pain, but pain is inherently subjective.[47] A condition that significantly affects the inmate's daily activities[48] or could cause a life-long handicap[49] can also constitute a serious medical need. However, medical needs can range from "a need for an immediate intervention to save the patient's life to the desire for medical treatment of trivial discomforts and cosmetic imperfections that most people ignore."[50] Therefore, it is difficult to determine a bright-line rule as to what constitutes a serious medical need. In *Ralston v. McGovern* the Seventh Circuit suggested that defining a serious medical need is difficult and "is a function both of objective need and of cost. The lower

43. *Id.* at 837.

44. Courts have found no serious medical need in a variety of cases. *See, e.g.*, Dye v. Lomen, 40 F. App'x 993 (7th Cir. 2002) (stating that back pain and a cut were not a serious medical need); Rodriguez v. Mercado, No. 00 CIV. 8588 JSRFM, 2002 WL 1997885 at *8 (S.D.N.Y. Aug. 28, 2002) (stating that bruises did not justify serious medical need). *But see* Green v. Mazzone, No. 99–3190(JEI), 2002 WL 1636709 at *5 (D.N.J. July 19, 2002) (stating that severe arthritis is a serious medical need); Davis v. Carter, 452 F.3d 686 (7th Cir. 2006) (deciding withdrawal from methadone constitutes serious medical need).

45. Monmouth Cnt.y Corr. Inst. Inmates v. Lanzaro, 834 F.2d 326, 347 (3d Cir. 1987) (quoting Pace v. Fauver, 479 F. Supp. 456, 458 (D. N.J. 1979), *aff'd* 649 F.2d 860 (3d Cir. 1981)).

46. *Id.*

47. *See* East v. Lemons, 768 F.2d 1000, 1001 (8th Cir. 1985) (holding arm cramps during physical work were a serious medical need).

48. *See* Scott v. Garcia, 370 F. Supp. 2d 1056, 1057 (S.D. Cal. 2005) (holding severe gastrointestinal condition interfered with ability to eat and thus qualified as a serious medical need).

49. *See, e.g.*, Layman ex rel. Layman v. Alexander, 343 F. Supp. 2d 493 (W.D. N.C. 2004) (holding serious medical need evident when arrestee hit his head, fell unconscious, and suffered brain damage as a result of lack of medical attention).

50. Ralston v. McGovern, 167 F.3d 1160, 1161 (7th Cir. 1999).

the cost, the less need has to be shown, but the need must still be shown to be substantial."[51]

Health care is a constitutional right for inmates as a result of the *Estelle* decisions.[52] The United States does not afford a constitutional guarantee to medical care for any other class of individuals. The idea that inmates are afforded more care than some law-abiding citizens draws criticism from the non-institutionalized public.[53] These criticisms worsen if the inmate is on death row.[54] However, the prison system is reluctant to execute an ill inmate.[55] As one law professor stated, "'Dead man walking is one thing' . . . '[d]ead man being pushed along to the execution chamber in a wheelchair' has a different feel."[56]

C. Strain of Health Care Costs on the Prison System

In 1970 7.2% of the United States' gross domestic product (GDP) was devoted to health care.[57] By 2010 that figure had risen to 17.9% of the GDP.[58] The cost of health care for prison systems has risen at almost the same rate as the cost of health care nationwide.[59] In prisons, older inmates and expanding inmate populations have caused a rise in the cost of health care.[60] Older inmates can cost as much as nine times more than their younger counterparts.[61] Further, prison administrators are hesitant

51. *Id.*

52. *See* Estelle v. Gamble, 429 U.S. 97, 104 (1976).

53. *Texans Deserve Relief from Prison Health Care Costs*, STATESMAN (Oct. 4, 2012, 1:01PM), http://www.statesman.com/news/news/opinion/texans-deserve-relief-from-prison-health-care-cost/nSTKc/ (discussing negative opinions on inmate health care policy due to high economic costs). *See also* NORMA B. GLUCKSTERN ET AL., NATIONAL CRIMINAL JUSTICE EXECUTIVE TRAINING PROGRAM, HEALTH CARE IN CORRECTIONAL INSTITUTIONS: MANUAL 1 (1979).

54. Karen Brandon, *Furor over Transplants for Death Row Inmates*, CHI. TRIBUNE (Mar. 1, 1996), http://articles.chicagotribune.com/1996-03-01/news/9603010235_1_liver-transplant-organ-transplant-mitchell-rupe.

55. *Id. See also* Yardley, *supra* note 12.

56. Richard Willing, *Death Row Population Is Graying*, USA TODAY (Feb. 10, 2005), http://usatoday30.usatoday.com/news/nation/2005-02-09-elder-death_x.htm.

57. KAISER FAM. FOUND., HEALTH CARE COSTS, A PRIMER: KEY INFORMATION ON HEALTH CARE COSTS AND THEIR IMPACT 4 (2012), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7670-03.pdf.

58. *Id.*

59. Jessica Wright, *Medically Necessary Organ Transplants for Prisoners: Who Is Responsible for Payment?*, 39 B.C.L. REV. 1251, 1253 (1998).

60. Timothy Williams, *Number of Older Inmates Grows, Stressing Prisons*, N.Y. TIMES, Jan. 26, 2012, at A19.

61. *Id.*

to allocate scarce funding to the prison health care budget, in part due to taxpayer frustration that state governments spend tax dollars on criminals while cutting funding to public schools or state infrastructure.[62]

Courts have generally held that cost cannot be a factor in determining what constitutes satisfactory health care.[63] The concern is that inmates in poorer states would not be afforded the same constitutional right to health care as their counterparts in wealthier states.[64] As stated in *Hamm v. Dekalb County*, the "state's interest in limiting the costs of detention . . . will justify neither the complete denial of . . .[food, living space, or medical care] nor the provision of these necessities below some minimally adequate level."[65] However, in *Bowring v. Godwin*, the Fourth Circuit explicitly stated that the right to a specific treatment is "limited to that which may be provided upon a *reasonable cost* and time basis and the essential test is one of medical necessity and not simply that which may be considered merely desirable."[66]

II. PRISONS' ABILITY TO LIMIT INMATES' MEDICAL DECISIONS

The prison system has significant control over an inmate's medical decisions. Inmates do not have an absolute right to refuse treatment, nor do inmates have the ability to choose a doctor, facility, or course of treatment. The BOP limits the scope of treatment provided to an inmate when the inmate is less than twelve months from release. Since the prison system can limit care in these ways, it should be able to limit health care to a death row inmate once he has exhausted all appeals.

A. Limitations on a Prisoner's Right to Refuse Treatment

Inmates generally have the choice to refuse medically necessary treatment.[67] The Supreme Court found in *Cruzan by Cruzan v. Director, Missouri Department of Health* that an inmate's ability to decline care is a constitutional right[68] under the Due Process Clause of the Fourteenth

62. Wright, *supra* note 59.

63. Harris v. Thigpen, 941 F.2d 1495, 1509 (11th Cir. 1991).

64. *Id.*

65. Marc J. Posner, *The* Estelle *Medical Professional Judgment Standard: The Right of Those in State Custody to Receive High-Cost Medical Treatment*, 28 AM. J.L. & MED. 347, 353 (1992) (quoting Hamm v. Dekalb County, 774 F.2d 1567, 1573 (11th Cir. 1985)).

66. Bowring v. Godwin 551 F.2d 44, 48 (4th Cir. 1977) (emphasis added).

67. *See* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 278 (1990) (stating "that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment").

68. *Id.* at 279.

Amendment.[69] An inmate can decline life-saving treatment if he so chooses,[70] but the prison system may override the inmate's constitutional right to refuse medical care if the state's interest outweighs the inmate's liberty interest in his refusal.

A prison system has the authority to balance various state interests with the inmate's liberty interest in his right to refuse medical treatment.[71] State interests include: "(1) the preservation of life; (2) the protection of interests of innocent third parties; (3) the prevention of suicide; and (4) the maintenance of the ethical integrity of the medical profession."[72] In *Polk v. Iowa*, the Supreme Court of Iowa found that an inmate's right to refuse care was secondary to the state's interest in preserving life.[73] Brown (the inmate in *Polk*) refused dialysis, and the court reasoned that his condition was not terminal and continuing treatment against his will carried no "heavy physical and emotional burden" for Brown.[74] The Supreme Court of Iowa held the prison system could force Brown to participate in dialysis against his will even though he was of sound mind and judgment to make the medical decision on his own.[75]

B. No Choice of Facility or Doctor

Unlike their non-institutionalized counterparts, inmates do not have the ability to choose their doctor, facility, or treatment method.[76] Inmates also do not have the ability to obtain a second opinion if they desire one.[77] Most inmates are treated through the sick call procedure in their correctional facility, whereby an inmate requests to see a medical professional at the correctional facility. In the BOP system, physicians'

69. U.S. CONST. amend. XIV, § 1 (stating ". . . nor shall any State deprive any person of life, liberty, or property, without due process of law . . .").

70. *See Cruzan*, 497 U.S. at 261 (holding the wishes of the guardians to end life-saving care of the patient in a vegetative state requires clear and convincing evidence that the unconscious patient would agree to such care); Stouffer v. Reid, 993 A.2d 104, 106 (Md. 2010) (holding that an inmate has a right to refuse kidney dialysis even though his refusal would result in serious injury or death).

71. *Cruzan*, 497 U.S. at 279.

72. Brophy v. New Eng. Sinai Hosp., Inc., 497 N.E.2d 626, 634 (Mass. 1986).

73. Polk Cnty. Sheriff v. Iowa Dist. Ct. of Polk Cnty., 594 N.W.2d 421, 427 (Iowa 1999).

74. *Id.* (quoting Comm'r of Corr. v. Myers, 399 N.E.2d 452, 456 (Mass. 1979)).

75. *Id.* at 431.

76. Posner, *supra* note 65, at 361 n. 101 ("In essence, *Estelle* holds that a prisoner is constitutionally entitled to the treatment prescribed by a medical professional. This right would not seem to encompass second opinions or choice of doctors or treatments.").

77. *Id.*

assistants and nurse practitioners usually provide primary care to inmates.[78] The staff physicians oversee the physicians' assistants and nurse practitioners.[79] Staff physicians also determine whether the assistants' and nurse practitioners' recommendations fall within the BOP services and policies.[80] Staff physicians then bring recommendations before utilization review committees for approval of procedures or referrals to other professionals outside of the sick call system in the prison.[81]

The prison system contracts with hospitals or specialists for treatments and procedures beyond the level of care provided at the correctional facility.[82] As a result, inmates are not allowed to choose which doctor treats them or in which hospital they receive treatment.[83] The procedures for finding a doctor, facility, or specialist for inmates can be difficult depending on the availability of the particular medical professional or facility within the community where the prison is located, the willingness of providers to travel to the corrections facility and subject themselves to security measures if the provider opts to treat the inmate in the prison, and the willingness of doctors or hospitals to see inmates at their facility.[84]

Robert Foley understands the difficulties associated with acquiring treatment outside of the prison in his effort to get his hip replaced.[85] The prison approved Mr. Foley to receive the hip replacement; however, the state could not find a doctor or facility willing to operate on a death row inmate under death warrant.[86] The practical availability of doctors and facilities is limited by proximity to the prison: the further prison personnel must transport a prisoner, the greater the financial and administrative burden on the prison.[87] Hospitals and medical providers

78. Alan Ellis, *BOP Health Care: What You (and Your Clients) Need to Know*, 23 CRIM. JUST. 45, 48 (2009).

79. *Id.*

80. *Id.*

81. *Id.* at 47.

82. *Id.* at 48.

83. PUBLIC WORKS, UNDERSTANDING GEORGIA'S CORRECTIONAL STANDARDS OF HEALTHCARE 8, *available at* http://www.dcor.state.ga.us/pdf/ReportCorrectionalHealthCareSystem.pdf (last accessed Mar. 22, 2014) ("This is especially true in a prison environment where inmates may not choose their own health care provider, may not select their own insurance plan, do not have access to over-the-counter medications and cannot take a 'day off for sick time,' at will.").

84. Ellis, *supra* note 78, at 48.

85. See *supra* Introduction.

86. Barrouquere, *supra* note 3.

87. *Id.*

have balked at performing Mr. Foley's procedure because he is a death row inmate, which requires additional security measures to keep all parties involved safe.[88]

C. Denial of Care Based on Date of Release

The BOP limits care based on the amount of time left on an inmate's sentence by attempting to define medically necessary treatments. If an inmate has less than twelve months of his sentence remaining, the prison will provide medical services only for conditions that fall under the "Medically Necessary – Acute or Emergent" or "Medically Necessary – Nonemergent" categories.[89] "Medically Necessary – Acute or Emergent" is defined as "[m]edical conditions that are of an immediate, acute or emergent nature, which without care would cause rapid deterioration of the inmate's health, significant irreversible loss of function, or may be life-threatening. Conditions in this category warrant immediate treatment that is essential to sustain life or function."[90] These conditions include stroke, heart attack, sudden loss of vision, and severe bleeding.[91] "Medically Necessary – Nonemergent" care includes:

> [m]edical conditions that are not immediately life-threatening but that without care the inmate could not be maintained without significant risk of serious deterioration leading to premature death, significant reduction of the possibility of repair later without present treatment; or significant pain or discomfort that impairs the inmate's participation in activities of daily living.[92]

"Medically Necessary – Nonemergent" cases include care of chronic diseases such as diabetes, cancer, and heart disease, as well as treatment of infectious diseases like HIV and tuberculosis.

Within twelve months of a release date, an inmate is no longer eligible for a medical procedure that would provide limited long-term gain, including procedures for minor conditions.[93] The BOP also limits an inmate's access to elective procedures such as reconstruction of the anterior cruciate ligament in the knee or joint replacements.[94] The BOP defines these procedures as "Medically Acceptable – Not Always Neces-

88. *Id.*

89. U.S. DEP'T OF JUSTICE, THE FEDERAL BUREAU OF PRISON'S EFFORTS TO MANAGE INMATE HEALTH CARE 6-7 (2008), *available at* http://www.justice.gov/oig/reports/BOP/a0808/final.pdf.

90. *Id.* at 6.

91. *Id.*

92. *Id.*

93. Ellis, *supra* note 78, at 46.

94. *Id.*

sary"[95] because their main purpose is to improve the inmate's quality of life.[96] Any procedure falling under this category must be approved by a Utilization Review Committee that can weigh the benefits of treatment, available resources, and the effect the procedure (or lack thereof) will have on the inmate's every day life.[97]

The BOP includes organ transplants for prisoners only if the prisoner meets specific criteria.[98] To date, no death row inmate has received an organ transplant, although an Oregon death row inmate requested one.[99] The concern is that organ transplants affect the life of the individual donating the organ, if the donor is alive, as well as other possible organ transplant recipients by allowing an incarcerated individual to take precedence over a non-incarcerated individual. Exceptions can be made to this general policy; however, when a general population inmate falls within twelve months of release, he is not allowed this course of treatment.[100] Inmates are still able to receive dialysis or other non-transplant treatments.

No court has directly criticized limiting care based on the inmate's release date. However, there are some cases that provide insight. Some jurisdictions have held that an inmate must show the potential of harm to have an Eighth Amendment claim under the *Estelle* standard.[101] In *Boring v. Kozakiewicz* the Third Circuit held that if a medical condition can be treated after a prisoner is released without harm from such a delay, the state would not be required to commence treatment.[102] However, courts have split on whether it is the state's responsibility to provide a time-sensitive procedure for an inmate, such as an abortion. The Sixth Circuit held that although a female inmate had a right to an

95. U.S. DEP'T OF JUSTICE., *supra* note 89, at 6-7.

96. *Id.* at 6.

97. *Id.* at 7.

98. U.S. Dep't of Justice, Fed. Bureau of Prisons, Patient Care, Policy No. 6031.03, at 40-41 (Aug. 23, 2012), *available at* http://www.bop.gov/policy/progstat/6031_003.pdf.

99. *See* Bryan Robinson, *Death-Row Inmate Seeks Organ Transplant*, ABCNEWS, http://abcnews.go.com/US/story?id=90611&page=1 (last visited Apr. 19, 2014).

100. Ellis, *supra* note 78, at 46 (stating that organ transplants fall under the category of "Extraordinary" treatment and are not available for inmates within a year of their release date).

101. Posner, *supra* note 65, at 359-60.

102. *See* Boring v. Kozakiewicz, 833 F.2d 468, 473 (3d Cir. 1987) (holding that if a pretrial detainee has a condition that can be treated after release, it is not the prison's responsibility to provide care). Pretrial detainees are afforded a reasonable standard of care under the Due Process Clause of the Fourteenth Amendment, which is the same level of care afforded to an inmate under the Eighth Amendment. *Id.*

abortion, the prison was not obligated to provide the procedure under the *Estelle* standard because the abortion was not medically necessary.[103] However, the Third Circuit held that failure to allow a female inmate access to an abortion puts undue burden on her and amounted to a violation of the *Estelle* standard, regardless of the elective nature of the procedure.[104]

III. RECOMMENDATION FOR LIMITING CARE TO DEATH ROW INMATE

Prison health care systems are restrained by the budgets afforded to them by their state. In fact, ten to twenty percent of a prison system's budget is used for inmate health care.[105] It is imperative that the money allotted to the prison health care system be used efficiently. Compared to non-institutionalized Americans of the same age, incarcerated individuals are more likely to have diabetes, hypertension, persistent kidney problems, cirrhosis, hepatitis, and HIV/AIDS.[106] For example, hypertension treatment costs relatively little[107] but benefits the largest percentage of inmates at the federal and state level.[108] It is important that the prison system effectively treat broad groups of inmates with easily treatable or avoidable illnesses without being burdened by exorbitantly high costs for surgeries and procedures for inmates who will be executed. An upper limit must be placed on prison health care.

The responsibility of limiting care lies with the state and the prison system. The treating physicians cannot be responsible for limiting care due to the nature of the physician-patient relationship.[109] Neither is the

103. Gibson v. Matthews, 926 F.2d 532, 536 (6th Cir. 1991).

104. Monmouth Cnty. Corr. Inst. Inmates v. Lanzaro, 834 F.2d 326, 348 (3d Cir. 1987).

105. *State Strategies for Controlling Inmate Health Care Costs*, NAT'L GOVERNORS ASS'N CTR. FOR BEST PRACTICES (Aug. 1, 2012), http://www.nga.org/cms/home/nga-center-for-best-practices/meeting--webcast-materials/page-hsps-meetings-webcasts/col2-content/main-content-list/state-strategies-for-controlling.html.

106. Wilper et al., *supra* note 19, at 669.

107. Peggy Peck, *Popular Blood Pressure Medicine May Do More Harm than Good*, WEBMD (Aug. 29, 2000), http://www.webmd.com/hypertension-high-blood-pressure/news/20000829/popular-blood-pressure-medicine-may-do-more-harm-than-good. The cost of hypertension treatment can range from $60 per year for a diuretic in 2000 to $990 per year for name-brand drugs in 2000. Although these figures do not account for inflation, it is still a relatively inexpensive ailment to treat. *Id.*

108. Wilper et al., *supra* note 19, at 669.

109. *See generally* Lawrence J. Schneiderman & Nancy S. Jecker, *Should a Criminal Receive a Heart Transplant? Medical Justice vs. Societal Justice*, 17 THEORETICAL MED. 33, 34 (1996).

judicial branch in the position to determine prison procedures adequately. All courts have consistently given significant deference to prison policies and practices and are "reluctant to interfere with a prison's internal discipline."[110] Further, the "courts are ill equipped to deal with the increasingly urgent problems of prison administration and reform."[111] Nevertheless, the courts will intervene in prison policies to protect the prisoners' constitutional rights.[112]

The policy rationale behind providing care is significantly different for death row inmates and the general inmate population. Procedures and treatment are given to general population inmates on the theory that they will, at some point, rejoin society. Treating short-term inmates in prison saves society the burden of paying the costs for treating the inmate later. Further, treating infectious diseases is imperative in prison due to the high transmission rate within the prison[113] and the chance that once released, the inmate could transmit diseases to the rest of the community.[114] However, death row inmates will never rejoin society, especially after the appeals process has concluded, so the prison system does not need to worry that they may infect the community or become a burden to the non-institutionalized health care or welfare systems.

It "shocks the conscience" that death row inmates may be eligible for organ transplants—another very costly procedure.[115] At least two cases where death row inmates attempted to receive organ transplants have been widely publicized, one of which prompted the state legislature to attempt to ban such procedures.[116] Organ transplants make economic sense for inmates who will live out their natural lives in prison because the date of their death is a relative unknown;[117] however, the long-term benefit is not the same for death row inmates who have a more definitive date of death. Not only will the death row inmate not be able to use the organ as long as another individual, but transplantable organs are a scarce medical resource. Over 117,000 individuals are awaiting organ

110. Jackson v. Bishop, 404 F.2d 571, 577 (8th Cir. 1968).

111. Procunier v. Martinez, 416 U.S. 396, 405 (1974).

112. Friedman, *supra* note 32, at 928.

113. Joseph A. Bick, *Infection Control in Jails and Prisons*, 45 CLINICAL INFECTIOUS DISEASES 1047, 1047 (2007).

114. *See* Tom Puleo & Lisa Chedekel, *Dollars and Lives: The Cost of Prison Health Care*, NEW ENG. CTR. FOR INVESTIGATIVE REPORTING, (Mar. 26, 2011), http://necir-bu.org/investigations/taxpayer-watch-series/dollars-and-lives-the-cost-of-prison-health-care-2/.

115. *See* Robinson, *supra* 99; Brandon, *supra* note 54.

116. Robinson, *supra* 99; Brandon, *supra* note 54.

117. Robinson, *supra* 99 (reporting that an Oregon death row inmate costs a reported $121,000 per year to remain on dialysis, while the surgery could cost between $80,000 and $120,000 and eliminate the need for dialysis).

transplants, and 74,000 of those patients are on the active waiting list, which means they are medically eligible to receive a transplant.[118] However, only slightly more than 28,000 transplants were performed in 2012.[119] Approximately eighteen individuals die each day in the United States because of a lack of transplant organs.[120]

Replacements and transplants can be incredibly costly. A hip replacement for an inmate can cost over $50,000, and a knee replacement over $40,000 just for the initial procedure and hospitalization.[121] These estimates do not factor in the costs of transportation or security for the inmate. Transplants are also very expensive procedures. Cornea replacement is the most prevalent transplant in the United States and has the lowest total cost of any transplant at around $20,000, including the thirty-day pre-transplant period, organ procurement, hospital admission for the transplant, the cost of the physician to perform the transplant, the 180-day post-operative admission to the hospital, and prescriptions.[122] Kidney transplants, the second most transplanted organ, have a total cost of over $250,000.[123] Other transplant procedures can total more than one million dollars.[124] None of these figures factor in the additional costs associated with treating death row inmates, such as transportation from the correctional facility to the health care facility and the cost of security while the inmate is away from the correctional facility.

To help restrain costs and conserve scarce medical and prison resources, death row inmate care should be limited and mirror the BOP standards for time limitations and definitions for medically necessary treatments.[125] Once a death row inmate has completely exhausted the

118. *Glossary,* ORGAN PROCUREMENT AND TRANSPLANT NETWORK, HEALTH RES. AND SERVS. ADMIN., http://optn.transplant.hrsa.gov/resources/glossary.asp (last visited Apr. 19, 2014).

119. *Statistics,* DONATE LIFE AMERICA, http://donatelife.net/understanding-donation/statistics/ (last visited April 19, 2014).

120. DEP'T OF HEALTH AND HUMAN SERVS., ORGAN DONATION AND TRANSPLANTATION FACT SHEET 1 (2010), *available at* https://www.womenshealth.gov/publications/our-publications/fact-sheet/organ-donation.pdf.

121. Barrouquere, *supra* note 3; INTEGRATED HEALTHCARE ASS'N, ORTHOPEDICS DATA COMPENDIUM: USE, COST, AND STRUCTURE FOR TOTAL JOINT REPLACEMENT 23 (2006), *available at* http://www.iha.org/pdfs_documents/medical_device/07_OrthopedicsDataCompendium.pdf.

122. MILLIMAN, INC., 2011 U.S. ORGAN AND TISSUE TRANSPLANT COST ESTIMATES AND DISCUSSION 4 (2011), *available at* http://publications.milliman.com/research/health-rr/pdfs/2011-us-organ-tissue.pdf.

123. *Id.*

124. *Id.*

125. *See supra* Part II.C.

appeals process, the inmate should be limited to care defined as Medically Necessary – Acute or Emergent or Medically Necessary – Nonemergent as defined by the BOP. This rule would provide care for "[m]edical conditions that are of an immediate, acute or emergent nature,"[126] including emergencies such as stroke, sudden loss of vision, heart attack, and severe bleeding. The BOP also requires treatment of illnesses such as diabetes, HIV, cancer, and tuberculosis because they are "not immediately life-threatening but . . . without care the inmate could not be maintained without significant risk of serious deterioration leading to premature death . . . or significant pain or discomfort that impairs the inmate's participation in activities of daily living."[127] Death row inmates are not allowed to receive joint replacements or other elective surgeries and are ineligible for organ transplants because the transplant would affect the lives of others by allowing an inmate to take precedence over a non-incarcerated individual.[128] Maintenance of life and management of pain should be priorities; providing a cure should not be.

If a diagnosis and treatment have already started prior to the completion of the appeals process, the prison would be obligated to continue that treatment. Failure to do so would result in a very apparent violation of *Estelle*. This would be a clear instance of deliberate indifference to a medical need because the prison officials would have known about the medical issue, begun treatment, and subsequently stopped treatment without the instruction to do so from a medical professional.

However, the issue is different if the illness is discovered after the completion of the appeals process. Physicians for the non-incarcerated population have the ability to decide if a treatment is overly burdensome based on the relative benefits and burdens of the treatment to the patient.[129] Physicians treating the prison population should be able to function in the same way. The commencement of cancer treatment or dialysis, for example, may have little benefit to the inmate, if any at all, before his execution, and the physician should be able to take the execution date into consideration when recommending treatment or deciding to cease treatment. Starting or continuing treatment could be overly burdensome to a prison system that lacks funding. Instead, the prison system should be allowed to focus on pain management and comfort instead of treatment or a cure, similar to end-of-life care.

The appropriate cut-off for health care provided to death row inmates is after the inmate has exhausted the appeals process. The appeals

126. OFFICE OF THE INSPECTOR GEN., *supra* note 89, at 6-7.

127. *Id.*

128. Ellis, *supra* note 78.

129. *See* Mildred Z. Solomon et al., *Decisions Near the End of Life: Professional Views on Life-Sustaining Treatments*, 83 AM. J. PUB. HEALTH 14, 19 (1993).

process is in place to ensure inmates have been properly convicted[130] and the execution process is constitutional.[131] After the appeals process is complete, the state will most likely carry out the death sentence. It "shocks the conscience"[132] of society that expensive procedures are performed on death row inmates[133] who will die at the hands of the state.[134] The money can be better spent on medications and procedures that affect large portions of the prison population who may eventually become free members of society.

IV. LIMITING CARE AFTER THE APPEALS PROCESS CONCLUDES IS CONSTITUTIONAL

A. Eighth Amendment Standard and the Turner *Test for Prison Regulations*

The Eighth Amendment provides a right to be free from "cruel and unusual punishment"[135] as determined by the "evolving standards of decency that mark the progress of a maturing society."[136] The Eighth Amendment does not have the same meaning today as it did when it was drafted. The *Estelle* decision was based on an "evolving standard of decency" and the understanding that the standard is constantly changing. As a result, Lester Wright noted, "[A]n acceptable, expected standard of health care in 2007 is not the standard that was in place when *Estelle* was decided [and] it is not the standard that was in place . . . in 1995."[137]

Limiting care for death row inmates after the completion of the appeals will satisfy *Estelle*'s "evolving standard of decency" standard.[138]

130. 142 inmates have been exonerated from death row since 1973. The inmate must have been convicted and sentenced to death and have been pardoned due to evidence of innocence, retried and found not guilty, or the prosecution has dropped the charges to be part of this number. *The Innocence List*, DEATH PENALTY INFO. CTR., http://www.deathpenaltyinfo.org/innocence-list-those-freed-death-row (last visited Apr. 19, 2014).

131. *See* Adam Liptak, *Judges Set Hurdles for Lethal Injection*, N.Y TIMES (Apr. 12, 2006), http://www.nytimes.com/2006/04/12/us/12lethal.html?_r=0.

132. Rochin v. California, 342 U.S. 165, 172 (1952).

133. *See* Robinson, *supra* note 99.

134. Barrouquere, *supra* note 3.

135. U.S. CONST. amend. VIII.

136. Trop v. Dulles, 356 U.S. 86, 101 (1958).

137. Lester N. Wright, *Health Care in Prison Thirty Years after* Estelle v. Gamble, 14 J. CORR. HEALTH CARE 31, 32 (2008).

138. This Note focuses on serious medical needs, tailoring the discussion to major treatments and surgeries.

Public perception, societal standards, and the Supreme Court's judgment are all factors in the "evolving standard of decency." Public opinion on the issue of death row inmate healthcare suggests that society is hesitant to allow inmates healthcare that a law-abiding citizen could not acquire. The State of Washington state legislature attempted to pass a bill that would limit death row inmates' care to "basic medical services, including administering medications necessary for pain relief" but would prohibit the use of public funds "to provide extraordinary, life-saving medical procedures."[139] This bill was the result of an inmate's placement on the transplant list and the public outcry that followed.[140] Although the bill ultimately failed, it suggests that there was a strong public opinion against the practice of allowing inmates' access to procedures and free care that are not equally available to non-institutionalized citizens. The Supreme Court typically defers to public opinion and the legislature for determining the "evolving standard of decency."

Limiting care during the appeals process would be unconstitutional. During the appeals process, the death row inmate's date of death is just as much of an unknown as that of an inmate serving life in prison without parole. Further, the appeals process is meant to ensure the inmate has been properly convicted. Limiting procedures before the appeals process concludes could be construed by a court as treating similarly situated inmates differently, a possible violation of the Fourteenth Amendment Equal Protections Clause.[141] It would also violate the *Turner v. Safley* test to determine if the prison regulation violates the Eighth Amendment, as described below.

To violate *Estelle*, the state must have "deliberate indifference" to a medical need that is serious.[142] However, the *best* treatment option is not required to avoid the violation of the inmate's Eighth Amendment rights.[143] A disagreement between the prisoner's expected level of care and the care the physician has prescribed does not rise to the level of a constitutional violation.[144] No constitutional violation results if a better treatment option is available, and the physician chooses the lesser

139. H.R. 2889, 54th Leg., Reg. Sess. (Wash. 1996).

140. Brandon, *supra* note 54.

141. *See infra* Part IV.B.

142. Estelle v. Gamble, 429 U.S. 97, 104 (1976).

143. *Id.* at 107 (treating Estelle's back pain with medication and rest did not violate the Eighth Amendment even if ordering x-rays on his back would have been a superior course of treatment).

144. *See* Cramer v. Winslow, 211 F. App'x 561 (9th Cir. 2006) (reasoning that a disagreement between an inmate and his doctor over treatment did not violate the Eighth Amendment); Hall v. Tyszkiewicz, 28 Fed. Appx. 493 (6th Cir. 2002) (holding prisoner's disagreement with physician over course of treatment and medication for esophageal reflux did not amount to deliberate indifference).

option.[145] Accordingly, utilization review boards have discretion over the appropriate course of treatment if a physician suggests more than one treatment regimen. The *Estelle* standard is satisfied as long as the utilization review panel is acting with sound medical judgment and is not disregarding a medical risk.

Limiting the care available to death row inmates after the appeals process has been exhausted will not violate the inmate's Eighth Amendment rights. Death row inmates engaged in the appeals process would be allowed the same treatment as an inmate serving a short-term sentence, or even life in prison without parole, because their date of death is unknown and there is a possibility of release. Death row inmates would still be required to have access to medication. At all times, inmates would have access to sick call and emergency services. This Note simply suggests that extraordinary procedures, such as organ transplants and elective procedures, should not be afforded to death row inmates after they have completed the appeals process.

The Supreme Court, in *Turner v. Safley*,[146] established a test to determine whether a prison regulation was reasonable. The standard for review is not heightened scrutiny but whether "a prison regulation that burdens fundamental rights is 'reasonably related' to legitimate penological objectives, or whether it represents an 'exaggerated response' to those concerns."[147] Limiting care to death row inmates who have appeals pending would constitute an exaggerated response to the concern of excessive health care costs in the prison system. Since the date of death is unknown for an inmate whose appeal is pending, failure to care for existing medical issues could result in higher medical costs later if the inmate is not executed. Therefore, this type of response is too exaggerated to satisfy the *Turner* test.

The *Turner* test sets out four prongs to determine if a prison regulation is reasonable and satisfies the constitutional duty the prison system has to the inmate. The first prong of the test states there must be "a 'valid rational connection' between the prison regulation and the legitimate government interest put forth to justify it."[148] The second prong asks whether alternative means for the prisoner to exercise his right remain open.[149] The third prong analyzes what impact the regulation has on prison resources.[150] Finally, the fourth prong of the test must

145. Stewart v. Taft, 235 F. Supp. 2d 763, 771 (N.D. Ohio 2002) (holding there was no Eighth Amendment violation when a six month regimen for medication was prescribed but a nine month regimen would have been superior).

146. Turner v. Safley 482 U.S. 78 (1987).

147. *Id.* at 87.

148. *Id.* at 89.

149. *Id.* at 90.

150. *Id.*

determine if there are "ready alternatives" to the regulation.[151] "If a claimant can point to an alternative that fully accommodates the prisoner's rights at de minimis cost to valid penological interests," a court may consider that as evidence to determine whether a prison regulation is invalid.[152]

Limiting death row inmates' access to extraordinary and elective procedures satisfies the first prong of the *Turner* test. The money that would have been used for an expensive procedure or treatment can be used to address other health concerns in the prison system, such as caring for a rapidly aging prison population[153] or treating common illnesses effecting large portions of the prison population.[154] The prison system's interest in reducing the cost of health care is a valid penological goal.[155] Security concerns are "perhaps the most legitimate of penological goals."[156] Death row inmates pose a higher security risk to the general public if they escape while they are outside the prison walls. The prison system has a valid interest in limiting inmate escapes.[157] The use of additional security stretches the level of security personnel in the corrections facility thin, which is also a valid reason to limit the movement of death row inmates outside the correctional facility.

As for the second prong of the *Turner* test, death row inmates have alternative means to exercise their right to care. Death row inmates would still have access to sick call and emergency care as well as care for conditions that become severely debilitating. The ailments that would not qualify for "Medically Necessary – Acute or Emergent" or "Medically Necessary – Nonemergent" under the BOP guidelines can still be treated without being cured. Inmate's pain can be managed and their symptoms can be kept at bay. Prisoners have no constitutional right to receive the most appropriate treatment or best care for their conditions as long as an acceptable standard of care is met.[158] This sentiment is illustrated in

151. *Id.*

152. *Id.* at 91.

153. Elderly inmates can cost up to twice the amount of their younger counterparts. *At America's Expense: The Mass Incarceration of the Elderly*, AM. CIVIL LIBERTIES UNION (June 13, 2012), http://www.aclu.org/criminal-law-reform/americas-expense-mass-incarceration-elderly.

154. *See* Wilper et al., *supra* note 19, at 668.

155. *See* Victoria W. v. Larpenter, 369 F.3d 475, 485 (5th Cir. 2005).

156. Overton v. Bazzetta, 539 U.S. 126, 133 (2003).

157. Roe v. Crawford, 514 F.3d 789, 795 (8th Cir. 2008) (stating that there is a penological interest in limiting inmate's opportunity to escape).

158. Treatment is "limited to that which may be provided upon a reasonable cost and time basis and the essential test is one of medical necessity and not simply that which may be considered merely desirable." Bowring v. Godwin 551 F.2d 44, 48 (4th Cir. 1977).

the Eighth Circuit's decision in *Clark v. Hedrick*.[159] Clark suffered from a type of leukemia in which one course of treatment was an autologous bone marrow transplant, and the prison officials would not allow him to receive the transplant.[160] The court found that his condition was not yet severe enough to warrant the transplant and that, if or when the condition became acute, the possibility of a transplant could then be assessed.[161]

The third prong of the *Turner* test is satisfied because limiting care to death row inmates would have a positive effect on prison resources. Death row inmates pose a higher security risk when they are transported away from the corrections facility for medical treatment and therefore cost state departments of corrections more money by requiring security detail for transport and the duration of their treatment at an outside facility.[162] The proposed regulation would limit a death row inmate's time away from the correctional facility, which conserves security resources. Limiting death row inmates' time away from the correctional facility also frees up security and resources for more routine prison health issues and reduces the number of prisoners leaving the facility.

Restricting care to inmates who have completed the appeals process satisfies the fourth prong of the *Turner* test. The goal of restricting care to death row inmates involves cost saving for the corrections system, which is a valid penological goal.[163] The restriction helps curb expenses by eliminating high cost procedures for death row inmates who ultimately die at the hands of the state.[164] The only other feasible option to allow death row inmates access to these prohibited procedures while limiting the impact on prison resources and security would be to build and staff a full hospital at the prison site. While building a medical facility may seem like a viable cost-saving option, this option could cost taxpayers millions of dollars with a minimal return on investment.[165] Therefore,

159. Clark v. Hedrick, 233 F.3d 1093, 1094 (8th Cir. 2000).

160. *Id.*

161. *Id.*

162. OKLA. DEP'T OF CORR., SECURITY OF OFFENDERS IN NON-PRISON HOSPITALS 5 (Sept. 6, 2012), *available at* http://www.ok.gov/doc/documents/op040114.pdf.

163. *See* Victoria W. v. Larpenter, 369 F.3d 475, 485 (5th Cir. 2005).

164. Barrouquere, *supra* note 3. Foley's hip replacement would cost the state around $56,000. *Id.* The quality of life may be increased for a short period of time, but the cost is not worth the relatively small reward. Similar arguments are made concerning organ transplants, in that the organ transplant goes to waste after the inmate is executed.

165. *See California Spending Big on Healthcare While Shipping Inmates to Outside Hospitals*, CBS SAN FRANCISCO (Nov. 5, 2012, 10:32 AM), http://sanfrancisco.cbslocal.com/2012/11/05/california-spending-big-on-healthcare-while-shipping-inmates-to-outside-hospitals. The first prison hospital at San Quentin had a $136 million price tag, but prisoners were

there is no reasonable alternative, making the proposed restriction the best option for the stated goals.

Looking at all of the *Turner* test prongs together, a restriction on death row inmate care based on whether the appeals process has been exhausted would not violate inmates' Eighth Amendment right to receive health care.

B. Fourteenth Amendment Equal Protections Challenge

Even though the proposed restriction on health care to death row inmates targets death row inmates generally and those that have exhausted their appeals specifically, the proposed restriction would pass scrutiny under the Fourteenth Amendment's Equal Protections Clause.[166] The Equal Protections Clause is meant to ensure that a state's power is not being used to unfairly discriminate against a specific class of individuals without an important state objective.[167] The court would have to determine whether the class of affected individuals is protected and the standard of review for a Fourteenth Amendment claim.

The affected class must be reasonable – "one which includes all persons who are similarly situated with respect to the purpose of a law."[168] The traits of the targeted group must have a reasonable relationship to the "mischief" – or negative result – the restriction is attempting to avoid.[169] In this case, the proposed restriction attempts to limit the "mischief" that results from providing expensive health care to an inmate with a short time to live. The cost to the prison health care system is high, while the benefit of the procedure to the prison and to the inmate is low.

Under the proposed restriction, death row inmates who have exhausted their appeals are the targeted class. Arguably, this grouping is both under-inclusive and over-inclusive. By way of example, an extremely unhealthy death row inmate who has yet to exhaust the appeals process costs the prison system a considerable amount of money but would not be subject to the proposed restriction. Therefore, the regula-

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still sent to outside hospitals, around 5,500 times in 2011. Although, the State of California is building a one billion dollar facility in Stockton, it will not be able to perform major surgeries. *Id.*

166. U.S. CONST. amend. XIV, § 1 ("No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.").

167. ERWIN CHEMERINSKY, CONSTITUTIONAL LAW: PRINCIPALS AND POLICIES 643 (2d ed. 2002).

168. Joseph Tussman & Jacobus tenBroek, *The Equal Protections of the Laws*, 37 CAL. L. REV. 342, 345 (1949).

169. *Id.* at 346.

tion is under-inclusive. At the same time, another death row inmate may have exhausted his appeals but have no need for a costly procedure, thus making the restriction over-inclusive.

The standard of review must also be determined when analyzing a Fourteenth Amendment claim. The standard of review for the proposed restriction would not fall under strict scrutiny because death row inmates who have exhausted the appeals process is not a suspect class of individuals. Suspect classes include race,[170] age,[171] or national origin.[172] For a class to receive a strict scrutiny review, the court will examine factors such as immutable characteristics or historical discrimination of the class the law or regulation affects.[173] Being a death row inmate is not an immutable characteristic nor is there historical discrimination of the class.

If the class is not suspect, then the standard of review lowers to intermediate review or rational basis review. Intermediate scrutiny is most commonly used for classes related to gender.[174] Intermediate scrutiny is inappropriate for the proposed regulation because of the incidental effect the proposed regulation would have on death row inmates of a particular gender. Death row inmates would not be treated differently because they are male or female but because of their status as a death row inmate. A greater number of male death row inmates would be affected but only because there are more male death row inmates than female death row inmates. As a result, rational basis review is appropriate, which is the lowest level of scrutiny the court may apply.

Like the first prong of the *Turner* test, to satisfy a rational basis review there must be a rational relationship between the proposed regulation and the goal it attains.[175] Conservation of prison resources is a valid penological goal.[176] Limiting high-cost procedures conserves monetary resources as well as security resources for the prison. Further, the same social concerns are not present with death row inmates. There is little worry that death row inmates will infect the non-institutionalized population or become a burden on the health care system because they will likely never be released. As a result, there is a rational relationship between limiting care to death row inmates and conserving prison resources.

170. *See* Korematsu v. U.S., 323 U.S. 214, 216 (1944).

171. *See* Mass. Bd. of Retirement v. Murgia, 427 U.S. 307, 309 (1976).

172. *Id.* at 313.

173. *See* Fullilove v. Klutznick, 448 U.S. 448, 496 (1980).

174. *See, e.g.*, Craig v. Boren, 429 U.S. 190, 197-98 (1976).

175. *See supra* Part IV.A.1.

176. *See* Victoria W. v. Larpenter, 369 F.3d 475, 485 (5th Cir. 2005).

V. POTENTIAL PROBLEMS WITH LIMITING HEALTH CARE

The most obvious argument against limiting care after the appeals process is that there is still a chance for the death row inmate to be removed from death row. Since 1976 there have been 273 instances of clemency granted for humanitarian reasons including doubts about defendants' guilt or a governor's judgment about the death penalty.[177] Many of these are a result of a moratorium on the death penalty and are separate from the appeals process.[178] It is unclear how many of these grants of clemency occur after the formal appeals process has ended for a specific death row inmate. However, the number of humanitarian clemency grants is minuscule compared to the number of individuals sentenced to death since 1976.[179] Critics may also point out that there is a small chance that a death row inmate may be exonerated[180] at any time during his sentence. However, only 142 inmates have been exonerated since 1973[181] and most of these inmates were exonerated during their appeals process, thus not falling under the proposed guideline. It is unclear how many death row inmates have been exonerated after they have exhausted all appeals. Even if all exonerated inmates were included in the proposed guideline, the number of individuals negatively affected would be relatively small compared to the rest of the death row population.

There is also a risk that a state may abolish the death penalty. The most recent states to abolish the death penalty did not do so retroactively, so the inmates on death row are still considered to be death row inmates.[182] There is a possibility that a death row inmate could be caught in limbo between the completion of the appeals process and an indefinite wait for execution, if the execution happens at all. That

177. *Clemency*, DEATH PENALTY INFO. CTR., http://deathpenaltyinfo.org/clemency (last visited Mar. 21, 2014).

178. *Id.*

179. As of 2002, a total of 6,152 individuals had been sentenced to death since 1973, of which 899 had been executed. Blume, *supra* note 21.

180. This number includes inmates who have been convicted and sentenced to death and have been pardoned due to evidence of innocence; retried and found not guilty; or had their charges dropped by the prosecutor. *The Innocence List,* DEATH PENALTY INFO. CTR., http://www.deathpenaltyinfo.org/innocence-list-those-freed-death-row (last visited Apr. 19, 2014).

181. *Id.*

182. *Death Row Inmates by State*, DEATH PENALTY INFO. CTR., http://www.deathpenaltyinfo.org/death-row-inmates-state-and-size-death-row-year#year (last visited Apr. 19, 2014). New Mexico, Connecticut, and Maryland have abolished the death penalty, in 2009, 2012, 2013 respectively, but the law was not made retroactive. As a result a total of 18 inmates remain on death row between these three states. *Id.*

situation would be extremely rare, and prison officials would be required to treat these death row inmates as inmates serving life in prison without parole, even though they maintain the "death row inmate" label, to avoid a constitutional violation.

Critics may also point out that there is case law pertaining to inmate health care for an inmate who will never be released. The United States District Court of Delaware grappled with this conundrum in *Derrickson v. Keve*.[183] Even though this decision was decided before *Estelle*, the court used the same standard as was prescribed in *Estelle.* Charles Derrickson was an inmate serving a life sentence who suffered from a deviated nasal septum and sinus headaches.[184] The doctor prescribed surgery as the best option to alleviate Derrickson's symptoms.[185] This particular set of symptoms would cause some individuals to elect to have surgery to alleviate symptoms, while others would forgo this treatment option.[186] Derrickson asserted that he would elect to receive the surgery if he was allowed.[187] Although this type of procedure could be defined as elective in nature, the court held that Derrickson's status as a prisoner serving a life sentence made the procedure required.[188] The condition would then be made irreparable because the recommended treatment would be impossible due to Derrickson's inability to be released to have the surgery.[189] As a result, a decision that would *never* allow an inmate to have a specific surgery violates the Eighth Amendment, according to the court.

Just as inmates serving life sentences without parole, death row inmates are generally incarcerated for the rest of their lives.[190] However, the district court failed to consider that the inability to receive an elective, but medically appropriate option, is one of the freedoms forfeited by an inmate for committing a crime, assuming there were, in fact, other medically appropriate options available. Further, if the opinion in *Derrickson is* considered precedential, inmates who will spend the rest of their lives in prison could argue that the prison is required to provide *any* care to the inmate so long as it is one of the possible treatment options for their medical need and they would elect to receive the treatment if they were free. The district court also did not consider

183. Derrickson v. Keve, 390 F.Supp. 905, 905 (D. Del. 1975).

184. *Id.*

185. *Id.*

186. *Id.* at 906.

187. *Id.*

188. *Id.* at 907.

189. *Id.*

190. Not including the 142 exonerated individuals. *The Innocence List*, *supra* note 130.

the vastly different policy reasons for treating an inmate serving life in prison without parole as compared to death row inmates. Inmates serving life in prison have a relatively unknown date of death and will live out their lives in prison, whereas a death row inmate's life will theoretically be cut short by the state.

The Supreme Court has noted that "death is different . . . from any other punishment."[191] There is an intrinsic difference between an individual who is allowed to serve the rest of his natural life in prison and an inmate who will be put to death. Those on death row have been convicted of crimes so heinous that they are eligible for, and receive, a death sentence. It does not "shock the conscience"[192] of society to limit care to this class of inmates, as seen by numerous opinion articles and legislative attempts to limit death row inmates' access of high-cost health care.[193]

CONCLUSION

The *Estelle* standard for care does not allow an inmate to receive the best care or the care he wishes to receive.[194] The prison health system should not be equivalent to a Cadillac insurance plan.[195] The corrections system has a vested interested in containing cost while providing more broad, basic health care to satisfy a large portion of the prison population's needs. One way to limit costs would be to restrict death row inmate access to extraordinary or elective procedures as their execution date nears. This policy does not violate the Eight Amendment and survives the *Turner* test for determining if a restriction of prisoner's rights is constitutional. The policy also withstands rational basis analysis under the Fourteenth Amendment. While this recommendation would not eliminate the cost of treating David Long in the ICU mere hours before his execution, it would limit Robert Foley from receiving a hip

191. Gregg v. Georgia, 428 U.S. 153, 188 (1976).

192. Rochin v. California, 342 U.S. 165, 172 (1952).

193. *See* Brandon, *supra* note 54; H.B. 2889 54th Leg., Reg. Sess. (Wash. 1996).

194. *See* Cramer v. Winslow, 211 F. App'x 561 (9th Cir. 2006) (reasoning that a disagreement between an inmate and his doctor over treatment did not violate the Eight Amendment); Hall v. Tyszkiewicz, 28 Fed. Appx. 493 (6th Cir. 2002) (holding prisoner's disagreement with physician over course of treatment and medication for esophageal reflux did not amount to deliberate indifference); Stewart v. Taft, 235 F. Supp. 2d 763, 771 (N.D. Ohio 2002) (holding there was no Eighth Amendment violation when a six month regimen for medication was prescribed but a nine month regimen would have been superior).

195. Jenny Gold, *"Cadillac" Insurance Plans Explained*, KAISER HEALTH NEWS (Mar. 18, 2010), http://www.kaiserhealthnews.org/stories/2009/september/22/cadillac-health-explainer-npr.aspx ("Cadillac plans often have low deductibles and excellent benefits that cover even the most expensive treatments.").

replacement after he exhausted the appeals process. This proposal is not perfect but would help curb exorbitant spending on inmates who will likely die by the hands of the state as a result of their crimes.