

EIGHTH AND FOURTEENTH AMENDMENT CONCERNS WITH THE BOP GUIDELINES FOR ADVANCE DIRECTIVES

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ABSTRACT

The current guidelines set forth by the U.S. Department of Justice Federal Bureau of Prisons (BoP) for institutional supplements to advanced directives (AD's) and do-not-attempt resuscitation orders (DNR's) potentially violate the Fourteenth and Eighth Amendment rights of inmates who do not wish to receive cardiopulmonary resuscitation (CPR).

INTRODUCTION

The current guidelines set forth by the U.S. Department of Justice Federal Bureau of Prisons (BoP) for institutional supplements to advanced directives (AD's) and do-not-attempt resuscitation orders (DNR's) potentially violate the Fourteenth and Eighth Amendment rights of inmates who do not wish to receive cardiopulmonary resuscitation (CPR). The BoP's guidelines state that an inmate may have an AD and DNR, and that, "The Bureau's withholding or withdrawal of resuscitative or life-support services pursuant to an Advance Directive or DNR order, is consistent with sound medical practice and is not associated with assisting suicide, voluntary euthanasia, or expediting the inmate's death."¹ In an external medical care facility the BoP follows the norms of the state and the facility providing care.² So far so good; however, the BoP states that an institutional supplement to an AD must:

State that DNR orders will never be invoked while an inmate is housed at a general population institution. Emergency resuscitative measures must always be performed on an inmate who suffers cardiopulmonary arrest at a general population institution.³

This stipulation is based on the government's claim that, "The patient's right to refuse medical treatment is not absolute and, in all cases, will be weighed against legitimate governmental interests, including the security and orderly operation of correctional institutions."⁴

However, if the only constraint on an inmate's right to refuse care is a legitimate government interest, then there should be nothing standing in the way of generally respecting an inmate's AD in a general population institution. There may be a legitimate government interest in not following through with an AD in cases of violence. Yet, for an inmate who goes into cardiac arrest without violence it beggars belief to claim that there is a government interest in performing CPR.

ANALYSIS

The government's claim becomes more incredulous when one considers the truth about CPR. Fractures and injuries to the stomach, liver, spleen, and heart are common.⁵ One physician described a patient who received CPR as, "barely conscious, vomiting, with broken ribs and a bruised lung. Her stomach was bloated and her chest was bleeding...When she died a few days later, I couldn't help wondering if she really knew what she was getting herself into."⁶ Thus, when CPR fails, "it may mean that the patient dies in an undignified and traumatic manner."⁷ Moreover, CPR's success rate outside of a hospital – such as in a prison – is abysmal: 10.2% of people who receive CPR outside of a hospital survive to hospital discharge with only 8.3% surviving with good or moderate cerebral performance.⁸ It is no surprise then that many people, including inmates, refuse CPR.

Based on the due process clause of the Fourteenth Amendment, patients' right to refuse care was first declared in *Cruzan v. Director, Missouri Department of Health* and then was echoed in the *Patient Self-Determination Act*.⁹ The due process clause states that no state may "deprive any person of life, liberty, or property, without due process of laws." The Supreme Court ruled that the state of Missouri violated the due process clause by refusing to allow the removal of Cruzan's life support, thus depriving her of her liberty to make decisions – in her case via surrogate – regarding her health care. Of importance for our purposes is that the state of Missouri's interest in protecting life on its own was not deemed sufficient grounds for depriving Cruzan of her right to refuse life sustaining treatment.

The Third Circuit Court ruled in *White v. Napoleon* that this right extends to prisoners in a qualified sense. Arguing by analogy from the way that the cases of "committed mental patients" are handled, the Third Circuit Court stated that "convicted prisoners ... retain a limited right to refuse treatment and a related right to be informed of the proposed treatment and viable alternatives." Unlike the near unlimited right to refuse treatment enjoyed by patients who are not inmates, the "limited right to refuse treatment" that inmates have "must be circumscribed by legitimate countervailing State interests." Continuing their analogy to the care of psychiatric patients, the court reasoned that, "a prison may compel a prisoner to accept treatment when prison officials, in the exercise of professional judgment, deem it necessary to carry out valid medical or penological objectives." However, just as the prisoner's right to refuse treatment is not absolute neither is prison authorities' right to compel treatment absolute. Instead, their "judgment ... will be presumed valid unless it is shown to be such a substantial departure from accepted professional judgment, practice or standards as to demonstrate that the person responsible actually did not base the decision on such judgment."¹⁰ In summary, a prisoner can refuse treatment when such a refusal is medically valid and does not interfere with the penological objectives of the institution, and the institution can compel treatment but the treatment must be in accordance with accepted professional judgment.

After *White*, the Supreme Court held in *Washington v. Harper* that, "The Due Process Clause [of the Fourteenth Amendment] permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if he is dangerous to himself or others and the treatment is in his medical

interest.”¹¹ Since *White* and *Washington*, cases of involuntary treatment of prisoners have been decided based on the government’s interest in the orderly operation of correctional institutions.¹²

In order for the BoP’s guidelines for AD’s to not be in violation of the Fourteenth Amendment, the BoP would have to prove two things. One, that there are “legitimate governmental interests, including the security and orderly operation of correctional institutions,” for forcing CPR upon an inmate who does not want it.¹³ Two, that there is a valid medical objective for performing CPR against the will of an inmate and that doing so does not constitute, “such a substantial departure from accepted professional judgment, practice or standards as to demonstrate that the person responsible actually did not base the decision on such judgment.”¹⁴

On the first point, the BoP cannot claim a legitimate government interest for two reasons. One, in both *Cruzan* and the PSDA, the government has shown that the government’s interest to preserve life is limited to some extent by patient autonomy even in the case of the removal of life-sustaining treatment. The government can offer no reason as to why they should suddenly have an interest in preserving life when a refusal of care comes from an inmate as opposed to a patient who is not incarcerated. Therefore, the government cannot claim that it is forcing CPR on inmates out of the interest to preserve life because it has already determined that the interest to preserve life does not extend to undesired resuscitation. Two, not attempting resuscitation and allowing an inmate to die can in no way seriously impede the orderly operation of a correctional institution. An inmate dying from cardiac arrest is different from a patient refusing vaccination, for the latter is refusing minimally invasive and highly effective care that also impacts the health of the staff and other inmates. Additionally, an inmate dying from cardiac arrest cannot use his cardiac arrest to manipulate prison staff like a prisoner on a hunger strike.¹⁵ Moreover, there have been cases in which an inmate has been allowed to make refusals of treatment, such as refusing dialysis, that place a far greater burden on the prison and its staff than refusing CPR ever could.¹⁶ Therefore, the BoP cannot claim that an inmate’s AD can be overridden on the grounds of “legitimate government interest” because the government has sanctioned AD’s, and an inmate dying from cardiac arrest does not interfere with the orderly operation of a correctional institution.

As for the second prong of a 14th Amendment due process challenge, the guidelines fail the “accepted professional judgment” test put forth in *White* for two reasons. One, it is standard practice in the medical community to respect a patient’s AD, out of respect for both patient autonomy, federal law, and the low success rate of CPR. Therefore, the BoP guidelines themselves are “a substantial departure from accepted professional judgment, practice or standards as to demonstrate that the person responsible actually did not base the decision on such judgment.”¹⁷ Two, the very nature of the guidelines prevents professional judgment from being exercised. As the Supreme Court ruled in *Chevron v. Echazabel*, a blanket policy did not allow for professional medical judgment to be made because the judgment could not be individualized.¹⁸ In order for a professional judgment to be made regarding whether or not an inmate’s AD should be respected, the individual inmate’s case must be examined to determine if forcing CPR would be medically indicated and if the inmate is seeking to undermine the orderly operation of the prison.

The Eighth Amendment of the Constitution which prohibits the use of cruel and unusual punishment is the basis for inmates’ right to health care. In *Estelle v. Gamble*, the Supreme Court held that the, “deliberate indifference by prison personnel to a prisoner's serious illness or injury constitutes cruel and unusual punishment contravening the Eighth Amendment.” Chief Justice Marshall bases the extension of Eighth Amendment protection to include the provision of healthcare on “the evolving standards of decency that mark the progress of a maturing society” precedent that was set by *Trop v. Dulles*:

These elementary principles establish the government's obligation to provide medical care for those whom it is punishing by incarceration. 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. In the worst cases, such a failure may actually produce physical "torture or a lingering death," ... the evils of most immediate concern to the drafters of the Amendment. In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose ... The infliction of such unnecessary suffering is inconsistent with contemporary standards of decency as manifested in modern legislation codifying the common law view that "it is but just that the public be required to care for the prisoner, who cannot, by reason of the deprivation of his liberty, care for himself."

On these grounds, the "deliberate indifference to serious medical needs of prisoners" is a cause of action under 42 U.S. Code §1983, and it does not matter if such indifference is, "manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed."¹⁹ However, Chief Justice Marshall in *Estelle* notes that not every instance of malpractice violates the Eighth Amendment:

In order to state a cognizable claim, a prisoner must allege acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs. It is only such indifference that can offend "evolving standards of decency" in violation of the Eighth Amendment.²⁰

Thus, in order to demonstrate that there has been a violation of his rights, a prisoner must first show that the maltreatment was sufficiently harmful and "a culpable state of mind on the part of prison officials."²¹ These are the objective and subjective components of an Eighth Amendment claim under *Estelle*.

In regards to the objective component, the violence of CPR described above is a source of "pain and suffering which no one suggests would serve any penological purpose."²² Furthermore, if "the evolving standards of decency that mark the progress of a maturing society" are taken into account, undesired CPR is cruel and unusual. For the standards of decency that mark the progress of a maturing medical society are such that not every patient should receive CPR, especially those who have a properly obtained DNR. As for the subjective component – establishing "deliberate indifference" – the BoP's policy that DNR's will not be implemented in a correctional setting establishes that the provision of CPR against an inmate's will is deliberate: it is not a matter of a prison guard not realizing an inmate has a DNR but a matter of official policy. That the policy is indifferent is evidenced by the lack of any consideration of the medical realities of CPR, its prohibiting true professional judgment, and its disregard for the medical decision making of inmates.

Additionally, the BoP guidelines violate the Eighth Amendment by failing to provide inmates with adequate medical care. In order to provide adequate medical care to a patient, a physician must know when to treat and when not to treat. Overtreatment, non-medically indicated treatment, and treatment against the patient's wishes are not adequate care. Moreover, refusals of treatment are necessary because what constitutes proper care is partly determined by the patient. In adopting a standard that equates medical care to medical treatment, the BoP provides inadequate medical care that fails to meet the medical needs of inmates which, "may actually produce physical 'torture or a lingering death.'"²³

CONCLUSION

The current BoP guidelines for AD's expose the bureau to civil action under 42 U.S. Code § 1983. They do so because they violate inmates' Fourteenth and Eighth Amendment rights. The guidelines violate the Fourteenth Amendment for two reasons. One, there is no legitimate governmental interest in forcing CPR

on inmates. Two, the decision to force CPR on inmates is not based on professional judgment. The guidelines also violate the Eighth Amendment for three reasons. One, CPR can be the source of torture and a lingering death and forcing it on inmates against their will fails to meet the standards of an evolving society. Two, by not considering the inmates' wishes as a matter of official policy, the BoP demonstrates deliberate indifference. Three, the guidelines equate medical treatment with medical care and in so doing provide inadequate medical care. My suggestion for the BoP is that it revise its guidelines for AD's in correctional facilities to compel prison staff to respect inmates' refusals of CPR in order to avoid potential future civil action for the violation of inmates' civil rights.

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² U.S. Department of Justice Federal Bureau of Prisons, “Patient Care,” 31-35.

³ *Ibid.* 34.

⁴ *Ibid.*

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¹¹ *Washington v. Harper* 494 U.S. 210 (U.S.C. 1990), accessed September 8, 2019, <https://www.law.cornell.edu/supremecourt/text/494/210>

¹² *E.g. Stouffer v. Reid* (MD Ct. Spec. App 2009), accessed September 8, 2019, <http://caselaw.findlaw.com/md-court-of-special-appeals/1250955.html>.

¹³ U.S. Department of Justice Federal Bureau of Prisons, “Patient Care.”

¹⁴ *White v. Napoleon*

¹⁵ *State Ex. Rel White v. Narick* 292 S.E.2d 54 (S.C. WV 1982), accessed September 8, 2019, <http://law.justia.com/cases/west-virginia/supreme-court/1982/15442-4.html>.

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¹⁶ *Stouffer v. Reid*

¹⁷ *White v. Napoleon*

¹⁸ *Chevron v. Echazabel*, 536 U.S. 73 (U.S.C. 2002), accessed September 8, 2019, <https://www.law.cornell.edu/supct/html/00-1406.ZO.html>.

¹⁹ *Estelle v. Gamble*, 429 U.S. 97 (U.S.C. 1976), accessed September 8, 2019, <https://www.law.cornell.edu/supremecourt/text/429/97>.

42 U.S. Code § 1983, accessed September 8, 2019, <https://www.law.cornell.edu/uscode/text/42/1983>.

42 U.S. Code § 1983 reads: Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer’s judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable.

²⁰ Ibid.

²¹ Wilson v. Seiter (U.S.C. 1991), accessed September 8, 2019, <http://caselaw.findlaw.com/us-supreme-court/501/294.html>.

²² Estelle v. Gamble

²³ Estelle v. Gamble