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Essay

ASSISTED SUICIDE FOR PRISONERS

David Lester[✉,1]

[1]Stockton University, New Jersey, USA

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Abstract: Handke and Bretschneider (2015) argued that prisoners should be eligible for assisted suicide as are members of the general population in some American states and in some countries. This proposition is examined. First, the concept of an appropriate death is discussed, followed by a brief review of suicide in convicted offenders. Finally, the issues of mental competence in making decisions and prisoner rights are discussed. It is concluded that, under appropriate guidelines, assisted suicide should be permitted for convicted offenders if members of the general population in those regions or countries have this right.

Keywords: prison suicide, assisted suicide, appropriate death

Handtke and Bretschneider (2015) argued that prisoners have civil rights as do individuals in the general population and, therefore, they should be eligible for assisted suicide. Handtke and Bretschneider noted that prisoners are able to make informed choices. They are imprisoned with a clearly defined sentence, and the prison system in their country may offer in-house palliative care or hospice care. They can rationally weigh their options in these matters. Regarding their autonomy, although this is limited in some areas, such as choice of physician or the number of family visits, their existential choices are not as limited. They can, for example, refuse life-saving treatment and issue do-not-resuscitate orders.

The present paper explores some of the issues involved in assisted suicide for prisoners.

✉ David Lester, Ph.D., Psychology Program, Stockton University, 101 Vera King Farris Drive, Galloway, NJ 08205-9441 or e-mail: lesterd@stockton.edu .

An Appropriate Death

Lester (1996, 2003) has discussed many of the issues surrounding choosing to die suicide and assisted suicide. Since we all have to die, the crucial decision is, of course, not whether to die, but how to die. Ideally, each of us should die an *appropriate death*, and Lester has discussed what this might mean. For example, in one definition of an appropriate death (Kalish, 1985), the different types of death should occur at the same time. When the organs of the individual and the organism cease to function, there is what we may call *physical death*. Individuals are *psychologically dead* when they cease to be aware of themselves and of their own existence. *Social death* is when the individual accepts the notion that for all practical purposes he or she is dead. Social death may be defined from the point of view of the individual or from the point of view of the significant others, such as when the elderly relative is put in a home and forgotten by his family and friends. The final kind of death is *anthropological death* in which the individual is cut off from the community and

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treated as if he or she no longer exists. The Orthodox Jew who marries a Gentile is anthropologically dead to the Orthodox community. These four kinds of death can occur at different times in an individual's life, and Lester suggested that a death could be considered appropriate when all four of these different kinds of death coincide in time. A person who falls into coma (psychological death) and physically dies much later has had an inappropriate death.

Binswanger (1958) judged a death to be appropriate if the person has played a role in his own death. A person struck down by chance factors, such as lightning, therefore, does not die an appropriate death as defined in this way. In contrast, a person dying by suicide plays the maximum role in his or her death.

Deaths are legally classified as natural, accidental, suicide or homicide (the NASH taxonomy). Some view a natural death as good since, in a natural death, the body retains its integrity. An act of suicide, such as shooting oneself, destroys the body's integrity and is, therefore, inappropriate in this definition. From this point of view, any life that is prolonged by the use of transplants and medical intrusions into the body is not appropriate. Suicide and assisted suicide could be appropriate under this criterion if an appropriate method is chosen for suicide. Arguing against this notion, Shneidman (1968) said that he saw nothing natural about bacteria or viruses entering his body and causing death any more than a bullet or a knife entering his body.

The timing of a person's death may be relevant. Shneidman (1967) argued that there may be times in a person's life when death would be appropriate and would give a self-consistent tone to the life-style of the person. Such a death can even heighten an individual's impact by making his or her memory more treasured.

If you ask people how they expect to die, they can often give you an answer. Perhaps they have thought about this and decided between preferred alternatives. Their choice will reflect something about themselves, their personality and their fears, and it may also reflect their life-style. The passive person may choose to die at the hands of another or from a virus. The self-destructive person may commit suicide. An appropriate death can, therefore, be defined as one which is consistent with the person's life-style. For example, Ernest Hemingway's suicide by firearm in the face of severe medical and psychiatric illnesses was consistent with the death-defying life-style he had cultivated during his lifetime.

Lester (1996, 2003) also argued that the quality of life *as perceived by the individual* should be taken into account. Some individuals may choose, for example, to undergo painful treatment for cancer whereas others may choose to forego treatment and let the cancer take its course. Still others may hasten their death by choosing suicide. Each individual makes a choice as to the quality of life under these different choices and chooses that option that provides the best quality.

Suicide and Assisted-Suicide among Convicted Offenders

Despite intense observation and supervision by correctional staff, suicide rates among prison inmates are high and comparable to men in the community. For example, Tartaro and Lester (2005) reported that suicide rates for male prisoners in the USA ranged from 13 to 18 per 100,000 per year whereas the suicide rate for American men in general is about 18. Lester and Tartaro (2002) estimated a suicide rate of 113 for inmates on death row in the USA in the 1990s despite the even more intense supervision present for prisoners on death row.

Relevant to this consideration is the fact that some inmates sentenced to death eventually cease appealing their death sentences and insist that attorneys representing them stop appealing on their behalf. Strafer (1983) noted that five of the first eight men executed after 1976 (after the United States Supreme Court permitted executions if certain conditions were met) volunteered at some point to accept the process leading to their execution. This phenomenon may be likened to victim-precipitated homicide (Wolfgang, 1957) in which the victims play a role in precipitating their own murder, a behavior seen as having suicidal component.

The geriatric inmate population in the USA is growing at such a rate that special geriatric prisons have been constructed (Aday, 1994). In recent years, almost a third of deaths among prisoners are a result of AIDS (Camp & Camp, 1995), and the incidence of AIDS among inmates is roughly ten times higher than in the general public (Hammett, et al., 1994). Slome, Mitchell, Charlebois, et al. (1997) reported that 53%

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of the physicians they surveyed had helped AIDS patients in the community to die by suicide, with a mean number of patients helped of 4.2 and a median number helped of 1.0. Thus, there are several risk factors for suicide which are becoming more frequent among American prisoners.

It is clear that life in jail and prison can be sufficiently harsh that inmates prefer to die by suicide than to continue to exist. The statistics on suicide are supported by scholars who have presented more general data on the harsh conditions in prisons (e.g., Rideau & Wikberg, 1992). It is, therefore, entirely conceivable that inmates may wish to die rather than live in such conditions, and such a decision may meet criteria for being logical and rational. If the inmate is, in addition, suffering from a severe or terminal illness, choosing suicide may be a rational choice.

Choosing Suicide and Mental Competence

In some of the criteria proposed for permitting an individual in the community to choose suicide and to receive aid from a physician or pharmacist in obtaining the necessary lethal medication, the mental competence of the individual is often included. It is usually proposed that only an autonomous, competent adult can make such a choice. Autonomy entails the individual being free to make choices, while competence entails the individual understanding the alternatives and being able to make a rational choice among them.

Children, the mentally retarded and those judged to be psychiatrically disturbed are typically not considered to possess autonomy or competence. The problem of psychiatric disturbance poses difficulties for approving assisted suicide in non-incarcerated individuals, and the difficulties are multiplied for those incarcerated. The majority of suicides in the community are typically diagnosed after the suicide as having had a psychiatric disorder (Robins, 1981), and the most common disorder is a mood disorder, usually a major depressive disorder.[1] Since depressive disorders can be treated (primarily by medication or psychotherapy such as cognitive therapy), should depressed individuals have their depression treated before they are permitted to choose suicide? However, depressed individuals in the community cannot be forced to take medication or undergo psychotherapy unless formal court orders are obtained for involuntary commitment to a psychiatric hospital and, even then, patients with good legal representation can resist treatment against their will.

In prisons, many inmates have chronic psychiatric disorders, while others experience transient situational disorders caused by the stress of imprisonment. The proportion of psychiatrically disturbed inmates has increased in the USA in recent years, possibly as a result of the deinstitutionalization of psychiatric patients, many of whom have ended up in prisons instead of psychiatric units (Winfree & Wooldredge, 1991). As a consequence, many inmates are medicated to help them (and the staff) cope with the stress of imprisonment. Deciding upon the criteria for assessing whether an inmate is competent to make a decision may prove difficult. However, solutions for the analogous problem in carrying out death sentences, in which inmates must be judged to be competent for execution, have been proposed (e.g., Radelet & Barnard, 1988).

Therefore, rational arguments in favor of assisted suicide may be more relevant for prisoners since the quality of their life is considerably worse than members of the general population.

Prisoner Rights

In the USA, prisoners do have the right to refuse medical treatment (including extraordinary interventions) and to refuse psychotherapy and psychiatric medications. *Washington v. Harper* (494 U.S. 210 [1990]), relying on *Turner v. Safley* (482 U.S. 78 [1987]), held that prisoners and involuntarily committed psychiatric patients can refuse antipsychotic medication, unless such medication is necessary for safety reasons. The result is that such decisions are usually left to the discretion of the medical staff of the prison, unless prisoners file lawsuits. It would not be surprising, therefore, if prisoners were granted in the future a right to assisted suicide similar to that which is granted to citizens in general. If prisoners requested such a procedure, they would probably have to have a severe or terminal illness and have been transferred

[1] It should be noted that rarely, if ever, do such studies include a control group. If research did include a control group, the diagnosis of those in the control group should be arrived at using the same techniques as those used for suicides (interviews with friends and relatives of the individuals), and those diagnosing the individuals should be "blind" as to which the individuals are suicides and which are controls.

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to a hospital setting. Thus, the staff involved in the decision would be medical rather than custodial.

Implications

The first question that arises is whether assisted suicide has occurred in prison settings. Many physicians admit that they have helped severely ill and terminal patients in public and private hospitals die by suicide even though such behavior is illegal (Quill, 1993), and it is quite possible that unofficial and undocumented assisted suicide has occurred in prison settings.

Assisted-suicide is already available in some American states (and in some countries) and so it may be argued that this option (or right) belongs also to prisoners. If it is decided that prisoners have this same right, procedures will have to be established for allowing an inmate to choose assisted suicide. A prisoner dying from a chronic illness and in psychological and/or physical pain who meets established criteria should be allowed to choose this option, if appropriate procedures have been followed.

One of the arguments made against permitting assisted-suicide available for the general public is that some people may be pressured into choosing this option by significant others or by the medical professionals with whom they consult. For prisoners, the possibility of pressure to choose this option may be greater. Established procedures should have provisions to minimize or eliminate this risk.

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