Balancing Punishment and Compassion for Seriously Ill Prisoners

Running title: Punishment and compassion

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Abstract

Compassionate release is a mechanism to allow some eligible, seriously ill prisoners to die outside of prison before sentence completion. It became a matter of federal statute in 1984 and currently has been adopted by the majority of U.S. prison jurisdictions. Incarceration is justified on 4 principles: retribution, rehabilitation, deterrence, and incapacitation. Compassionate release derives from the theory that changes in health status may affect these principles and thus alter justification for incarceration and sentence completion. The medical profession is intricately involved in this process because eligibility for consideration for compassionate release is generally based on medical evidence. Due to an aging prison population, overcrowding, rising deaths in custody, and soaring criminal justice medical costs, many policy experts are calling for broader use of compassionate release. Yet, the medical eligibility criteria of many compassionate release guidelines – which often assume a definitive prognosis – are clinically flawed and procedural barriers may further limit their rational application. We propose changes to address these flaws.
Compassionate release is a mechanism that allows some eligible, seriously ill prisoners to die outside of prison before sentence completion. Compassionate release programs are based on 2 premises: (1) it is ethically and legally justifiable to release a subset of prisoners with life-limiting illnesses, and (2) the financial costs to society of continuing to incarcerate such persons outweigh the benefits. The U.S. federal prison system and the majority of state systems have a compassionate or medical release program.(1,2) With increasing numbers of older prisoners, overcrowding, rising numbers of in-prison deaths, and soaring criminal justice costs, correctional and public policy experts are calling for broader use of compassionate release.(3,4,5)

Compassionate release consists of 2 entwined, but distinct elements: eligibility (based on medical evidence) and approval (based on legal/correctional evidence).(5) We argue that the medical eligibility criteria of many compassionate release guidelines are clinically flawed because they rely heavily on the inexact science of prognostication and additional procedural barriers may further limit their rational application. Given that early release is politically and socially charged and that eligibility is based largely on medical evidence, it is critical that such evidence be based upon the best possible scientific evidence and that the medical profession help minimize medical-related procedural barriers. We propose changes to make compassionate release guidelines more clinically meaningful and to address medical-related procedural barriers.

The history and rationale underlying compassionate release

Compassionate release is a matter of federal statute under the Sentencing Reform Act of 1984,(1) and now all but 5 states have some mechanism through which dying prisoners can seek release.(2,6,7) Additionally, in the past 3 years, 12 states passed legislation to expand early release programs for dying and incapacitated persons.(8-12) Whereas medical eligibility guidelines vary by jurisdiction; most require: (1) a terminal (or severely debilitating) medical
condition, (2) a condition that cannot be appropriately cared for within the prison, and (3) a prisoner who poses no threat to society.(5,13)

Compassionate release was established under the premise that changes in health status may alter justification for incarceration. Incarceration is based on 4 principles (5,14): 1) as retribution through deprivation of liberty, when other punishment is deemed insufficient, 2) as rehabilitation (e.g., drug-treatment or educational programs), 3) as deterrence for future criminal acts, and 4) as incapacitation, by separating prisoners from society to enhance public safety. These justifications may be substantially undermined for prisoners who are too ill or cognitively impaired to be aware of punishment, too sick to participate in rehabilitation, or too functionally compromised to pose a risk to public safety. In recognition of society’s need for retribution for particularly heinous criminal acts, virtually all states exclude some prisoners from eligibility based on crime severity.(15)

Compassionate release was also designed to address correctional costs. Between 1982 and 2006, U.S. state and federal prison populations grew 271%, (16) prisoners 55 years or older increased 418%, (17-19) and spending increased 660%. (20) For the 79,100 prisoners over age 55, (21) the cost of incarceration is over 3 times that of younger prisoners – primarily due to healthcare costs. (22) Although releasing prisoners who are very close to death (days to weeks) may simply shift healthcare costs (to Medicare/Medicaid,) (23) in cases felt to be appropriate and safe, earlier release will likely reduce costs related to hospital security, medical transport for treatments such as dialysis, and construction of disability-accessible, protective housing. (4,13)

Indeed, the average annual costs for healthcare, protective transportation, and guards for 21 seriously-ill prisoners in California (just 0.01% of the state’s prison population) exceed $1.97 million per prisoner. (24) In comparison, the median annual cost of nursing home care in
California is $73,000 per person. (25) Further discussions of the ethical, legal, and financial aspects of compassionate release are reviewed elsewhere. (5, 13)

The precise number of compassionate release requests is unknown, in part because many prisoners die during review. (4, 13, 23) What is known is that a small percent of dying prisoners are granted compassionate release. For example, in 2008 there were 399 deaths in the Federal Bureau of Prisons and 27 compassionate release requests approvals. Six applicants died during the final review process, Table 1. (26, 27) We do not mean to suggest, given the importance of public safety, that any death in prison be viewed as a failure of the compassionate release process. Yet, medical and procedural flaws in eligibility guidelines described below coupled with the small number of persons who receive compassionate release suggest the importance of reevaluating and transforming current guidelines.

The compassionate release process

Compassionate release varies by jurisdiction. Within federal prisons, a prisoner or advocate initiates a written appeal describing the “extraordinary and compelling reasons” for release and proposes release plans. The application receives 4 additional levels of review after a medical evaluation. State processes have differing requirements for eligibility, application, and approval. (15) The review process in both federal and state systems can extend for months, and occasionally years. (13)

Medical-related flaws in compassionate release programs

Compassionate release eligibility guidelines are often fraught with clinical flaws. To meet most guidelines, prisoners must have a predictable terminal prognosis, be expected to die quickly, and/or have health or functional status that substantially undermines the aforementioned justifications for incarceration. As such, compassionate release requires that physicians predict not only limited life expectancy, but functional decline as well. Prognosis is difficult to establish
for conditions such as advanced liver, heart and lung disease, and dementia (28-29) - increasingly common causes of death and disability in prisons.(30-32) Moreover, for patients with more predictable prognoses such as cancer, functional trajectories are variable and unpredictable, often declining only in the last weeks of life.(33,34)

Reliance on prognostication can create a “Catch 22”: if compassionate release is requested too late, an eligible prisoner will die before their petition is completed; too early and a terminally ill prisoner in good functional health can be released, live longer than expected, and perhaps pose a threat to society. Yet, requiring a predictable, time-limited prognosis (e.g., 6 months or less) excludes prisoners with severe, but not end-stage, dementia, persistent vegetative state, or end-stage organ disease (e.g., oxygen-dependent COPD). Some such patients may live for months to years, at great expense to criminal justice systems, incapable of posing harm, participating in rehabilitation, or, in the case of dementia, experiencing punishment. These flaws reflect a fundamental tension between the eligibility guidelines for compassionate release and people’s actual disease trajectories.

Procedural barriers may also hamper medically-eligible persons from obtaining compassionate release and invite potential inequity. For instance, persons with profound cognitive incapacities (the majority of patients with advanced illness (28,35)), could be incapable of completing a written petition. Prisoners also have the nation’s lowest literacy rates,(36) are frequently distanced from family or friends impeding access to social support to navigate the process,(37) and many are not aware that early release programs exist.(4) Yet, formal mechanisms to assign and guide a prisoner advocate have neither been universally accepted nor optimized. For example, for a terminally ill prisoner in California, the warden must enable the prisoner to designate an outside agent to act as an advocate.(12) However, once an advocate is appointed, there are no formal guidelines to help the agent navigate the system. In states without
formal advocates, (e.g., New York) implicit expectations have arisen that prison medical staff should advocate for such prisoners. This expectation is not formally codified and is infrequently operationalized.(13) Another procedural barrier is time: while a few states, such as Vermont, have a “fast-track” option for imminently dying prisoners,(13) for many prisoners the process may be too lengthy to achieve evaluation for release before death. While these procedural barriers do not relate directly to the clinician’s role, they may act as functional barriers to a meaningful process and should be reformed along with medical eligibility criteria.

Addressing medical-related flaws in compassionate release eligibility guidelines

We recommend the development of standardized national guidelines by an independent advisory panel of palliative medicine, geriatrics, and correctional healthcare experts. Such external evaluation would require transparency and public sharing of information about the varied compassionate release processes across jurisdictions and could help identify other avenues for improvement system-wide.(38) At a minimum, the new guidelines should embrace evidence-based principles and a transparent process that includes: (1) assignment of a prisoner advocate to help navigate the process and represent incapacitated prisoners; (2) a fast-track option for evaluation of rapidly-dying prisoners; and (3) a well-described and disseminated application procedure. The guidelines also must delineate distinct roles for physicians (assessment of medical eligibility) and parole boards/corrections (balancing prisoner health, public safety, and retribution in the approval process).(39) Other areas that should be reviewed include mechanisms for identifying potential candidates and avenues for addressing request denials.(4,13,38) As with other guidelines (40), standardization of compassionate release guidelines, in concert with a patient advocate, should help avoid inequities in compassionate release access - particularly for those too cognitively impaired to advocate for themselves.
We also propose that national criteria for medical eligibility for compassionate release categorize seriously-ill prisoners into 3 groups, based not only upon prognostication, but also disease trajectory, and functional and cognitive status. These groups consist of: (1) prisoners with a terminal illness with predictably poor prognoses; (2) prisoners with Alzheimer and related dementias; and (3) prisoners with serious, progressive, nonreversible illness with profound functional/cognitive impairments. Use of such an evidence-based categorization could provide a framework within which medical professionals’ roles can be tailored (Table 2), and serve as the starting point for the redesign of medical eligibility criteria, release settings, and in-prison medical needs.

Finally, to address concerns about retribution and public safety, we propose that recall mechanisms for prisoners whose conditions improve substantially after release (17) be expanded to all state and federal programs.

**Palliative medicine and the criminal justice system**

Efforts to transform compassionate release programs should concurrently develop prison-based palliative care. Any prisoner with an illness or debilitating condition that is serious enough to consider a compassionate release application would benefit from a palliative medicine evaluation to decrease their symptom burden while awaiting a decision. Additionally, while incarceration may no longer be justified for prisoners who are both medically eligible and meet legal/correctional approval, palliative care should be provided to the many prisoners with serious illness who will not be eligible for early release. At present, access to prison palliative care is limited. For example, only 75 of 1719 state correctional facilities and 6 of 102 federal facilities have hospices.(41,42) Additionally, as with palliative care programs in the community,(42,43) prison-based palliative care programs are likely to improve healthcare while lowering costs.(3,37)
Conclusion

Although compassionate release could address fiscal pressures posed by the aging prison population, medical and procedural barriers may prevent its rational application. Determining medical eligibility, as distinguished from approval, for compassionate release is a medical decision and falls within physicians’ scope of practice. Moreover, many states are considering expanding medical eligibility to include physical incapacity and/or the “elderly” in addition to terminal diagnoses. Physicians thus have an opportunity to use their unique expertise and knowledge of prognosis, geriatrics, cognitive and functional decline, and palliative medicine to ensure that medical criteria for compassionate release are appropriately evidence-based. Using this medical foundation, criminal justice professionals can balance the need for societal punishment with an eligible individual’s appropriateness for release. As a society, we have incorporated compassionate release into most prison jurisdictions. As a medical profession, we must lend our expertise and ethical suasion to ensure that compassion is fairly delivered.
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