Balancing Punishment and Compassion for Seriously Ill Prisoners

Brie A. Williams, MD; Rebecca L. Sudore, MD; Robert Greifinger, MD; and R. Sean Morrison, MD

Compassionate release is a program through which some eligible, seriously ill prisoners are able to die outside of prison before sentence completion. The program functions on 2 premises: It is ethically and legally justifiable to release a subset of prisoners with life-limiting illnesses, and the financial costs to society of continuing to incarcerate such persons outweigh the benefits. The U.S. Federal Bureau of Prisons and most state systems have a compassionate- or medical-release program (1, 2). Due to increasing numbers of older prisoners, overcrowding, increasing numbers of in-prison deaths, and the soaring medical costs of the criminal justice system, correctional and public policy experts are calling for broader use of compassionate release (2–4).

Compassionate release consists of 2 entwined but distinct elements: eligibility (based on medical evidence) and approval (based on legal and correctional evidence) (4). We argue that the medical eligibility criteria of many compassionate-release guidelines are clinically flawed because of their reliance on the inexact science of prognostication, and additional procedural barriers may further limit rational application. Given that early release is politically and socially charged and that eligibility is based largely on medical evidence, it is critical that such medical evaluation be based on the best possible scientific evidence and that the medical profession help minimize medically related procedural barriers. We propose changes to address these barriers to make compassionate-release guidelines more clinically meaningful.

The History and Rationale of 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, 5, 6). Over the past 3 years, 12 states passed legislation to expand early-release programs for dying and incapacitated persons (7–11). Whereas medical eligibility guidelines vary by jurisdiction, most states require the following: a terminal or severely debilitating medical condition, a condition that cannot be appropriately cared for within the prison, and a prisoner who poses no threat to society (4, 11).

Compassionate release was established under the premise that changes in health status may alter the justification for incarceration. Incarceration is based on the following 4 principles (4, 12): retribution through deprivation of liberty when other punishment is deemed insufficient, rehabilitation through drug treatment or educational programs, deterrence to committing future criminal acts, and incapacitation through 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. Recognizing society’s need for retribution for particularly heinous criminal acts, virtually all states exclude some prisoners from eligibility on the basis of crime severity (13).

The compassionate-release program was also designed to address correctional costs. Between 1982 and 2006, U.S. state and federal prison populations grew by 271% (14), prisoners aged 55 years or older increased by 418% (15–17), and spending increased by 660% (18). For the 79 100 prisoners older than 55 years (19), the cost of incarceration is more than 3 times that for younger prisoners, primarily due to health care costs (20). Although releasing prisoners who are very close to death (days to weeks) may simply shift health care costs to Medicare or Medicaid (21), in cases believed to be appropriate and safe, earlier release will probably reduce costs related to hospital security, medical transport for such treatments as dialysis, and...
construction of disability-accessible protective housing (3, 11). Indeed, the average annual costs for health care, protective treatment, and guards for 21 seriously ill prisoners in California (just 0.01% of the state’s prison population) exceed $1.97 million per prisoner (22). In comparison, the median annual cost of nursing home care in California is $73 000 per person (23). Further ethical, legal, and financial aspects of compassionate release are discussed elsewhere (4, 11).

The precise number of requests for compassionate release is unknown, in part because many prisoners die during review (3, 11, 21). What is known is that a small percentage of dying prisoners are granted compassionate release. For example, in 2008, 399 deaths occurred in the Federal Bureau of Prisons and 27 requests for compassionate release were approved. Six applicants died during the final review process (Table 1) (4, 24, 25). Given the importance of public safety, we do not mean to suggest that any death in prison be viewed as a failure of the compassionate-release process. However, the medical and procedural flaws in eligibility guidelines described here, 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. In federal prisons, a prisoner or an 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 prisons have different requirements for eligibility, application, and approval (13). The review process in both federal and state systems can extend for months and sometimes years (11).

### Medical-Related Flaws in Compassionate-Release Programs

Eligibility guidelines for compassionate release are often fraught with clinical flaws. To meet most guidelines, prisoners must have a predictable terminal prognosis, be expected to die quickly, or have a health or functional status that considerably undermines the aforementioned justifications for incarceration. As such, compassionate release requires that physicians not only predict limited life expectancy but functional decline as well. Prognosis is difficult to establish for such conditions as advanced liver, heart, and lung disease and dementia (26, 27), which are increasingly common causes of death and disability in prisoners (28–30). Moreover, for patients with more predictable prognoses, such as cancer, functional trajectories vary and are unpredictable, often declining only in the last weeks of life (31, 32).

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

### Table 1. Outcomes of Compassionate-Release Requests That Reached the Final Review Stage in the Federal Bureau of Prisons*

<table>
<thead>
<tr>
<th>Year</th>
<th>Federal Prison Population, n</th>
<th>Deaths, n‡</th>
<th>Mortality Rate per 100 000 Federal Prisoners</th>
<th>Requests Reaching Final Review Stage, n</th>
<th>Requests Approved, n</th>
<th>Requests Denied, n</th>
<th>Applicant Deaths During Final Review Process, n†</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>178 630</td>
<td>399</td>
<td>229</td>
<td>36</td>
<td>27</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>2007</td>
<td>176 346</td>
<td>368</td>
<td>211</td>
<td>30</td>
<td>16</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>2006</td>
<td>169 320</td>
<td>328</td>
<td>192</td>
<td>44</td>
<td>26</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>2005</td>
<td>175 954</td>
<td>388</td>
<td>233</td>
<td>36</td>
<td>18</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>2004</td>
<td>169 370</td>
<td>333</td>
<td>208</td>
<td>21</td>
<td>6</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>2003</td>
<td>173 059</td>
<td>347</td>
<td>227</td>
<td>46</td>
<td>25</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>2002</td>
<td>163 528</td>
<td>335</td>
<td>232</td>
<td>38</td>
<td>24</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>2001</td>
<td>156 993</td>
<td>303</td>
<td>221</td>
<td>34</td>
<td>26</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>2000</td>
<td>145 416</td>
<td>285</td>
<td>218</td>
<td>40</td>
<td>32</td>
<td>5</td>
<td>3</td>
</tr>
</tbody>
</table>

* To reach the final review stage, the application had already been initiated by the inmate, citing both justification and postrelease plans recommended by the warden of the institution where the inmate is held (including the attending physician’s medical summary and life expectancy estimate), reviewed and approved by the Regional Director, reviewed and approved by the General Counsel of the Bureau of Prisons, evaluated and forwarded by the Medical Director or Assistant Medical Director of the Correctional Programs Division, and ultimately approved by the Director of the Bureau of Prisons. The Director of the Bureau of Prisons then forwards a motion for release to the U.S. Attorney in the district where the prisoner was sentenced and to the sentencing court (5). As reflected in this table, the data consider the Director of the Bureau of Prisons the final review stage. All data are from reference 27 unless otherwise noted. Of note, the data listed for each year reflect all activity during 1 calendar year. Approvals and denials may carry over from one year to the next. The numbers of approvals, denials, and deaths in 1 year do not always add up to the total number of requests from that year.

† Data in this column are from reference 26.

‡ Death occurred before final decision was made regarding compassionate release.
Table 2. Proposed Categorization Scheme for Assessing Medical Eligibility for Compassionate Release for Seriously Ill Prisoners

<table>
<thead>
<tr>
<th>Prisoner Group</th>
<th>Pace of Disease Progression and Predictability of Prognosis</th>
<th>Disease Examples</th>
<th>Primary Medical Criteria for Release</th>
<th>Need for Fast-Track Assessment for Compassionate Release?</th>
<th>Time Point of Assessment for Potential Medical Eligibility</th>
<th>Individual Responsible for Identifying Candidate for Potential Eligibility and for Initiating Process</th>
<th>Release Site</th>
<th>Alternative to Release</th>
</tr>
</thead>
<tbody>
<tr>
<td>Terminal illness with predictable prognosis</td>
<td>Steady progression with predictable prognosis (months to years, depending on stage at diagnosis)</td>
<td>Metastatic solid-tumor cancer, ALS</td>
<td>Life expectancy/prognosis</td>
<td>No</td>
<td>Diagnosis of new cancer or rapidly progressive terminal illness</td>
<td>Physician/health care provider, patient, advocate*</td>
<td>Hospice, palliative care program, family home-hospice</td>
<td>Prison hospice unit or long-term care unit</td>
</tr>
<tr>
<td>Profound cognitive impairment or dementia</td>
<td>Steady progression of disease, functional and cognitive impairment; predictable long-term prognosis (steady worsening of cognitive and functional abilities over years from diagnosis) until end-stage dementia when short-term prognosis is difficult to predict (months to years)</td>
<td>Alzheimer disease and other types of dementia, persistent vegetative state</td>
<td>Cognitive status</td>
<td>No</td>
<td>Annual medical evaluation or following acute event (e.g., stroke, hospitalization for pneumonia)</td>
<td>Physician/health care provider, advocate*</td>
<td>Nursing home, family caregiver</td>
<td>Prison dementia unit or long-term care unit</td>
</tr>
<tr>
<td>Serious, irreversible, progressive disease with profound cognitive and/or functional impairment†</td>
<td>Steady progression of symptoms and functional impairment, unpredictable prognosis (months to years)</td>
<td>Oxygen-dependent COPD, NYHA class IV heart failure, advanced liver disease with cirrhosis</td>
<td>Cognitive and functional status</td>
<td>No</td>
<td>Annual medical evaluation or following seminal events (3 or more hospitalizations in a year, ICU admission, new inability to complete self-care activities)</td>
<td>Physician/health care provider, patient, advocate*</td>
<td>Nursing home, family caregiver</td>
<td>Prison assisted-living facility until end stage, then prison hospice</td>
</tr>
</tbody>
</table>

ALS = amyotrophic lateral sclerosis; COPD = chronic obstructive pulmonary disease; ICU = intensive care unit; NYHA = New York Heart Association.

* The Society of Correctional Physicians Position Statement on Compassionate Release “encourages responsible prison and jail physicians to take a leading role in initiating and shepherding the medical release process for possible candidates” (59). Given that a prisoner with newly diagnosed profound dementia may be too cognitively impaired to initiate a request for release, the physician or a patient advocate would be the most appropriate person to initiate a request.

† “Functional impairment” refers to criteria for nursing home eligibility, specifically impairment in 2 or more activities of daily living.

Procedural barriers may also prevent medically eligible persons from obtaining compassionate release and invite potential inequity. For example, persons with profound cognitive impairment (which includes most patients with advanced illness [26, 33]) could be incapable of completing a written petition. Prisoners also have the nation’s lowest literacy rates (34); are frequently distanced from family or friends, impeding access to social support to navigate the process (35); and are often not aware that early-release programs exist (3). However, formal mechanisms to assign and guide a prisoner advocate have been neither 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 (10); however, once an advocate is appointed, there are no formal guidelines to help him or her navigate the system. In states without formal advocates (such as 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 (11). Another procedural barrier is time. Although a few states, such as Vermont, have a “fast-track” option, for imminently dying prisoners (11), 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.
ADRESSING 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 health care 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 (36). At a minimum, the new guidelines should embrace evidence-based principles and a transparent process that includes assignment of an advocate to help navigate the process and represent incapacitated prisoners, a fast-track option for evaluation of rapidly dying prisoners, and a well-described and well-disseminated application procedure. The guidelines also must delineate distinct roles for physicians regarding assessment of medical eligibility and parole boards and correctional administrators to help balance medical evaluation, public safety, and retribution in the approval process (37). Other areas that should be reviewed include mechanisms for identifying potential candidates and avenues for addressing request denials (3, 11, 36). As with other guidelines (38), standardization of compassionate-release guidelines in conjunction with a patient advocate should help avoid inequities in access, particularly for persons 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 on prognostication but also disease trajectory and functional and cognitive status. These groups consist of prisoners who have a terminal illness with a predictably poor prognosis; prisoners with Alzheimer disease or related dementia; and prisoners with serious, progressive, irreversible illness with profound functional or cognitive impairment. Use of such evidence-based categorization could provide a framework within which the roles of medical professionals 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 (15) 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. Prisoners being considered for compassionate release have an illness or a debilitating condition that is serious enough for them to benefit from a palliative medicine evaluation to decrease the symptom burden while they await a decision.

In addition, while incarceration may no longer be justified for prisoners who are both medically eligible and meet legal and correctional approval, palliative care should be provided to the many prisoners with serious illnesses who will not be eligible for early release. At present, access to palliative care in prison is limited. For example, only 75 of 1719 state correctional facilities and 6 of 102 federal facilities have hospices (39, 40). As with those in the community (40, 41), prison-based palliative care programs are likely to improve health care while lowering costs (2, 35).

CONCLUSION

Although compassionate release could address fiscal pressures created 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 a physician’s scope of practice. Moreover, many states are considering expanding medical eligibility to include physical incapacity and elderly prisoners, in addition to terminal diagnoses. Physicians and other medical professionals 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 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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