Society of Correctional Physicians
Position Statement

Compassionate Medical Release

Introduction

As the burden of chronic illness increases in society, more people are entering custody with serious medical conditions or disabilities. Others may develop serious illness during the course of an often lengthy incarceration. Inmates have similar or higher prevalence rates of many chronic conditions such as HIV infection, cardiovascular disease, cancer, and diabetes, when compared with the general population[1].

Along with the trend towards longer terms of incarceration and mandatory minimum sentencing guidelines, American jails and prisons house an increasingly aged population with higher rates of morbidity and mortality, as well as those with terminal illness (individuals with a life expectancy of less than one year due to illness).

Many states have a process that provides for the possibility of shortening the term of incarceration, often referred to as a “Compassionate or Early Release due to Medical Conditions.” Rationales include a significant change in medical condition since sentencing, no purpose to be gained by further incarceration, a lowered risk to public safety due to the illness or disability, an acknowledgment of the difficulty or expense of providing extensive medical care in a correctional setting, and a respect for human and family dignity at the end of life.

Ultimately decisions on sentence, sentence reduction, parole, and public safety should come from those with legal responsibility and authority. The awareness of the medical/mental condition of the patient (and thus the process) is usually triggered by the correctional health care staff which determines and states when a patient is “seriously ill without possibility of recovery” and/or “severely disabled without possibility of recovery.” Usually this determination is based firmly on that medical provider’s knowledge of the patient’s medical condition and functional status regarding inability to carry out fundamental activities of daily living.

If the legal authority determines that “Compassionate Medical Release” is not an option, the health care staff needs to provide appropriate clinical interventions that respect the principles of beneficence and patient autonomy.

---

[1] Hornung CA, Greifinger RB, and Gadre S. A Projection Model of the Prevalence of Selected Chronic Diseases in the Inmate Population. National Commission on Correctional Health Care. The Health Status of Soon-to-be-Released Inmates, a Report to Congress. August 2002.

Position Statement

1. The Society of Correctional Physicians encourages responsible prison and jail physicians to take a leading role in initiating and shepherding the medical release process for possible candidates. All correctional physicians should be familiar with the medical release policy and process in effect in their jurisdictions. In jurisdictions where there is no defined medical release policy and/or process, correctional physicians should take a leading role in proposing and developing such policies and processes, in conjunction with criminal justice authorities.

2. Physicians requesting medical releases should limit their consideration to the diagnosis, prognosis, and functional status of the inmate in determining eligibility, leaving security/safety status and crime severity assessments to criminal justice authorities.

3. An integral part of the process should be consideration of the environment where the individual will be placed and for continuity of care (i.e., discharge planning and re-entry considerations).

4. Terminally ill patients who are not released may require special health services to provide comfort, relief from pain, and special counseling and support in optimizing function, and/or in anticipation of death. This should include:

   - Having medical providers who are knowledgeable in all aspects of end of life care, including expertise in the management of opioid pain medication. Pain management plans should adhere to community guidelines, with providers appropriately assessing individuals with complaints of pain and, when needed, writing dosing schedules that seek to avoid both under and over prescribing of analgesics.

   - Multidisciplinary care of the terminal patient, which may also include resources from outside the health unit, such as faith counselors and community based hospice workers.

   - Balancing the needs of the correctional system to house the patient in a medically appropriate setting with the desire to maximize visitation access for loved ones.

   - Having and documenting discussions with the patient about what levels of care and intervention the patient will want at the end of life. Policy and procedure for addressing care if the patient becomes unable to participate in health care decisions (e.g., advance directives and living wills) should also be developed.