Palliative Care for Prison Inmates

“Don’t Let Me Die in Prison”

John F. Linder, MSW, LCSW
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THE PATIENT’S STORY

Mr L is an inmate in his early 40s, incarcerated in a state correctional facility where he is serving a 10-year sentence for manslaughter. In June 2005, he was transferred to a prison treatment setting after he complained of back pain and bloody sputum. His hemoptysis was evaluated with a chest x-ray, which was abnormal. A subsequent computed tomography (CT) scan showed a right upper-lobe mass; a biopsy confirmed adenocarcinoma. A magnetic resonance imaging scan to evaluate his back pain revealed metastatic invasion of T12 and L1, confirming stage IV disease.

Dr V, the prison physician, referred Mr L to a cancer center at a university medical center, where he completed a course of radiation and received first-line chemotherapy. Unfortunately, a reassessment of his disease by repeat CT after several months of chemotherapy showed tumor progression. A second chemotherapy regimen was undertaken, but it also failed to stop disease progression. Mr L was then referred to hospice inside the correctional facility. He was simultaneously referred for medical parole.

A Perspectives editor interviewed Mr L; the prison’s internist, Dr V; and the prison’s hospice caregiver coordinator, Dr S, in April and May 2006. Dr S suggested Mr L as a hospice patient who would be willing to talk about his own disease, and Mr L, Dr V, and Dr S all provided signed informed consent forms. Mr L’s interview was conducted by telephone in the office of his caseworker on the prison staff. A student intern was present when the interview took place; Dr V and Dr S were not present during Mr L’s interview.

PERSPECTIVES

Dr V (PRISON PHYSICIAN): My role is to admit inmates from any of the 4 correctional institutions in the area into a local community hospital for medical treatment . . . [and] to supervise treatment of inmates . . . on our medical wing. While [Mr L] is here, I am his primary care physician. I’m not an oncologist, so I have to defer to the experts on the treatment of his cancer, but I take care of his primary medical needs, like any other internist would.

Mr L (PATIENT/INMATE): I was supposed to have surgery done in September. It took the prison 21⁄2 months to get me out to the doctors. By that time, it had turned malignant and gone into all of my body. . . . The cancer started in my lung and spread through my chest and into my spine. The cancer broke my back.

Dr S (PSYCHOLOGIST AND HOSPICE CAREGIVER COORDINATOR): . . . The hospice caregivers are all inmate volunteers. . . . They visit [patients] as much as their schedules allow.

The number of older inmates in US correctional facilities is increasing and with it the need for quality palliative health care services. Morbidity and mortality are high in this population. Palliative care in the correctional setting includes most of the challenges faced in the free-living community and several unique barriers to inmate care. Successful models of hospice care in prisons have been established and should be disseminated and evaluated. This article highlights why the changing demographics of prison populations necessitates hospice in this setting and highlights many of the barriers that correctional and consulting physicians face while providing palliative care. Issues specific to palliative care and hospice in prison include palliative care standards, inmate-physician and inmate-family relationships, confidentiality, interdisciplinary care, do-not-resuscitate orders and advance medical directives, medical parole, and the use of inmate volunteers in prison hospice programs. We also include practical recommendations to community-based physicians working with incarcerated or recently released prisoners and describe solutions that can be implemented on an individual and systems basis.

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Perspectives on Care at the Close of Life is produced and edited at the University of California, San Francisco, by Stephen J. McPhee, MD, Michael W. Rabow, MD, and Steven Z. Pantilat, MD; Amy J. Markowitz, JD, is managing editor. Perspectives on Care at the Close of Life Section Editor: Margaret A. Winker, MD, Deputy Editor.

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PALLIATIVE CARE FOR PRISON INMATES

Dr V: There are an awful lot of 50-, 60-, 70-year-old inmates who come to prison with chronic illnesses. Even the younger inmates are not as healthy as typical Americans their age. We have a lot of inmates coming in with hepatitis C, untreated coronary disease, untreated or poorly treated diabetes, you name it.

Inmates are sicker than the general population. The need for good general medical assessment and care, and especially for hospice and palliative care, logically follows the demographic patterns. To Dr V’s list, we could add human immunodeficiency virus and AIDS, chronic obstructive pulmonary disease, end-stage renal and liver disease, hypertension, and numerous other conditions. Contributory factors include substance abuse and addiction, prior limited access to health care, low health literacy, poverty, homelessness, and undiagnosed or untreated mental illness. The cycle of recidivism accentuates the lack of continuity of care between prison-based and community-based health care.

In the period 2001-2004, the state prisoner death rate nationwide was 19%, lower than that of the general adult population of the same age, although the composition of the populations differ by age bracket. The black prisoner death rate was 57% lower than that of the same-age white adult population. Despite lower mortality rates, the absolute number of deaths among current inmates is climbing. However, release from prison can result in sharply increased mortality risks. Inmates and the free-living populations share 6 of the 10 leading causes of death: heart disease, cancer, cerebrovascular disease, respiratory diseases, influenza/pneumonia, and sepsis. Prisoners’ remaining 4 leading causes of death are chronic liver disease, AIDS, intentional self-harm, and digestive diseases.

The other key demographic factor is the sharp increase in the absolute number of inmates, placing even greater strains on the correctional health system. In 2005, an estimated 1 in 491 US residents was in prison. Health care costs in 2001, the most recent available, were approximately $7.41 per inmate per day, a total of $3.3 billion annually.

Women constitute a small but rapidly growing segment of prisoner demographics. Many enter the system with morbidity greater than age-matched peers. Women often serve shorter sentences, limiting their opportunities for screening and chronic disease management. A number of notorious inmate deaths have recently served to highlight deficiencies in end-of-life care for women in prison.

Deficits in Prior Access to Care, Family Support, and Information

Physicians should recognize that for many inmates, prison is the first time in their adult lives that they have consistent access to health care. Nevertheless, with security a paramount concern in prisons, timely access to treatment can sometimes be impeded, as Mr L perceived. Inmates do not enjoy the benefit of family support during medical visits and have only limited access to health ombudsmen or patient advocates.

Approximately 20% of adults in the United States have limited literacy skills, meaning that they find it difficult to read and therefore understand and act on health information. Although low health literacy affects persons of all age, race, educational achievement, and income groups, the prevalence is higher for adults in ethnic minorities and of lower socioeconomic status. Incarcerated individuals are more likely to have both low literacy and low health literacy, often resulting in misunderstandings, frustration, and poorer health outcomes. In this case, Mr L misunderstood essential elements of his cancer pathogenesis and the effects of treatment and treatment delays on his prognosis.

Most free-living patients and caregivers can search the Internet for information, but access to the Internet for inmates is severely restricted. They also have very little say in choosing their clinicians. These deficits accentuate the physician’s greater responsibility to communicate clearly, to provide information at an appropriate literacy level, and to allow time for questions when delivering an inmate’s diagnosis and discussing treatment and palliative options.

Financing and Resources

Dr V: From the standpoint of care of an individual patient, [prison physicians] don’t have the kind of financial concerns that a community-based physician might. We do have a prior-approval process, but there are never any insurance issues. . . . If an inmate has a need for care to maintain life or health, the inmate gets that care.

Correctional health services, including hospice, operate independently of Medicare, Medicaid, and all private insurers.
Often, 1 or 2 prisons are designated as the central health care facilities for an entire state system or federal region. Designated facilities also house most of the nation's prison hospices. Contrary to Dr V's assertion, some data suggest that curative and life-prolonging approaches are limited for inmates.31

Innovative approaches can improve inmate health including palliative care. Examples include chronic disease management clinics,32 use of telemedicine,33-35 partnerships between academic medical centers and penal institutions,32,36 and the outsourcing of inmate health care.37 These innovations and partnerships are increasingly implemented in correctional hospice programs, although only anecdotally reported.

PALLIATIVE CARE AND HOSPICE WITH INCARCERATED POPULATIONS
Ethics and Standards of Care
Although many in free-living society assign a low priority to providing prisoners with high-quality health care, medical ethicists, provider organizations, and the judiciary see it as an ethical imperative.38-40 This extends to palliative care as well.41 Courts have generally affirmed that incarceration itself, not substandard health care, is the intended punishment for criminal acts. The judiciary does so by increasingly ruling against deliberate indifference,42-44 affirming an inmate's constitutional right to health care,45 and defining the community standard of care as the constitutionally protected minimum acceptable threshold for inmate health care,46-48 although the judicial record is not uniform.49 When the quality of care delivered falls below the acceptable threshold, the courts have not been timid about intervening.50 For example, California is currently undergoing a court-ordered revamping of its inmate health care system,51,52 estimated to cost hundreds of millions of dollars.

The National Commission on Correctional Health Care advocates for high-quality inmate health care, including palliative care, and has published clinical guidelines for health services in prisons.53,54 The Centers for Disease Control and Prevention also has issued clinical guidelines for use in correctional settings.55 Specific end-of-life care standards of practice for inmates in correctional settings56 are adapted directly from the National Hospice and Palliative Care Organization standards of practice.57 Evaluation of the standards would be a valuable contribution to the research and quality improvement in prison hospice.

Providing hospice services in prison dates back to the early 1980s. In 2001, the most recent US-Canadian survey data available, hospice programs existed in 25 of the 49 jurisdictions reported on (including US territories and states and Canada). Twenty-two operate hospice as part of their infirmaries; 5 are free-standing hospice units.50

Descriptions of a number of these programs20,54-56 reveal both the strengths and vulnerabilities of prison hospice. Elements of best practice include staff and security personnel training in hospice philosophy; comprehensive symptom management training for medical personnel; dedicated staffing; inmate volunteers; bereavement services for inmates, volunteers, and staff; increased family contact and visitation; interdisciplinary care including psychosocial and spiritual services; community volunteers and community hospice involvement; and comprehensive care planning and advance medical planning.

A comparison of prison and community hospices is shown in the Table. Prison physicians have greater flexibility in some respects, for instance, in being able to overlap dialysis with hospice care when patients or families are just learning of a terminal prognosis, or in offering hospice to patients with a prognosis of more than 6 months. Prisons are left to define which palliative services will be provided and how, as long as they abide by the judicial rubric of comparability with the community standard of care.

Despite these advantages, prison physicians confront challenges, including restrictions on inmate and staff movement; limited access to urgent care facilities; restricted pharmacy formularies; impediments to dispensing medications on an “as needed” basis; limited patient autonomy, as corrections department policies sometimes restrict the use of do-not-resuscitate (DNR) orders and advance medical directives; finding, training, and employing hospice volunteers; and defining patients’ “families” and determining when and how to work with them.

Some policies or statutes may simplify palliative care treatment decisions for inmates. For example, laws intended to protect inmates from unethical research practices prevent prisoners from participating in clinical trials. Although this limits treatment options, it simplifies the decision to transition from disease-directed therapy to palliative care. Simultaneous care, providing concurrent disease-directed therapy and palliative or hospice care,51,54 is more easily accomplished unencumbered by Medicare’s conditions of participation criteria.

Symptom Management
Dr V: All medicines are given at pill call: 3 or 4 times a day, inmates line up, and a nurse will pass them their medications, narcotics, or otherwise, with an officer sitting right there. The whole process is observed. The medication is given in a cup. The inmate does not put the pill in his hands. The pill goes directly to the mouth, drink the water, and swallow. Controlled substances, narcotics in particular, are crushed. The one exception to that are medicines that can’t be crushed, like MS Contin, long-acting narcotics that need to be swallowed intact.

Mr L: Get MS Contin, I believe 90 mg every 8 hours. He can have Vicodin at pill call for breakthrough pain. When I ask him about pain, he says it’s fine. I have no reason to doubt him.

Mr L: [The pain] gets pretty out of hand sometimes. If you can catch the right nurse or the right doctor, they can situate you where they can help you some. If you were to gauge my pain on a scale of 1 to 10 right now, it would be about 8.5. I’ve learned to deal with that kind of pain. I don’t want to be totally out of pain because then I won’t know what I’m really going through.

In prisons and jails, pain management can be particularly vexing. Many inmates have addiction histories. The risks
of drug diversion and abuse are real. As Mr L’s case illustrates, there can be a mismatch between physician assessment and patient report of pain. Adherence can be an issue as well. Inmates are not forced to come to pill call. Inmates retain the right to consent and participate in or refuse treatment. In the general prison population, few options for intervention or relief exist between pill calls. Though the challenges of inmate symptom management are well-described, very little has been written in the United States about strategies for managing inmates’ symptoms specifically and virtually no research has been conducted. The paucity of research literature reflects both the historical abuses of inmates in research and the resultant severe restrictions placed on inmate participation in research today.

Noncorrectional physicians providing prison patients with active treatment can independently assess a patient’s pain and make recommendations directly to the correctional physician. Inmates may be more willing to discuss inadequate pain control with an outside physician. The community physician can also work with the inmate and the corrections physician to identify the level of care best suited to the inmate’s symptom management needs; this in turn dictates which is the appropriate care unit.

The involvement of outside physicians with palliative care and hospice experience as trainers and consultants can aid in corrections institutions’ implementation and adherence to the published correctional hospice standards and helps ensure continuity of care between shifts and among clinicians inside the prison.

**Table. Comparison of Medicare-Certified and Correctional Hospices**

<table>
<thead>
<tr>
<th>Hospice Component</th>
<th>Medicare-Certified Hospice</th>
<th>Correctional Hospice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goals of care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forgo disease-directed therapy</td>
<td>Required</td>
<td>Not required</td>
</tr>
<tr>
<td>Patient-driven care</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Aggressive symptom control</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Do-not-resuscitate order</td>
<td>Not required for enrollment; patient driven</td>
<td>Not required for enrollment; often policy driven</td>
</tr>
<tr>
<td><strong>Prognosis ≤ 6 mo</strong></td>
<td>Required</td>
<td>Not required</td>
</tr>
<tr>
<td><strong>Services and personnel</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interdisciplinary team care model</td>
<td>Required</td>
<td>Not required</td>
</tr>
<tr>
<td>Patient and family as the unit of care</td>
<td>Required</td>
<td>Not required</td>
</tr>
<tr>
<td>Social work involvement</td>
<td>Required</td>
<td>Not required</td>
</tr>
<tr>
<td>Chaplaincy services</td>
<td>Required</td>
<td>Not required</td>
</tr>
<tr>
<td>Volunteers</td>
<td>Required</td>
<td>Not required</td>
</tr>
<tr>
<td>Family involvement</td>
<td>Highly desirable, encouraged, actively facilitated</td>
<td>Wide variability in level of family involvement</td>
</tr>
<tr>
<td>Volunteers or staff available for death vigil</td>
<td>Rarely</td>
<td>Frequently</td>
</tr>
<tr>
<td>Bereavement services</td>
<td>Mandatory to offer services for 13 mo following the death</td>
<td>Seldom provided to biological families beyond immediate death; availability to inmate “family” widely variable</td>
</tr>
<tr>
<td><strong>Level of patient psychosocial needs</strong></td>
<td>Variable</td>
<td>Uniformly high</td>
</tr>
<tr>
<td><strong>Regulations, practice standards, and finances</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governed by Medicare conditions of participation</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Practice standards and guidelines</td>
<td>Medicare, professional organizations (AAHPM, NHPCO, HPNA, NASW)</td>
<td>GRACE Project, professional organizations (AAHPM, NHPCO, HPNA, NASW, NCCHC, Academy of Correctional Health, SCP)</td>
</tr>
<tr>
<td>Insurance funded</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Abbreviations: AAHPM, American Academy of Hospice and Palliative Medicine; HPNA, Hospice and Palliative Nurses Association; NASW, National Association of Social Work; NHPCO, National Hospice and Palliative Care Organization; NCCHC, National Committee on Correctional Health Care; SCP, Society of Correctional Physicians.

The Guiding Responsive Action for Corrections in End-of-Life (GRACE) Project was funded by the Robert Wood Johnson Foundation “Promoting Excellence in End-of-Life Care” initiative and administered by the Volunteers of America.

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**Prognosis and Site of Care**

Dr V: If those of us that are treating an inmate agree that the inmate has a terminal condition, whether it’s 6 months or not, we provide hospice care, [and] we can provide nursing care at the nursing facility, if that’s appropriate.

Mr L: I’m locked up in a medical wing with a lot of sick people. There’s a lot of people in there that have cancer, too. They’re all benign. They can recover from theirs and I can’t.

Moving Mr L to a medical unit within the prison affects his daily life dramatically. In this case, the medical unit is physically separated from the general prison population. Potential advantages to the inmate include increased security and fewer physical demands; frequent symptom assessment, medication titration, as-needed dosing and enhanced modes of delivery of medications; and perquisites like access to books or television, special diets, and smok-
imbalance between physicians and inmates further impair raising personal safety considerations for physicians. Led and may be in jumpsuits. Hands-on care of felons may of inmates can be restricted because they are routinely shackled and may be in jumpsuits. Hands-on care of felons may raise personal safety considerations for physicians.

Patient-Physician Relationships

Mr L: [Doctors should] be honest with the people they’re talking to. . . . If a person has cancer, like me, I wanted to know exactly what was wrong with me. You can deal with the honest truth a lot better. If you go to a doctor who tells you it would be a cyst or something else when there’s a thought in his mind that it might be cancer, then he should tell the patient that it might be.

Mr L emphasizes the importance of a trusting patient-physician relationship to him. Noncorrectional physicians are likely to see an inmate patient in a clinic or hospital setting with 1 or more security officers present, raising concerns of patient confidentiality. Privacy is not possible with outside observers to the clinical encounter, potentially violating the Code of Medical Ethics. Physical examination of inmates can be restricted because they are routinely shackled and led and may be in jumpsuits. Hands-on care of felons may raise personal safety considerations for physicians.

The financing of inmate health care and the inherent power imbalance between physicians and inmates further impair a secure and trusting relationship. That mistrust is amplified during end-of-life care. Some recent mortality data comparing median survival with national cancer statistics for the same cancer diagnoses, adjusted for stage, support inmate skepticism about putting their faith in prison health care systems.

In this case, Mr L’s poor understanding of his disease led him to conclude that the time spent waiting for approval of his care outside the prison made the difference between a benign or malignant disease and between cure and terminal prognosis. Though inaccurate, he may share this perception with fellow inmates, deepening the atmosphere of mistrust.

Community physicians can build stronger relationships and overcome this mistrust by asking inmates about their health care access history; acknowledging (when applicable) the inmate’s lack of experience with consistent care and providers; explaining their relationship and committing to follow-up with the inmate for the duration of treatment; acknowledging the awkwardness, stigma, and lack of privacy of the current encounter; and listening attentively to questions and checking for understanding.

Family Relationships

MR L: The worst thing to me right now is that I have 4 children. I’d like to see them before I die in a place like here. . . . My oldest daughter is 17, my youngest son is 7. . . . They live so far away that I don’t get to see them. . . . That’s the hardest part of it all, being away from my family, being away from my children.

Many inmates are estranged from their families. Other inmates’ families have limited resources and thus transportation and accommodations for visits to the inmate are beyond their financial capabilities. Out-of-state placement of inmates can also exacerbate estrangement and impede visits from family members. In this case, Mr L does have family, including children; limited contact with them weighs heavily on him.

In prison, “family” may also mean other inmates. This adds a layer of complexity to an ill inmate’s decision to self-identify as having special health needs. Institutional policies may neither recognize nor support inclusion of other inmates as “family.” Noncorrectional physicians can emphasize the integral role that interpersonal support plays in quality end-of-life care in their plan of care.

Interdisciplinary Team Care

Dr V: We don’t have a specific hospice nurse. . . . Staff nurses will take care of the hospice patients. Dr S, a psychologist who is deeply involved with the hospice program, would be the person who would deal with the psychosocial issues. We have chaplains from all the major religions. . . . Inmate hospice volunteers are available to provide whatever assistance they can. It’s not that much different from the outside. It really isn’t.

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Resuscitation Status and DNR Orders in Prison

Dr V: [T]he Department of Corrections rules say that there is no such thing as a “do not resuscitate” for inmates in the general population. . . . [A] lot of our wardens are of the opinion that it gives comfort to other inmates to see that somebody who is seriously ill is getting maximal treatment. They feel that it is important to get this message out to prevent unrest within the prison population. . . .

Most of our guys are not real sophisticated folks, and I’d say the majority of them have the feeling that when they get sick, we ought to do something to cure them. . . . A better educated, middle-class American might realize sooner that this is a case where cure is not possible. These guys tend to come to that conclusion a little bit slowly. They tend also to be a little bit distrustful of you when you do say that. Their first thought is that the department just doesn’t want to spend the money.

Mr L: If I die, I want them to leave me alone. . . . Dying doesn’t scare me, which really puzzles most people. Most people are scared to death [of] the unknown. The loss. It would probably be different [if I were living outside] because I would be with my family. I’d be with my children.

Advance care directives and DNR orders can carry added meaning in the criminal justice setting,20 fueled by inmate distrust that the correctional system acts with their best interests in mind, administrative concerns that resuscitative efforts be highly visible and ubiquitous to avoid accusations of neglect or indifference, and clinicians’ doubts that inmates who will not agree to a DNR do not fully understand the hospice philosophy.20 In 2001, 35 of 49 jurisdictions reporting (71%) allowed DNR orders,20 though research on inmate selections indicated that inmate volunteers are used to assist terminally ill inmates; 3 of these indicated that volunteers are only used in their hospice programs.20 No question specific to hospice inmate volunteers was included.

Mr L’s prison does use inmates as hospice volunteers. Programs that involve inmate volunteers must deal with issues of selection, training, defining volunteers’ scope of practice, ensuring security and patient confidentiality, and attending to volunteers’ emotional and spiritual support needs. Inmate volunteers must be able to overcome differences of race, religion, and committal offense in order to be successful. Training is essential. Debriefing with the volunteers is often one of the duties of the inmate volunteer coordinator, who sometimes can then advocate more effectively on an inmate-patient’s behalf. Little research has been conducted on the effects of participation on hospice inmate volunteers, but anecdotally, for many volunteers this work can be redemptive,80,81 providing an opportunity to make reparations. One Angola (Louisiana) hospice volunteer said, “I did a lot of wrong and hurt a lot of people out there. When I heard about hospice, it was in my heart to join because this would be my way of giving back to society.”82 Research in this area would be quite valuable.

Volunteers

Mrs T: One of the things that I hear in the general population a lot is, “Of all the things that could happen, please don’t let me die in prison.”
Dr V: If we are successful in obtaining his medical parole, [until release] we will try to control his pain. On 10 B (a medical housing unit), he is fairly functional and independent. If he gets to the point where he can’t do that, we will move him to our nursing care facility. They will care for [him] there and give him whatever assistance he needs with activities of daily living, and so on. If he doesn’t get parole and he doesn’t serve out the time, he will die in prison.

Mr L: I’m hoping my doctor will put me in front of the medical parole board. The last time I spoke with the oncologist, he said I didn’t have more than about 3 months left to live.

Medical parole, or compassionate release, is the procedure for securing a terminally ill inmate’s release from prison; the process varies by jurisdiction. Of the 49 agencies surveyed in 2001, 43 offered some form of compassionate release. The average number of annual requests was 18, and the average granted was 8.20 A final decision is reached only after a long and cumbersome process, usually involving the warden or parole or review board, and even the state’s governor.20,83 Given that the safety of society is the primary mandate of the corrections system, prison systems consistently err on the side of continued confinement of the inmate, even if this means death behind bars.84 Inmates granted compassionate release are almost always in the final days of life.

Ideally, prisons have developed relationships with hospices in their area for the care of prisoners freed on compassionate release. Prisons and community hospices should work together to achieve a seamless transfer of care, facilitating placement if necessary, arranging insurance coverage, which often entails applying for Medicaid coverage, and if possible facilitating a successful return to family for home hospice care. Family and community reluctance to accept patients eligible for compassionate release heightens the importance of prerelease care coordination.20 Occasionally, inmates are released to a residential hospice or skilled nursing facility with ties to a hospice program. Because such patients are usually bed bound or obtunded, such medically paroled prisoners pose almost no threat to society. Yet even in an advanced state of illness, the inmate’s greatest fear, dying “inside,” is relieved by compassionate release.

CONCLUSION

Correctional hospice challenges physicians to use all of their communications and palliative care skills. Collaboration between local correctional and community-based palliative care service providers through joint trainings, site visit exchanges, and funding initiatives that support continuity of care for released inmates who are terminally ill will transform prison end-of-life care and perhaps serve as a model for inmate health care overall. Evaluation studies of current correctional hospice programs and of the Standards of Practice for Inmates in Correctional Settings will move the cause of inmate palliative care forward. More rigorous research into the efficacy of specific palliative interventions would further refine the care standards.

Noncorrectional and correctional physicians are increasingly aware of systemic and demographic strains threatening the treatment of prisoners with advanced chronic illness and terminal conditions. The aging inmate population, their overall morbidity, and the mandate that they be provided the community standard of care means that community physicians will increasingly care for people like Mr L. Correctional and community physicians can do a great deal in partnership to relieve the pain and anguish of those inmates dying in prison who have paid for their crimes with loss of freedom and who should not have a painful or poorly managed death as part of their sentence.

Financial Disclosures: Mr Linder and Dr Meyers provide training to inmate volunteers and staff under a contract between the California Department of Corrections and the Regents of the University of California. This work is performed at the California Medical Facility, Vacaville, California.

References

PALLIATIVE CARE FOR PRISON INMATES


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Resources for Correctional Hospice

**National Committee on Correctional Health Care**
http://www.ncchc.org
The mission of the National Commission on Correctional Health Care is to improve the quality of health care in jails, prisons, and juvenile confinement facilities.

**Society of Correctional Physicians**
http://www.corrdocs.org
The Society of Correctional Physicians was formed in 1993 to provide a forum for the support, education, and professional development of physicians delivering health care in a correctional setting. It aims to promote, improve, and if necessary, defend the standards of care extended by its members.

**Academy of Correctional Health Professionals**
http://www.correctionalhealth.org/index.asp
The Academy of Correctional Health Professionals is the nation’s community for correctional health care. Through publications, educational activities, and special events, the academy works to connect clinicians with peers from across the country.

**The GRACE (Guiding Responsive Action For Corrections in the End-of-Life) Project**
This is the forward for *A Handbook for End-of-Life Care in Corrections Facilities*. It summarizes the issues challenging health care and hospice in the corrections system and includes valuable links related to prison hospice.

**End-of-Life Care Standards of Practice for Inmates in Correctional Settings**
http://www2.edc.org/lastacts/archives/archivesMay00/standards.asp
Standards of Practice were developed by the GRACE (Guiding Responsive Action for Corrections in End-of-life) Project, a Robert Wood Johnson Foundation Promoting Excellence in End-of-Life Care initiative, administered by Volunteers of America. Included is Innovations in End-of-Life Care, an international journal of leaders in end-of-life care.

**American Correctional Health Services Association**
http://www.achsa.org
The American Correctional Health Services Association’s mission is to be the voice of the correctional health care profession and to serve as an effective forum for communication addressing current issues and needs confronting correctional health care. The association holds annual multidisciplinary conferences designed to provide education on the latest developments in correctional health care, including continuing educational credits.

**American Correctional Association**
http://www.aca.org
The American Correctional Association is the oldest and largest international correctional association in the world. It serves all disciplines within the corrections profession and is dedicated to excellence in every aspect of the field: from professional development and certification to standards and accreditation, from networking and consulting to research and publications, and from conferences and exhibits to technology and testing.

**American Board of Hospice and Palliative Medicine**
http://www.abhpm.org
The American Board of Hospice and Palliative Medicine was formed in 1995 to establish and implement standards for the certification of physicians practicing hospice and palliative medicine. It creates and administers the certifying examination, works to implement high standards for training, and contributes to setting the standards for excellence in palliative medicine.

**American Academy of Hospice and Palliative Medicine**
http://www.aahpm.org
The American Academy of Hospice and Palliative Medicine is an organization of physicians and other medical professionals dedicated to excellence in and advancement of palliative medicine.

**National Institute of Corrections**
http://www.nicic.org
The National Institute of Corrections is an agency within the US Department of Justice, Federal Bureau of Prisons. The agency provides training, technical assistance, information services, and policy and program development assistance to federal, state, and local corrections agencies.

**National Prison Hospice Association**
http://www.npha.org
The National Prison Hospice Association promotes hospice care for terminally ill prisoners. Its purpose is to
assist corrections and hospice professionals in their continuing efforts to develop high-quality patient care procedures and management programs. It also provides a network for the exchange of information between corrections facilities, community hospices, and other concerned agencies about existing programs, best practices, and new developments in the prison hospice field.

**Palliative Care Leadership Centers**
http://www.capc.org

Palliative Care Leadership Centers is a national training and mentoring initiative supported by a consortium of funders, with direction and technical assistance provided by the Center to Advance Palliative Care. Exemplary palliative care programs located at 6 different institutions, the center offers training and mentoring to help start and expand hospital palliative care programs in the United States.