MY patient, a man in his 60s, whispered “Gracias, God bless” over and over as I moved his legs during an exam. Our palliative care team had been called in to help manage his pain after his liver cancer recurred. The cancer had already metastasized to his spine, creating pressure on his spinal cord that left him nearly paralyzed from the waist down. He seemed like a felled tree. We found him tearful and scared. But he wasn’t alone.

At his side were the corrections officers who had accompanied him from the prison where he was incarcerated on a conspiracy charge related to a drug arrest. They guarded his door day and night and screened all his visitors. As the doctors told him that his life would soon be over, his officers watched television, ate snacks, and read the newspaper. One day on my way out of his room, I asked an officer whether the patient would be told that he was being moved to a different prison once he left the hospital. He wasn’t entitled to know, said the officer flatly, because he was “property of the state.”

In our prison system, there are various programs called “compassionate release” or sometimes “medical parole,” whereby elderly or seriously ill prisoners may be released to the community before the end of their sentence. Since 1992, 371 people have been released through the medical parole program in New York State. (For the sake of comparison, about 100 inmates die from natural causes every year in the New York prison system.) Only 30 inmates filed applications for medical release in
2014, of whom 17 were released and six died before their review. In the federal prison system, the numbers are even more dismal; 101 federal inmates were approved for compassionate release in 2014 out of a total federal prison population of 214,000 people.

My patient’s sentence was short and he would have been eligible for parole within a year. He had a loving family desperate to have him home, where they could care for him. I called the prison to follow up and asked the doctor there if he intended to file a petition for medical parole. He told me he had, but warned that the process was cumbersome. Still, he was hopeful.

There are medical reasons, not just compassionate ones, for early release. Providing care to a patient with an illness this serious is complex and prone to error in the best of circumstances. He needed palliative care teams to do what they do well: develop advanced care plans, identify the patient’s goals of care, aggressively manage pain and other symptoms, and facilitate communication among different specialists.

While my patient was in the hospital, we could not provide him with any information about when he was leaving or when he would follow up with his doctors. After being discharged, he was sent to a different prison and was housed in its medical facility. Scared and alone, he began to decline quickly. Initially, his wife wasn’t allowed to visit. When she finally got permission, she was alarmed to find him so ill and she struggled with being apart from him.

Within a few weeks, he became acutely sick with an infection, and was admitted to a hospital near the prison. His wife traveled two hours each way to see him. His children had to get special permission to visit, and his daughters initially had trouble getting approved because they did not share his last name. His wife told me she sat at his bedside and sang him their private love song, over and over.

When his time came, she was in a car making the long drive home for the night, and a corrections officer was at his side. A date to review his application for release had been set for four weeks after the night that he died. His wife later lost her job for having spent so much time with him.
Our aging, ill prisoner population is both a humanitarian crisis and an economic challenge that demands the collaborative attention of physicians, corrections officials, legislators and advocates who can devise national guidelines for medical parole. Dr. Brie Williams, a palliative care physician at the University of California, San Francisco, who is an expert in correctional health, has called for a national commission to develop an evidence-based approach to address the compassionate release process, with an eye toward reducing the red tape that can tie up critical cases when every day matters.

It shouldn’t be acceptable that my patient, who posed no danger to the community and who had a family who loved him, should have died incarcerated. He deserved the chance to make peace at the end of his life, to be with family. If we value sparing other people this kind of death, we need a fairer, more functional and quicker system that makes compassionate release a real possibility.

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