Testimony of Raya Elfadel Kheirbek, MD, MPH, FGSA
Maryland Senate Judicial Proceedings – February 8th at 1:00pm
HB 157/SB 98- Correctional Services – Geriatric and Medical Parole

I recommend a favorable report for **HB 157/SB 98** on behalf of the incarcerated patients I have cared for. My name is Raya Elfadel Kheirbek, and I am both a Professor of Medicine and Chief of Geriatrics and Palliative Medicine at the University of Maryland School of Medicine in Baltimore. *Geriatrics* is the medical discipline focused on delivering cost-effective, quality medical care to older adults. *Palliative Medicine, including Hospice,* is specialized, patient-centered medical care for patients with serious illness, or at the end of life, that has been shown to result in better health outcomes and lower costs. My experience in the last two decades caring for my patients leads me to write this testimony today.

Older prisoners pose a low public safety risk due to their accelerated biological age, general physical deterioration, and low propensity for recidivism. "Compassionate Release," adopted by Congress as part of the Sentencing Reform Act of 1984, was enacted in part to lower the cost of incarcerating the seriously ill by allowing those who pose no safety risk to die outside of prison. Across the nation, nearly all jurisdictions have adopted some form of health-related early release policy, but relatively few dying, or aged and seriously ill prisoners are released under such mechanisms.

Providing access to health care services is both a moral duty and a legal requirement for all people, incarcerated or not. In 1976, the U.S. Supreme Court ruling Estelle vs Gamble found that deliberate indifference to healthcare for the incarcerated population constituted cruel and unusual punishment and was thus prohibited by the U.S. Constitution. In the state of Maryland Correctional Facilities, access to geriatrics remains limited and access to palliative and hospice services simply does not exist.

While Maryland has both medical and geriatric parole options, approval rate is low. Between 2015 and 2020, the Maryland Parole Commission denied 253 medical parole applications and approved only 86—a 75 percent denial rate. Currently, there are about 630 individuals over the age of 60 in Maryland's prison system who have served at least 15 years. In the state of Maryland, 6.4 percent of the prison population, or 3,324 individuals, are over 50 years old which in several states are considered geriatric due to accelerated biological aging while incaracerated. Moreover, 2,341 individuals, or about eleven percent of the prison population, are serving life sentences. They are overwhelmingly Black. A 2019 Justice Policy Institute report found that nearly eight in ten people who are serving the longest prison terms in Maryland are Black. Of the population serving those terms, 41 percent are Black men who were sentenced to prison as emerging adults (under the age of 25). It's important to recognize the racial inequities being perpetuated by the current system.

Cost should also be considered. Incarcerated inmates are not eligible for public health benefit programs (Medicare, Medicaid, Social Security Insurance, Veterans Health Administration) upon entering the prison. The cost of care falls upon the state to cover. Nationally, the annual cost to incarcerate an individual is $34,000. Older prisoners have a disproportionately high burden of chronic medical conditions, cognitive impairment and disability compared to younger prisoners and compared to their age-matched counterparts outside of prison. On average, older prisoners generate between 4 and 9-fold higher annual costs than younger prisoners with an estimated cost of $35.5 million a year in the state of Maryland for incarcerated individuals over 60 years. The underutilization of compassionate release suggests an opportunity to achieve a more cost-effective system by incarcerating fewer older and seriously ill prisoners.

The Geriatric and Medical Parole bill is a good step in the right direction because historically, the misalignment of compassionate release eligibility with medical realities results in a very few compassionate releases—despite a quickly rising number of deaths in inmates. Studies have demonstrated that even when physicians are relatively certain of a prognosis, they are frequently uncomfortable to prognosticate and— when they do— they are apt to significantly overestimate prognosis. For example, they assess their patient has twelve months to live when in fact they have only two. This amount of time is obviously way too little to get through an entire burdensome compassionate release evaluation process. Therefore, it would be appropriate to include the provision of a fast-track option for prisoners deemed to face "imminent death" who are either actively pursuing or wish to pursue compassionate release. The 6-month prognosis approach is best for a medical illness that has a predictable course, such as many metastatic cancers. However, many conditions that are ultimately terminal are not predictably so. These include conditions such as advanced heart failure, liver cirrhosis, lung disease and dementia. All these maladies are increasingly common causes of complication and death among inmates yet prognosticating the exact date or month of death for these conditions is likely to be very difficult. These terminal illnesses tend to result in sudden death or a sudden, less predictable, precipitous decline in health. In both of these instances, the scientific reality of prognostication and the dying process do not match the intent of the bill, and as a result, many patients will be dying in prison instead of more humanely in the community. The fields of geriatrics, palliative and hospice medicine have adopted the end-of-life trajectory framework. It has been incorporated into the Federal First Step Act with success

It's important to clarify that compassionate release in no way means the patient automatically gets out of prison; it simply allows for doctors to use their expert clinical judgment

based on scientific evidence to conclude that their patient has entered an “end of life trajectory” of a serious, life-limiting disease, where death in the next several months would not be a surprise. The treating physician could initiate the corrections and court-based assessment process for their patient to be assessed for their suitability for compassionate release. This would require each prison facility housing older prisoners to receive comprehensive education in geriatrics principles and training in how to identify and care for inmates of older age (geriatrics training) and to those with serious and terminal illnesses (palliative care and hospice training).

The state of Maryland remains behind the rest of the country with compassionate release , which makes the passing of this bill imperative. We cannot wait any longer, it’s the right thing to do.

Resources:

- National Institute of Justice, "Compassionate Release of Terminal Inmates," 2019.
- American Medical Association, "Hospice and Palliative Medicine Principles," 2017.
- National Hospice and Palliative Care Organization, "Improving Prognostication in Terminal Illness," 2020
- Justice Policy Institute,
- “Compassionate Release in Maryland: Recommendations for Improving Medical and Geriatric Parole.”
- Families Against Mandatory Minimums (FAMM): States Compassionate Release: The National Picture, October 2022