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Hospitalized While Incarcerated: Incarceration-Specific Care Practices

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More than 2 million people in the United States are incarcerated; Black, Latinx, and Native American persons are overrepresented in this population (1). Incarcerated persons have lower levels of education and income, higher rates of preincarceration homelessness and chronic medical conditions, and shorter life expectancies than those who are nonincarcerated (2, 3). Although most medical care for these persons is provided in carceral facilities, transfers to community hospitals occur when medical needs outweigh what can be provided on-site. As of 2011, hospitalization in the community accounted for approximately 20% of state carceral health care budgets (4). Here, we define "community hospital" as any hospital outside of carceral control.

When incarcerated persons are hospitalized, elements of their care frequently differ from the care provided to nonincarcerated patients for various reasons, such as standard operating procedures of the hospital or carceral facility and/or security concerns of health care staff. In this article, we draw on available literature and professional experience to describe 7 types of health care delivery differences experienced by incarcerated patients in community hospitals, which we term "incarceration-specific care practices." We argue that these deviations from standard practice may exacerbate existing disparities in the health of this medically vulnerable population.

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Incarceration-Specific Care Practices

Decreased Provider Engagement

Whether admitted to dedicated correctional units or standard rooms, incarcerated patients may experience reduced time with health care professionals. Emerging data suggest that physical barriers such as locked doors may decrease both the quantity and quality of time spent with providers (5). Even for patients who are not incarcerated, barriers such as contact isolation precautions are associated with reduced provider engagement and increased patient depression and anxiety (6). Moreover, incarcerated patients in community hospitals are under the continual presence of correctional officers (COs); even in the absence of physical barriers, the presence of COs has been shown to interrupt care through intimidation of both providers and patients (7).

Privacy Violations

Incarcerated patients are entitled to the same level of medical privacy as nonincarcerated patients, with exceptions allowed only when necessary for the health and safety of the patient, supervising COs, and/or carceral institution. Federal privacy laws mandate that disclosures should be the minimum necessary for care and should be made only after a provider has completed a clinical assessment of the patient in the absence of COs. Yet, in the only available study from the United States, 65% of physicians and 21% of nurses acknowledged they do not ask officers to leave the room before examining incarcerated patients (5).

Impaired Patient Autonomy

Incarcerated patients with decision-making capacity retain the same right to medical decision-making autonomy as nonincarcerated persons. Only in rare cases have the courts compelled treatment of capacitated incarcerated patients. Qualitative data, though, highlight the confusion and lack of knowledge common among health care professionals regarding decision-making rights and surrogacy hierarchies for these patients (5). In addition, hospital or carceral system policies that prohibit communication with family or friends may further limit shared decision making, even though incarcerated patients have the right to include such people in their care (8).

Fewer Medical Interventions

Limited available data suggest that incarcerated patients receive fewer medical interventions while hospitalized, including fewer subspecialty consultations, physical therapy and nutrition evaluations, and social work assessments (5). On discharge, clinicians who are unaware of carceral facility pharmaceutical limitations or are wary of drug diversion may not initiate necessary medications, including controlled substances, biological agents, or medication-assisted treatment for opioid use disorder. Underprescribing of medication-assisted treatment may have particularly severe consequences, as opioid-related overdose is the leading cause of death in the period after release from carceral facilities (9).

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Continuous Shackled Restraint

When medically indicated, health care professionals may use soft restraints in the least restrictive manner and for the shortest duration of time needed to ensure patient and staff safety. In contrast, case reports describe incarcerated patients who are shackled with metal cuffs indefinitely, even while intubated, paralyzed, or in labor. Most health care professionals are well aware of the negative consequences of restricting patient movement during hospitalization, including delirium and venous thromboembolism, and although most hospital policies allow health professionals to request removal of shackles for medical necessity, such requests are rarely made (5). Incarcerated patients often remain shackled for the duration of their hospitalization, independent of any individual risk assessment.

Limited Environmental Control

The ability to control one's environment can reduce the risk for inpatient delirium and hasten recovery. The restrictions on environmental control present in carceral facilities often extend into the hospital where patients or clinicians may be prohibited from turning off lights, closing curtains, or providing access to outdoor space. The amount of control afforded to incarcerated patients differs across hospitals and states, with variability based on the availability of forensic units and supervising COs.

Impaired Transitions of Care

Transitions of care are high risk for all patients. Incarcerated patients may arrive with limited (or no) medical records, and—in part due to substantial budgetary constraints—many carceral systems do not have electronic medical records. Discharge planning for incarcerated patients is compromised by carceral policy that may limit shared decision making between patient and family, and inadequate knowledge of the carceral health care system often makes it challenging for inpatient clinicians to contact carceral medical providers (10). The unpredictable release time of patients in jails can also make it difficult to create firm follow-up plans.

Future Steps

When incarcerated persons are hospitalized, they encounter incarceration-specific care practices that may exacerbate their existing risk for poor health outcomes. Incarcerated patients are entitled to the same standards of medical care as the overall population, yet we are far from achieving this health equity goal in community hospitals. An understanding of how incarceration affects inpatient care, as delineated herein, can serve as a framework for essential future studies.

Research into justice-involved populations has focused primarily on longitudinal outpatient care provided within carceral facilities, rather than on community hospitalizations. As the incarcerated population ages and health care becomes increasingly expensive, research is needed to improve quality of care, reduce cost, and mitigate existing disparities. Such work could inform the development of incarceration-specific standards of hospital care, analogous to the National Commission on Correctional Health Care's Standards for Health Services in Prisons. Such standards, along with nationally accepted hospital accreditation

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practices, would support clinical practices that improve, rather than worsen, the health of this vulnerable population.

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