

Delivering Hospital-based Medical Care to Incarcerated Patients in North Carolina State Prisons: A Call for Communication and Collaboration

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Many incarcerated patients will require in-hospital care outside prison facilities. Often, this care is provided by clinicians unfamiliar with the correctional context. In this article, we reflect on our experiences caring for incarcerated inpatients in non-carceral settings in North Carolina and highlight sources of misunderstanding and potential conflicts that arise in the care of these patients.

A 27-year-old incarcerated man is stabbed in the neck at a rural prison. He is seen by the surgeon on call in the local emergency room. Air is bubbling from the wound. The surgeon recommends an immediate operation and asks the patient for his consent. The patient's nurse tells the surgeon that the patient can't consent for himself because "prisoners are wards of the state." The surgeon, however, has obtained consent from prisoners in the past. She proceeds to obtain consent, but the nurse refuses to witness the required documentation. The surgeon asks the patient who he would like notified about his injury. He provides his mother's contact information. The anesthesiologist arrives and obtains the patient's consent for anesthesia. The correctional officers enter the operating room with the patient and shackle him to the OR table. After the surgery is completed (repair of a large tracheal injury with tracheostomy), the patient moves to the ICU and is shackled to the bed. The nurse expresses concern over his ability to turn the shackled patient from side to side in order to avoid pressure injury. The surgeon calls the patient's mother who asks if she can visit. The surgeon walks to the bedside and asks the corrections officers about visitation. The officers are angry that the surgeon has called the mother. They tell her she needs to get permission before communicating with families. The warden denies permission for visitation. On postoperative day three, the patient is transferred to an inpatient unit in the state prison hospital for tracheostomy care until the tube can be safely removed. The surgeon wishes he could stay under her care, but the care manager, who seems quite knowledgeable, tells her that transfer is "better for everyone." When the patient does not return for follow-up, the surgeon wishes she knew more about the resources in the prison hospital.

**This hypothetical case is based on multiple experiences in many North Carolina settings and does not reflect the care of a single individual.*

Introduction

The incarcerated population in the United States is rapidly aging [1]. As this occurs, the prevalence of chronic diseases in state prisons is increasing, with associated growth in the need for inpatient care [2]. This places a significant financial burden on the state prison system. The Pew Charitable Trusts reports that in 2015, \$8.1 billion was spent on state prison health care in the United States, consuming approximately 20% of state correctional budgets [2]. The cost of off-site care represented a significant portion of these health care expenditures, including hospitalization at non-prison hospitals, dialysis, and emergency room visits [2]. In commenting specifically on the expense of off-site hospital care, the Pew report cites data from Virginia and New York where 23% and 27% of the respective state prison health care costs were consumed by off-site hospitalization alone [2].

There are just over 36,000 incarcerated people in North Carolina state prisons as of August 2019 [3]. In 2011, in an attempt to decrease costs and increase coordination and continuity of care for this population, North Carolina opened an inpatient hospital at Raleigh's Central Prison with inpatient medical and mental health beds, subspecialty clinics, and operating and procedure rooms [4]. Care there is provided by employed and contracted staff. The facility serves incarcerated men only.

Even states with inpatient prison hospitals, like North Carolina, still send patients to off-site hospitals for many types of specialty inpatient care. Care in these off-site hos-

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pitals is complex. When patients are prisoners, both hospital and prison staff must balance the usual expectations of patient privacy, confidentiality, and autonomy against the need to ensure the safety and security of hospital staff, patients, corrections officers, and the prisoners themselves. This intrinsic tension can lead to conflict amongst caregivers and between caregivers and corrections officers as is illustrated in the hypothetical case previously described. When care occurs in off-site facilities, discharge planning and coordination with the prison health system are also complicated.

In this commentary, we reflect on our experiences caring for incarcerated inpatients at multiple off-site hospitals in North Carolina. Reflecting on our hypothetical case, we highlight sources of misunderstanding and potential conflicts that arise in the care of these patients. We will also propose ways to mitigate these conflicts and misunderstandings.

Incarceration and Autonomy

In the case described, there is discord related to the ability of the incarcerated patient to consent to surgery. The nurse believes that because he is incarcerated, the patient has lost his right to self-determination. In our experience, this belief is common, albeit incorrect. In fact, throughout the United States, incarcerated patients maintain the right to autonomy in medical decision-making [5].

Just as they can consent to treatment, incarcerated people are able to refuse treatments, including those that might be life-prolonging. Incarcerated people can also engage in advance care planning and designate preferences for end-of-life care. Nevertheless, we have encountered many clinicians who believe that the prison warden must be involved in decisions related to end-of-life care, or that incarcerated people cannot refuse life-sustaining treatments.

In North Carolina, incarcerated patients also maintain the right to choose their own surrogate decision-makers [6]. For unrepresented patients who cannot choose a surrogate, designation of a surrogate should proceed according to the state surrogacy ladder, a hierarchical list governing all North Carolina patients and designating who may serve as decision-makers. In North Carolina, family, then friends, and even a patient's physician are potential surrogates [5, 7]. North Carolina state statute does not incorporate correctional staff in this hierarchy [5]. However, in our experience, off-site caregivers sometimes believe that the warden acts as a surrogate.

Incarceration and Security in Off-site Hospitals

While incarceration has little impact on fundamental rights to autonomy in medical decision-making, it has significant impact on day-to-day patient care in off-site hospitals in which the security and the safety of correctional officers, caregivers, patients, and visitors is of critical importance. North Carolina statute gives the Department of Public Safety (DPS) the responsibility of creating standards for health services provided to prisoners [6, 7]. Neither statute nor the

DPS Health Care Policy Manual, however, contains specific rules and regulations related to the exact structure of off-site hospital care. Instead, the statute indicates simply that DPS "shall seek the cooperation of public and private agencies, institutions, officials and individuals in the development of adequate health services to prisoners" [7]. Thus, individual hospitals in North Carolina must work with DPS liaisons to create policies and resources that include safety and security measures appropriate for each unique hospital context. In the authors' experience in multiple North Carolina hospitals, room selection, diet, patient activity, patient education, communication with family, and conduct in the operating and delivery rooms are among many aspects of care that are addressed in these policies.

Not surprisingly, we have observed that patients from the state prison system are cared for in single rooms. They are typically shackled to the bed with two-point restraint (often one arm and one leg) and attended by two in-room armed corrections officers. Patients may be unshackled to use the bathroom and to walk or exercise, but this generally requires a specific physician order and must be approved by both hospital police and DPS officers. We have observed that diet for incarcerated patients is commonly limited, mirroring the diet available in the state prison system. Items that could be used as weapons, such as metal utensils, are prohibited.

As noted in the hypothetical case we described, communication with family and/or surrogate decision-makers is strictly limited for both patients and caregivers and must be approved by a designated authority at the prison. Visitation is treated similarly and is extremely limited even in end-of-life situations, presumably for security reasons. When discharge occurs, patients are not informed of the dates and locations for future appointments. DPS has its own patient education material, so standard hospital education materials are given to correctional officers, not patients [6]. Any patient discharge teaching is done verbally by the nurses who have cared for the incarcerated inpatient. However, those nurses cannot reinforce this teaching with written material.

Each of these security restrictions has the potential to negatively impact patient care and recovery. In the authors' specialty—general surgery—ambulation and movement are often an important part of recovery. Requirements for shackling and in-room confinement limit this. All patients require good nutrition to heal and those with gastrointestinal problems may have limited appetite and specific medically related diet restrictions. Dietary limitations may impede their nutritional rehabilitation. Limited communication may create difficulty for surrogate decision-makers whose ultimate responsibility is to make decisions based on patients' values and beliefs.

In the authors' experience, one of the most contentious restrictions involves shackling of laboring women and anesthetized patients during procedures. The former has been condemned by national professional organizations but dis-

putes still arise between correctional officers and hospital personnel about whether or not the patient is laboring [8]. In the authors' opinion, shackling the patient to the OR table provides little additional security over the sedating and paralytic medications that are provided for anesthesia and are always immediately available. Additionally, the presence of correctional officers in labor and delivery, the OR, and procedural suites decreases the patient's privacy unnecessarily and may actually violate the Prison Rape Elimination Act, which prohibits viewing of patients' breasts, buttocks, or genitals by correctional officers of a different sex [9].

Because concerns for safety and security are so significant in off-site hospitals, both hospital and correctional staff are attentive to the possibility for discharge that returns the patient to the prison system at the earliest possible time. Sometimes even patients are eager to return to prison where rules about visitation and communication are clearly articulated and contact with family may actually be easier than in off-site hospitals. Unfortunately, many providers have little familiarity with the specific services available at different prison sites. Providers at outside hospitals don't realize, for example, that they can restrict a patient who has returned to prison to the lower bunk of a bunk bed during their recovery from surgery. In our hypothetical case, the surgeon arranged a follow-up appointment for tracheostomy tube removal. However, a consulting surgeon in the prison hospital felt comfortable removing the tube and canceling the patient's appointment.

Conclusion

Caring for incarcerated patients in off-site hospitals is difficult. Most providers will do it infrequently. Despite the presence of armed correctional officers, providers may find themselves frightened of the patients and eager to see them discharged. Uniformed armed officers present an imposing authority in hospitals and their interpretation of policy and procedure may go unquestioned, limiting provider advocacy for patient care. In the absence of specific knowledge about the medical resources at different prison sites, providers may cede discharge planning to hospital staff who appear more knowledgeable about the prison system but are less able to negotiate about the specifics of resource availability.

Many hospital physicians, nurses, and ancillary personnel will care, at least occasionally, for incarcerated patients in off-site hospitals. We believe that regular discussion and collaboration between DPS and North Carolina hospitals and providers can improve and standardize the care of incarcerated patients and protect their autonomy as it relates to medical care. We recommend the following in order to minimize misunderstanding and conflict in the care of this patient population:

- 1) Clinicians caring for incarcerated persons should be familiar with hospital policies related to their care and with hospital-specific mechanisms for clarifying confusion about issues related to autonomy and restrictions

related to security and safety. Education on this topic could be incorporated into credentialing and regular hospital-based educational meetings.

- 2) Since careful discharge planning is critical to avoiding complication and readmission, the discharge planning system must ensure that discharging providers are aware of the circumstances to which patients will return. In addition to nurse-to-nurse handoff, provider-to-provider communication should be standard to facilitate consensus on resources available for care.
- 3) Hospitals should consider enlisting interested physicians, nurses, care managers, and others who can develop expertise in this area and provide assistance to their hospital when incarcerated persons are patients.
- 4) DPS should consider provision of monitored, "read-only" electronic medical record (EMR) access to off-site providers, so they can maximize their knowledge of the patients' premonitory medical condition and follow their post-hospital progress. An EMR that facilitates collection of data related to off-site hospitalizations could be used to identify problems and pitfalls with off-site care of incarcerated persons.
- 5) Health care professionals across the state should collaborate and communicate regarding individual institutional policies. Regular state-based conferences and educational materials regarding correctional health care should be available. The North Carolina Hospital Association, Area Health Education Centers (AHEC), and teaching hospitals could collaborate with DPS to provide these resources. NCMJ

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