

# Incarceration and Health Care in the United States

Aniketh Naidu, BS; Farzana Hoque, MD

## A Real Case Scenario

A 32-year-old incarcerated man presented with abdominal pain and diarrhea. Later that day, he expressed a desire to return to prison without treatment against medical advice. A resident physician was called to evaluate the patient, who was alert and oriented. The resident informed the patient that he could not leave against medical advice due to his incarcerated status. In response, the patient became visibly agitated, asserting his right to refuse treatment and using profane language toward the resident and nursing staff. The attending physician was notified and subsequently evaluated the patient. A thorough assessment confirmed that the patient had decision-making capacity. The attending clarified that, in the absence of legal or safety-related restrictions, the patient retained the right to refuse treatment against medical advice.

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The United States has the highest incarceration rate in the world, representing only 5% of the global population but 20% of the world's incarcerated population.<sup>1</sup> As a result

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**Author affiliations:** Saint Louis University School of Medicine, St. Louis, Missouri (Naidu); Department of Medicine, Saint Louis University School of Medicine, St. Louis, Missouri (Hoque).

**Corresponding author:** Farzana Hoque, MD, 1201 S Grand Blvd, St Louis, MO 63104; email farzahanahoquemd@gmail.com; ORCID ID 0000-0002-9281-8138

of widespread incarceration, nearly half of all American families have had a loved one incarcerated in jail or prison.<sup>2</sup> Incarceration is a major social determinant of health in the United States, exacerbating disparities by limiting access to care during and after imprisonment and affecting individuals, families, and communities.<sup>3</sup> It adversely affects health at

access.<sup>5</sup> Stigma and discrimination may discourage individuals after incarceration from seeking health care, leading to poorer health outcomes.

Given the prevalence of incarceration and the high health needs of incarcerated individuals, many hospitalists care for these patients—even without working in a jail or

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individual, institutional, and societal levels, contributing to entrenched health disparities.<sup>1,4</sup> Research suggests that each year spent in prison can reduce life expectancy by up to 2 years, due to poor health care access and harsh living conditions.<sup>4</sup> Mental health services in correctional facilities are often under-resourced, leading to untreated or misdiagnosed conditions such as depression, anxiety, posttraumatic stress disorder, and substance use disorders.<sup>5</sup> The opioid epidemic has disproportionately affected incarcerated populations; fewer than half of US jails offer medications for opioid use disorder (MOUD), and only 12.8% provide MOUD to all eligible individuals.<sup>5</sup> Racial and ethnic minorities—particularly Black individuals—face additional barriers to care, with studies linking social vulnerability and racial inequality to lower rates of MOUD

prison. While incarcerated patients remain under the custody of the correctional system, their right to make informed decisions about medical care—including the decision to refuse treatment against medical advice—is generally upheld, provided they have decision-making capacity.<sup>6</sup> Exceptions may include specific legal or medical restrictions, such as court orders or risks to public safety. In the case described above, the patient was determined to have capacity, meaning he understood the risks, benefits, and alternatives involved. Ethical dilemmas frequently arise when incarcerated patients refuse court-mandated treatments. In such situations, if capacity is confirmed, their autonomy should be respected, even if their choices conflict with medical or legal directives.<sup>6</sup> If a patient lacks decision-making capacity, clinicians must engage sur-

rogate decision-makers or act in the patient's best interest, as they would for nonincarcerated patients.<sup>6</sup>

US medical education has traditionally offered limited training on health care for incarcerated populations, leaving clinicians underprepared to navigate the ethical and clinical complexities of their care.<sup>7</sup> Although some medical schools have begun integrating correctional health curricula through electives, case-based discussions, or clinical experiences, these efforts remain rare, nonstandardized, and often student-driven. While national organizations recognize incarceration as a significant social determinant of health, there is currently no formal requirement for correctional health content within US medical education.

To effectively prepare future physicians, institutions must integrate structured, justice-informed training across multiple curricular levels. Educational strategies should include didactic sessions addressing incarceration as a social determinant of health. Interdisciplinary panels featuring clinicians, legal experts, and

individuals affected by incarceration can enrich learners' understanding through diverse, real-world perspectives. Clinical training should also expand to include rotations or shadowing experiences in jail-based clinics or hospital settings that frequently serve incarcerated patients. Objective Structured Clinical Examinations (OSCEs) and simulation scenarios focused on correctional health care dilemmas should be systematically incorporated to provide hands-on experience. Without formalized and widespread implementation of these educational measures, medical education will continue to fall short in preparing physicians to equitably care for this disproportionately ill and often stigmatized population. By proactively addressing the health care challenges associated with incarceration, we reaffirm our profession's commitment to justice, dignity, and equitable care for all patients.

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