AMA Journal of Ethics®
April 2025, Volume 27, Number 4: E277-282

AMA CODE SAYS: PEER-REVIEWED ARTICLE

Care of Patients Who Are Incarcerated

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Abstract
This article considers AMA *Code of Medical Ethics* opinions relevant to the care of patients who are incarcerated.

Treating Patients Who Are Incarcerated

Clinical expectations for treating patients who are incarcerated present many ethical questions that have potential to influence a physician's ability to provide care.[1] From the moment patients present, they face potential for bias due to the impossibility of concealing their incarceration or other factors.[2,3] For example, when a patient is incarcerated, a representative of the carceral system, such as a corrections officer, is present during patient-physician encounters or posted outside of the patient's door.[3] Such patients, when treated in community health centers, will also often be shackled for reasons beyond what is medically indicated.[4] Further contributing to potential for bias is, in some cases, inquiry about reasons a patient is incarcerated.

Beyond potential for bias, incarceration restricts one's physical autonomy, which can exacerbate confusion about who is legally and ethically able to make health decisions for a patient who is incarcerated, whether the patient can have visitors during an in-patient hospitalization, and whether it is appropriate to have a representative of the carceral system present during examinations or procedures. This article examines guidance from the American Medical Association (AMA) *Code of Medical Ethics* on how to ethically engage care of patients who are incarcerated during clinical practice.

The AMA *Code* on Treating Patients Who Are Incarcerated

When faced with treating a patient who is incarcerated, physicians—even if they are aware or assume that the reason for incarceration is for morally reprehensible offenses—are called on by the AMA *Code* to provide the same quality of care to all patients regardless of personal characteristics and other nonclinical or nonmedically relevant factors.[5] The *Code* also calls on physicians to foster an environment of trust, which includes cultivating self-awareness of implicit bias, so that their patients feel comfortable disclosing information exchanged during clinical encounters.[6,7] The AMA *Code* requires that all patients be treated equitably, regardless of their status, unless there is a specific law or policy that otherwise directs the process of treating incarcerated patients.[8] Additionally, the history of state abuse of prisoners, including torture and nonconsensual experimentation, coupled with the plausibility of coercion due to the physical loss of autonomy, warrants classifying this population as

vulnerable.[9,10,11] Considering their patients' vulnerable status, it is important for physicians to recognize that the AMA *Code* provides additional ethical recommendations for ensuring the protection of patients who are incarcerated, including the prohibition of physicians engaging in torture and a call for physicians to exercise caution when asked to perform court-ordered medical treatments.[12,13]

Applying the AMA *Code* to Clinical Practice

Who makes medical decisions for prisoners or patients who are incarcerated? Treating patients who are incarcerated raises questions regarding their competency and capacity to make medical decisions because prisoners are wards of the state and, therefore, do not have custody of their own body, a concept which challenges the ethical principle of respect for autonomy.[14,15] *Competency* refers to the legal ability to engage in health decisions and is determined by a judge, whereas *capacity* is a clinical determination referring to a patient's ability to process information necessary to make informed health decisions and is determined for a specific decision at a specific point in time by the clinical team.[16] Once a patient is declared incompetent by a court, only a court can remove this standing; however, capacity can wax and wane.[16,17] While patients who are incarcerated are under the physical custody of the warden of their facility, they maintain their autonomy and the right of self-determination regarding their medical decisions.[14] Generally, when a patient is declared incompetent by a court, they are not able to consent or refuse specific interventions, or make broader medical decisions, as this responsibility falls to their court-appointed guardian.[18] It is a unique premise, then, that patients who are incarcerated can maintain capacity to make medical decisions and still not be allowed to do so because they are physically in the custody of the government.[18] While the carceral system maintains physical control of patients, patients' capacity to make decisions should be assessed and respected, just as it is for other patients.[14]

It is important to note that patients who are incarcerated have the ethical ability to engage in medical decision-making in the same manner as patients who are not incarcerated.[19] Therefore, an advance directive or advance care planning document should be considered in the same manner for patients who are and are not incarcerated.[20] When a patient who is incarcerated lacks capacity to make decisions, the patient's legally appointed health care representative should serve as their proxy decision maker. If a patient who is incarcerated has not appointed a legal representative, state law should be followed regarding the appointment of a surrogate medical decision maker.[21] When a patient who is incarcerated lacks capacity, assent should be sought, when possible, in the same manner as for a patient who is not incarcerated. Representatives of the carceral system—for example, the prison warden—should refrain from making medical treatment decisions for patients who are incarcerated and have capacity.

Is it appropriate to ask a patient why they are incarcerated or to search for information about the patient's reason for incarceration online? The patient-physician relationship is a covenant that requires physicians to provide high-quality care regardless of the social, political, or economic standing of their patient.[22] Whatever the background of the patient, physicians must put forth every effort to remain impartial regardless of *why a patient is incarcerated*, if known. Additionally, patients are entitled to privacy and confidentiality; therefore, seeking information about a patient outside of the information they provide within the context of the patient-physician relationship has the potential to violate the patient's trust in the physician, can harm the relationship, and should be avoided.[6,23]

Is a patient who is incarcerated able to decline the presence of a correctional officer during discussions or examinations? The ability to provide high-quality care is premised on the trust inherent in the patient-physician relationship.[22] Trust allows patients to feel comfortable disclosing their most intimate and private information, which is the foundation for providing effective treatment.[6] Part of confidentiality is allowing patients to determine to whom their personal health information is disclosed. Although patients who are incarcerated have restraints on their autonomy, their autonomy is not fully eclipsed by the carceral system. As such, outside observers of a patient's clinical encounter should only be permitted if the patient has explicitly agreed to their presence or if it is necessary to uphold the safety of the patient or physician.[23] In the event an examination involves a patient's sexual anatomy or is sensitive in nature, a properly trained chaperone should be offered to the patient in the same manner as a patient who is not incarcerated.[24] In the same way that a patient's family member or trusted companion is not qualified to serve as a chaperone, a member of the carceral system should not serve as a chaperone; this role should be filled instead by a trained member of the health care team.[24] A patient who is incarcerated may request to decline the presence of a representative of the carceral system, such as a correctional officer; however, a physician or the carceral system representative may determine that a representative of the carceral system is necessary in order to maintain the safety of the physician or the patient.[24,25] When an outside observer is present, whether that observer is a chaperone or representative of the carceral system, conversations regarding the patient's medical condition, including their history, should be minimized.[24]

Are hospitalized patients who are in the carceral system permitted to have visitors? Visitors of hospitalized patients play an underrated role in recovery by improving both well-being and satisfaction.[26,27] The same holds true for hospitalized patients who are incarcerated, as visitation is important for their emotional and psychological well-being. Additionally, visitation by a patient's surrogate medical decision maker has a direct effect on patient care, as the efficiency of the surrogate's communication with physicians increases the quality of medical decision-making.[26] Patients should be allowed to have their surrogate medical decision maker present to make or assist with making medical decisions. Although the literature has found negative effects on decision-making and patient well-being when hospital visitation is restricted,[27,28] there is no standard or consistent policy ensuring that patients who are incarcerated can receive visitors during their hospitalization. Visitation policies for hospitalized patients who are incarcerated are established by either the hospital or the carceral system whose jurisdiction the patient is under. Patients with a terminal diagnosis are generally permitted to have a visitor or visitors and ought to be able to engage in at least minimal physical contact with their visitor. Ethically, prisoners should have more extensive visitation rights than they are currently provided.

Should physicians comply with court-initiated or mandated medical treatments of patients who are incarcerated? There is a long history of state-sponsored abuse of persons who are incarcerated, including denial of treatment for punishment and using prisoners in medical experiments without their consent.[9,29] While incarcerated persons maintain their ethical right to medical decision-making, there are times when the court may mandate or initiate medical treatments for a patient who is incarcerated. Physicians must not participate in the administration of cruel, inhumane, or degrading treatments or punishments of such patients under the guise of medical treatment.[12] Importantly, physicians should decline to provide treatment when court-mandated medical treatments are not based on sound medical diagnosis and standards of care,

not therapeutically efficacious, or undoubtedly a form of torture, punishment, or mechanism of control.[12,13] Physicians should act in good conscience to ensure that the patient who is incarcerated has given their voluntary consent without coercion.[13]

Conclusion

Treating patients who are incarcerated evokes ethical challenges that, due to the restraint on their physical autonomy, are unique to this patient population. Despite this constraint, patients who are incarcerated are ethically entitled to autonomy regarding their decisions, including the appointment of a health care proxy of their choosing to make decisions in the event of their incapacitation.[20,21] Importantly, patients who are incarcerated should ethically be treated the same as other patients.

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Citation
AMA J Ethics. 2025;27(4):E277-282.

DOI
10.1001/amajethics.2025.277.

Conflict of Interest Disclosure
Author disclosed no conflicts of interest.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

ISSN 2376-6980