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FROM THE EDITOR

Ethics at the Intersection of the Criminal Justice and Health Care Systems

Entering a jail for the first time can be an intimidating experience. The building itself is imposing, the metal detectors beep and ring, and heavy doors slide closed behind you with a bang. Yet the exam rooms look quite the same as any other, the dental chair just as mundane. As a dentist, I find my work there profoundly moving: patients routinely tell me that seeing a dentist is "the only good thing that's happened to me here" or "at least I finally got to see a doctor." Yet as much as I cherish the ability to build relationships with patients in such a potentially dehumanizing environment, the subtext of my patients' words is both striking and tragic. How can we do better for my patients and the 2.1 million other people experiencing incarceration in the United States each day [1]?

People who are incarcerated are the only group in the United States with a constitutionally protected right to health care [2]. Since patients affected by incarceration are also less likely to have access to the health care system prior to their incarceration, medical care in the criminal justice system represents an opportunity to dramatically improve patients' health and connect them with necessary services [3, 4]. Yet patients with a history of incarceration continue to have higher rates of medical, psychiatric, and dental disease; higher mortality; and a shorter life expectancy [5-8].

These facts are even more troubling given the high incarceration rates of people from groups already experiencing inequality in health care access and outcomes, including people of color, people with mental illness, and people with low incomes [8, 9]. The health harms caused by incarceration also impact the communities and family members of incarcerated people, perpetuating health disparities in communities across the nation [9].

The United States incarcerates a higher proportion of its population than any other nation [10], a practice that disproportionately punishes men of color [11]. Attorney General Jeff Sessions recently issued guidance from the Justice Department indicating a turn towards more draconian sentencing policies [12], suggesting that, under the new presidential administration, the small improvement in the incarceration rate that has occurred in the last few years [1] might be lost. Now more than ever, clinicians must be aware of the ways the criminal justice system and the health care system interweave in the lives of our patients and in the structure of our society.

This issue of the *AMA Journal of Ethics* explores the complex ways in which incarceration can influence patients' health and health care both during and after their time in prison or jail, as well as the challenges clinicians face in navigating their responsibilities to these vulnerable patients both in the correctional setting and in the community.

Clinicians in correctional institutions often face institutional barriers that limit their ability to provide care. Sarah E. Wakeman discusses the lack of access to opioid agonist therapy in jails and prisons, which can contribute to suffering during incarceration and high rates of overdose deaths in people recently released from incarceration [8]. Responding to a case about an incarcerated patient who refuses a necessary medication and requests a medication that might be restricted in the correctional setting, Tom Peteet and Matt Tobey discuss how clinicians can build patients' agency within the clinician-patient relationship. Correctional clinicians can also diagnose medical conditions that could affect patients' criminal proceedings; David Beckmann considers a clinician's responsibilities when considering the sharing of medical information with a legal team in the case of a patient diagnosed with mild cognitive impairment. Finally, Cyrus Ahalt, Rebecca Sudore, Marielle Bolano, Lia Metzger, Anna M. Darby, and Brie Williams discuss the importance of researchers assessing participants' comprehension of informed consent in conducting studies with incarcerated populations.

Medical students and residents can care for incarcerated patients even if they do not step foot in a correctional institution when ill patients are transferred to hospitals for additional care [9]. Sara Scarlet and Elizabeth Dreesen discuss the practice of keeping patients in shackles or under guard during surgery and the distress both staff and patients experience in these situations, and Satyajeet Roy contributes a drawing of a shackled patient. And Oliver Schirokauer, Thomas A. Tallman, Leah Jeunnette, Despina Mavrakis, and Monica L. Gerrek describe an educational initiative in which clinical ethics students observe and reflect on health care in an urban jail.

The population of corrections-involved people who are supervised in the community (such as through probation) is more than double the incarcerated population [1]. Amy B. Cadwallader explores the logistical and ethical challenges of mandated urine drug testing in this population and how repeated incarceration can be avoided. And Andreas Mitchell and Brie Williams argue for extending and improving compassionate release policies that permit incarcerated patients with serious or debilitating illnesses to be granted early release or parole.

Given the impact of justice involvement on health outcomes and life expectancy, clinicians outside of the correctional system must also be prepared to approach patients' history of incarceration as an important health risk factor [8]. Lisa Puglisi, Joseph P. Calderon, and Emily A. Wang describe the impact of incarceration on the health of patients returning to their community and strategies that clinicians and the medical

system can implement to empower patients and their communities to improve health. In her commentary on a case about a patient with a history of incarceration who is uncomfortable discussing it with his physician, Kimberly Sue uses the framework of "structural competence" to describe how a physician in a primary care office can approach a history of incarceration while respecting a patient's desire for privacy and work to prevent stigmatization of formerly incarcerated patients within and beyond the clinic.

Education can be one of the most potent tools for improving the ability of medical professionals to provide care for people who have experienced incarceration. Clinicians who are well trained in the health care needs of incarcerated people might be more likely to work in correctional settings and to provide care in their communities that is informed by patients' correctional experiences [13]. Jonathan Giftos, Andreas Mitchell, and Ross MacDonald discuss efforts at the Rikers Island complex in New York City to train health care professionals in the impacts of corrections involvement on health in order to inform clinical practice and advocacy. In the podcast, the interaction between health care and incarceration is explored from multiple perspectives. In particular, Troy Williams discusses his own health care experience at San Quentin State Prison, Dan McGuire describes volunteering at the Suffolk County Jail while attending physician assistant school, and Lisa Puglisi discusses her role as a physician caring for patients with a history of incarceration at a dedicated transitional clinic.

Above all, I hope the multifaceted exploration of correctional health care in this issue of the *AMA Journal of Ethics* highlights the fundamental humanity of patients who experience incarceration. As health care professionals, we have unique opportunities to provide compassionate, affirming care for patients in the justice system while advocating for criminal justice reforms that can improve the health and well-being of our patients, their families, and our communities.

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