2026, Volume 59, Issue 0, 1-2, e-ISSN 1938-3800

Family Medicine

COMMENTARY

Every Resident Should Go to Jail

Tyeler Rayburn, MD

AUTHOR AFFILIATION:
University of Florida Department of Community Health & Family Medicine, Gainesville, FL

CORRESPONDING AUTHOR:
Tyeler Rayburn, University of Florida Department of Community Health & Family Medicine, Gainesville, FL, tyelerrayburnmd@gmail.com

HOW TO CITE: Rayburn T. Every Resident Should Go to Jail. *Fam Med.* 2026;59(0):1-2.
doi: 10.22454/FamMed.2026.0170

FIRST PUBLISHED: November 16, 2026

KEYWORDS: Health care disparities, Special populations, Clinical electives, Minority healthcare, Community/academic partnerships

© Society of Teachers of Family Medicine

ABSTRACT

Incarceration is a profound structural force shaping the health and lives of those involved. It is such a strong equalizer of social determinants of health that many ethnic, gender, and age disparities of disease in the free world disappear under one common factor: being in jail. Family medicine departments serve at the frontier between the community and the health system. Since our inception 50 years ago as a deliberately counterculture specialty, we have always practiced at odds with an increasingly fragmented and hyperspecialized system. Corrections settings magnify this dilemma. Places like these are exactly where we should be sending our future physicians. If every resident went to jail, our communities would be a little healthier and a little more just.

The United States criminal justice system represents a critical frontier for health care delivery. Over 2% of our population is behind bars or under close correctional supervision.[1] Incarceration is a profound structural force shaping the health and lives of those involved.[2] It is such a strong equalizer of social determinants of health that many ethnic, gender, and age disparities of disease in the free world disappear under one common factor: being in jail. Mental illness is twice as prevalent and chronic and infectious disease burden is up to four times higher among those in in confinement.[3] Despite a constitutional right to health care for those in state custody,[4] there is no statutory guarantee of *health*.

At family practice's doctrinal core is the provision of comprehensive and continuous care to the individual, who themselves are inseparable from the unit of family and community. Since our inception 50 years ago as a deliberately counterculture specialty, we have always practiced at odds with an increasingly fragmented and hyperspecialized system.[5] Corrections settings magnify this dilemma. If our Aristotelian inheritance of our art holds that health is a basic and irreducible human good, and the practice of medicine is inherently oriented toward this end, then health care in jail is almost certainly counter to the punitive system of justice as it exists today.[6] Such settings are exactly where we should be sending our future physicians.

A mentor once succinctly made the case for training family doctors in settings of greatest need: "You gotta go where the sick people are." Jails and prisons are a crucible for multimorbid disease burden, health disparity, and soul-searching ethical and diplomatic challenges. Clinical training in corrections medicine, whether structured as a discrete senior elective or a longitudinal experience, is both feasible and aligned with family medicine's mission and educational objectives. Proficiency in infectious and psychiatric disease, emergency response, substance use and withdrawal, and all urgent and office-based procedural skills is prerequisite. Every patient needs the resident to apply their medical knowledge in the context of the logistically-complex, protocol-laden, and resource-limited environment. Every encounter cultivates the resident's humanistic center while they uphold professional ethical boundaries, balance patient dignity and autonomy, and contend with disparate and sometimes opposing interests in a place where it is not immediately apparent to everyone around them that patients need or deserve better health.

Our communities are only as healthy as our relationships with them. At our program, core faculty and community preceptors, including the jail's medical director and former medical director, provide a scaffold for community partnerships.[7] In our case, we have a reciprocal relationship with our county custodial center: we send resident and student doctors, they send patients. Each year, our residents visit the largest jail in our state through our Longitudinal Underserved Community Curriculum (LUCC) where they tour the facility from intake to dining hall, meet the medical staff, observe patients in the infirmary, and attend court proceedings. After their morning in jail, residents spend an afternoon immersed in community postincarceration organizations, ending their journey from rehabilitation to reintegration. The county refers incarcerated patients through the emergency department or by direct admission to our inpatient academic service for a higher level of care than the county corrections center infirmary can provide. Additionally, our core longitudinal clinic serves as a continuity site for medical care from our city and county jails and state prisons. In the second and third year, residents have a 4 week elective opportunity to work with the medical director and other staff clinicians at county, during which they participate in direct patient care, gain technical competencies in all conceivable office-based procedures, treat addiction and psychiatric comorbidity, and participate in public health and quality improvement efforts. The most recent of these electives included a hepatitis screening pilot in incarcerated adolescents. A steady pipeline of talented minds between our college of public health and our county corrections team has yielded multiple public health initiatives and nationally-presented research, providing more opportunity for residents.

Logistical concerns such as scheduling and safety are surmountable with clear protocols and the regular interface of custodial staff with faculty, resident, and student physicians. Programs without existing correctional partnerships can explore collaborations with local facilities, many of which would likely welcome academic affiliations. Alternatively, if not a categorical rotation in itself, corrections medicine can be integrated into required experiences in special populations or community health. Collaboration with correctional facilities also corresponds with funding priorities for graduate medical education and can foster institutional support and grants from organizations for public health initiatives and quality improvement. Even in early affiliations where credentialing and resident physician role are still being delineated, the structure of corrections health ecosystems can allow high-fidelity shadowing preceptorships unconstrained by productivity demands or high patient volumes. These opportunities allow plenty of self-directed learning under attendings who are willing to teach.

Family medicine departments serve at the boundary between the community and the health system. This is the interface from which all the C-functions of the primary physician are derived—first Contact, Critical, Continuous, Comprehensive, Coordinated, patient-Centered. Our practice at this interface is our curriculum.[8] Within this context, our relationship with our patients, our departments, our community, and with ourselves is itself the therapeutic means to that healing end. Sending residents where the sick people are reaffirms our commitment to the frontier, reminds us of patients' structural challenges to health and well-being, and emboldens us to make our health system work better for those who need it most. If every resident went to jail, our communities would be a little healthier, and a little more just.

REFERENCES

1. Prison Policy Initiative. United States profile. Accessed July 1, 2026. https://www.prisonpolicy.org/reports/pie2026
2. Izenberg JM, Morris NP. The freedom cure—structural intervention as medicine. *N Engl J Med*. 2023;389(5):389–391. doi:10.1056/NEJMp2301818
3. Office of Disease Prevention and Health Promotion. Incarceration. Healthy People 2030. Accessed May 26, 2025. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/incarceration
4. Estelle v. Gamble, 429 US 97 (1976). Accessed May 26, 2025. https://supreme.justia.com/cases/federal/us/429/97/
5. Stephens GG. Family medicine as counterculture. *Fam Med*. 1989;21(2):103–109.
6. Baker SH. Aristotle on the nature and politics of medicine. *Apeiron*. 2021;54(4):411–449. doi:10.1515/apeiron-2019-0052
7. Rottneck F. Every medical student should go to jail. STFM Education Column. Published July 2011. Accessed May 26, 2025. https://www.stfm.org/publicationsresearch/publications/educationcolumns/2011/july/
8. Neutze D, Hodge B, Steinbacher E, Carter C, Donahue KE, Carek PJ. The practice is the curriculum. *Fam Med*. 2021;53(7):567–573. doi:10.22454/FamMed.2021.154874