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Primary Care in Correctional Medicine: Redefining Medical Education for Incarcerated Patients

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To the Editor:

Incarcerated patients are highly vulnerable as they experience barriers to medical care before, during, and after incarceration. This predisposes them to higher rates of advanced medical comorbidities, chronic medical conditions, substance use disorders, and psychiatric conditions, resulting in reduced life expectancy and poorer health outcomes.[1,2] Residency training centers, particularly in family medicine, are the foundation of medical care for vulnerable populations, including those with a history of incarceration. Nonetheless, physicians and medical students experience difficulties in honing medical care toward this unique patient population while inadvertently holding stigmatizing views.[3] With the United States' imprisonment population of 2.4 million, and with 95% of incarcerated patients eventually returning to their communities, understanding physical, mental, and social risks can improve medical counseling, delivery, and quality of care all while reducing recidivism.[2] We applaud the authors of "Third-year medical students' self-perceived knowledge about health disparities and community medicine" for highlighting medical students' attitudes toward health disparities and incarcerated patients. After surveying students' level of comfort in providing care for a variety of underserved patients, the study found that they were least as comfortable in caring for incarcerated individuals as any other group, including adolescents, the elderly, and immigrants/refugees.[4]

It is imperative that instruction regarding the unique needs of those currently and formerly incarcerated be imbedded in core medical education. Structured curricula on these complex social and health factors can improve learners' competency and comfort in interacting with and treating this population.[2] The number of correctional health medical school curricula is low, and those that do exist are optional electives.[5] Though incorporating experiential learning and allowing medical students to work in carceral settings have been found to increase knowledge and improve attitudes toward incarcerated patients, senior medical students' survey scores remained poor, which underscores the necessity of structured curriculum.[5] Structured curricula should not be limited to medical students, but should also be extended into residency programs with an emphasis on family medicine residencies due to their historical nature in caring for a disproportionate proportion of incarcerated individuals. Encouraging an affiliation between correctional facilities and academic medical centers can be mutually beneficial as residents can learn how to provide medical care under challenging circumstances while increasing the number of physicians delivering care to an already-understaffed health care setting.[5] Moreover, increasing resident presence in local re-entry programs or transition clinic networks can be a judicious way to maximize limited resources. These programs aid in navigating health care needs for patients as they move from carceral settings into their communities.

Family physicians inevitably enter practice where formerly-incarcerated patients are present in their community,

while others will practice correctional medicine. Physicians at all levels of training should be cognizant of this population's social determinants of health in order to positively impact their health outcomes. The lack in formal training surrounding medical delivery to the incarcerated can become a barrier to educational awareness, empathy, equity, and competency. Fostering dedicated training and establishing a formal curriculum can improve outcomes in this area.

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