

PEER-REVIEWED CME ARTICLE: MEDICAL EDUCATION

Ethics Students Go to the Jail

Oliver Schirokauer, PhD, MD, Thomas A. Tallman, DO, MMM, Leah Jeunnette, PhD, Despina Mavrakis, MBA, and Monica L. Gerrek, PhD

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Abstract

This article describes an educational initiative in which clinical ethics students, who were either in a bioethics master's degree program or in the fourth year of medical school, spent two days observing health care in an urban jail. Students submitted reflections about their experience, in which they drew attention to concerns about privacy, physical restriction, due care, drug addiction, mistrust, and the conflicting expectations that arise when incarcerated people become patients. The rotation was of great value to the students both because it exposed them to many of the ethical issues that arise in a correctional setting and because it deepened their understanding of various ethical concerns that are pervasive in health care.

Introduction

Results published in 2001 from a national survey that looked at correctional health care education in medical residencies [1], two articles that appeared more recently and discuss the merits and importance of partnerships between academic medical centers and correctional institutions [2, 3], and our own literature and internet searches suggest that there is not widespread placement of health care trainees in correctional facilities. Nevertheless, we found descriptions of programs that provide trainees in various clinical professions—including medicine, nursing, and occupational therapy—the opportunity to learn and practice in a correctional setting [3-10]. All attest to the enormous educational value of the experience. Some of the challenges trainees face and the skills they acquire when rotating in a correctional institution are specific to correctional health care. For instance, they must learn to negotiate the [conflicting demands](#) inherent in caring for incarcerated persons while also respecting the need of the institution to maintain order and security through measures such as regimented medication management and restrictions on privacy [4, 5, 11]. Much of what trainees gain from working in correctional

health care, however, is transferable to noncorrectional settings, including the learning that comes from managing a wide range of chronic conditions [2-9], providing care to a diverse and generally underserved population [2, 4, 6-8], and negotiating relationships in which mistrust is a potential factor [4-6, 9, 12]. In this paper, we consider whether there are analogous benefits for clinical ethics students who rotate in a correctional facility.

The health care system we are associated with is the MetroHealth System in Cleveland, Ohio. It oversees the medical division of the Cuyahoga County Corrections Center (CCCC) and is affiliated with Case Western Reserve University School of Medicine, whose bioethics department staffs MetroHealth's Center for Biomedical Ethics (CBME). Each year, bioethics master's students and fourth-year medical students, as part of clinical ethics electives in their respective programs, are given the opportunity to observe many different areas of MetroHealth's main campus, including all of the intensive care units, the emergency department, the skilled nursing facility, and the police department. Last year, when the health care staff at the CCCC communicated to members of the CBME that they were open to having ethics students visit, the center began requiring that any student coming through the CBME spend at least two days at the corrections facility. In what follows, we present the details of this initiative and describe how it exposed students to a host of ethical concerns they did not see elsewhere and simultaneously engaged them in considering ethical issues in health care that extend well beyond the CCCC.

Setting and Rotation

The CCCC is a jail, which means that the persons incarcerated there are awaiting either trial or sentencing. In both 2015 and 2016, the average number of people housed at the facility each day was approximately 2,160, and the average length of stay was approximately 30 days [13]. Health care is provided by a team consisting of physicians (including a psychiatrist and an ob-gyn physician), advanced practice clinicians (certified nurse practitioners and physician assistants), an operations manager, a director of nursing, a nursing supervisor, a paramedic, a dentist, a dental hygienist, a pharmacist, registered nurses, licensed practical nurses, and clinical technicians. The medical unit has a dispensary with examination rooms, a pharmacy, in-house imaging including digital x-rays and ultrasound, and comprehensive laboratory support. A telemedicine program provides weekly access to hospital specialty expertise including cardiology, neurology, infectious disease, and psychology. In general, the medical staff sees between 70 and 100 patients each day. Frequent concerns include chronic disease management, drug and alcohol addiction, behavioral health, and chronic pain.

In the spring of 2017, the first cohort of students, consisting of six bioethics master's students and one medical student, rotated at the CCCC. Under the supervision of the facility's ambulatory director, they visited for two days, one or two students at a time. While there, they were given the opportunity to see the full scope of medical activity

occurring at the jail. Namely, they spent time observing medical encounters with patients including psychiatric appointments, accompanied staff who were seeing patients in their cells or delivering medications throughout the jail, and witnessed telemedicine encounters with off-site practitioners. Following each trip to the CCCC, the students were asked to submit to a faculty preceptor from MetroHealth's CBME an open-ended description of what they had experienced, with a focus on any ethical issues they had identified. Subsequently, they met with fellow students and a faculty preceptor in order to discuss the visit more fully. In addition, four students chose to fulfill a course requirement by submitting a more extensive case study based on what they had seen at the jail.

Themes

From the students' written reports, we identified the six ethical themes described below. We note that what follows is a record of student perspectives and caution that these views are not necessarily accurate accounts of what actually occurs at the jail.

Conflict of duties. An incarcerated person who seeks medical attention in the jail is in the dual position of being both a patient and someone who is incarcerated. Students recognized that the way a health care professional approaches an incarcerated patient might not align with the way the jail does. One example that the students took note of, and that is discussed in the next subsection, is the conflict stemming from the medical staff's responsibility to [protect a patient's privacy](#) and the facility's need to keep an eye on all areas of the jail to ensure safety. Another example comes from a student who described the case of an 85-year-old male who was ready to be released by the jail and required skilled nursing. However, because of his past behavior, no facility would take him, placing the medical team in the difficult position of trying to determine to what extent, as health care professionals in a jail and not a hospital, they are responsible for arranging a safe release. As a third example, we quote a student who explicitly commented on her decision to use the word "patient" instead of "inmate," stating, "I am still sympathetic with all of the competing priorities and needs the nurse needs to reconcile: tax payer dollars, the needs of the state.... However, the inmates, when visiting the nurse, become patients and should be treated as such."

Privacy. Multiple students commented that the institutional need for security had a significant impact on the amount of privacy that those incarcerated at the jail are afforded, both inside and outside of the medical areas of the jail. One student, in response to learning about a recent case in which a woman who was showering had a medical emergency that was caught on film by a correctional officer's body camera, expressed significant concern about the possibility that this film would be viewed and the "infringe[ment] on her self-determination" that such a viewing would represent. This student went on to describe the ways confidentiality was compromised in the medical encounters she witnessed and concluded, "Although it is understandable that there

needs to be some kind of supervision from the correctional officers for the safety of the doctors and the staff, it still feels like there could be more protection around patient information.”

Physical restriction. The need for safety in the jail and the accompanying use of [physical restraints](#) including solitary confinement was a profound concern for students. Two students, for example, were disturbed to learn of an incident that occurred nearly a decade ago in which a patient was put in restraints for an extended period of time and died while still restrained. Solitary confinement was a particularly complex topic, since it is used not only punitively but also at times as a means to ensure the safety of an incarcerated person in protective custody. One student was especially troubled by the case of a patient who revealed to a nurse that he did not feel safe in his pod and was then placed briefly in solitary confinement for protection. The student’s lengthy analysis, in which she acknowledged the benefits of solitary confinement in this circumstance and the limited options available to jail staff, nevertheless concluded with an impassioned rejection of the practice on the grounds that its “cruelty” could not be justified.

Due care [14]. Students recorded instances when the care that a patient received appeared to be less comprehensive than that which a patient would get outside of jail. Examples included the absence of [opioid substitution therapy](#) for those addicted to opioids, the lack of aggressive pain management, the lack of dietary support for certain chronic conditions, and the decision not to start a psychiatric medication for a patient with depressive symptoms but in no acute danger. Students understood these examples in the context of the jail’s limited mandate to ensure only that the health status of an incarcerated person does not deteriorate while in custody, which in turn they understood to be a consequence of limited financial resources. One student also discussed how uncertainty about follow up after an incarcerated person leaves the jail might affect treatment decisions. He noted that initiating a workup that would not be completed may not be good use of funds and that initiating antimicrobial treatment that would not be maintained may result in resistance.

Drug addiction. Almost every student made reference to the prevalence of [substance use](#) and addiction among those incarcerated at the jail. Many commented on the challenges that the health care professionals at the jail deal with when caring for patients who have an addiction problem. In particular, students discussed the psychiatric and social difficulties that these patients face, the implications of giving or not giving opioid substitute treatment to incarcerated patients, and the question of how to treat patients who repeatedly need an expensive cardiac valve replacement because their continued intravenous drug use leads to case after case of infective endocarditis. In addition, multiple students noted that the jail under no circumstances will provide opioids to a patient in pain, partly out of a concern that the patient may have a history of addiction and partly out of a concern that the opioid medication might be diverted to an

unintended user. For one student, the unavailability of opioids led to the comment that “it is troubling to think of how many inmates have been forced to suffer because of the fear that they may pose a safety risk by possibly (1) getting addicted or (2) getting someone else addicted.”

Mistrust. Many students took note of the complicated social dynamics that exist between the health care professionals working at the jail and the people incarcerated there. They focused, in particular, on the medical staff’s concern that patients might be trying to manipulate them. For example, students observed clinicians being wary of patients who might be feigning symptoms or fabricating a story about their history in order to get attention, free medication, or some kind of special treatment such as relocation within the jail. Interestingly, students did not comment on the mistrust that incarcerated patients might have for the medical staff.

Discussion

In our clinical ethics teaching, we ask our students to form and articulate opinions about the values and motivations that influence the choices made by people and institutions involved in health care. To help them shape and organize their thoughts, we encourage them to consider the framing principles of respect for patient autonomy, justice, beneficence, and nonmaleficence [14]. Having students visit the county jail supported this educational process by exposing them to specific and difficult ethical questions and by inducing them to engage with the broader issues and principles associated with these questions. We consider two examples.

Respect for patient autonomy. As a discipline, clinical ethics is deeply concerned with practices that protect patient autonomy, especially in the context of medical decision making. In a jail, autonomy is, of course, intentionally and severely constrained. Being confronted by this reality had a dramatic impact on our students emotionally and stretched their conceptual grasp of the principle of respect for autonomy in two ways.

First, it forced students to inquire about the nature of the autonomy that an incarcerated person retains in jail and to consider under what circumstances such a person’s choice should not be respected. For instance, many students accepted that the security and financial requirements of the institution necessitate denying freedom of movement or choice of food to those incarcerated there, but they became uncomfortable when someone’s entitlement to care or right to refuse treatment appeared to be compromised. A representative articulation of this stance is given by one student who wrote that “[an] inmate can never make a fully autonomous choice because he is limited in his choices by being in jail and there are certain amounts of control over his actions. However, this does not mean that he cannot make choices about his well-being and health, as individuals know their health status the best.”

Second, being in an environment in which autonomy is so constrained put a spotlight on aspects of health care that involve patient autonomy but might not get a lot of attention in other clinical settings. The students' heightened concern about the lack of control incarcerated people have over their private information and their physical circumstances, for example, provided a natural platform from which to examine how privacy can be compromised and patients restrained in other health care settings. Similarly, the students' exposure to instances of mistrust between incarcerated patients and the medical staff presented an opportunity for a preceptor to draw attention to the fundamental role that trust plays in clinical decision making and, in particular, to explore with students how informed consent, shared decision making, and patient-clinician partnerships promote respect for patient autonomy and depend on effective, bidirectional, and trusted communication to do so.

Justice. For our purpose here, we take justice to mean the "fair, equitable, and appropriate distribution of benefits and burdens" [15] among the various members of our society. Although this notion of distributive justice is a prominent principle in bioethics, it can become an afterthought in clinical education courses that largely focus on the dynamics and challenges inherent in the individual encounter. In the jail, however, concerns about justice gain attention for two reasons.

To begin with, like other publicly funded institutions, the jail has limited resources. Students were aware of this and, in fact, discussed their perception that decisions about testing and treatment are at times made not solely on the basis of what is medically optimal but instead on the basis of an assessment that might take into account factors such as nonadherence to treatment, length of stay in the jail, and, especially, expense. This unveiling of the harsh financial, behavioral, and social limitations placed on health care in the jail provided an opportunity for them to consider how the same constraints play a role in how health care is distributed in our society at large.

Additionally, justice became a focus of concern for students when the encounters they witnessed raised questions about patient access to resources outside of the jail. For example, one student, in regard to a patient with posttraumatic stress disorder and depression, wrote:

Although these cannot be used to excuse his crimes, he might not have the same access to health care that others his age from different areas or populations have, and therefore is [sic] never got the proper treatment or stood a chance to attempt to recover and was more at risk to be involved in crime and end up in jail.

For this student, as well as the others, meeting incarcerated people with significant health concerns provided a glimpse into health disparities that exist in the greater community.

Conclusion

This paper is a preliminary account of an initiative to have ethics students observe how health care is administered in the county jail. The writing our students produced and the discussions we had with them strongly indicate that the experience had a significant intellectual and emotional impact on them. Students were moved both by the difficult circumstances of the people incarcerated at the jail and by the challenges clinicians face trying to provide care there. Moreover, they struggled to understand both the societal and the personal forces that shaped what they were seeing and to place them in an ethical framework.

Although we consider this first implementation of the rotation to have been successful, we recognize that there is room for improvement and expansion. For example, we believe that our students would be better able to make sense of what they observe if they were given more information up front about how the jail operates (e.g., logistics within the jail, available treatment programs, safety issues), and so we are exploring the idea of having them attend an introductory presentation given by the sergeant responsible for educating new staff at the jail. To further help the students contextualize, process, and expand on what they are seeing at the jail, we intend to develop curricular materials for use between their visits there. We also believe that students would benefit from getting feedback on their writing from the medical staff at the jail and that the clinicians, in turn, would be interested in learning how the students view their visits. We therefore plan to ask members of the medical staff to read and comment on some of the students' written work. Finally, in order to deepen the students' experience, we are considering an increase in the number of required visits to the jail. Our conviction that exposure to correctional health care pushes ethics students to think carefully about the nature of ethical health care in our society has even led us to imagine designing an entire course on health disparities in which the jail figures prominently. Wherever it leads, we view a two-day rotation at the jail as a promising first step.

References

1. Kraus ML, Isaacson JH, Kahn R, Mundt MP, Manwell LB. Medical education about the care of addicted incarcerated persons: a national survey of residency programs. *Subst Abuse*. 2001;22(2):97-104.
2. Wakeman SE, Rich JD. Fulfilling the mission of academic medicine: training residents in the health needs of prisoners. *J Gen Intern Med*. 2010;25(suppl 2):S186-S188.

3. Trestman RL, Ferguson W, Dickert J. Behind bars: the compelling case for academic health centers partnering with correctional facilities. *Acad Med.* 2015;90(1):16-19.
4. Alemagno SA, Wilkinson M, Levy L. Medical education goes to prison: why? *Acad Med.* 2004;79(2):123-127.
5. Holoyda BJ, Scott CL. Psychiatric education in the correctional setting: challenges and opportunities. *Int Rev Psychiatry.* 2017;29(1):11-20.
6. Bouchard MT, Swan BA. Integrating correctional and community health care: an innovative approach for clinical learning in a baccalaureate nursing program. *Nurs Forum.* 2017;52(1):38-49.
7. Clarke JG, Cyr MG, Spaulding A. Prisons: learning about women's health and substance abuse. *Acad Med.* 2000;75(5):544.
8. Filek H, Harris J, Koehn J, Oliffe J, Buxton J, Martin R. Students' experience of prison health education during medical school. *Med Teach.* 2013;35(11):938-943.
9. Kaufman A, Holbrook J, Collier I, Farabaugh L, Jackson R, Johnston T. Prisoner health and medical education. *J Med Educ.* 1979;54(12):925-931.
10. Provident IM, Joyce-Gaguzis K. Creating an occupational therapy level II fieldwork experience in a county jail setting. *Am J Occup Ther.* 2005;59(1):101-106.
11. Kalra R, Kollisch SG, MacDonald R, Dickey N, Rosner Z, Venters H. Staff satisfaction, ethical concerns, and burnout in the New York City jail health system. *J Correct Health Care.* 2016;22(4):383-392.
12. Garland BE, McCarty WP. Job satisfaction behind walls and fences: a study of prison health care staff. *Crim Justice Policy Rev.* 2009;20(2):188-208.
13. Cuyahoga County Sheriff's Department. 2016 Annual report.
14. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics.* 7th ed. New York, NY: Oxford University Press; 2013.
15. Beauchamp, Childress, 250.

Oliver Schirokauer, PhD, MD, is a senior research associate in the Department of Bioethics at Case Western Reserve University (CWRU) in Cleveland, Ohio, where his responsibilities include oversight of the ethics curriculum for CWRU's medical students. He is also a clinical ethicist at the MetroHealth System. He recently launched a clinical program to support patients adjusting to major illness by helping them with communication, information processing, and decision making.

Thomas A. Tallman, DO, MMM, is medical director of the MetroHealth Correctional Health Program at the Cuyahoga County Corrections Center and a faculty member at the Cleveland Clinic Lerner College of Medicine in Cleveland, Ohio. A Navy veteran, he is board certified in emergency medicine and is a certified correctional health professional through the National Commission on Correctional Health Care. His interests include emergency preparedness, disaster medicine, education, and hands-on teaching.

Leah Jeunette, PhD, is a senior research associate in the Department of Bioethics at Case Western Reserve University and a clinical ethicist at the MetroHealth System in Cleveland, Ohio. She has interests in clinical ethics consultation, ethics education, and the ethics of fertility preservation.

Despina Mavrakis, MBA, is the ambulatory director of the MetroHealth Correctional Health Program at the Cuyahoga County Corrections Center in Cleveland, Ohio. She is certified in executive coaching, serves on MetroHealth's ethics committee, and has an interest in ethics education.

Monica L. Gerrek, PhD, is an assistant professor in the Department of Bioethics at Case Western Reserve University in Cleveland, Ohio, where she is co-director of the Center for Biomedical Ethics. She is also the co-director of the MetroHealth Institute of Burn Ethics. Her interests include food ethics, the ethics of addiction, and international perspectives on health care.

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