Recently UMMS had 2nd year students participate in the annual 2-week population health clerkship. Students spend time in various community settings and learn larger lessons about social determinants of health and resources. Jacqueline Chipkin worked with Warren Ferguson and others in the correctional health setting. Below is her reflection. Clearly she has learned a great deal about how prisoners are treated and at times, not treated, with lessons for all of us in medicine to reflect upon.

You can respond with comment to Jacqueline at Jacqueline.chipkin@umassmed.edu or to the listserv directly. Enjoy.

**Our Patients’ Right to Autonomy**

How can physicians provide quality, compassionate care to incarcerated patients? As I shuffled through a never-ending maze of metal detectors and locked doors on the first day of my correctional health elective, I was daunted by this question. I was still learning how to care for patients in outpatient offices and hospital beds; comforting those who lived in jails and prisons seemed like an impossible challenge.

As lecturers and textbooks alike have taught me, medicine, at its core, demands that we grant patients autonomy. In addition to honoring principles of justice, beneficence, and nonmaleficence, as ethical healthcare providers, we must afford competent adults the right to make informed decisions about their bodies and medical care. We are obligated to create conditions necessary for autonomous choice as we discuss risks and benefits of procedures, disclose adverse effects of medications, and consider goals of care as patients near the end of life. Informed consent is more than just signatures and paperwork; it is the process by which we encourage patients to make the protocols and recommendations of standardized medicine their own.

Yet the criminal justice system, at its core, functions to strip prisoners of bodily autonomy. As I crossed the main prison yard, eyes darting and fingers fidgeting, I began to grasp the tangible implications of incarceration. Immured by concrete walls and barbed-wire fences, the bodies of inmates are rendered immobile. Instructed when to sleep and what to eat by booming alarms and loudspeakers, basic bodily functions are precisely regulated. Shrouded in monochrome uniforms, individual bodies blur together as prisoners line up and walk the halls.
As corrections and healthcare intersect, these foundational, conflicting theories of bodily autonomy clash. Behind bars, medical exam rooms are islands of preserved bodily autonomy within a sea of its forceful, regulated denial.

Throughout my week in correctional medical facilities, I saw the same common diagnoses I saw in the community—diabetes, hypertension, dyslipidemia, and backpain. However, I also witnessed firsthand the increased prevalence of infectious diseases and mental illness that epidemiology tells us disproportionately affect the incarcerated[1]. Like incarceration itself, these conditions violently deny patients control over their own bodies. I talked to a new mother who became infected with HIV when a trusted partner failed to disclose his disease status to her. I interviewed a depressed man who explained how the voices in his head ordered him to attempt suicide. I listened as a survivor of domestic violence grappled with the alcohol addiction that led to a car crash she can’t remember. Before prisoners end up in prison, trauma, poverty, race and myriad psychosocial overlays expose patients to diseases that ravage their bodies without consent.

The physicians with whom I worked are acutely attuned to the dissonance between medical autonomy and criminal heteronomy, and they practice medicine with a heightened awareness of the importance of each prisoner’s bodily sovereignty and right to informed consent. They requested permission to take vitals, and if patients prefer the right or left arm. They furnished their exam rooms with multiple chairs and offer patients a choice of seat. They asked before removing socks and sweatshirts. When possible, they gave patients the option of pill line or Keep on Person (KOP) prescriptions for administering medications. They prompted patients to weigh in on potential consults, inquiring if patients would rather travel off-site or see visiting specialists within their facility. These practitioners infused every possible interaction with invitations for patients to direct their own care. Through these actions, the physicians I met strived to create spaces that reflected roles of caretaker and patient rather than correctional health employee and inmate.

These doctors, like the patients they care for, are often stigmatized by the medical community. Yet every day, they choose to treat our nation’s most medically and socially complex patients in limited-resource settings with compassion and dignity. They challenge the institutional forces of mass incarceration and structural violence that disproportionally imprison

bodies of poor people[2] and people of color[3] by offering patients evidence-based recommendations and the choice to accept or reject them. I believe all physicians—wherever they practice—can learn from physicians who practice in correctional health facilities. Because when we not only respect, but advocate for, our patients’ right to autonomy, we move beyond algorithms and regimens. We foster partnerships that individualize care to promote health, healing and wellness.
