



Violence at Rikers Island: Does the Doctor Make It Worse? A Clinician Ethnographer's Work Amidst Carceral Structural Violence

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Abstract In this article, I describe the dilemmas of working as a physician-ethnographer within the Rikers Island jail healthcare system before and at the beginning of the COVID-19 epidemic in April 2020. The Rikers Island jail system in New York City has been in the national spotlight as a space of violence, trauma, and death amidst calls to decarcerate by community members and abolition advocates. This article is a personal reflection on the labor and subjectivity of healthcare providers and their positionality to multiple axes of structural and interpersonal violence while attempting to provide care in carceral institutions. I observe how COVID-19 functioned as an additional form of structural violence for incarcerated people. Clinical ethnography remains an essential tool for understanding complex social phenomena such as violence. However, physician-ethnographers working in these spaces of structural violence can have unique and conflicting constraints: tasked with providing evidence-based medicine but also simultaneously participating in an unusual form of labor that is an amalgamation of care, social suffering, and punishment. Despite and across at-times conflicting roles and obligations, I propose that these fragmented subjectivities can foment social criticism, propel advocacy toward decarceration, and produce a critically engaged dialogue between fields of anthropology and medicine toward a goal of health justice.

Keywords Incarceration · Health · Violence · COVID-19 · Care · Clinician ethnography

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Becoming A Jail Physician

Physically arriving to the jail clinic space in the assigned building on Rikers Island requires significant attention and care to enter with minimum hassle and maximum speed. It routinely requires locking up a cellphone and keys (bring your own lock), putting your see-through backpack through the security detector (no liquids, not even water), going through a metal detector yourself, and then walking through and into the trap, which is a space located between two sets of heavy metal doors. In the trap, when one door is open, the other door is closed. Then you travel up and down a set of often broken elevators and bang on the door to the clinic, entering a door that can only be opened with a giant set of metal keys from a correctional officer standing on the inside of the door.

A single cubicle exam room, with a computer that works intermittently, as well as broken or inadequate equipment that is pilfered from the other cubicles, comprises home base for the next eight to sixteen hours, depending on if you're doing a single or a double shift. Often, the chairs are stolen or switched leaving the last person to arrive in the morning with the worst chair, a chair that's peeling, or the stuffing on the arms is worn or ripped off. There are sometimes fights between providers over these chairs.

This is the intended site of health and healing for the jail clinician to do their routine primary care, chronic disease management, urgent care visits, and return with patients from emergency runs to housing units. While it has the trappings of a routine clinical space, the scope of what is performed here by the jail clinician is far out of ordinary compared to the work of taking care of patients in a community-based setting.

To understand the work of a jail physician, it is critical to understand the jail system more broadly. Rikers Island is the main New York City jail complex located in the East River that serves as a central location for mostly pre-trial detainees from all five boroughs (Manhattan, Bronx, Brooklyn, Queens, and Staten Island), meaning that most of the people there have been charged with a crime but are awaiting court and have not been convicted. The "Island," as it is colloquially known, is accessed through a long bridge on the north side of Queens very proximal to La Guardia Airport. The complex itself contains approximately ten separate buildings, with some buildings housing over a thousand people at any one time. Detained people are placed into these buildings based on a variety of factors (e.g., gang affiliation, charge status, conviction, gender identity, health status, among others). There is one building equipped for medically complex infirm patients that require nursing home level of care, such as patients with HIV/AIDS, Type 1 diabetes, or on dialysis. Several of the other boroughs have a jail building that also can house people charged within that borough or to house them temporarily while awaiting local court proceedings.

A prominent campaign known as "Close Rikers" launched in 2016 featuring community coalitions that sought to close the antiquated central island facility, decrease the jail population, and rebuild and rehouse incarcerated individuals into home boroughs. An opposing community group called "No New Jails" positioned themselves as an abolitionist group that demanded both closing the central Rikers

facility while also stopping renovation or rebuilding of borough jail complexes, instead arguing that this funding should go toward community alternatives to safety and restorative justice (Eisenberg-Guyot 2021). While these campaigns waged, the New York City system had also been slowly decreasing the standing population of the jail, down to approximately 4,000 people by April 2020 (NYC Press Office 2020). At the end of the campaigns, New York City Council voted 36–13 in favor of Close Rikers, agreeing to shut down the Rikers Island complex by 2026 by renovating borough-based jails, decreasing the population by 75%, and transferring remaining detained people from the island to local borough jails. Within this debate, advocates of improving conditions on Rikers Island for people currently incarcerated argued for the necessity of upkeeping the failing infrastructure on the jail complex and continuing to afford ongoing services, so the NYC budget continued to include both the cost of building four new borough jails to meet Local Law codes for minimum standards, as well as a line item to maintain the aging facility infrastructure until it closed (Rivera 2022).

Many of the calls to Close Rikers and to decarcerate were because Rikers Island had a reputation as a space of violence, self-harm, and injury (particularly increased because of solitary confinement policies), and generally inhumane living conditions. Like many antiquated and dilapidated jail and prison systems around the country, the physical infrastructure of the buildings was poorly maintained. Running to a medical emergency in the building meant navigating out-of-order elevators, exposed plumbing, decayed ceiling and wall infrastructure, broken windows taped over with a sheet of plastic, and flooded floors; reportedly, 79% of weapons were fashioned from decaying building materials of the facility (Rakia 2016). Across these environmental hazards and exposures, patients were transported to and from the clinics from their housing units for medical appointments by at least one or more correctional officers, which made the execution of care plans onerous at best.

In general, incarcerated people have high rates of both acute and chronic health conditions, as well as higher prevalence rates of mental health and substance use disorders than the general population, often requiring frequent and significant interactions with the jail and prison healthcare systems (Binswanger et al. 2009; Massoglia and Remster 2019; Steadman et al. 2009; Fazel et al. 2017). Rikers Island-specific data demonstrated frequent incarceration for people with multiple axes of structural vulnerability, including substance use, homelessness, and mental illness (MacDonald et al. 2015). Given this data, the physician leadership at Rikers Island's Correctional Health Services were committed to improving the healthcare of incarcerated people despite the significant challenges. Several of the jail medical leadership within the NYC jail system outlined what they call the triple aims of correctional health: patient safety, population health, and human rights (MacDonald et al. 2013). They described the unique epidemiological challenge of encountering patients with increased morbidity and mortality within jail system settings and the urgent need to provide them high-quality prevention and treatment. In fact, incarcerated patients are the only population of individuals in the United States with a legal right to health care as outlined in *Estelle v. Gamble* (Marshall, Thurgood and Supreme Court of the United States 1976).

However, the provision of this care is made possible only within the context of the security apparatus, including all the jail correctional officers and their associated leadership divisions, which often takes paramount importance over even urgent or emergency health concerns or issues. MacDonald, Parsons, and Venters define “dual loyalty” as a problem unique to the provision of healthcare in correctional settings where the clinician has both a loyalty to the patient but also to the security apparatus, often placing the clinician in a space of ethical conflict (MacDonald et al. 2013). The dilemma of actually enacting clinical medicine within these sites of concentrated structural violence entailed daily direct conflicts and even participation in violence itself.

Many of the principles of providing healthcare in a carceral system were outlined in the medical staff orientation to working in a jail. In many clinical settings, the practice of medicine involves some form of learning by doing, including navigating how to actually get things executed for patients rather than being problems of medical knowledge or clinical competency (Good 1994). Enacting medical care, such as ordering an x-ray of a hand after a patient got into a fight, was easier said than done in the jail infirmary. However, this learning curve, and the medical field’s pedagogical reliance on learning by doing, presented ethical and safety issues within sites of social control and extreme imbalances of power such as carceral systems. I soon learned that while I might see patients for diabetes or high blood pressure or HIV, I was just as often called to write clearance forms to condone correctional officers spraying detainees with capsaicin or pepper spray, or alternatively, using tasers on them.

Initially, and perhaps profoundly naively, I signed up to work in jail healthcare to ameliorate individual and collective harms to structurally vulnerable populations, yet I wondered how and in what ways I simultaneously became complicit in enacting additional violence or harm. Based on fieldnotes and clinician ethnography in my role as an internal medicine physician at Rikers Island from October 2018–April 2020, before and in the beginning of the NYC COVID-19 pandemic, this paper explores the conundrums of delivering care that providers faced on a daily basis. This exploration builds on seminal work by Carolyn Sufrin, who has also worked as a physician and an anthropologist in a large urban jail (Sufrin 2017). In her paper on this topic, she lays out the “constantly shifting roles and obligations of practicing medicine and anthropology” and explores both tensions and ethical quandaries that come about precisely because “I was a doctor at the jail before I was an ethnographer,” thus leading her to propose the term “observant participation” for the unique role of physician-anthropologists who are attempting to practice medicine with a critical ethnographic lens (Sufrin 2015).

This clinical work that I intended to do was undoubtedly affected by a deep distrust of carceral systems. As I outlined in previous work, my concern with the expanding range of social and healthcare services offered by prisons and jails coalesced in what I called the “carceral therapeutic state”(Sue 2019), caused by the merging and instantiation of the criminal legal system with therapeutic attention to substance use disorders. I worried that the jail and prisons had become fixed infrastructure in the American society and documented the effects of these carceral institutions on women’s lives as they dealt with opioid use disorder in and out of these

spaces. I approached the work at Rikers with trepidation, however, I felt that utilizing the critical inquiry and methodological approaches of ethnography (“observant participation”) could help me to retain a socio-structural lens both within and outside of the direct care that I provided.

Here, I present a case study examining the multi-faceted nature of the violence of care in a jail facility based on self-reflections from routine clinical practice. As a case study, this work falls under university IRB exemption.¹ However, to ensure confidentiality and anonymity given the sensitive topic, all individuals have been deidentified and merged into composite cases. Ages, genders, diagnoses, dates/times, and locations have all been changed or removed. Field notes have been edited for clarity and individuals deidentified.

“Contras”: The Disorientation of Everyday Violence

A typical 8-h jail shift routinely involved violence in a myriad of forms. At times during these shifts, there was actual physical violence either perpetuated by incarcerated patients and/or the correctional officers, often involving both parties. I routinely encountered the threat of violence or the aftermath of violence on an average shift.

In addition to this, there was a disorienting everyday violence of simply providing clinical care in a surveilled, restricted carceral environment. Nancy Scheper-Hughes and Philippe Bourgois note that “everyday violence ... destroys socially marginalized humans with even greater frequency are usually invisible or misrecognized” (Scheper-Hughes and Bourgois 2004). In this case, violence took numerous forms that was routinized, bland, and knit into the everyday fabric of the jail operations. It might even take a form such as not having an escort to clinic for routine diabetes care in order to adjust insulin dosing or other medications, or having to endure frigid or unbearably hot temperatures for months on end that could exacerbate asthma. Carceral violence operated at numerous levels and was knit into the existence and operation of the institutions, themselves permitted by the existing sociopolitical conditions.

Early on in my time working within the Rikers Island jail system, after a week of orientation to the policies and procedures for new staff physicians, I started shadowing clinical shifts where I would tag along with a seasoned jail clinician. In many cases, this could be a Haitian physician assistant who had worked at the jail for twenty years or more. However, these shifts felt like a blur, and I was taking notes by hand, trying to keep up with a new computer system and figuring out how to actually get things done. After several clinical shifts of shadowing, including one in the intake center of one of the buildings where I was told to ignore a naked man screaming, urinating, and defecating in a tiny plexiglass room within the bustling main intake, I was considered ready to staff my own shifts. However, upon entering

¹ See Yale University IRB statement on case studies: <https://hipaa.yale.edu/sites/default/files/files/Case%20Reports%20and%20Patient%20Privacy.pdf>

my own cubicle at Anna M. Kross Center (AMKC) I realized I knew very little. The clinical medicine I knew was hardly sufficient to fulfill the necessary tasks required of me within the jail infirmary.

One of the first non-medical tasks I was asked to do was evaluate for “contras.” When a security officer strolled into my cubicle, I was immediately on guard. I knew that they would only enter the actual cubicle space if they needed something. It was not technically in my job description to work for them; however, it seemed impossible to deny them their requests. I felt distrustful of them as I saw myself aligned and in spirit with incarcerated patients at the bottom of the power dynamic and social hierarchy. “I need a contra,” he said to me. “A what?” I asked. “A contra,” he repeated. As I wrote in a fieldnote after the incident:

Officers come to me for contras and say "we got two contras, we gotta get a spray." Turns out when it says DOC stun or DOC spray says "NO" it means NO contraindications. Whoops. I told them they can't spray either of them. Whoops? I think I understand now. I will ask one of the physicians when I come in tonight or when they come in tomorrow morning. Yikes. I feel so violent being asked to participate in the use of spray.

The “contra” request, in fact, was the correctional officer asking if the patient had any medical contraindications for the use of the stun shield/taser or use of oleoresin capsicum (“OC” spray). I had learned in my orientation to the jail that OC spray contained a capsaicinoid irritant that would lead to brief, self-limited symptoms that were supposed to resolve in 15–30 min, with reportedly < 1% requiring medical attention. These symptoms ranged across organ systems, including burning and irritation of the eyes and ears, cardiovascular effects (tachycardia, hypertension), respiratory issues (wheezing, drops in oxygen, pulmonary edema), and/or skin redness or blisters. Seeing patients who had just gotten sprayed was a common clinical visit.

When I turned to a physician in a neighboring cubicle to ask how to fill out the forms, I learned that I had, in fact, misunderstood the form. I had checked “no” thinking it meant that the patient could not be sprayed, when in fact checking “no” on the form actually meant “no contraindications to spray.” The contraindications to spray from a medical standpoint included pulmonary illness (such as chronic obstructive pulmonary disease or asthma), medical frailty of any kind, or mental health conditions that could be exacerbated by the use of the spray.

However, the medical policies and procedures clarified that filling out the “contra” form was not “medically clearing” patients for this use, it was simply advising the Department of Corrections staff about possible conditions in which that use could be particularly harmful. The policies also stated that there was scant scientific literature on this topic and that it was difficult actually gauge risk in the jail context. Much later, I also learned that despite my naïve efforts to protect the patients from being sprayed, that the correctional officers might utilize other equally harmful methods to achieve behavioral compliance, such as possibly beating or physically assaulting the patient to comply.

After a patient was sprayed with OC spray, the regulations in place stated that correctional officers had to offer the patient a medical visit. Many of them refused or did not want to get checked out, however many others wanted to be seen. There was

not much we could do from our cubicles to ameliorate the effects of the capsaicin spray in their eyes or on their face. They had usually already been encouraged to wash their eyes and skin with water and to change the clothes they had been wearing. There was nothing we did or could prescribe to lessen the burning sensations of the spray, which is why many of them did not bother trying to get assessed.

As a staff physician, another part of the roles I performed including assessing either patients or correctional officers after what were known as “Uses of Force.” The “DOC Use of Force” included any incident that involved an altercation between an inmate and a correction officer. The “Use of Force” was often but not exclusively conducted by correctional officers or a special squad of officers named the “Probe Team” who suited up in riot gear and batons. When entering or exiting the building, I would sometimes see a “Probe Team” preparing to engage with a detained person, with one correctional officer holding up a handheld camcorder as was legally required. However, my role entailed examining a patient after a so-called “use of force” and filling out the necessary injury report. Sometimes, I might be additionally asked to examine one or more correctional officers who participated in the “use of force” incident.

Fieldnote excerpt: When I saw the DOC [Department of Corrections] officer for “assault” I’d already seen the inmate, a very young man, who got sprayed, and got scratched up. Seeing as patients both the person in power and knowing that he is going to get money from his insurance company for assaulting this young man, who got all scratched up on the ground, it just made me sick. My face is furrowed... they want me to like smile or joke or whatever with them, no. It makes me sick to be complicit in the endeavor. The suffering of the torturer vs the one in power is not the same.

Essentially this officer is here to get his [insurance] reimbursement. As clinicians we used to have to see them so they could file to get occupational hazard insurance. I knew one CO who got \$1100 a year for filing for “assault” from inmate patients. The ways in which I was complicit in bureaucratic or actual violence, literal profit off distress, are mind-blowing.

Filling out two kinds of forms in the aftermath of these incidents was confusing. One was a form to document where and whether there were any injuries on the incarcerated patient. It included a map of the body and the clinician was asked to put an X over where there were injuries incurred and describe the injuries in detail and any further necessary follow-up (x-rays, emergency room evaluation). I was told that these injury reports were evaluated by medical and security leadership to ensure that certain kinds of assault, for example, blows to the head, were not frequently occurring.

The other form that was often requested was by the correctional officers for reimbursement for their occupational hazards. This required logging into a separate medical documentation system for the officers and logging one of often numerous encounters they had been involved with over months and years, then printing them out documentation of the encounter so they could submit to their insurance company for monetary compensation for their occupational hazard.

In the aftermath of the uses of force, I felt complicit being forced to see both the patients who had been injured and the officers who were usually not injured, as if it was a level playing field. Refusal to participate in filling out the injury report forms—requiring a map of the body with my assessment of the injuries—was simply not done. At times, I could refuse to see the officers if I felt like resisting them, begging off that I was taking care of patients or otherwise busy, but they would often insistently hang around the cubicle and refuse to leave.

My clinical assessment of both parties—the incarcerated patient and the correctional officer—became a bureaucratic tool that could be variably wielded. And the act of sitting with them serially and examining one, then the other, as well as the assessment I was asked in each case to perform, was altered by the power differential. For my patients, I did the best I could. I cleaned and disinfected wounds, offered pain medication, or sleeping or anxiety medication. I was attentive to filling out the injury form in handwriting that was as legible as possible. But often there was little I could do. For the officers, I checked off that their skin or clothing was sprayed with capsaicin spray or saliva and they were encouraged to wash it off with soap and water. I often checked off on their forms that they had no hazardous exposure at all. Despite similar incident through-lines, this occurred several times a week, and each time I performed these assessments was a variation on a theme, with the incarcerated person much more likely to sustain any serious injury than the officer.

As a physician-ethnographer tasked with filling out these forms, I struggled with a fractured habitus compromised of shifting identities and roles. Bourdieu interpreted habitus as a socially inculcated, mental and embodied disposition classifying how one exists in the world (Bourdieu 1984), and in this context of disparate training philosophies, methods and practices, I felt three selves at play in this interaction. My physician self was often foregrounded. The work required was demanding, immediate, and time-consuming. The paperwork was rushed as officers or others waited impatiently for them to be filled out by hand. My ethnographer self was witnessing, observing, critical of my physician self's complicity in a sociopolitical institution perpetuating inequality and violence. It accused my physician self as being what Foucault had called "the immediate anatomist of pain: wardens, doctors, chaplains, psychiatrists, psychologists, educationalists; by their very presence near the prisoner, they sing the praises that the law needs" (Foucault 1995: 11). And my third self, a moral self, responding affectively and instinctively as a human being reacting to the harms done by and to others, was simply aggrieved and upset. This self was no less a part of the three, however was often relegated to the realm of affect and vague unease, to the unceasing frown on my brow or the pit in my stomach as I filled out the form.

I worried that the forms could not account for the ongoing harms of the constant injuries between incarcerated patients and correctional officers. I hated filling them out although I did them diligently. However, upon reflection and greater contextualization, I realized that the paper injury reports were potentially doing something much more subversive in some ways, documenting what Homer Venters, the former chief medical officer of Rikers' Correctional Health Services, has called the "epidemic of brutality in the NYC jail system" (Venters 2019, 36).

As Venters argued, the medical documentation was necessary to counteract the myriad of ways that systematic underreporting of these injuries occurred, and to call for outside investigators to look into patterns of beatings, abuses, particularly to the head and face, or injuries incurred even after patients were already restrained. Many times, both officers and incarcerated people took advantage purposefully of areas that were known to be out of view of surveillance cameras to beat others (or cameras were deliberately covered over with toilet paper or toothpaste). While the documentation seemed onerous to me, the statistics and documentation were vital to not erasing the grievous injuries that otherwise went underreported or under-analyzed by health department or external committees: “Part of our responsibility ... was to point out how the jail system creates its own set of health risks for the people who pass through and to measure the uneven ways in which these risks are distributed across our patients” (2019: 42). The documents were collated for review by external jail oversight board known as the New York City Board of Correction, whose mandate was to oversee and improve policies and practices at the jail.

However, social scientists have noted that statistics and quantitative data, just as much as ethnography or archival work, tell specific narratives, often of those who wield the most power and social influence. Anthropologists have documented how metrics within the field of global health have been used to tell certain partial narratives that contribute to certain social outcomes (Adams 2016; Nguyen 2010; Biruk 2018). In the case of the jail injury reports, as onerous, partial and pain-staking as they were for me to fill out, they were one, albeit partial, attempt to account for suffering and create the metrics for advocacy and structural change. This is particularly relevant in the carceral setting in that that the stories of incarcerated patients are often disbelieved, ignored or distorted by the security apparatus. This phenomenon—that some stories and some data count more than others, such as physician notes versus patient narratives in the case of refugees experiencing trauma—has been observed by physician-anthropologists elsewhere (Fassin and Rechtman 2009).

One counterpart to the way in which these acts of violence become flattened into statistics is the knowledge production performed by ethnography. After I filled out the injury reports, I thought about the ways in which injury has been theorized and harkened back to the pit in my stomach. Laurence Ralph, in his ethnography working with people disabled by gang violence in Chicago, conceived of injury not only as an adjustment to the physical reality, but also representing potential transformation in spiritual, social, economic, and moral realms (Ralph 2014). How and in what ways did the injury evaluations and reports that I performed and the injuries sustained by my incarcerated patients change them and change me? Of course, it disillusioned me from the work, as I spent hours within a shift on paperwork rather than the provision of thorough, evidence-based medical care.

I believe that the triadic interactions of myself, an incarcerated patient, and a correctional officer, mattered far beyond the forms and the profit off distress. It seemed more important than simply witnessing or enacting bureaucratic necessity. Rather, the ethnographic attention to the incident revealed the culture of everyday violence and the ongoing injuries to the bodies and souls of incarcerated people that was made possible by the carceral system itself and by the

sociopolitical system that accepted the ongoing existence of Rikers Island itself. It made me yearn for an abolitionist future, one where these interactions were not quotidian and acceptable.

Threats of Violence in the Infirmary

Even within the clinic itself, there was a non-zero risk of violence enacted upon healthcare workers. On one of the first days where I was starting to practice alone and had finished shadowing other clinicians, the central administrators requested that I leave the building I had trained in and “float” me to another building. Earlier that week at the other building, one of the frontline healthcare staff had been taken hostage by a patient for several hours (both individuals emerged physically unharmed). The staff had all been discussing what made that particular building a site of increased risk of violence and harm to staff, including factors such as prevalence of serious mental illness, solitary confinement and low staffing. I refused to go over to that building, not only because I didn’t have a car and I had never worked in that facility before, but also because I simply did not feel set up to be safe. Motivated largely by fear, and the feeling of self-preservation, I said no to participating in the suggested float and the medical director of the building allowed me to stay working in AMKC.

The configurations of economic, political, and criminal legal conditions that created risk environments for violence cannot be ignored. In some ways, it makes logical sense for an incarcerated person to access whatever means they can to feel seen or have their needs met. Often times, the usual access to medical, via what is known as a “sick slip,” or a piece of paper bearing symptoms triaged by nurses, are repeatedly ignored (Friedman, Burr, and Sufrin 2021). In this case, the act of taking a clinical staff member hostage does effectively upend the “jailer-jailed” paradigm. The person can no longer be ignored. The hostage situation, however, penetrated my psyche as well as the collective psyche of the other healthcare providers. In addition, earlier in the year, one of the clinicians had been strangled by a patient. There was, as expected, significant ongoing fear and outrage among the medical staff. Some other staff even confided to me they felt that the correctional officers deliberately were not keeping them safe, in order to justify their increased presence and increased staffing.

Several months later, I was confronted with the threat of violence while working an overnight shift. Around 5:30am, I was asked to see an incarcerated man who was complaining of stomach pains. I had been instructed that on the “night tour” shift that medical staff were required to see any patients who felt they were sick as a reason that they did not want to be transported to court that morning. As one of the other doctors told me, the only condition in which I was told that they could avoid going to court was if they were so sick they were in need of urgent hospitalization and we were calling 911 for an ambulance. Effectively, I was told to make everyone “fit for court.”

As I wrote in my fieldnotes:

Fieldnote Excerpt: I also got threatened and backed up against the gate by a patient whom I made fit for court. He was a middle-aged man, and he was complaining of a hernia in his stomach that made lying on his back or sitting uncomfortable, he said he had had it for two to three months but he literally had never seen sick call for it. My job in the morning is to troubleshoot things for them and attend to their medical conditions but inevitably I have to make them fit for court. I offered him pain medication and then maybe a surgical consult for his hernia, and pts [patients] just don't understand, you can't just all of a sudden see a surgeon, and not to go court. He was like I don't even care about my court thing, it's small and stupid, but he just didn't want to sit all day in shackles. I try to be sympathetic but then I told the officer I was done with him, and honestly I didn't even see or feel a hernia, and then I was telling the officer to take him away, and he started to cuss me out. I backed up and the officer was standing between us and he was like, I'm going to punch your face. I was like, we've dealt with your issue. And there are like 15 ppl watching by the way, and I was like well, call 311 on me [make a complaint to the city], and he's like, no I'm just going to beat you the fuck up."

Upon analyzing my fieldnotes, it was clear that only several months into socialization in the carceral infirmary space, that I had already assumed some of the clinical brusqueness that I saw in many of my colleagues. I had responded flatly and coldly to the patient to make a formal complaint to the city. But I couldn't help wondering about the myriad of complex dynamics including disparate age, gender, ethnicity, and power that could have been part of this interaction. Importantly, I refused to recognize and respond to his symptoms in the moment. I dismissed him, summarily, to go to court, and in doing so dismissed his suffering and recognition of his humanity.

Escalating the encounter into one of potential violence—at least with threats and words—was one way of demonstrating his potential power and his disagreement with the conclusion of our encounter. This resonates with ethnographic work of Philippe Bourgois with Puerto Rican people in East Harlem, where violence becomes a means of asserting local dignity and respect within a devastatingly crushing neoliberal system that does not afford recognition to many of its most structurally vulnerable people (Bourgois 2003).

So the threat of violence was what was necessary for him at that moment, not the threat of making a civil complaint on the phone against me several hours later in private. And my actions and inactions—to determine if he was to go to court or to go to the hospital—had direct consequences on his life that day. What was disturbing, however, was the routine way in which the incident erupted and then receded. No one came to talk to me about the incident, about the threat of violence, and everyone went on with their quiet early morning routines, wrapping up the night's work and preparing to leave within the next hour. This was just another form of everyday, quotidian violence knit into the work of the jail physician.

Kleinman has insisted in his previous work that "experience-near" ethnography is a means of making sense of human experience. He posits that we must understand what is at stake for each individual within "local moral worlds" as they play their part within social hierarchies and relationships. He and Joan Kleinman were critical

of the involvement that individuals in both professionalized anthropology and medicine had to play in structural oppression, transforming illness experience into a diagnostic code (Kleinman and Kleinman 1991). They argue instead for an interpersonal form of subjectivity and the value of presenting interpersonal experience captured within ethnography, biography, and the arts. It is through the ethnographic method and analysis that I sought to make sense of my physician duties and also make sense of the violence.

However, sometimes the jail infirmary had an air of the truly absurd about it that broke us all out of conventional roles and relationships. The circular nature of witnessing and violence, as well as the complicated nature of purported victims and perpetrators across a very uneven social hierarchy, was mystifying. One incident demonstrates this absurd reality, where I mused, does the doctor make it worse?

Fieldnote excerpt:

I arrive and the clinic is in a state of chaos, but I don't see the [other] doctor. I have no idea what is going on. It turns out [Dr. Smith]*² called 911 for a patient who was probably drunk and assaultive off of "hooch" [home brewed alcohol]. I had seen this particular patient only three days ago, and gave him some ibuprofen. When I walked by him on my way into the clinic I had no idea it was him. There was a huge standoff and he had been refusing to go with the paramedics for like 1.5 hours. They were going to have to use a "Use of Force" against him. UGH!!! So this squad team comes up with their riot gear on and I hunker into the treatment room with the nurses. They tell me that I don't want to be out there to get injured, and I don't want to be out there to be seen on the camera to have to file a Nunez, which is a form you have to do if you see a Use of Force against a patient. I feel as if there is a moment in which I lost that I could have turned it around but by the time I recognized that I had seen the patient before, he was threatening to punch people.

The patient had come to file a Confidential Allegation, but was drunk, and refused vital signs with [Dr. Smith] so [Dr. Smith] punished him and called 911. Then Dr. Smith left and I'm like, damn, I'm having to deal with this mess. He's [the patient] cussing and he's like wait 'til I come back here, they're not going to do anything to me, which certainly probably was somewhat true. Ugh. They made me go out of the treatment room to examine him and fill out an injury report after a Use of Force. He had been given versed [a benzodiazepine] so was sleepy, but seemed okay, not visibly injured.

So I did not actually witness the violence that took place against the patient in the infirmary space, although I was adjacent to the Use of Force. The nurses, in fact, had purposely corralled me out of the main clinic area into a side nursing room where they were sitting to avoid the space where the Use of Force was taking place, both for practical reasons, but also for obviating the systems in place intended to protect patients from Uses of Force. My fieldnotes reflect a brief moment of possibility, the potential of an intervention, however foreclosed. Even if I had tried to intervene,

² Names have been anonymized here for privacy and composite cases have been utilized.

given my relative newness to the clinic, and the personalities and the power dynamics within the clinic itself, it was unlikely I would have had success in de-escalation.

I read my fieldnotes again. “[Dr. Smith] punished him and called 911.” How could it not be an absurd reality? Again, everyone seemed to be acting out predetermined roles: both the doctor and the patient knowing that he doesn’t need to go to the hospital, that he’s just drunk, that “they won’t do anything to me” (at the hospital emergency room), but each are doing what they must do. The patient, resisting vital signs. The doctor, punishing him for resisting vital signs.

Upon further reflection, I realized what was actually one of the most disturbing elements about the incident is that the patient had come to file a Confidential Allegation, which is a formal complaint to medical staff of physical, verbal or sexual abuse, assault or harassment, to an individual by another incarcerated person or a staff member. It was in and itself a tragic outcome, additionally more so if he was unable to file this serious report of harm.

On top of that, I felt guilty about my inaction, my lack of witnessing. The nurses had pulled me away on purpose. This was to avoid having to fill out Nunez paperwork, which I had never completed before. On Rikers Island, the legal proceedings *Nunez and the United States v. City of New York in 2011* led to the formation of a group known as the Nunez Commission. The Nunez Commission was a group of outside observers that became required after 11 plaintiffs were beaten by officers at Rikers Island. The lawsuit that led to the formation of the group asserted that Rikers Island leadership tolerated “a culture of routine and institutionalized staff violence against inmates”(Weiser 2012). What Nunez meant for staff, including healthcare workers, was mandatory reporting to try to create conditions of increased safety and transparency at Rikers.

However, the medical staff, including myself, had ducked that responsibility, and they often tried to avoid witnessing. None of us witnessed the Use of Force, subverting the existence of Nunez intended for us to document and witness violence. In this case, medical staff (Dr. Smith) had actually participated in the calling for the Use of Force, which resulted in chemical sedation, possible trauma, and a visit to the Emergency Room for the patient. Did the doctor make it worse? How had we been a part of aiding the security apparatus rather than enacting clinical duties of health and healing that we all purported to do?

Incarceration as Violence Itself: The Arrival of COVID-19

The arrival of COVID-19 onto this already fraught and tense delivery of healthcare within the jail system presented an additional layer of risk and potential harm to incarcerated individuals. A notable fact of jails, from a contagion and infection control perspective, is that the staff, including the correctional officers, who often have close and contained interaction in the air space of detained people inside, is that the officers and even healthcare staff posed risks to detained people by fact of their community interactions and engagements (Reinhart and Chen 2020). Incarcerated patients expressed to me their inability to control the behaviors and risks that non-incarcerated staff took.

COVID-19 fueled new anxiety and stress for the officers, medical staff, and patients alike. Buildings that had been previously closed as housing units in part of the consolidation and decarceration efforts were suddenly re-opened up to become COVID-19 isolation units. Entire housing units were put on quarantine, which made the people inside both anxious and aggressive, and disrupted the very flow and transport required for accessing healthcare services. Many of the officers refused to wear masks, although their union demanded and then took N95 masks from the health department of the city. All individuals, including correctional staff and healthcare providers, were seen as vectors of possible contagion from the outside world.

In April 2020, the court system had effectively been shut down. I saw many patients who were incarcerated on violations of parole (which in New York City, could be something as simple as not being at the address listed on parole at 7am on a Saturday). They were incarcerated for technical violations and were effectively unable to go home, since the courts were not essentially non-functional, keeping patients in a state of unending limbo and viral exposure.

The new infectious airborne threat of COVID-19 was another layer of possible harm, both psychic and physical, to patients. On one of my shifts, a patient with a certain high level of security designation, who also happened to have a serious cancer, was not allowed to be transferred to a health unit because his security status trumped his health risks. I tried to ensure at the minimum that the nurse could give him a mask. Security would not allow him to be transferred to the medical unit because of his high security classification.

The social relations were entirely upended by the presence and even the threat of the virus. Affiliated groups of incarcerated individuals, who belonged to established regional and national gangs, effectively “locked down” their housing units, patrolling who could enter and who could not, with threats of physical violence or coercion. I had one elderly patient with multiple medical co-morbidities return from the hospital to his housing unit telling me that he hadn’t eaten in four days because the “gang unit will jump someone [physically assault them] if they want to eat.” Individuals who belonged to gangs were prohibiting guards from bringing in food trays or allowing other incarcerated people to accept food trays. The gang leaders out of fear of contamination with the new virus were stopping the flow of community members like guards to the inside housing units where they felt they remained COVID-free.

COVID-19, therefore, represented environmental and structural violence on top of the quotidian, everyday violence such as getting pepper sprayed, as my patient’s comment demonstrated. Critically, the threat of the virus did represent for patients also a psychic harm, an unceasing anxiety. It was not only the emergence of a new viral pandemic, it was also an “epidemic of signification,” as Paula Treichler argued about the HIV/AIDS epidemic (Treichler 1999). In the jail, similar to the emergence of the HIV epidemic, the rapid transmission of illness caused by COVID-19 was not only biological in nature but also carried with it an explosion of meanings, many often based on emotions like fear, with such significations having a central role in social discourse and even institutional or public policy, no matter how biologically unfounded. The fight for masks and airspace within the jail were just beginning. The terror was real, as we had no treatments and barely any tests for an entirely new viral entity. This was stressful to patients and providers alike, within a carceral institution

in which many incarcerated people lacked access to accurate news or means to prevent or treat the virus.

As a physician, I believed the best thing for these patients beginning to be released was that they could go home. Nothing seemed safer than going home. I could not write a prescription for their release, however, one year into the pandemic, the Chief Medical Officer of Correctional Health Services, Dr. Ross MacDonald, did in fact write an impassioned plea to the New York City Council in September 2021 for de-carceration as a means to decrease in-custody COVID-19 deaths (MacDonald 2021; Barnert et al. 2021).

The COVID-19 pandemic in carceral institutions signified structural violence and social suffering en masse, with the jail and prison systems suffering disproportionate amounts of harms and deaths (Kim et al. 2022; Toblin and Hagan 2021; Saloner et al. 2020). It was one additional vector of structural harms to burden those already sickest and most structurally marginalized.

My reflections on the environment of trauma and violence in carceral institutions, as well as my own role in the violence of care within these spaces, made me realize that I was marked as an agent of possible harm and violence despite my efforts to provide healing, patient accompaniment, or excellent care in spaces of violence. The question remained for me as it has for others who work within oppressive socio-structural political environments: can I both participate in a structurally violent apparatus and also work toward structural change within or against this system?

What was essential to my ability to undertake this work was a deep commitment to envisioning a world where all people, especially the most structurally vulnerable, could access the primary care, addiction and mental health care, that they needed where they live, without bars and without mandates. It was a calling to do so at the exhortations of one of my mentors, Paul Farmer, whose careful delineation of structural violence as a necessary theoretical lens had, in part, led me to the jail infirmary to study, work, observe, and write. He implored us all to use ethnography as a means to attend to social suffering: “The task at hand, if this silence is to be broken, is to identify the forces conspiring to promote suffering, with the understanding that these are differentially weighted in different settings” (Farmer 2005).

Having trained as both a physician and an anthropologist allowed to me to approach unpacking and undoing structural violence and the specific violence of carceral care from very different angles. As opposed to many of my colleagues in jail medicine, having an ethnographic stance, social medicine theories and a philosophy of critical inquiry allowed me to both document and assess the settings and systems in which this violence occurs.

In addition, quantitative data can lack the ability to comprehensively tell stories and contribute to a deeper understanding of why things happen. Ethnography, however, can produce knowledge that elucidate social forces at-play. In this instance, I used my clinical work as a physician combined with the analytic lens of anthropology to advocate and call for decarceration during COVID-19 in local newspapers to maximally improve the health of people at risk of harms or death related to incarceration (Thill and Sue 2021). Through these observations and this dual training, I sought to draw attention to issues that could be considered violations of human rights and lack of proper jail oversight and to call for person-centered care at Rikers

and beyond. This is part of reinforcing a larger community call to both improve the material conditions that detained people currently face as well as to work toward a world of abolition, where individuals can access the care that they need in their own communities (Davis 2003; Kaba and Ritchie 2022).

Claire Wendland proposes that the uniqueness of dual training of a physician anthropologist allows individuals to “illustrate the connections between microscopic harm and macrosocial arrangements” (Wendland 2019). Remaining committed to the dual subjectivities and the fractured habitus of being both a physician and an ethnographer, in the tradition of critical medical anthropology, requires the ability to zoom out and examine structural socioeconomic forces of oppression in which we all participate (Singer and Baer 2018). It is a call to Farmer’s “pragmatic solidarity” (Farmer 2005) to using our dual training in medicine and the social sciences as a basis for data and compassion driven action.

In our current era of COVID-19 and the refutation of scientific evidence, ethnography proves to be a powerful and necessary means of gathering socially resonant data. Our writing and our work, therefore, can be means to contextualize both the individual experiences of patients as well as those of physicians, in order to illuminate the structural forces that disproportionately burden the poor, drawing attention to the failing healthcare and social apparatus in which we operate as citizens and laborers.

There is a new generation of critically engaged physician-anthropologists that are using this engaged witnessing to engage in pragmatic solidarity and advocacy for structural change as well as challenge pedagogical and theoretical approaches. They use experience-near clinical cases of individuals to highlight structural forces of oppression and poor health. Hansen and Metzl, as leading physicians-anthropologists, have formulated theories of structural competency and structural vulnerability that explicitly help trainees to understand how social and structural forces, not simply individual behaviors, influence and condition poor health outcomes (Metzl and Hansen 2014; Quesada et al. 2011; Bourgois et al. 2017).

Holmes has used his work and his embodied experience to document and advocate for the Mexican migrants who break their bodies picking fruit for pennies to satisfy demands of U.S. consumption (Holmes 2013). Sufrin has used her work and her “proximity near” experiences to advocate against the practice of shackling women during labor (Sufrin 2018). As the paper in this issue by Levenson and Samra illustrates, physicians and academics can use their social and political privilege to assist abolitionist community members to effectively call for stopping jail expansion. Many are teaching these concepts and engaging in advocacy and social activism within their institutions, to new medical and social science trainees, and within their communities more generally.

Because of the social platform and credibility of physician-anthropologists, many are positioned to be able to partner with their communities to conduct meaningful research with and for their communities and advocate successfully for direct changes to the upstream social structural determinants of health on issues like structural racism, enduring poverty, and ongoing violence. While recognizing fractured habitus and varying levels of complicity in structurally violent systems, they are able to engage with trainees about the messy systems in which we live and work within

medicine and the academy, conduct relevant and impactful research, and use ethnographic and/or clinical narrative to inform policy and social action. However, future work should prioritize centering and partnering with people most directly affected and the ongoing work; one significant limitation of this case study is the elision of their voices.

This case study is intended to highlight how ethnographic and clinical work can be enlisted to improve socio-structural conditions from a myriad of angles, as was the case with my provision of medical care at Rikers Island. Rather than elide the messiness of both ethnographic and clinical endeavors across fractured subjectivities within biosocial engagements, it is critical to recognize them as a space of fruitful tension. Witnessing, combined with a critical theoretical lens, is necessary if not sufficient, for our pressing social conditions. Our work seeks to both engage in a new intersubjectivity of care and transform observations into meaningful and sustained social action.

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