Diversity, Equity, Inclusion, and Justice

Vulnerable yet Unprotected: The Hidden Curriculum of the Care of the Incarcerated Patient

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In the wake of the social unrest in the summer of 2020, many academic medical centers in the United States issued statements about their commitment to health equity and eliminating health care disparities. However, the discussion has been notably silent on the care of patients who are incarcerated, a vulnerable population with complex social, ethical, and medical considerations. In the absence of recognition and education around incarcerated patients, a hidden curriculum has been allowed to flourish.

In the United States, about half of the 2.2 million incarcerated people, defined as those awaiting trial in jails or those serving sentences in prisons, report a chronic health condition.[1] Additionally, during the COVID-19 pandemic, the incarcerated population has had greater than 5 times the infection rate and triple the mortality rates of the general public.[2] This population's second most common source of health care are academic medical centers,[3] which commonly have guidelines regarding the care of the incarcerated patient. However, these guidelines are often narrowly focused on resident safety, only outlining security requirements and not acknowledging patient vulnerabilities.[4] While resident safety is paramount, it is a disservice to both residents and patients if the nuances of working with a vulnerable population are not explicitly addressed.

Previous studies have shown that learners are exposed to negative moral judgments by attendings and staff about patients who are incarcerated, as well as comments about secondary gain and malingering.[5,6] Additionally, learners exposed to this population without a formal curriculum perform poorly on attitude and knowledge tests.[7] By its very nature, the hidden curriculum is not found in a course syllabus or clerkship objectives but rather taught through perceptions, modeling, and workplace culture and norms.[8] We propose that these coalesce to form a hidden curriculum against incarcerated patients that teaches trainees to distrust them, have deference to other loyalties, and disregard incarcerated patient rights. As a result, we argue this negatively impacts patient evaluation, care, and outcomes.

The hidden curriculum teaches learners to view incarcerated patients as less trustworthy. For example, at our institution, a resident recently presented an incarcerated patient's severe chest pain as "incarceritis," a term describing patients thought to be faking symptoms to avoid incarceration, despite the patient having had coronary stents placed 2 months prior. This diagnostic skepticism was not taught in any preclinical foundation course but rather through a hidden curriculum that teaches learners to view patients in custody as often having secondary gain when reporting their medical symptoms, as has been established in other studies and articles.[6,9,10] The resident learned via the hidden curriculum to evaluate the patient's chest pain through the lens of his incarceration status rather than through the lens of his recent stents. Furthermore, racism in both the health care and the criminal legal systems cause both distrust and disproportionate incarceration, doubly disadvantaging incarcerated Black and Latinx populations needing health care.[11-13]

Second, residents learn through the hidden curriculum to have deference to other loyalties, such as perceived or real obligations to the state and carceral system.[14] While all physicians experience dual loyalties, such as hospital administrators pushing for a premature discharge of a patient with unmet social needs, the conflict is starker when a patient is in custody. For example, an adolescent presented from jail with flexor tenosynovitis and needed an urgent washout of his hand. However, the accompanying guard withheld the parent's contact information and prevented proper consent from being obtained, citing the theoretical danger to staff should the parent present to the hospital in a disruptive manner. The residents deferred to the guard, even though this was in direct violation of hospital policy, ethical principles of informed consent with a minor, and the standard of

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care. If residents had been taught an ethical framework through an explicit curriculum, they would have been empowered to obtain parental consent for the operation and maintain a singular loyalty to the patient. One framework suggests explicitly identifying dual loyalty situations when they arise, using independent judgment to maintain loyalty to the patient, relying on standard of care, being knowledgeable about relevant guidelines and policies, and resisting pressure to change decisions.[15]

Third, despite clear case law establishing rights for incarcerated patients, in practice the hidden curriculum rationalizes infringement on patients' rights.[16-18] Specifically, trainees routinely perform substandard history taking and physical examinations due to indiscriminate shackling and the presence of guards who are actually nonclinical observers outside of the care team.[17] This is the norm due to a lack of formal instruction regarding incarcerated patients' privacy rights and areas of vulnerability. These lapses in care delivery can have serious clinical ramifications. A detained patient in our institution required urgent chemotherapy but was deemed to lack capacity due to his unwillingness to discuss treatment options. During a private moment in the CT scanner, away from the guards, he revealed that he was unwilling to talk about his diagnosis in front of the guards, as he thought it may negatively impact his immigration case. Another patient with cirrhotic ascites and abdominal pain could not receive a diagnostic paracentesis because the guards refused to reposition his shackles. A formal curriculum would teach learners to be aware of institutional policies and that patients in custody have a right to privacy, including from guards.[18-20] Although shackling and constant attendance by guards is presented as a way to avoid violence toward health care workers, there is a dearth of evidence establishing a higher rate of patient violence in the incarcerated population than in the general population. In fact, altered mental status associated with delirium, dementia, mental illness, and intoxication has consistently been found to be the top risk factor in incidents of workplace violence.[21]

We call for a radical shift in the approach to the care of the patient who is incarcerated. First, academic medical centers must include carceral health in the discussions about equity and social determinants of health. While some institutions have begun to examine their relationship to mass incarceration, these are often trainee-led efforts and thus serve to highlight a lack of institutional curricula.[22,23] Curricula should include explicit training regarding the rights of patients who are incarcerated, as well as a code of conduct for learners participating in the care of incarcerated patients.

Second, the Accreditation Council for Graduate Medical Education (ACGME) should take a leading role in offering guidance for programs that provide care for the patient who is incarcerated. To start, ACGME competency IV.B.1 already calls for respect for patient privacy and responsiveness to diverse patient populations—adding incarceration status to the current examples of patient characteristics would be a small but meaningful change.[24] Additionally, the ACGME should encourage specialties to develop educational standards for academic medical centers affiliated with correctional facilities and programs that routinely take care of patients who are incarcerated. Education should include, but not be limited to, the context of mass incarceration in the United States, ethical frameworks for complex situations, addressing diagnostic skepticism, antibias training, and institutional policies regarding incarcerated patients. Our hope is that more robust curriculums will equip residents to provide equitable care to patients who are incarcerated. Further work will need to be done to include faculty development for physicians who have completed their formal training.

Third, more effort is necessary to establish the disparities facing patients who are incarcerated, as well as the impact of specific policies regarding their rights and treatment in hospitals. In an effort to protect this vulnerable population from exploitation, the pendulum has swung too far, and the dearth of data allows misinformation to flourish.[25,26] Institutional review boards should work with correctional health experts to ensure that research is noncoercive and safe for this population rather than halting research altogether. Additionally, as academic medical centers seek to improve patient satisfaction and implement quality improvement projects, incarcerated patients should be considered for these initiatives.

Lastly, academic medicine must change the way it treats vulnerable populations. Too often, patients who are in custody are treated as opportunities for advanced pathology and learner autonomy.[6] As these marginalized populations have no other recourse for medical care, we must approach their care not only as a benefit to trainees but also as a chance to learn what it means to deliver the best care possible in challenging circumstances. As academic medical centers undergo a transformation in how they approach vulnerable populations, we must combat hidden curriculums by providing explicit and equitable training in the care of patients who are incarcerated.

References

1. U.S. Department of Justice. Maruschak LM, Berzofsky M, Unangst J. Medical Problems of State and Federal Prisoners and Jail Inmates, 2011–12. Accessed March 1, 2021. https://www.bjs.gov/content/pub/pdf/mpsfpji1112.pdf
2. Saloner B, Parish K, Ward JA, DiLaura G, Dolovich S. COVID-19 cases and deaths in federal and state prisons. *JAMA*. 2020;324(6):602-603. doi:10.1001/jama.2020.12528
3. Min I, Schonberg D, Anderson M. A review of primary care training programs in correctional health for physicians. *Teach Learn Med*. 2012;24(1):81-89. doi:10.1080/10401334.2012.641492
4. Texas Tech University, Health Sciences Center, El Paso. Ambulatory Clinic Policy and Procedure. Accessed March 1, 2021. https://elpaso.ttuhsc.edu/opp/_documents/EP-6/ep-6-05.pdf
5. Hashmi A, Bennett AM, Tajuddin NN, Hester RJ, Glenn JE. Qualitative exploration of the medical learner's journey into correctional health care at an academic medical center and its implications for medical education. *Adv Health Sci Educ Theory Pract*. 2021;26(2):489-511. doi:10.1007/s10459-020-09997-4
6. Glenn JE, Bennett AM, Hester RJ, Tajuddin NN, Hashmi A. "It's like heaven over there": medicine as discipline and the production of the carceral body. *Health Justice*. 2020;8(1):5. doi:10.1186/s40352-020-00107-5
7. English M, Sanogo F, Trotzky-Sirr R, Schneberk T, Wilson ML, Riddell J. Medical students' knowledge and attitudes regarding justice-involved health. *Healthcare (Basel)*. 2021;9(10):1302. doi:10.3390/healthcare9101302
8. Bennett N, Lockyer J, Mann K, et al. Hidden curriculum in continuing medical education. *J Contin Educ Health Prof*. 2004;24(3):145-152. doi:10.1002/chp.1340240305
9. Schoenherr L. He's faking it: how to spot inmates' invented illnesses. *Corrections1*. Published September 30, 2017. Accessed September 29, 2022. https://www.corrections1.com/correctional-healthcare/articles/hes-faking-it-how-to-spot-inmates-invented-illnesses-dx3GtdjSL9acMbxn/
10. Berry S. Deciphering when patients feign symptoms to avoid incarceration. *J Emerg Med Serv*. August 7, 2014. Accessed September 29, 2022. https://www.jems.com/administration-and-leadership/deciphering-when-patients-feign-symptoms/
11. U.S. Department of Justice. Jail Inmates in 2020—Statistical Tables. Accessed September 29, 2022. https://bjs.ojp.gov/content/pub/pdf/ji20st.pdf
12. Sawyer W. Visualizing the racial disparities in mass incarceration. Prison Policy Initiative. Published July 27, 2020. Accessed March 1, 2021. https://www.prisonpolicy.org/blog/2020/07/27/disparities/
13. Hoffman K, Trawalter S, Axt J, Oliver M. Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between Blacks and Whites. *Proc Natl Acad Sci U S A*. 2016;113(16):4296-4301. doi:10.1073/pnas.1516047113
14. Pont J, Stöver H, Wolff H. Dual loyalty in prison health care. *Am J Public Health*. 2012;102(3):475-480. doi:10.2105/AJPH.2011.300374
15. Williams JR. Dual loyalties: how to resolve ethical conflict. *South African J Bioethics Law*. 2009;2(1):8-11.
16. Tuite H, Browne K, O'Neill D. Prisoners in general hospitals: doctors' attitudes and practice. *BMJ*. 2006;332(7540):548-549. doi:10.1136/bmj.332.7540.548-b
17. National Institute of Corrections. Correctional Health Care: Guidelines for the Management of an Adequate Delivery System. Accessed September 29, 2022. https://nicic.gov/correctional-health-care-guidelines-management-adequate-delivery-system
18. American College of Emergency Physicians. Recognizing the needs of incarcerated patients in the emergency department. Accessed September 29, 2022. https://www.acep.org/administration/resources/recognizing-the-needs-of-incarcerated-patients-in-the-emergency-department
19. Haber LA, Pratt LA, Erickson HP, Williams BA. Shackling in the hospital. *J Gen Intern Med*. 2022;37(5):1258-1260. doi:10.1007/s11606-021-07222-5
20. Scarlet S, Dreesen E. Surgery in shackles: what are surgeons' obligations to incarcerated patients in the operating room? *AMA J Ethics*. 2017;19(9):939-946. doi:10.1001/journalofethics.2017.19.9.pfor1-1709
21. Phillips JP. Workplace violence against health care workers in the United States. *N Engl J Med*. 2016;374(17):1661-1669. doi:10.1056/NEJMra1501998
22. Afolabi T. Starting the conversation: students call for training on care for incarcerated. Harvard Medical School. Published October 10, 2018. Accessed March 1, 2021. https://hms.harvard.edu/news/starting-conversation
23. Giftos J, Mitchell A, MacDonald R. Medicine and mass incarceration: education and advocacy in the New York City jail system. *AMA J Ethics*. 2017;19(9):913-921. doi:10.1001/journalofethics.2017.19.9.medu1-1709
24. Accreditation Council for Graduate Medical Education. Comment Program Requirements. Accessed March 10, 2022. https://www.acgme.org/what-we-do/accreditation/common-program-requirements
25. Wang EA, Zenilman J, Brinkley-Rubinstein L. Ethical considerations for COVID-19 vaccine trials in

correctional facilities. *JAMA*. 2020;324(11):1031-1032. doi:10.1001/jama.2020.15589

26. Trotter Ii RT, Camplain R, Eaves ER, et al. Health disparities and converging epidemics in jail populations: protocol for a mixed-methods study. *JMIR Res Protoc*. 2018;7(10):e10337. doi:10.2196/10337

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