"See Me as Human:" Reflections on an Experiential Curriculum Led by People With Lived Experience of Incarceration

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ABSTRACT: Improving physical and mental healthcare delivery to incarcerated patients and people with carceral histories provides an opportunity to improve health equity more broadly. This article provides a medical curriculum perspective led by the firsthand narratives of two women with lived expertise of incarceration in collaboration with interdisciplinary health professions students and faculty. Together we state that recognizing the humanity of individuals with carceral involvement precedes the ability to provide ethical or equitable healthcare: this humanity begins with students and the community sharing places and spaces together. We herein detail our experiences in honoring community educators with lived expertise of incarceration while pioneering a grant-funded, interdisciplinary medical education event offering early exposure to experiential learning in hopes of preparing future clinicians to transcend the status quo of substandard care through individual-level and systems-level advocacy. By sharing humanity and building relationships directly with community experts, we endeavor to offer future clinicians the relational framework to inform their advocacy efforts to improve healthcare systems from the bottom up throughout their clinical training and lifelong careers. Most importantly, we highlight the reasons why we believe medical curricula aiming to dismantle inequities facing people with carceral histories must be taught alongside those with lived expertise.

KEYWORDS: experiential, incarceration, racism, discrimination, lived expertise

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Introduction

The United States has the highest incarceration rate globally. The scale of carceral control represents over 1.2 million individuals currently in prisons and 7.6 million jail admissions between July 2022 and June 2023.[1,2] Its reach further encompasses over 3 million people under probation and parole, and nearly 80 million people living with a criminal record.[3] Systemic discrimination within carceral practices disproportionately targets persons minoritized through racialization, poverty, immigration status, mental illness, and more. These same intersecting forms of discrimination are also well-known to render these populations as less physically and mentally healthy.

Beyond broader mechanisms of societal harm to well-being, healthcare systems also deliver inequitable physical and mental healthcare to these individuals impacted by incarceration, both during their incarceration and after.[4] For example, according to the National Alliance on Mental Illness, despite roughly 40% of incarcerated people having a history of mental illness, prisons failed to continue providing psychiatric medications to over half of people upon admission. Prisons also failed to offer 63% of people with mental health needs any form of mental health treatment while incarcerated.[5] People with carceral involvement also receive healthcare in community settings, where they experience a multitude of inequitable health practices that perpetuate the dehumanization of incarcerated people and stresses their mental health well-being.[6,7] Too often, hospitals stand as the theater within which people with carceral histories are further dehumanized. Instead of compassionate, patient-centered care, medical staff prejudicially resort to the use of restraints, seclusion, and law enforcement. This perpetuates a cycle of trauma and reinforces the perception of these individuals as threats rather than patients in need. At the intersection of physical and mental health, systems of dehumanized care within hospital settings are exemplified by carceral responses to clinical behavioral emergencies and a myriad of disparate health outcomes perpetuated upon patients with carceral histories.[8–10]

Healthcare cannot offer justice and humanized care to incarcerated patients without first upholding multidisciplinary and interprofessional accountability for their physical and mental well-being. Therefore, a combination of educational, system, policy, and individual-level transformation is required to center the physical and mental health needs of people with carceral histories. Nonetheless, health professional schooling and residency curricula on caring for incarcerated people are inconsistently offered and currently fail to equip students with knowledge and experiences needed to correct these disparities and

meet healthcare needs of incarcerated patients.[11,12] In a national survey of U.S medical schools deans, less than one quarter reported that their institution offered curricular content explicitly dedicated to the interaction between the criminal justice system and health.[13]

In response to these growing needs, in September 2023, the Association of American Medical Colleges funded Yale School of Medicine to partner with a local community-based organization, Women Against Mass Incarceration (WAMI), as part of an education grant entitled, "The DePART Initiative: Detained Patients' Advocacy and Rights throughout Treatment." This medical education event was featured as part of Yale's Interprofessional Longitudinal Clinical Experience (ILCE) course, where students pursuing education to become nurse practitioners, physicians, and physician associates learn alongside each other for their first year of graduate studies. The ILCE experiential education day at the heart of this article is entitled, "Accountability to the Community." This event begins with an hour-long large group panel discussion where 4 to 6 experts teach our 250 first-year ILCE students. Next, students break into small groups of 15 to 18 students, where approximately 20 community experts partnered with 20 interdisciplinary faculty members with vested interest in social justice to cofacilitate a more intimate educational setting. Community experts were paid a total of $278 for their participation. Also, although beyond the scope of this article, other DePART grant activities include conducting a community expert needs assessment using qualitative methods and focus groups, and then using the results of that needs assessment to develop a patient bill of rights and clinical care pathway for the Yale-New Haven Hospital. Interdisciplinary students were invited to become a member of the DePART team through word of mouth and during the ILCE event itself, which includes attending WAMI's annual gala, conducting focus groups at halfway houses, and authoring this and future papers.

As the community experts, healthcare students, and faculty involved in the DePART Initiative, we are collectively detailing our perspectives about why we believe that experiential learning featuring community experts with lived expertise of incarceration is best to meet the needs of healthcare students to provide humanistic care to incarcerated individuals in hospital settings. We choose to focus on experiential learning because, as suggested by Kolb's Experiential Learning Theory, it is a dynamic process that is uniquely poised to humanize medical education.[14] Together we state that recognizing the humanity of individuals with carceral involvement precedes the ability to provide ethical and equitable healthcare.

Community expert experience

As two formerly incarcerated women, we—Dr Tiheba Bain, founder of WAMI, and Monya Saunders, community health worker at Yale's SEICHE Center for Health and Justice—offer these firsthand observations about what healthcare students need to learn directly from our community to best advocate for our needs.

Recognize that healthcare systems perpetuate harm

You are an "inmate first, never human," a correctional officer told us in prison. His statement reflects the pervasive dehumanization that people endure in the American carceral system. One might expect clinicians caring for people within prisons and jails, emergency rooms, mental health clinics, birthing centers, and operating rooms to be a respite from unjust treatment. However, they are often complicit, if not perpetrators, of this same dehumanization. We have endured doctors, nurses, physician assistants, and more to deny our concerns and wield their authority to exert control and cruelty. We have heard expressions of suicidal thoughts dismissed as shelter-seeking, pleas for pain relief dismissed as drug-seeking, people giving birth shackled to beds during labor, and cancer patients chained to beds for months-long inpatient chemotherapy. Such dehumanization has far-reaching consequences for the individuals directly affected and for society as a whole. Faculty and trainees must recognize that by treating patients as inmates devoid of dignity and respect, healthcare providers perpetuate a cycle of suffering and neglect that promotes disparate outcomes.

A common yet egregious cruelty occurs when health professionals weaponize their unqualified fear to justify hospital police or security involvement, including the excessive use of physical restraints. Despite holding greater positions of power, health professionals often claim to feel threatened by those of us whose lives are under constant control. This distortion obscures the reality that incarcerated individuals are often the most vulnerable people in medical settings. Instead, this warped perspective positions the powerless as powerful. It perpetuates harmful stereotypes against us—such as being the "dangerous prisoner," out of control, violent, and less than human. Especially when psychiatric diagnoses and behavioral emergencies are involved, this uncontrolled fear subjects us to being forcibly restrained using handcuffs, hospital restraints, or chemical injections.

Center lived expertise and experiential learning in health education

This health injustice requires an urgent response. The medical establishment, however, cannot "fix us without us." As the ones closest to the problem, we are closest to the solutions. Currently, however, educational institutions too often favor deficit frameworks; they relegate us as passive subjects needing medical saviors. If educational institutions are committed to justice, they must honor people with carceral involvement as experts in our own lives. Our insights are born of real-world

experiences and authentic struggles. They are invaluable for understanding the complexities of receiving healthcare while incarcerated.

Thus, for all the reasons expressed above, we believe that experiential learning taught directly by those who have endured harm is the best tool for interdisciplinary healthcare students to learn to care for the comprehensive well-being of incarcerated patients. Educational institutions intent on addressing the dehumanization of people in carceral care should commit to shared leadership and coteaching in educational spaces. That is, those with lived experience should be actively involved teaching directly in the classroom and shaping curricula alongside clinicians and academics. We know what we need, and we have the expertise to guide the way. For example, Dr Bain led work at the state to pass Connecticut S.B.13, which is an antishackling mandate pertaining to incarcerated women giving birth.[15] Only we can bring this community-led policy work to the table. We, the two lead authors, cannot speak on behalf of all incarcerated people. Moreover, the sociopolitical climate of mass incarceration reasonably changes from state to state, city to city, or even community to community. Therefore, we encourage each teaching institution to invest the effort to build genuine, trustworthy relationships with their local community experts with lived expertise of incarceration. These partnerships facilitate the best understanding of each community's context and allow building reciprocal relationships based on shared power, rather than tokenization.

The Yale DePART Initiative embodies the critical importance of experiential learning to undo inequities facing incarcerated patients' physical and mental well-being. It featured numerous small-group sessions of students taught directly by a community member with lived expertise of incarceration. We just completed our second annual event, and we hope to continue this work past the grant's official end in 2025. Students listened to our stories in our own voices on our own terms. It is imperative, however, that bidirectionality becomes incorporated into this educational format. When we share our narratives, it is our invitation to you, the learners, into our lives. This is a radical act of vulnerability. It can be a painful and potentially retriggering experience. This risk may, however, be mitigated through reciprocity, where faculty and students alike are also prepared to partake through their own expressions of vulnerability. We want to know your stories and your motivation for being involved in this work, too. Through this bidirectional vulnerability, we can forge a bridge of empathy together that helps providers see us as humans rather than objects to be feared.

Student experience

As called upon by our community expert coauthors, to effectively advocate for humanized care for incarcerated patients with dignity and respect, we—as health professional students (CM, ES, CB, AA, TH)—report the following curricular and mentorship needs from our educational institutions.

Orient students to critically interrogate clinical power dynamics

To advocate for the physical and mental well-being of incarcerated patients, we must first be able to critically interrogate the power dynamics within clinical encounters that create and sustain their dehumanized treatment. No one can detect abuses of power better than those experiencing the harm. Thus, beyond faculty educators, we desire to receive clinical education about incarcerated patients directly from impacted members of society.

Medicine's core ethical virtues allege universal standards guiding care among all populations. Yet, we are struck by disconnect between our espoused values and what we sometimes observe: incarcerated patients consistently receive unequal treatment from a health system composed of presumably well-meaning, bias-informed providers. This dehumanization highlights a central issue in the way medicine approaches "health equity." Though boldly proclaiming commitment to justice, health providers fail to recognize our power to function as an oppressor whose actions refute the personhood of another. We acknowledge disparate, preventable outcomes while negating our individual and collective roles in creating or sustaining those outcomes. Instead, we believe we must reorient our professional obligations with an understanding of our capacity to cause harm. Also, we must redefine what harm means to enable us to realize our shared vision of health justice. Those with the lived expertise are the best authors of that new definition.

Recognize that the status quo fails students and incarcerated patients

The status quo of most current medical education models tends to simply describe disparate outcomes through statistics and to place students on clinical rotations where they witness dehumanizing care as standard practice. For example, students on psychiatry rotations may witness defensive, fearful reactions from staff in response to a patient with a carceral history, and this fear precipitates disproportionate use of physical and chemical sedation. Students' passive exposure to demeaning healthcare further dehumanizes incarcerated communities. Before giving students the knowledge and skills to improve the physical or mental health outcomes of individuals impacted by incarceration, the current reality must be accepted by our educators and our fellow students: through either negligence or deliberate actions, healthcare practitioners and students often fail to uphold the fundamental principle of "do no harm" when caring for persons experiencing incarceration.

Empower students with skills to intervene upon injustice

We assert that equitable care honoring our professional standards cannot be provided under current systems of oppression. For example, even if we recognize the injustice, we cannot provide ethical care to a patient giving birth while shackled to the bed, and we cannot deny the psychological harm inflicted upon that parent and child. During our medical education event, we heard firsthand narrations from community experts who have endured police presence during gynecological procedures, being forcibly restrained, and being subjected to a bedside surgical procedure without anesthesia. Our lived experts all decried how these experiences of discrimination directly perpetrated unmet health needs as they coped with discrimination. These stories redefined how we understand our professional credo. Doing good, preventing harm, and acting with fidelity require us to honor the central notion of human dignity.

In addition to interrogating clinical power dynamics and recognizing systems failures, educational institutions must empower students with advocacy skills and standardized operating procedures that students can leverage during real-time health injustice. Indeed, one goal of Yale's DePART grant is to create a clinical care pathway that guides clinicians caring for incarcerated patients, including establishing patient-centered boundaries with correctional officers, antishackling policies, and discharge and follow-up guidelines. These are tools that students can learn from across the country and be empowered by as well.

Center pedagogical approaches on lived expertise

Though much of our medical education focuses on "problems" or "cases," with the patient as a passive subject of our learning, we believe that educational material on caring for people with experience of incarceration must meaningfully engage people with lived expertise through experiential learning and patient educators.[16] Beyond the ILCE day, at WAMI's 2023 gala, we witnessed people with carceral histories function in a social context where they were the standard, not the minoritized. At one point, audience members who experienced incarceration were asked to stand. Together, they represented over 200 years lost to incarceration—a demonstration that gave names and faces to the depersonalized statistics presented in traditional class settings. At meetings in local halfway houses, we engaged the community on the community's terms. Therefore, we call upon our teaching institutions to transfer power and resources directly to impacted communities for invaluable learning to occur on the community's turf, something most academics are not accustomed to and where health professional learning is rarely based.

Faculty educators should pair experiential opportunities with structured learning about emotional intelligence and processing. The education default is currently to merely become aware of one's problematic attitudes towards a minoritized group. However, recognizing bias without processing it risks projection, particularly within stressed clinical environments prompting us to rely on cognitive shortcuts. Our educational institutions must provide students with real-time skills and structural resources to process emotions so that we can translate recognition to behavioral change.

Faculty experience

As medical educators (LP, SOJ, CGB), creating curricula and opportunities for health professional learners to see the humanity in the myriad patients they will serve fosters the achievement of core professional competencies including professionalism, empathy, and ethical practice. Engaging with community members in creating these curricula, and demonstrating humanism in action, can be enriching and synergistic. Failure to do so perpetuates the curricular status quo which compounds into inequitable outcomes through a kaleidoscope of pathways —justifiable mistrust of physicians, reluctance to seek care at local healthcare systems, intergenerational medical and racial trauma, among others.

Using our authority to transfer power to and respect the dignity of marginalized populations is our highest calling as medical educators. Indeed, faculty participation in community activism is how DePART first began. Our senior author, Dr Black, first met Dr Bain and heard about her organization, WAMI, while educating the public about psychiatry's past involvement in reproductive injustice at a community activism event for reproductive rights. Thus, DePART began with engaging the community on the community's terms in community settings. When faculty discovered a call for applications for justice-oriented student education, we knew we had to continue our service to the greater New Haven area. We sought to replicate and maintain community empowerment as we brought them onto Yale's campus as experts who held knowledge that we, the academy, had the responsibility to learn. We endeavored to maintain the empowerment of our community experts by (1) welcoming community-driven dialogue during small groups by having no preconceived topics we wanted them to cover; (2) welcoming them to freely share their experiences in whatever vernacular felt natural, without a need to "be professional" or "code-switch," (3) being intentional about referring to them with the honorific title of "expert" in front of students, and (4) leaning into moments when community experts had new or opposing ideas to those held by faculty members, as a role model of ceding power to the true knowers of minoritized knowledge. These types of transference of power into impacted members' hands are perhaps the greatest form of faculty advocacy.

Conclusion

By sharing humanity and building relationships directly with community experts, we believe that future clinicians can

better transcend the status quo of dehumanization and substandard care for people with histories of incarceration. Therefore, we call upon health educators and academic institutions to provide early, interdisciplinary, experiential learning opportunities. The future clinicians receiving this education may bring these experiences into their residency training and clinical care, thereby improving the system from the bottom up. Most importantly, as we have presented, these learning opportunities must invite people with lived experience of incarceration to directly teach health professional students in ways that allow authenticity, transfer of power, and reciprocal vulnerability.

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Author Contributions

All listed authors were involved in the writing of the original draft, reviewing, and editing. CB, LP, and SOJ provided conceptualization, acquisition of grant funding, and supervision.

Ethics

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REFERENCES

1. Bureau of Justice Statistics. "Preliminary Data Release - Prisons (2022)," Sept. 2023, bjs.ojp.gov: https://bjs.ojp.gov/preliminary-data-release-prisons.
2. Bureau of Justice Statistics. "Preliminary Data Release - Jails (2023)," June 2024, bjs.ojp.gov: https://bjs.ojp.gov/preliminary-data-release-jails-2023.
3. Sawyer W, Wagner P. "Mass Incarceration: The Whole Pie 2024". *Prison Policy Initiative*. 2024. Accessed October 1, 2024. https://www.prisonpolicy.org/reports/pie2024.html
4. Wildeman C, Wang EA. Mass incarceration, public health, and widening inequality in the USA. *Lancet*. 2017;389(10077):1464-1474.
5. "Mental Health Treatment While Incarcerated." National Alliance on Mental Illness (NAMI). 2023. Accessed June 29, 2024. https://www.nami.org/advocacy/policy-priorities/improving-health/mental-health-treatment-while-incarcerated/.
6. Armstrong RE, Hendershot KA, Newton NP, Panakos PD. Addressing emergency department care for patients experiencing incarceration: a narrative review. *West J Emerg Med*. 2023;24(4):654-661.
7. Higgins EM, Smith J, Swartz K. "We keep the nightmares in their cages": correctional culture, identity, and the warped badge of honor*. *Criminology*. 2022;60(3):429-454.
8. Parker CB. Psychiatric emergencies in nonpsychiatric settings: perception precludes preparedness. *Psychosomatics*. 2019;60(4):352-360.
9. Black C, Calhoun A. How biased and carceral responses to persons with mental illness in acute medical care settings constitute iatrogenic Harms. *AMA J Ethics*. 2022;24(8):E781-E787.
10. Parker CB, Calhoun A, Wong AH, Davidson L, Dike C. A call for behavioral emergency response teams in inpatient hospital settings. *AMA J Ethics*. 2020;22(11):E956-E964.
11. Douglas AD, Zaidi MY, Maatman TK, Choi JN, Meagher AD. Caring for incarcerated patients: can it ever be equal? *J Surg Educ*. 2021;78(6):e154-e160.
12. 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.
13. Simon L, Tobey M. A national survey of medical school curricula on criminal justice and health. *J Correct Health Care*. 2019;25(1):37-44.
14. Senok A, John-Baptiste A-M, Al Heialy S, Naidoo N, Otaki F, Davis D. Leveraging the added value of experiential co-curricular programs to humanize medical education. *J Exp Educ*. 2022;45(2):172-190. doi:10.1177/10538259211021444
15. American Civil Liberties Union (ACLU) of Connecticut. *S.B. 13, An Act Concerning Fair Treatment of Incarcerated Women*. American Civil Liberties Union (ACLU) of Connecticut; 2018. Accessed June 29, 2024. https://www.acluct.org/en/legislation/sb-13-act-concerning-fair-treatment-incarcerated-women.
16. Rees CE, Knight LV, Wilkinson CE. User involvement is a sine qua non, almost, in medical education": learning with rather than just about health and social care service users. *Adv Health Sci Educ Theory Pract*. 2007;12:359-390. https://doi.org/10.1007/s10459-006-9007-5.