Does behind bars mean beyond reach?

How the paucity of discourse about medical care of people who are incarcerated propagates systemic discrimination and institutional racism in Canada

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Over the past several years, social accountability has woven its way into the missions and values of medical organizations across Canada, yet persons who are incarcerated continue to find themselves in the shadows of society. Thus, they remain invisible to the lens of 'social' accountability. Inequitable incarceration rates are widely recognized as downstream effects of disparities in social determinants of health including race, socioeconomic status, and education.[1-4] However, concerted efforts directed at training medical learners to provide competent and compassionate care to this marginalized population is profoundly lacking. By allowing implicit bias to permeate into medical education and stifle discourse we are failing to recognize and address the profound systemic discrimination that dissolves the health of some of our most vulnerable patients.

Implicit bias is not a failing of character, but rather an evolutionary adaptation developed to assist humans in the interpretation of complex data streams.[5] It works beyond an individual's awareness, without their knowledge, and despite their values or best intentions.[5] Unfortunately, these very characteristics allow implicit bias to impact the provision of care, perpetuate health disparities, and cause significant harm to marginalized populations.[5] In the Canadian context, these patient populations often include people of colour and people of Indigenous ancestry - both of whom are critically overrepresented in the Canadian prison population.[1,2,6,7]

Correctional Service Canada reports trends and key figures regarding persons serving federal sentences. Their most recent reports concern the 2018 population of 23,223 federally incarcerated persons.[6,7] To put this number into perspective, if all of these incarcerated persons were to attend a Maple Leafs game at the Scotiabank Arena in Toronto, they would fill the arena seats and still have enough to fill one quarter again.[8] Despite making up only 4% of the general Canadian population, 27% of incarcerated persons in 2018 were Indigenous.7 This number increased by over 17% over the preceding 5 years, while the proportion of Caucasian inmates decreased by 4% in the same time period.[7] Even more shockingly, 40% of women who were incarcerated during this time were Indigenous.[7]

Indigenous peoples and people of colour are more heavily policed and generally face heftier burdens relating to social determinants of health.[1,2] Indigenous populations in particular are more likely than the general population to experience numerous chronic conditions including heart disease, diabetes, and hypertension.[2] Compounding these health disparities with overcrowding, poor ventilation, decreased hygiene, increasingly limited healthcare access and other endemic phenomena that continue to plague prisons produces a storm of inequitable disease burden and negative health outcomes. While this vulnerability has been apparent for some time, especially with respect to communicable diseases, it has become blatantly evident throughout the COVID-19 pandemic.[1,2] For instance, even the most basic protective measure of physical distancing is complex within prison walls and is often difficult to implement without impinging on human rights.[2]

Yet, despite the profound intersectionality of oppressions and care needs there is a paucity of prison-oriented training available to medical learners. The Association of Faculties of Medicine of Canada is deemed the "voice of academic medicine in Canada", yet a search of their 2019-2020 annual report returns exactly zero matches for any of: "prison", "incarceration", "inmate", or "corrections".[9] However, inclusivity is listed as one of three core values, and the mission strives to "achieve excellence in education, research and care for the health of all Canadians."[9]

The College of Family Physicians of Canada released a position statement in 2016 which stated: "All provincially sentenced, and almost all federally sentenced, individuals eventually return to the community. Therefore, the

health of a country's prison population is intrinsic to the physical, mental, and social health of a country's general population. International studies support at least four compelling reasons to improve the health of this population: human rights and equivalence, public safety, public health, and economics."[10] Though these assertions remain true today, it is unclear what progress has come from this position statement in the realm of medical training.

As family physicians we are experts in the impact of social determinants and relationships on the health and wellbeing of our patients. Our guiding principles, and I would argue our very nature, dictate that we "consider the effects of health, illness, and adverse life events on the person as an individual and as part of a family and community."[11] While social distancing has been key during the COVID-19 pandemic, the perpetual social, cognitive and moral distancing of medical training from incarcerated persons highlights pervasive structural discrimination and institutional racism that is in direct contradiction to these principles.[3] We must make ourselves aware of both personal and institutional biases, reflect on how these are propagated by the silence created from a paucity of medical training aimed at caring for persons who are incarcerated, and deliberate on how we can come together to effectively tackle this pressing health inequity.

We family physicians strive to exemplify our Hippocratic Oath, remaining "a member of society, with special obligations to all of [our] fellow human beings." Now, more than ever, it is time to act to ensure that incarcerated persons are treated as human beings - deserving of our attention and compassionate care. We must take action to dismantle the stigmatization of this medically complex and often neglected population that has historically suffered deeply at the hands of the medical profession and society at large. It is only in embracing society in its entirety that we can strive toward true social accountability.

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